

# Surviving MI

AN ACC QUALITY INITIATIVE

## Questions-and-Answers from the Best Practice Webinar

*Presentations by: Michael Kourany, MD Barbara Weiler, RN, BSN, and Sarah Spinler, PharmD*

**Q: What specific metrics are you following?**

**A.** This webinar focuses on SAMI success metrics 2 and 4 - the physician-nurse dyad and the involvement of Pharmacists in the management of AMI Care, respectively. There are seven metrics in the SAMI project.

**Q. What registries do you use to monitor AMI performance?**

**A.** We currently participate in the ACC (NCDR) Cath/PCI and GWTG-ACTION. We also monitor our readmit rates for AMI.

**Q. You mentioned that you sponsor EMS education quarterly, is this open to all EMs in your community? Does your facility have your own EMS? What is your EMS response on this project?**

**A.** One of our nurses is the process leader for both the ER and the Cath Lab. Through our AMI initiative she is responsible for providing feedback to EMS as well as arranging education. St Vincent does not have their own EMS. Approximately once a quarter one of our physicians will give a lecture/ECG tutorial to any EMS personnel interested. This is always well received and appreciated by EMS. It's also a great way to get to know each other outside of the acute patient care setting.

**Q. For your monthly data review, it sounds like you use an internal data base. Does this make your data timelier than waiting for a 3rd party (sometimes up to 3-4 months) to send you your data?**

**A.** Our 3rd party ACC certified vendor is Ncompass. We have created internal reports within Ncompass to monitor our quality. Most of them are standard reports within Ncompass. Ncompass offers automatic verifications that we use to signal a case for second review when a case is non-compliant for a quality metric (i.e. Door to Device >90 minutes). We review it quickly after the RN abstractor completes a case. If there is a documentation issue, we are able to refer it back to the physician on the case within the documentation window. If not resolved, we send to our PI chair for review.

**Q. Can you provide an example of the monthly Dashboard? We do quarterly Dashboards but we would like to move to monthly.**

**A.** Our monthly/quarterly dashboard includes over 50 metrics, however, we primarily focus on root causes related to AMI readmission, ACC Door to Device, PCI Composite DC meds, Vascular Access Site Injury or Major Bleeding, Bleeding Events (those that would be included in ACC risk adjusted bleeding), PCI Mortality, and Readmits. Of those we choose to monitor closely, we include separate summary pages. As for the dashboard, we include data from: the prior month, the last quarter, and the previous 12 months.

**Q. How do you perform your Root Cause Analysis?**

**A.** By going through and looking at each case individually.

**Q. Do you ever "pause" to have a conversation between the ED MD and the Interventionist in those cases where the patient had an unwitnessed arrest with unknown downtime and may survive the PCI but not the hospitalization?**

**A.** Yes, depending on the situation – how long has the patient had CPR, how much downtime has occurred – then I would talk with the ED physician. It's a case by case basis.

**Q. ACC Door To Balloon goal is 90 mins or less; the AHA has an EMS to balloon time of 90 mins or less - what does your facility 'recognize'?**

A. Our facility recognizes door to balloon of 90 minutes or less but also tracking first medical contact to balloon and with mission lifeline they have seen a time of 55-60 minutes.

**Q. Could you provide more information on concurrent data abstraction for Cath/PCI? Do you have data abstractors in the cath lab? Could you share a bit more about the specifics of the concurrent abstraction process?**

A. We do not have abstractors in the cath lab. We currently use Xims in the cath lab for the intra-cath lab portion of the data set which is mapped to data warehouse within Navion Healthcare Solutions. The certified software we use is called Ncompass. In addition to the intra-cath lab portion of the data set, we have RN's concurrently reviewing charts for the pre/post portions of the data set while patients are still in the hospital. Our RN's collect pre/post data for many different registries while in a "single" patient's chart if the patient qualifies for more than one registry e.g. ACC, GWTG or even the STS. We had this process for over 20 years and it is very successful and resource efficient.

**Q. Does your facility have a pharmacist who rounds on STEMI AND nonSTEMI patients?**

A. Yes, for example, in our CCU and Step Down Cardiology 60 bed area, we have four pharmacists that care for these patients.

**Q. How does the use of pharmacist performed medication use evaluation impact care?**

**Q. Describe the role of MUE's in quality efforts?**

A. If implemented appropriately, MUE can improve the performance of medication use by assessing individual steps in the process with the focus being on improving patient outcomes and quality of life. This is in contrast to DUE (Drug Use Evaluation) that looks specifically at the actual prescribing, dispensing and administering drug processes. Pharmacists are helpful at every step of the medication use process with research showing that pharmacists improve discharge rates of aspirin, beta-blockers and ACE inhibitors, decrease the frequency of ADEs and prescribing errors when they participate in ICU patient care rounds and provide services that lower mortality rates and fewer bleeding complications in hospitals with ICU clinical pharmacies. There are numerous studies moving toward using pharmacists in all areas of hospital care, particularly in regard to redundancy of medication prescription. Pharmacists can also provide a second look at continuous accuracy of EMR.

**Q. Are the pharmacists available for weekend discharges?**

A. In our institution, there are pharmacists (through weekend staffing by pharmacy residents) to perform medication discharge counseling