

Flex AMI Project Update

Date: July 27, 2009



Agenda

- Welcome
- Project recap
- Update from 7 Oregon AMI demonstration sites
- Roundtable discussion
- Next Steps

2008 Flex AMI Project

The Need –

“growing body of research pointing to the need to implement appropriate care and transfer protocols for patients admitted to rural emergency departments who present with Acute Myocardial Infarction (AMI) and chest pain symptoms.”

On August 22, 2007, NQF released a set of 11 proposed national voluntary consensus standards:

- 4 AMI measures
- 7 ED communication measures

Project Recap

Project Period 6 Months:

- January – June 2008

Deliverables:

- Individual on-site consultation and assessment (baseline at completion) for 7 CAH sites, 4-6 hour per visit
- Two education conferences
- Resource manual/project toolkit

Hospitals Participating

- Blue Mountain Hospital
- Cottage Grove Community Hospital
- Grande Ronde Hospital
- Harney District Hospital
- Mountain View Hospital
- Pioneer Memorial Hospital
- Southern Coos Hospital & Health Center

Key Findings

- Project identified staff deficits in knowledge and performance expectation regarding data entry and abstraction.
- Prompted:
 - Discussion of statistical value of “small numbers.”
 - Identified of opportunities for improvement.
- Recognition that acute coronary syndrome (ACS) is more common and need for standard approach and protocols.
- Importance of joint meetings between rural ED physicians and consult cardiologists.
- Despite clear evidence-based guidelines and documented opportunities for improvement, obstructive provider behavior can frustrate quality improvement.

Blue Mountain Hospital

- Only 2 STEMI patients during project period.
- Data entry is a challenge.
- Times to EKG and ASA improved significantly.

Cottage Grove Community Hospital

- Developed unit competencies for ED.
- Data entry remains a challenge (despite “anatomical” clock).
- Improved relationships with Quality and Governing Board – members interested in project.
- Linking with other hospitals is beneficial.

Cottage Grove Community Hospital

- Cardiologists prefer no fibrinolysis
- Increased interest from larger system hospitals
- Meeting goals for ASA, ECG, and PCI Transfer
- Share AMI stats with Board

Data:

- Patients receiving ASA - 98%
- Mean time to ECG – 8 minutes
- Mean throughput to PCI Transfer – 65 minutes (Median 58 minutes)

Grande Ronde Hospital

- Getting passionate docs involved key to success.
- Added CEO to project.
- Cardiology recommendation at variance with evidence-based care problematic.
- Care not consistent with guidelines referred for peer review may feel punitive.

Harney District Hospital

- Data entry a challenge.
- Discovered ECG timestamp different than wall clocks, many ECG times are prior to patient admission.
- Nursing staff must document too.
- Planning to change flow sheets to checklists.
- Prior to project, docs not using fibrinolysis.

Harney District Hospital

1/1/09 – 7/31/09

Chest Pain AMI Patients – 10

Patients receiving ASA – 70%

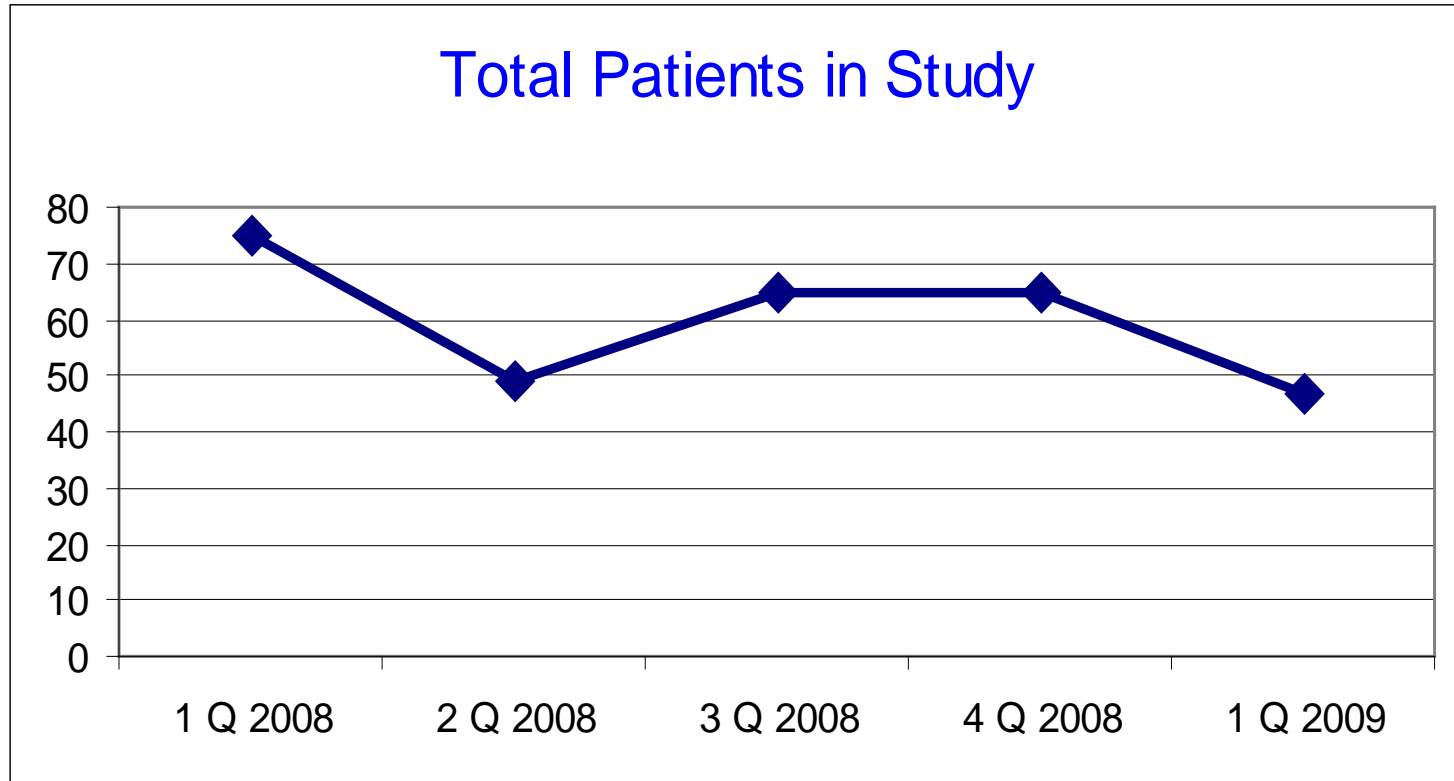
Patients receiving fibrinolysis in 30
minutes – 100%

Mean time to ECG – 9 minutes

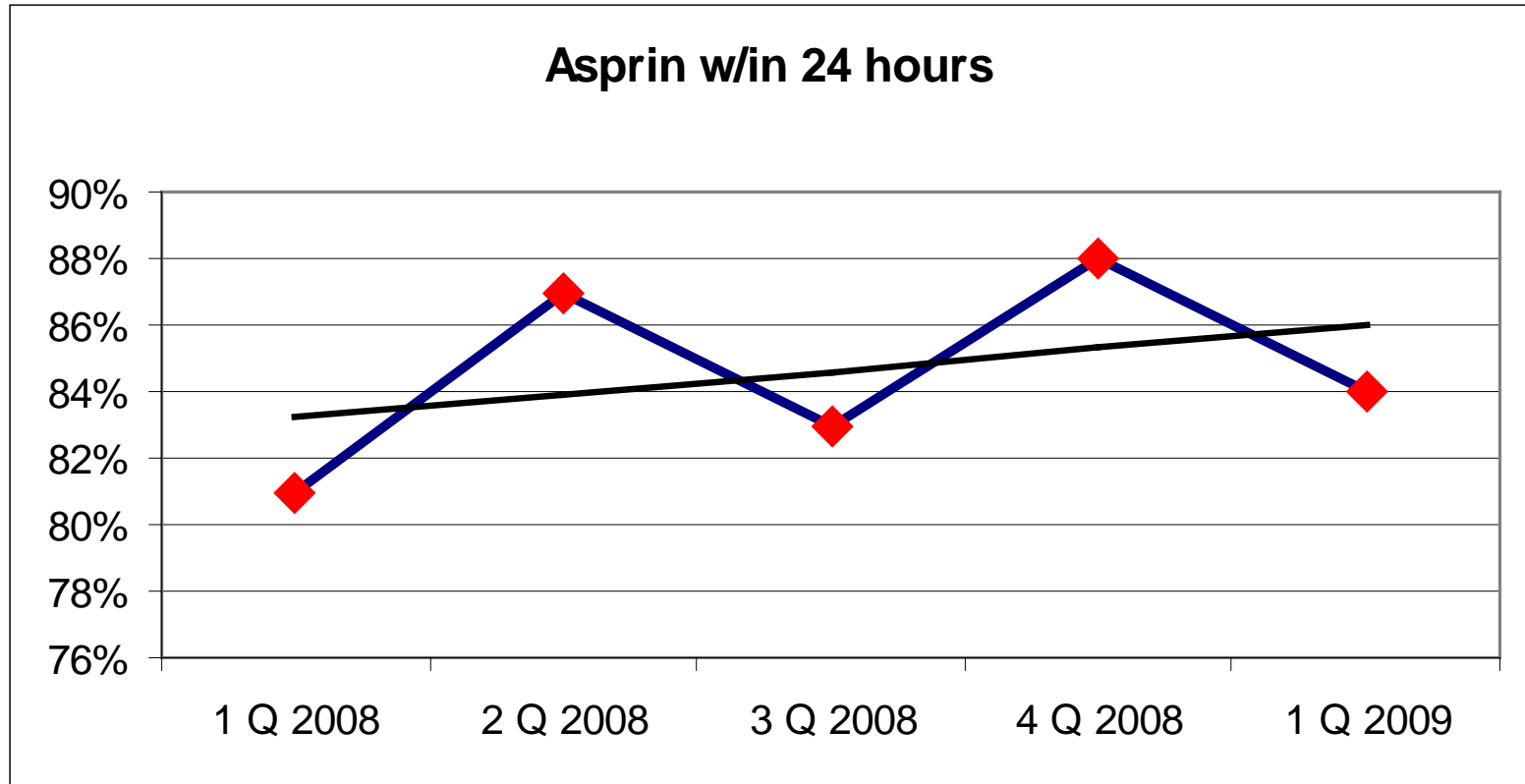
Pioneer Memorial Hospital - Prineville

- Discovered variation between cardiologists.
- Project required significant staff education.
- Implemented “code triage,” similar to rapid response team.
- Community presentation very well received.
- Chest pain algorithm order sheet – implemented and updated with changes
- Heart 1 process with CHC Transfer Center

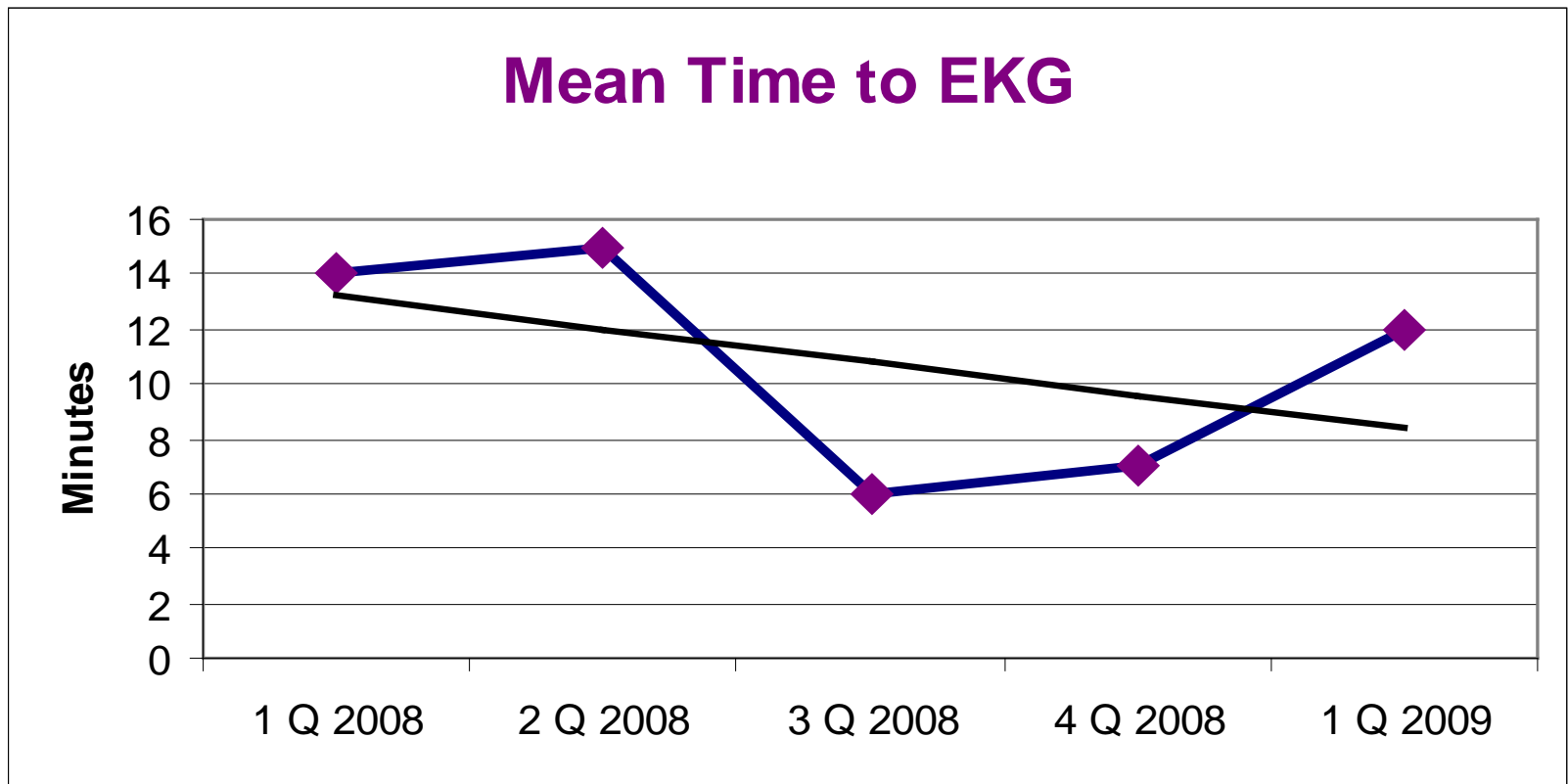
Pioneer Memorial Hospital Data



PMH Data

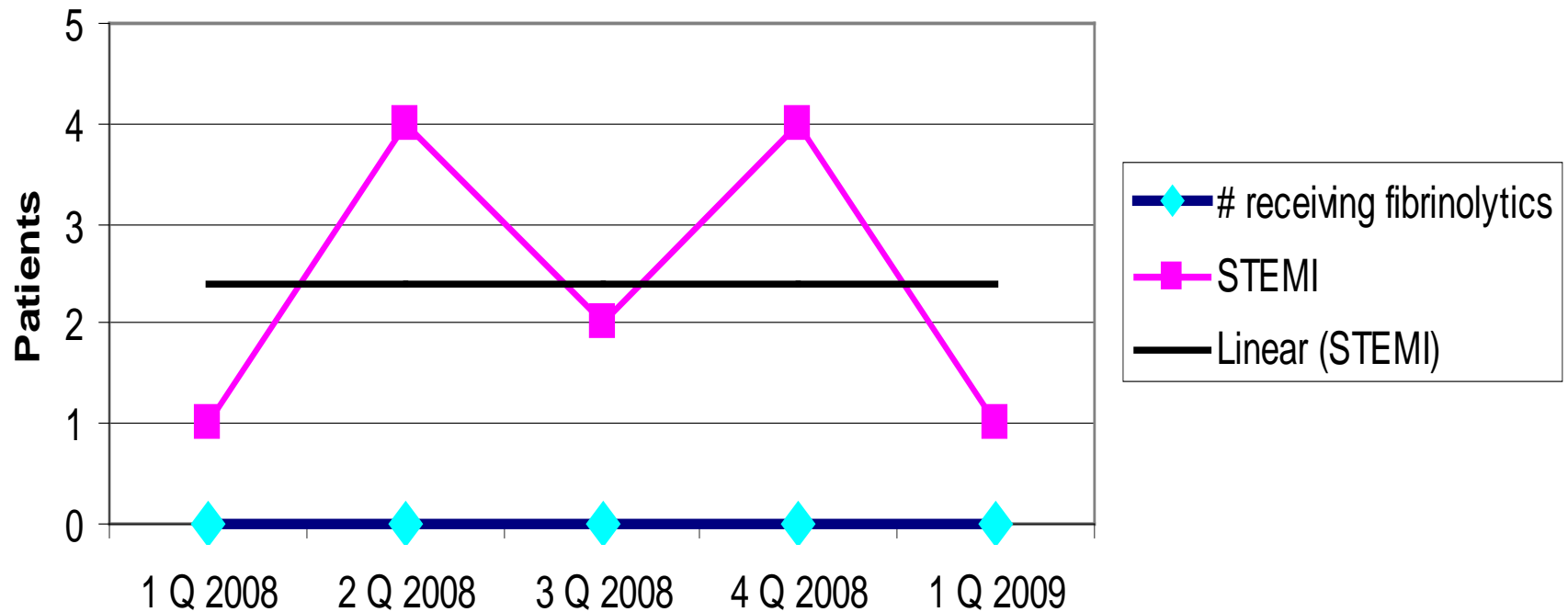


PMH Data



PMH Data

Number of STEMI and Number Receiving Fibrinolysis



PMH – What's next?

- Changes to Physician T- sheet
- Standardize data with CART requirements
- Transfer algorithm
- Ongoing dialogue with Cardiologists and ED physicians
- In-depth analysis of each STEMI case

Mountain View Hospital

- Inconsistent cardiology recommendations.
- Poor follow-up data from cardiology.
- Low volumes demands attention to “process.”
- Much better communication with Bend as a result of the project.

Mountain View Hospital

- RPM reports difficult since move to new system
- Data entry is inconsistent (3 STEMI cases in reporting period)
- Implemented TeamSTEPPS for AMI Care, developed Master Trainers and trained all associated AMI Care staff.

Southern Coos Hospital

- Chest pain patients now get ASA and ECG within 10 minutes.
- Hard to get docs to listen.
- Began doing bilateral blood pressures rather than wait for chest x-ray.
- Discontinued consent for fibrinolysis.
- Placed checklist on front of fibrinolysis box.
- Large clock placed in ED.
- Data entry remains significant challenge.

Southern Coos Hospital

- Continue to work on ways to meet 10 ECG time on patients with atypical Chest pain.
- Large digital clock has improved documentation discrepancies between admitting/lab/ER – all times match.
- Obtained MD by in on fibrinolysis – impossible to transfer to cath lab in recommended time frame.
- Continued need to identify/assign specific staff for data entry “if it is everybody's job it is nobody’s job”.

We feel participation in this project was extremely beneficial. It opened the lines of communications and improved direct patient care and employee satisfaction. Staff has clear guidelines/steps to follow. We are not consistently at 100% in all areas but are getting closer. Thank you!

Roundtable Discussion

- Have you continued the project?
 - If so, what has been most beneficial and what barriers have you encountered?
 - If not, what about the project was not sustainable?
- What recommendations do you have to improve the project?

Next Steps

- Follow up on your recommendations.
- Update existing project manual.
- Problem-solve data collection/reporting and fit with CMS outpatient measures.
- Meet with key stakeholders – EMS, Cardiologists etc.