Surviving MI
AN ACC QUALITY INITIATIVE

Questions-and-Answers from "Tools and Strategies" Webinar

Presentations by: Richard Kovacs, MD, FACC, and Eva Kline-Rogers, MS, RN, NP

Q: Does having a pharmacist involved in AMI care replace an existing role within the AMI care team in the hospital?
A: *Dr. Kovacs*- No, not at our institution. We have utilized the existing, for example, in the coronary care unit there is a pharmacist for the floor. That person automatically becomes part of the process improvement team and the "go to" person for problem solving, but they still have a day job. It hasn't lessened the work load in other places. People look for tradeoffs in order to find the time for pharmacy to participate in AMI care.

Ms. Kline-Rogers- In all of the QI teams that I've been a part of, it works to sit down with the team members and look at what the priorities are and how change can be implemented within the existing personnel. When you bring all of these folks together (i.e. the inpatient pharmacy director, the outpatient nursing director, etc.), usually there is a way to recreate roles so that the work is still getting done and the additional roles can be filled. Sometimes this requires incremental staff, but you can be very creative in how you fund those incremental staff positions.

Q: Is having a cardiology PA 24/7 an equal benefit to having an interventional cardiologist?
A: *Dr. Kovacs*- From the evidence base, the research that was done looked at cardiologists and did not drill down to the level of a PA. But I would think that as local solutions for cardiology presence are formed, we will find a variety of ways to have cardiology expertise readily available. At teaching institutions, we're fortunate in that we have trainees and more resources/manpower, but I think that we are going to find other cardiology specific providers will provide equal benefit that was not in the original evidence base.

Ms. Kline-Rogers- As a mid-level provider (nurse practitioner), we are not cardiologists, but we are up to date on evidence because it is expected as part of our roles. In addition to that, I know how to reach cardiologists 24/7 and it is part of my working relationship with my faculty. When I am faced with a complex condition, I can reach a cardiologist any minute of any day.

Q: Where would we find the data regarding the 30 day mortality rate for hospitals with a 24/7 cardiologist versus hospitals without?
A: The Annals of Internal Medicine evidence based papers can be found on the Surviving MI website.

Q: Our hospital cannot dispense medicine at discharge; however, we do provide vouchers for the medication and we refer them to the local 24 hour pharmacy to fill the script. Does this qualify for the metric?
A: *Ms. Kline-Rogers*- The context of the metric is much bigger than just providing medicine at discharge. The metric itself is intended to be looked at more broadly, for pharmacist involvement with the care of the patient throughout the course of their hospitalization, including at discharge. If you're looking at it from that perspective, then no, that would not qualify for the metric because it doesn't meet what the whole intent of the metric is, which is to have the cardiologist involvement throughout the care.

Q: Any advice on moving from non-specialized to specialized nurses in the Cath Lab?
A: *Ms. Kline-Rogers*- There was a time as a CCU nurse that I had to rotate down to the Cath Lab. For me, it was a frightening experience because I was very comfortable in the ICU and this was a new environment with new people. You want to get a couple of people that consistently do it, then those folks should know the staff in the Cath Lab, should know where things are located, where phone numbers are, etc.

Q: Related to RSMR data, is it STEMI or NSTEMI? Can you differentiate between the two?
A: These are CMS data and what is coded as an acute myocardial infarction includes both STEMIs and NSTEMIs.