At the end of this webinar you will...

1. **Understand the benefits of joining the Surviving MI Initiative**
   - Potential cost savings
   - Potential reduction in mortality rates
   - Continuous improvements in hospital culture

2. **Understand program features**
   - Webinars – best practices, lessons learned
   - Email discussions (“listserv”)
   - Community calls – coaching, networking
   - Online assessment – benchmarking reports
   - Online tools and resources
Speaker Bio

Henry H. Ting, MD, MBA, FACC
Senior Vice President and Chief Quality Officer, New York-Presbyterian Hospital, The University Hospital of Columbia and Cornell

Prior to July 2014
- Professor of Medicine
- Associate Dean, Mayo Clinic College of Medicine
- Director, Mayo Clinic Quality Academy

Speaker Bio

MaryAnne Elma, MPH
Director, Quality Improvement Solutions
American College of Cardiology

In her 15 years at the ACC, MaryAnne has led efforts that bring evidence-based medicine into the field with practical solutions using social marketing practices and information design. She oversees a portfolio of QI implementation programs, including the Hospital-to-Home (H2H) Initiative, Surviving MI Initiative, Clinical Tools – and the ACC’s new Quality Improvement for Institutions program.

MaryAnne received her BA from Bucknell University and Masters in Public Health at the Johns Hopkins University School of Public Health.
MI Statistics

New MI
635,000

Recurrent
280,000

Silent
150,000

~1,000,000

AMI 30-Day RSMR

Distribution Of Risk-Standardized Thirty-Day Mortality Rates By Hospitals, For Patients With Heart Attacks

15.2%

2-fold variation in MI mortality rates:
Top decile: 10.1%
Lowest decile: 21.9%

Surviving MI Initiative

15%

Δ 20%

30,000 lives / yr

12%
## Value Based Purchasing

### FY 2013 Program Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Included Measures</th>
<th>Domain Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>• Value-le, Hematocrit, therapy need within 30 mins of hospital arrival&lt;br&gt;• AMI Da, Primary PCI Reo within 90 mins of Hospital Arrival&lt;br&gt;• HF-1, Discharge Instructions&lt;br&gt;• PM-3, Blood Cultures Performed in ED Prior to Initial Antibiotic in Hospital&lt;br&gt;• PM-4, Initial Antibiotic Selection for CAP in Immuocompetent Patient&lt;br&gt;• SCP-INF-1, Prophylactic Antibiotic Reo within 1 hr Prior to Surgical Incision&lt;br&gt;• SCP-INF-2, Prophylactic Antibiotic Selection for Surgical Patients&lt;br&gt;• SCP-INF-3, Prophylactic Antibiotics Discontinued within 24 hrs After Surgery End Time&lt;br&gt;• SCP-INF-4, Cardiac Surgery Patients with Controlled DIA Postoperative Serum Glucose&lt;br&gt;• SCP-Card-2, Surgery Patients on a Beta Blocker Prior to Arrival that Received a Beta Blocker during the Perioperative Period&lt;br&gt;• SCP-VEE-1, Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered&lt;br&gt;• SCP-VEE-2, Surgery Patients who Received Appropriate Venous Thromboembolism Prophylaxis in Mins 24 hrs Prior to Surgery vs. 24 hrs After Surgery.</td>
<td>70%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>8 HOAHSY Items:&lt;br&gt;• Communication with Nurses&lt;br&gt;• Communication with Doctors&lt;br&gt;• Responsiveness of Hospital Staff&lt;br&gt;• Pain Management&lt;br&gt;• Communication about Medicines&lt;br&gt;• Cleanliness and Quietness of the Hospital Environment&lt;br&gt;• Discharge Information&lt;br&gt;• Overall Rating of Hospital</td>
<td>30%</td>
</tr>
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### FY 2014 Program Measures

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<tr>
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<tr>
<td>Clinical Process of Care</td>
<td>Same as FY 2013 with one addition: SCP-INF-9, Postoperative Urinary Catheter Removal on Post-Operative Day 1 or 2</td>
<td>45%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Same as FY 2013</td>
<td>45%</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Same as FY 2013</td>
<td>25%</td>
</tr>
</tbody>
</table>

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Background

Hospital Strategies for Reducing Risk-Standardized Mortality Rates in Acute Myocardial Infarction

Elizabeth H. Bradley, PhD; Leslie A. Curry, PhD, MPH; Enric S. Spatz, MD, MPH; Joseph H. Heith, MD; Emily C. Chellet, ARNP, PhD; Jephtha P. Curtis, MD; Jennifer W. Thompson, MPH; Henry H. Ting, MD, MHA; Yung-Wei Wang, MD; and Harlan M. Krumholz, MD, SM

Background: Despite recent improvements in survival after acute myocardial infarction (AMI), U.S. hospitals vary 2-fold in their 30-day risk-standardized mortality rates (RSMRs). Nevertheless, information is limited on hospital-level factors that may be associated with RSMRs.

Objectives: To identify hospital strategies that were associated with lower RSMRs.

Design: Cross-sectional survey of 527 hospitals (91% response rate) and weighted multivariate regression by using data from the Centers for Medicare & Medicaid Services to determine the associations between hospital strategies and hospital RSMRs.

Strategies included monthly meetings to review AMI cases, between-hospital clinicians and staff who transported patients to the hospital (RSMR lower by 0.07 percentage points), having cardiologists always on stand-by (lower by 0.04 percentage points), fostering an organizational environment in which clinicians are encouraged to solve problems creatively (lower by 0.04 percentage points), not cross-training nurses from intensive care units for the cardiac catheterization laboratory (lower by 0.44 percentage points), and having physician and nurse champions rather than nurse managers alone (lower by 0.08 percentage points). Fewer than 10% of hospitals reported using all 5 of these 5 strategies.

AMI 30-Day RSMR
AMI 30-Day RSMR

- Hospital volume
- Urban or rural location
- Hospital teaching status
- Geographic region
- Safety net status
- Socioeconomic status of patients

Key Themes of Top Performers

1. Organizational values and goals
2. Senior management involvement
3. Broad staff engagement & expertise in AMI care
4. Communication & coordination among groups
5. Problem solving and learning
Key Themes of Top Performers

2. Senior management involvement

- “this is not acceptable and this is where we need to go, what do you need to get this done”
- “we use quality data to make strategic planning and resource allocation decisions”
- “accountability for low performers and recognition for high performers”

× “I have been here 7 years, and this is the third CEO, the second medical director, and third VP of nursing”

Key Themes of Top Performers

3. Broad staff engagement & expertise in AMI care

- “empowered physician and nurse champions”
- “a nurse started writing notes in physician progress note section – this is my assessment...I want you to read it, it’s not in the nurse’s section...I have some ideas and am open to talk about it”

× “there are no physicians on the committee...and they try to implement changes...and get it wrong”
× “cardiologists are little bit like bears and not the kindest, if a nurse calls about meds, they say I gave you orders, why are you calling me again?”
### Strategies Associated with Lower MI Mortality

<table>
<thead>
<tr>
<th>Strategy associated with lower RSMR</th>
<th>% Points Decrease in RSMR</th>
</tr>
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<tbody>
<tr>
<td>Physician AND nurse champions for AMI care</td>
<td>0.88</td>
</tr>
<tr>
<td>Organizational culture that supports creative problem solving</td>
<td>0.84</td>
</tr>
<tr>
<td>Monthly meetings with EMS to review AMI cases</td>
<td>0.70</td>
</tr>
<tr>
<td>Cardiologists on site 24/7 (including fellows)</td>
<td>0.54</td>
</tr>
<tr>
<td>Nurses are not cross trained from ICU for the cardiac catheterization laboratory</td>
<td>0.44</td>
</tr>
<tr>
<td>Pharmacists round on all patients with AMI</td>
<td>0.41</td>
</tr>
</tbody>
</table>

Bradley EA, Ting HH. Annals Intern Med. 2012; 156:618-626

### Strategies Associated with Lower MI Mortality

<table>
<thead>
<tr>
<th>Strategy associated with lower RSMR</th>
<th>% Points Decrease in RSMR</th>
<th>% Hospitals Using Each Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician AND nurse champions for AMI care</td>
<td>0.88</td>
<td>43</td>
</tr>
<tr>
<td>Organizational culture that supports creative problem solving</td>
<td>0.84</td>
<td>40</td>
</tr>
<tr>
<td>Monthly meetings with EMS to review AMI cases</td>
<td>0.70</td>
<td>15</td>
</tr>
<tr>
<td>Cardiologists on site 24/7 (including fellows)</td>
<td>0.54</td>
<td>14</td>
</tr>
<tr>
<td>Nurses are not cross trained from ICU for the cardiac catheterization laboratory</td>
<td>0.44</td>
<td>82</td>
</tr>
<tr>
<td>Pharmacists round on all patients with AMI</td>
<td>0.41</td>
<td>35</td>
</tr>
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Bradley EA, Ting HH. Annals Intern Med. 2012; 156:618-626
These strategies work!

Key strategies affect the whole hospital and different members of the care team including physicians, nurses, pharmacists and hospital administrators.

Our Goal

- Disseminate and implement strategies of top performers
- Increase adoption of evidence-based strategies linked with lower 30-day RSMR
- Improve hospital organizational culture

Create lasting change...
How We’ll Measure Success

- At least **350** ARG hospitals by June 2016
- Adoption of at least **2** implementation strategies by **80%** of all Surviving MI hospitals
- **100%** of total hospitals monitoring 30-day RSMR for AMI patients
- **Reduction** in 30-day RSMR for AMI patients over time

What “Joining” Means
What “Joining” Means

1. Ability to collect and report in-hospital MI mortality
2. Activate with Quality Improvement for Institutions
3. Have quality improvement team available
4. Participate in webinars and community calls
5. Complete online self-assessments
6. Implement at least 2 strategies or tools
7. Share your story online
8. Post to the listserv

What “Joining” Means

1. Ability to collect and report in-hospital MI mortality
   • Quarterly
   • Using any data source
     o ACTION-Get With the Guidelines Registry
     o Health system reports
     o Hospital self-reported report
What “Joining” Means

2. **Activate with Quality Improvement for Institutions**
   - ACC program integrating registries, initiatives, and toolkits under one umbrella
   - Website to access Surviving MI Initiative resources
   - Free for NCDR hospitals
   - Non-NCDR hospital have a $5K fee

Program Website: [CVQuality.acc.org/SurvivingMI](http://CVQuality.acc.org/SurvivingMI)
What “Joining” Means

3. Have a quality improvement team available
   - Clinical and administrative cardiovascular and quality organizational leadership
4. Participate in webinars and community calls
5. Complete online self-assessments
6. Implement at least 2 strategies or tools
7. Share your story online
8. Post to the listserv

Surviving MI Activities
Implement a structured improvement project...

Surviving MI Activity Plan

Learning Sessions: 6 Webinars and 3 Community Calls
Online Resources: 1 Assessment (complete regularly), 1 Toolkit (updates ongoing)
### Self-Assessment Surveys

- Helps hospitals prioritize QI efforts
- Identify tools for improvement
- Enables hospital to monitor progress quarterly
- Compares hospitals that have completed the assessment

<table>
<thead>
<tr>
<th>Overall Score (71 possible points)</th>
<th>64%</th>
</tr>
</thead>
</table>

#### Organizational Priority (9 possible points)

| Success Metric 1: HF and MI patients are identified prior to discharge and risk of readmission is determined (15 possible points) | 7 |
| Tools to help meet this metric |
| 1a. Strategies to Identifying HF patients in the hospital |
| 1b. Readmission Risk Calculator and Score www.readmissionscore.org |
| 1c. LACE Index Tool - HF Readmission risk assessment |

| Success Metric 2: Follow-up for cardiac rehab appointment within seven days is scheduled and documented in the medical record (15 possible points) | 4 |
| Tools to help meet this metric |

| Success Metric 3: Patient is provided with documentation of the scheduled appointment |

### Change Culture to Change Care

**Today**
- **Improvement is possible:** There are known evidence-based strategies you can adopt

**Tomorrow**
- **Sustainable change:** Changing culture will improve other patient outcomes
Your Next Steps

1. Have your baseline in-hospital MI mortality
2. Activate your ACC Quality Improvement for Institutions account
3. Confirm your quality improvement team and related resources with leadership
4. Tune in for the next webinar in Fall 2014: “Introduction to Evidence”
5. Visit CVQuality.acc.org/SurvivingMI for more resources on Getting Started

To Activate Your Online Account

• Enter your ACC (CardioSource) login information (not your NCDR login) in the “Login” section.
• If you are not an ACC member, fill out the registration form under “Register” to access Quality Improvement for Institutions.
• If you have questions or need help activating your free account, call 800-257-4737 or email CVQuality@acc.org.
Thank you

Surviving MI
AN ACC QUALITY INITIATIVE

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.

Release the power of your data at CVQuality.acc.org.