## How this webinar is organized

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00pm</td>
<td>Welcome and Introductions</td>
</tr>
<tr>
<td>2:10pm - 2:50pm</td>
<td>Improving AMI Care</td>
</tr>
<tr>
<td></td>
<td>Kingman Regional Medical Center</td>
</tr>
<tr>
<td></td>
<td>Kingman, AZ</td>
</tr>
<tr>
<td></td>
<td>Dartmouth-Hitchcock</td>
</tr>
<tr>
<td></td>
<td>Lebanon, NH</td>
</tr>
<tr>
<td></td>
<td>Billings Clinic</td>
</tr>
<tr>
<td></td>
<td>Billings, MT</td>
</tr>
<tr>
<td>2:50pm</td>
<td>Q&amp;A</td>
</tr>
<tr>
<td>2:57pm</td>
<td>Wrap-up and Next Steps</td>
</tr>
</tbody>
</table>
Improving Organizational Culture and AMI Outcomes

1. Established evidence base

2. Disseminated via two approaches
   - Surviving MI: American College of Cardiology
   - Leadership Saves Lives: Mayo Clinic Care Network

3. Integrate efforts
   - Distil and package LSL lessons and tools for broader audiences

Surviving MI: Leadership Saves Lives
Kingman Regional Medical Center
Kingman Regional Medical Center

- 235 Beds
- Independent, not for profit health system
- Member of Mayo Clinic Care Network
- Teaching Hospital – Family Practice & ER
- 8700 admissions
- 53,000 ER visits
- 417,000 outpatient visits
- 1900 employees
- 270 physicians on staff

Service Area

Primary Service Area – Approximately 75,000 people
- Disproportionate number of elderly and poor when compared to national demographics
- Some communities are over 60 miles from the hospital

Payer Mix:
- 57% Medicare
- 22% Medicaid
- 18% Commercial
- 3% Self Pay

Mohave County, Arizona
KRMC Service Area
Mission and Vision

Kingman Regional Medical Center Mission
Serving our community with compassion and commitment.

Our Vision
To provide the region’s best clinical care and patient service through an environment that fosters respect for others and pride in performance.

Problem and Objective

• The problem is AMI mortality is too high

• Our objective is:
  • Reduce in hospital AMI mortality rate, not risk adjusted by 50% of baseline by June 2016.
  • Reduce risk standardized AMI mortality rate by 15% of the National Average by June 2016.
Our Journey

Guiding Coalition Formation August 2014
• Initial group > 20 members
• Initial Objective: Not S.M.A.R.T.

Root Causes Identified:
• Timeliness of EKGs
• Pathways, Protocols and Guidelines
• Discharge Process

Our Journey

Strategies Selected:
1. Partnership with EMS
2. Organizational culture that supports creative problem solving
3. Physician and nurse champion for AMI care
4. Nurses consistently assigned to the Cardiac Catheterization Laboratory
Our Journey

• The team initially looked perfect, but had internal struggles. We were too big and we had silos. We were making individual contributions, but not functioning as a team.

• We were “Transactiona” leaders, but were not “Transformational” leaders.

Our Journey

• CEO Visits Guiding Coalition Meeting March 2015
  “Our vision is to provide the regions best clinical care and patient service through an environment that fosters respect for others and pride in performance.”
  
  ▪ Our results did not match our vision.
Our Journey

With a renewed sense of urgency, we:
- Reconnected to our vision.
- Our Guiding Coalition was re-defined and downsized.
- Re-defined our objective, making it S.M.A.R.T
- Empowered front line staff to support creative problem solving and process improvement.
- Began making more “transformations” than “transactions”.
- Stopped frequent meetings!

Our Journey: Evidence of Creative Problem Solving

- Implemented “Nurse First”
- Trained ED CNA staff to perform EKGs
- Created space in our ED to obtain EKGs
- Synchronized Clocks
- Created “Stemi Boxes”
- Created AMI order Set

- Improved Pt. Education at Discharge
- Pharmacist rounding on all AMI patients from Cath Lab
- Improved Compliance with PCI in 90 minutes
Our Journey

Evidence that we were moving in the right direction

Inspired by our progress, our Guiding Coalition began:

- Regular “drill down” on all AMI mortalities as well as PCI in 90 minute fallouts.
- Checked patient status:
  - Admission vs. Observation
  - Post Procedure in a bed
- Checked/Validated Coding
- Problems were noted, but with the collective efforts of the team issues were identified and addressed.
Percutaneous Coronary Intervention (PCI)
Door to Balloon Time

Percent of Patients with Door to Balloon time of <90 minutes

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2016 Target</td>
<td>95%</td>
</tr>
<tr>
<td>FY 2015</td>
<td>84.6%</td>
</tr>
<tr>
<td>FY 2016</td>
<td>93.4%</td>
</tr>
<tr>
<td>FY 2017 (through January)</td>
<td>100%</td>
</tr>
</tbody>
</table>

Our Results

AMI Mortality Rate

November 2014

- Sept. 2014-Feb. 2015: 6.38%
- Mar. 2015-Sept. 2015: 4.31%
- Oct. 2015-Mar. 2016: 3.97%
- Apr. 2016-Sept. 2016: 6.38%
Our Results

AMI Mortality Rate
Excluding Open Heart Program Patients

<table>
<thead>
<tr>
<th>Month</th>
<th>Baseline</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 2014-Feb. 2015</td>
<td>6.38%</td>
<td>3.45%</td>
</tr>
<tr>
<td>Mar. 2015-Sept. 2015</td>
<td>6.38%</td>
<td>2.68%</td>
</tr>
<tr>
<td>Oct. 2015-Mar. 2016</td>
<td>6.38%</td>
<td>5.73%</td>
</tr>
<tr>
<td>Apr. 2016-Sept. 2016</td>
<td>6.38%</td>
<td>2.53%</td>
</tr>
<tr>
<td>Oct. 2016-Feb. 2017</td>
<td>6.38%</td>
<td>6.54%</td>
</tr>
</tbody>
</table>

Our Change Process

1. Pull together a team to drive the change
2. Define a S.M.A.R.T. goal
3. Create the Vision
4. Instill a sense of urgency
5. Empower staff to preform / utilize creative problem solving
6. Engage direct care staff – “Our Staff Save Lives”
7. Link efforts to outcomes
8. Reward short term wins
9. Communicate. Don’t fall back, and never let up!
Reducing Mortality in Acute Myocardial Infarction
Dartmouth-Hitchcock LSL Journey

Dartmouth-Hitchcock is a non-profit academic health system in Lebanon, NH serving communities in northern New England. 396 licensed beds and has more than 27,000 discharges and close to 31,000 Emergency Department visits annually. Member of the Mayo Clinic Care Network

Nathaniel W. Niles, MD
Sheila M. Conley, BSN, RN

Surviving MI
AN ACC QUALITY INITIATIVE

LEADERSHIP SAVES LIVES
Initial Action Steps

• Recruit a multi-disciplinary “Guiding Coalition” at DHMC

• Learned about what AMI mortality (STEMI vs NSTEMI) looks like here at DHMC
Finding More Strategies

*Root Cause Analysis = Mortality Chart Review*

- Researched and designed Chart Review tool
  - Modeled after Mayo Clinic tool
    - Focuses reviewer on judging Preventable, Possibly Preventable and Not Preventable in hospital mortality
  - 11 domains of contributory issues
  - Tool placed on line (REDCap) for easy access

- Forty-three deaths in the ≥ 65 years age group reviewed (2 years period ending Dec 2014)
  - 43 reviewed by MD and RN
  - 43 reviewed by 2nd MD to de-conflict ratings/opinions
# AMI Mortality Chart Review

<table>
<thead>
<tr>
<th>&quot;Discharge&quot; Diagnosis</th>
<th>STEMI</th>
<th>NSTEMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%)</td>
<td>17 (40%)</td>
<td>26 (60%)</td>
</tr>
<tr>
<td>Age</td>
<td>78.8</td>
<td>79.4</td>
</tr>
<tr>
<td>Female Gender</td>
<td>25%</td>
<td>37%</td>
</tr>
<tr>
<td>Admitted to Cardiology</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>Mean TIMI risk score</td>
<td>7.9 (max 14)</td>
<td>5.1 (max 7)</td>
</tr>
<tr>
<td>Mean Risk</td>
<td>26% 30 day mortality</td>
<td>26% death, re-MI, recurrent ischemia, urgent revasc.</td>
</tr>
<tr>
<td>Initial code status DNR</td>
<td>50%</td>
<td>11%</td>
</tr>
<tr>
<td>Cath performed</td>
<td>70%</td>
<td>65%</td>
</tr>
<tr>
<td>PCI attempted</td>
<td>55%</td>
<td>22%</td>
</tr>
<tr>
<td>Cardiogenic shock</td>
<td>62.5 %</td>
<td>55.5%</td>
</tr>
<tr>
<td>Death within 48 hours</td>
<td>62.5%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

## Root Cause Analysis (n=43)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Patients</th>
<th>Ongoing effort to address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Preventable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggressive care – Death not preventable</td>
<td>18</td>
<td>NA</td>
</tr>
<tr>
<td>Patient/Family did not wish aggressive care</td>
<td>7</td>
<td>✓</td>
</tr>
<tr>
<td>Definitely Preventable</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Possibly Preventable</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>STEMI with Cath lab Complication</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>STEMI with iatrogenic infection</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>STEMI with poor communication with referring hospital</td>
<td>2</td>
<td>✓</td>
</tr>
<tr>
<td>NSTEMI with Cath lab Complication</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>NSTEMI -- Missed STEMI/Delay in revascularization</td>
<td>2</td>
<td>Opportunity?</td>
</tr>
<tr>
<td>NSTEMI with delay in initial evaluation, timely re-evaluation</td>
<td>2</td>
<td>Opportunity?</td>
</tr>
<tr>
<td>NSTEMI with Suboptimal Hospitalist/Cardiology fellow supervision/communication</td>
<td>2</td>
<td>Opportunity?</td>
</tr>
<tr>
<td>NSTEMI with Delay in Catheterization</td>
<td>1</td>
<td>Opportunity?</td>
</tr>
<tr>
<td>NSTEMI with Delay in ECHO</td>
<td>2</td>
<td>Opportunity?</td>
</tr>
<tr>
<td>NSTEMI with delay in CT surgery evaluation</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>NSTEMI with CABG Complication/failure to wean from pump</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>Coding Error (not AMI)</td>
<td>2</td>
<td>Opportunity?</td>
</tr>
</tbody>
</table>
Timing of Development of Critical Illness

<table>
<thead>
<tr>
<th>Admit Dx</th>
<th>Pre hospital</th>
<th>ED</th>
<th>ICCU/CVCC (pre cath)</th>
<th>Cath Lab</th>
<th>Post Cath</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEMI (n=17)</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>NSTEMI (n=26)</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Can we shorten or eliminate the time NSTEMI patients spend in ICCU/CVCC waiting for cath?

Can we detect clinical deterioration in ICCU/CVCC at an earlier point in time and intervene before an irreversible deterioration occurs?

Process Maps

STEMI

1. EMS
2. Remote ED
3. Our ED
4. ED
5. Cath Lab
6. CVCC
7. ICCU
8. Discharge
9. 2-6 hours

NSTEMI

1. EMS
2. Remote ED
3. ED
4. CVCC
5. Cath Lab
6. CVCC
7. ICCU
8. Discharge
9. 12-48 hours
Strategies (Focus on NSTEMI)

- Improve pre-transfer triage of NSTEMI patients coming from referral Emergency Departments
- Push NSTEMI process of care toward earlier treatment decision
- Lower the threshold for decision for early invasive evaluation in NSTEMI patients - Recent RIDDLE-NSTEMI randomized trial supports this approach
- Lower the threshold to initiate formal re-evaluation of an admitted patient with an ACS diagnosis and new, recurrent or worsening symptoms

Selected Strategy #1
NSTEMI Process of Care Proposal

- All NSTEMI transfers have ECGs screened by cardiology attending at the time of the transfer request
- Define “At Risk” NSTEMI Patients
  - Refractory angina or resting/low threshold angina despite medical management
  - Grace Score >140
  - New or presumed new ST depressions on ECG
  - Significantly increasing temporal troponin pattern (>20%)
  - Signs or symptoms of Heart Failure
  - Hemodynamic instability
  - VT or VF
- All “At Risk” NSTEMI transfers verbally presented to attending as part of initial evaluation
- All “At Risk” NSTEMIs have echo evaluation for LV function assessment as part of the initial evaluation
NSTEMI Process of Care Proposal

Implementation Experience

- Cardiology attending physician push back
  - Change = bad
  - Evidence is anecdotal
  - Perceived negative impact on ‘work-life’ balance
- Routine early echo ‘not feasible’
- With support of section leadership and some compromise → successful implementation
- Focused education on: house staff:
  - hospitalist night coverage
  - associate providers
  - cardiology fellows
  - cardiology triage nurse (accepting transfers)
- Gradual acceptance of “at risk” status as criteria for acceptance for immediate transfer from referring hospitals

Changing Behaviors
Selected Strategy #2
“ACS Patient in Distress Protocol”

- Goal: To identify clinical deterioration of admitted, non-ICU ACS patient and speed up the provider response and evaluation
- Completed best practices process mapping for patient admitted with ACS patient with suspected recurrent or ongoing ischemia
- Redo the “Chest Pain Protocol” to encompass more varied and atypical symptoms and signs of ischemia (SOB, nausea, general malaise, dizziness with hypotension, palpitations/tachycardia)
  - all nurses on floor trained to perform ECGs
  - nurse driven protocol

Strategy #2
Implementation Experience

- Pre-work was comprehensive with nursing leadership
- Protocol/proposals were well thought out and well designed
- Senior nursing leadership support was strong
- User group chosen carefully
  - Enthusiastic reception by cardiac nurses
  - Empowerment to initiate protocol
  - New skill training (ECG)
**Patient Identification**

- Unique ID: __________
- Onset of symptoms: __________
- Patient report of symptoms: __________
- Date: __________
- Time: __________ HH:MM (24 HR)

**Bundle Inclusion Criteria**

- Chest pain or discomfort (retro-sternal, jaw, neck, arm, back)
- Chest pressure or tightness, altered color, sweating, lightheadedness
- "Heartburn" (epigastric pain or persistent nausea)
- Known anginal equivalent or patient report of anginal equivalent (or other symptoms suspicious for ischemia)
- New or sudden change in HR (greater than 100 or less than 50 or symptomatic arrhythmia)
- Syncope or severe weakness (pre-syncope associated with SBP less than 90)
- SOB/dyspnea with no obvious non-cardiac cause with decreasing PO2 with increasing FiO2

**Patient Demographics and Physiologic Information**

<table>
<thead>
<tr>
<th>Height(cm)</th>
<th>Age</th>
<th>HR</th>
<th>Rhythm</th>
<th>Weight(kg)</th>
<th>SpO2</th>
<th>BP</th>
<th>MAP</th>
</tr>
</thead>
</table>

**Bundle Start Time ("Time Zero")**

- Date: __________
- Time: __________ HH:MM (24 HR)

**Bundle Non Adherence?**

- STEMI or not STEMI
- STEMI Alert called by cardiology fellow
- Patient transferred to cath lab
- Other (please explain): ________________________________

**With Provider Order**

- ECG Complete
  - Date: __________ hh:mm (24 HR)
  - Time: __________ mm/dd/yy
- Labs if ordered
  - Start Time: __________ hh:mm (24 HR)
  - Start Date: __________ mm/dd/yy
- Oxygen Administration for SpO2 less than 92%
  - O2 delivered: __________ lpm
  - O2 delivery method: __________

**ACS Patient in Distress Pilot**

- 12 week period in Intermediate Coronary Care Unit (ICCU)
- ~750 Discharges in that period
- Protocol initiated in 69 patients (~9.2%)

**Results**

- Median time to ECG = 5 min (79% obtained within 10 min of symptom onset)
- Median time to Provider at bedside = 9 min.
- Troponin triggered in 39 of 69 (57%)  
- Troponin (converted to positive or increased by 20%) in 14 of 39 (36%)
- Emergent cath triggered 7/69 (10.1%)
- Acute STEMI 1/69 (1.4%)
Ongoing Work – Maintain the Gain

- The coalition continues to meet monthly to assure focus on AMI mortality
- Concurrent mortality review with verbal feedback to care team to identify potentially preventable events
- “Dashboard” Creation = using the EMR to track strategy implementation and outcomes

DHMC AMI In-Hospital Mortality
(Apr ’11 - Nov ’16)

- # of CMS AMI Cases ≥ 65yrs (2 month moving average)
- Mortality AMI Cases ≥ 65yrs (2 month moving average)
DHMC AMI In-Hospital Mortality
(Apr '11 - Nov '16)

- DHMC Monthly AMI Cases: 29 (Apr '11) to 32 (Nov '16)
- 30 Day AMI RSMR From CMS: 12.3% (Apr '11) to 11.6% (Nov '16)
- ≥65 yr AMI In-hospital Mortality: 7.2% (Apr '11) to 6.0% (Nov '16)
- Overall AMI Mortality: 4.0% (Apr '11) to 4.0% (Nov '16)

Thank you!
Questions?

Contact info: sheila.m.conley@hitchcock.org
Improving AMI Mortality Through Cultural Change

Our Champions Led the Charge

Date: April 24, 2017
Regional work raised awareness of AMI care

Awarded Innovation in Health Care for our regional work with LSL September 2015

Montana PCI Centers

- 9 Total PCI Centers
- 8 Provide 24/7 Coverage
- 2 in Missoula
- 2 in Billings

Legend:
24/7 PCI
Billings Clinic provides AMI coverage for ~ 105,000 square miles in our region

Wyoming

4 Total PCI Centers
3 Provide 24/7 Coverage
AMI STEMIs and Transfers

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Total AMI's</th>
<th>Total STEMI</th>
<th>Total NSTEMI</th>
<th>Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>329</td>
<td>126</td>
<td>203</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60% transfers</td>
</tr>
<tr>
<td>2015</td>
<td>364</td>
<td>87</td>
<td>277</td>
<td>199</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>55% transfers</td>
</tr>
<tr>
<td>2016</td>
<td>359</td>
<td>109</td>
<td>250</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60% transfers</td>
</tr>
</tbody>
</table>

Health Care, Education and Research
Date: 9/21-9/23/15  Gender: 75 y/o Male

**Health Care, Education and Research**

*Chief Complaint/Diagnosis:* Acute onset chest/back pain, diaphoresis and indigestion 1 ½ hours prior to ED arrival/

**Acute Inferior ST Elevation MI**

---

**Referral Hospital:** XXX
**Transport Agency:** Ground ALS

---

**ECG post PCI to RCA**

---

**Chest Syncope:** Upon arrival at Billings Clinic, patient taken directly to cath lab emergently due to continued chest pain post thrombolytic administration. Left heart cath demonstrated a critical subtotal occlusion of the distal portion of the RCA prior to the posterior descending and posterolateral branches. First attempts for reperfusion were unavailing due to occluded tortuous lesion, and was ultimately intervened via implantation and placement of a drug-eluting stent. Patient remained in LCU immediately post procedure and transitioned to ICU the following morning. Echo on 9/22 demonstrated an EF 55-58% with no evidence of wall motion abnormalities and normal systolic function. Troponin I levels distant was noted alongside a mildly elevated cardiac. He was discharged home on day 4 in stable condition with a cardiac regimen of beta-blockers, 90 mg twice daily x 1 year, aspirin 81 mg daily indefinitely, metoprolol tartrate 2.5 mg twice daily, HCTZ 12.5 mg daily and pravastatin 40 mg at bedtime. Will follow up with cardiology in 2-3 months and enroll in cardiac rehab.

---

**Provider Champions were instrumental in our successes**

---

**Health Care, Education and Research**

---

26
Previous patient education prior to *My Heart and I* for all AMI/PCI patients

*My Heart and I*
Measuring Progress

Upward trend of NSTEMI Cases

<table>
<thead>
<tr>
<th>Year</th>
<th>% NSTEMI</th>
<th>% STEMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2013</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>CY 2014</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>CY 2015</td>
<td>75</td>
<td>25</td>
</tr>
</tbody>
</table>
O/E Ratio Per Year

Leadership Saves Lives AMI
Mortality Observed to Expected Ratio by Month

O/E Ratio < 1 better than expected
O/E Ratio = 1 as expected
O/E Ratio > 1 worse than expected

CY13 20/319 1.19
CY14 10/527 0.70
CY15 16/382 0.76
Jan16-Jul16 6/22 0.82

Source: Quality Advisor

Health Care, Education and Research

CMS AMI 30-Day Mortality

AMI 30-Day Mortality Measure Results

– CMS FY 2018 Hospital VBP Performance Period
– Hospital Discharge Period: Oct 1, 2013 through June 30, 2016
– Billings Clinic AMI performance better than Achievement Threshold and Benchmark
– AMI Predicted Deaths less than Expected Deaths for the Risk-Standardized Mortality Rate
– Billings Clinic AMI survival rate 87.7%
Leadership Saves Lives Team

- Project Manager, Beth Degenhart Director of Cardiology
- Physician Champion, Dr. Brian Rah Chief of Cardiovascular Services
- PA Champion, Erin LaFavor PA
- RN Champion, Carrie Wright, CPC Coordinator
- Clint Seger, MD CMO Regional Services
- Annie Smith, Cardiology Technical Assistant
- Lori Linder, RN Quality Specialist
- Operational Excellence, Tom Bick
- Nick Wolter, CEO
- Laurie Smith, CNO
- Chad Miller, VP Clinic Services
- Bob Merchant, MD CMO Hospital
- Randall Gibb, MD CMO Clinic
- Karen Cabell, DO Assoc. Chief
- Randy Thompson, MD CMIO
- Dave Bunkers, Executive Director Critical Care Services
- Shere Cooney, CVU RN
- Susan Keys, Pharmacists CVU
- Rich Mickelson, Manager Cardiology
- Dania Block Manager CVU
- Rikki Rumph, Clinical Coordinator Emergency Department
- Ellen Edlund, Cath Lab RN
- Karrie Cleveland, Manager Care Management
- Chris Candelaria, Clinical Coordinator Intensive Care Unit
- Micaleen Fulkerson, Emergency Department RN
- Casey Harrod, Exercise Physiologist

References

- Centers for Disease Control and Prevention, Know the Signs and Symptoms of a Heart Attack, retrieved June 16, 2016 from, http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heartattack.htm
- National Cardiovascular Data Registry, Retrieved June 16, 2016 from www.NCDR.com
- Premier Quality Advisor
Thank You

Surviving MI
AN ACC QUALITY INITIATIVE

Please submit your questions for the moderated question and answer session.

SurvivingMI@acc.org
CVQuality.ACC.org/SurvivingMI

The Quality Improvement for Institutions program combines the ACC’s NCDR data registries with toolkits and proven hospital-based quality improvement initiatives like Hospital to Home, the D2B Alliance and Surviving MI.