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Engaging Physicians in Quality Efforts

North Carolina Association for Healthcare Quality

April 24, 2009
Wilmington, NC

Stephen Wallenhaupt, MD, FACS, FCCP
EVP and Chief Medical Officer
Novant Health

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What's that structure right there?

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Objectives

- Identify key elements in building a strategy for productive communication with Medical Staff
- Learn techniques for long term cooperation and partnership with Medical Staff in Quality Initiatives
- Discuss examples of tools that help support Medical Staff in quality efforts and methods to influence “more challenging” Medical Staff

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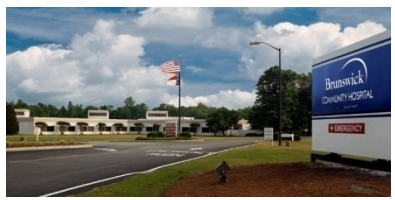
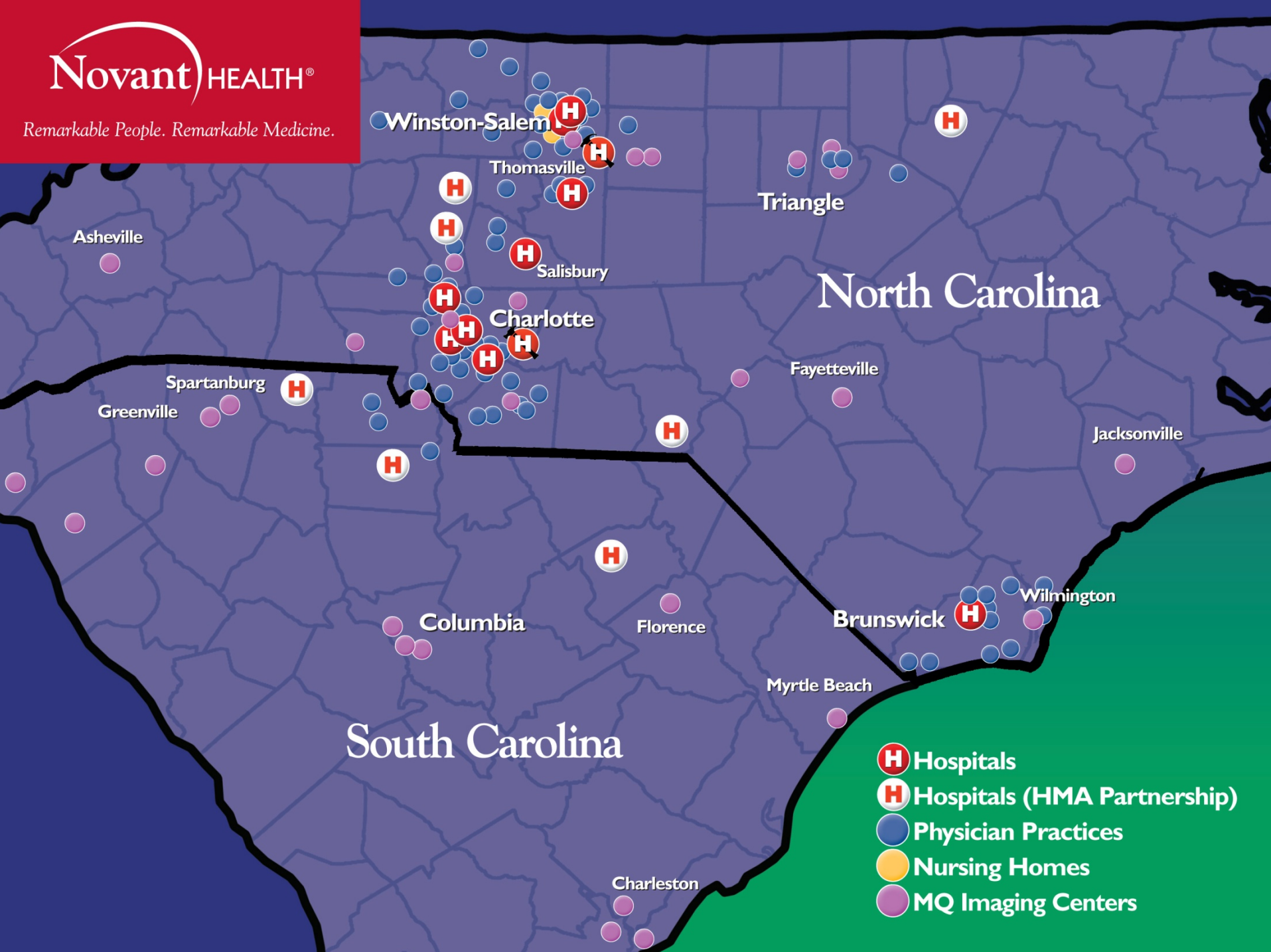
Multi-region Organization

- 9 acute care hospitals
- ~ 24,500 employees
- ~ 100,000 discharges
- ~ 100,500 procedures
- ~ 380,000 ED visits
- ~ 3,000 active medical staff
- 1,060 Novant physicians
- 361 physician practices
- 91 MedQuest imaging centers

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Charlotte
Fayetteville
Spartanburg
Greenville
Jacksonville
Columbia
Florence
Wilmington
Brunswick
Myrtle Beach
South Carolina
Charleston
Hospitals
Hospitals (HMA Partnership)
Physician Practices
Nursing Homes
MQ Imaging Centers

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Engaging Physicians

- What are the issues or barriers that are preventing you from gaining physician support today?
- Is there an issue with pracitioner support?
- Is there an element of “us and them”?
- Is it widespread, specialty specific, or…….. a few outliers?
- Do you have the support of senior leaders?

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Engaging Physicians

Physicians…

- Feel embattled and less valued
- May believe that the hospital has a focus on the bottom line…not on quality
- Have a strong bond from the rite of passage…they listen to each other
- Physician to physician communication is an essential component
- It is essential that physicians understand the clinical indication for change…it needs to "make sense"

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Mission

Novant Health exists to improve the health of communities, one person at a time

Vision

We, the employees of Novant and our physician partners, will deliver the most Remarkable Patient Experience, in every dimension, every time

Values

- **Compassion**
- **Personal Excellence**
- **Diversity**
- **Teamwork**


"Because I wear one of these, every patient is my patient."
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LENA
SPRINGWOOD CARE CENTER
Novant HEALTH
YANG
MATERIALS MANAGEMENT
Novant MEDICAL GROUP
CHARLOTTE
FOOTHILLS FAMILY MEDICINE
Brunswick COMMUNITY HOSPITAL
PAULA
PHARMACY
Thomasville MEDICAL CENTER
TERRY
RADIOLOGY
Novant HEALTH
PAUL
ADMINISTRATION
Presbyterian HOSPITAL
ZHADA
PATIENT ACCESS
Presbyterian HOSPITAL
GAYLE
WOMEN'S & CHILDREN'S SERVICE
Forsyth MEDICAL CENTER
JASON
PUBLIC SAFETY
Novant HEALTH®
VISION 2010 & BEYOND
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Engaging Physicians

- The most important common factor is that the *patient* is at the center of every decision, every effort, every program…
- When physicians are genuinely involved in the process and their input is valued, they will partner for best patient care
- Best care yields best outcomes
- "Demonstrate publicly the excellent care you are delivering"

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Physicians' Perspectives

"I'm different because…"

- Physicians have a strong desire to provide quality patient care
- Physicians don't want to be outliers…unless it is because they are the best!
- "Best practice" can be a turn-off
- Just seeing the information can impact change
- "How can we help you be the best?"
- Provide factual information from recognized clinical resources

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Provide Clinical Resources

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

◄ Previous Volume 353:349-361 July 28, 2005 Number 4 Next ►

Perioperative Beta-Blocker Therapy and Mortality after Major Noncardiac Surgery

Peter K. Lindenauer, M.D., Penelope Pekow, Ph.D., Kaijun Wang, M.S., Dheeresh K. Mamidi, M.B., B.S., M.P.H., Benjamin Gutierrez, Ph.D., and Evan M. Benjamin, M.D.

ABSTRACT

Background Despite limited evidence from randomized trials, perioperative treatment with beta-blockers is now widely adv
We assessed the use of perioperative beta-blockers and their association with in-hospital mortality in routine clinical prac

Methods We conducted a retrospective cohort study of patients 18 years of age or older who underwent major noncardiac
In 2000 and 2001 at 329 hospitals throughout the United States. We used propensity-score matching to adjust for differen
between patients who received perioperative beta-blockers and those who did not receive such therapy and compared in-
mortality using multivariable logistic modeling.

Results Of 782,969 patients, 663,635 (85 percent) had no recorded contraindications to beta-blockers, 122,338 of whom
percent) received such treatment during the first two hospital days, including 14 percent of patients with a Revised Cardia
Index (RCRI) score of 0 and 44 percent with a score of 4 or higher. The relationship between perioperative beta-blocker
and the risk of death varied directly with cardiac risk; among the 580,665 patients with an RCRI score of 0 or 1, treatmen
associated with no benefit and possible harm, whereas among the patients with an RCRI score of 2, 3, or 4 or more, the
odds ratios for death in the hospital were 0.88 (95 percent confidence interval, 0.80 to 0.98), 0.71 (95 percent confidence
0.63 to 0.80), and 0.58 (95 percent confidence interval, 0.50 to 0.67), respectively.

Conclusions Perioperative beta-blocker therapy is associated with a reduced risk of in-hospital death among high-risk, bu
low-risk, patients undergoing major noncardiac surgery. Patient safety may be enhanced by increasing the use of beta-blockers in high-risk
patients.

THIS ARTICLE
- Abstract
- PDF
- PDA Full Text
- PowerPoint Slide Set
- Supplementary Material

COMMENTARY
- Editorial by Poldermans, D.
- Lazara

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CHEST Supplement

ANTITHROMBOTIC AND THROMBOLYTIC THERAPY 8TH ED: ACCP GUIDELINES

Executive Summary*

American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)

Jack Hirsh, MD, FCCP, Chair; Gordon Guyatt, MD, FCCP; Gregory W. Albers, MD; Robert Harrington, MD, FCCP; and Holger J. Schünemann, MD, PhD, FCCP

(CHEST 2008; 133:71S–105S)

Key words: guidelines; recommendations

Abbreviations: ACCP = American College of Chest Physicians; ACS = acute coronary syndromes; AF = atrial fibrillation; AIS = arterial ischemic stroke; APTT = activated partial thromboplastin time; CABG = coronary artery bypass grafting; CrCl = creatinine clearance; CSVT = cerebral sinovenous thrombosis; CTPH = chronic thromboembolic pulmonary hypertension; CVL = central venous line; DVT = deep vein thrombosis; GCS = graduated compression stockings; GP = glycoprotein; HIT = heparin-induced thrombocytopenia; IPC = intermittent pneumatic compression; INR = international normalized ratio; LDUH = low-dose unfractionated heparin; LMWH = low-molecular-weight heparin; MVP = mitral valve prolapse; NSTE = non–ST-segment elevation; PCI = percutaneous coronary intervention; PE = pulmonary embolism; PMBV = percutaneous mitral valve balloon valvotomy; PTS = postthrombotic syndrome; PVT = prosthetic valve thrombosis; SC = subcutaneous; SCI = spinal cord injury; TEE = transesophageal echocardiography; tPA = tissue plasminogen activator; UAC = umbilical artery catheter; UFH = unfractionated heparin; VFP = venous foot pump; VKA = vitamin K antagonist; VTE = venous thromboembolism

This executive summary accompanies the publication of 8th edition of "Antithrombotic and Thrombolytic Therapy: American College of Chest Physicians (ACCP) Evidence-Based Clinical Practice Guidelines." These guidelines provide an extensive critical review of the literature related to management of thromboembolic disorders.

In each chapter, the clinical question under consideration, the clinical trials evaluating the evidence, and the recommendations are linked by a numbering scheme common to these three items. The recommendations are included at the beginning of the chapters and are presented in this executive summary.

The grading system in the 8th edition of the ACCP guidelines reflects the system adopted for all ACCP guidelines, and is similar to the GRADE system, which is being widely adopted by many guideline groups. The strength of any recommendation depends on two factors: the trade-off between benefits, risks, burden, and cost, and the level of confidence in estimates of those benefits and risks. If benefits do or do not outweigh risks, burden, and costs, a strong recommendation is designated as Grade 1. If there is less certainty about the magnitude of the benefits and risks, burden, and costs, a weaker Grade 2 recommendation is made. Support for these recommendations may come from high-quality, moderate-quality, or low-quality evidence, labeled, respectively, A, B, and C. The phrase "we recommend" is used for strong recommendations (Grade 1A, 1B, 1C) and "we suggest" for weaker

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Physicians' Perspectives

- Changes in practice are challenging
- "Different is not necessarily better"
- Influenced by having "real" data
- "Regulatory requirements" can be a red flag
- Physicians are less persuaded by the need for operational changes - length of stay or improving reimbursement, but they do understand the current issues

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Surgical Complications

	Hospital Costs ($)	Reimbursement	Profit (%)
No complications	$10,978	$14,266	$3,288 (23)
With complications	$21,156	$21,911	$755 (3.4)
Increase in reimbursement		$7,645 (54)	

- Hospitals and payors both suffer financial consequences from complications, but the greater burden falls on health care payors

- Conclusion: “Strong incentives exist for health-care payors to become more involved in supporting quality improvement activities”

Dimick JB, et al., J Am Coll Surg 2006; 202: 933-7

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Physicians and Data

"Something is wrong with your data…"

- Understand their reservations about the data
- Work with physicians to get the "right" data
- Make sure that your data is correct and can be authenticated
- Start with global data before going to individual physicians
- Work closely with Physician champion or Medical Staff chair/leader as a start

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Physicians and Data

Physician Quality Report

PHYSICIAN TOTALS 07/01/2007 - 06/30/2008

Physician ID		IP Attending Cases	124
Physician Name		Average LOS	
Region	Brunswick	Mortality	1.6%
Primary Specialty	General Surgery	30 Day Readmits	9.7%

DISEASE SPECIFIC BENCHMARKS 07/01/2007 - 06/30/2008 — Above Acceptible | Within 10% of Acceptible | Beyond 10% of Acceptible

Disease/ Procedure	Cases	Avg Severity	LOS	Severity Adjusted Expected	Mortality Rate	Severity Adjusted Expected	UTI	Severity Adjusted Expected	Readmit 31 Days	Severity Adjusted Expected	Wound Infection	Severity Adjusted Expected
Lumpectomy or Mastectomy	68	1.26	0.7	0.7	0.0%	0.0%	0.0%	0.1%	0.0%	0.3%	0.0%	0.1%

Disease/ Procedure	Cases	Avg Severity	LOS	Severity Adjusted Expected	Mortality Rate	Severity Adjusted Expected	DVT Prevention and Prophylaxis	Severity Adjusted Expected	Readmit 7 Days	Severity Adjusted Expected	Wound Infection	Severity Adjusted Expected
Cholecystectomy	65	1.63	1.5	2.1	0.0%	0.2%	100.0%	68.1%	0.0%	1.2%	0.0%	0.2%

Disease/ Procedure	Cases	Avg Severity	LOS	Severity Adjusted Expected	Mortality Rate	Severity Adjusted Expected	DVT Prevention and Prophylaxis	Severity Adjusted Expected	Postop Stroke	Severity Adjusted Expected	ICU/ CCU/ NICU	Severity Adjusted Expected
Endarterectomy	21	1.61	1.0	1.6	0.0%	0.0%	100.0%	98.2%	0.0%	0.1%	76.9%	51.1%

QUALITY MEASURES PERFORMANCE 07/01/2007 - 06/30/2008 — Above Target | Below Target but Above Average | Below Average

= Patients, O = Observed, T = Target

		Quarter 2			Quarter 4			Quarter 1			Quarter 2		
		#	O	T	#	O	T	#	O	T	#	O	T
Surgical Care Improvement Project	Prophylactic ABX within 1 hr prior to surg inc	1	100%	95%	1	100%	95%	4	100%	96%	5	100%	96%
	Appropriate ABX	1	100%	100%	1	100%	100%	4	100%	100%	5	100%	99%
	Prophylactic ABX DC within 24 hr after surgery	1	100%	95%	1	100%	95%	2	100%	95%	5	80%	96%
	Cardiac surgery patients with controlled 6am posto	0		100%	0		100%	0		100%	0		100%
	Surgery patients with appropriate hair removal	12	100%	100%	14	100%	100%	10	100%	100%	8	100%	100%

= Patients, O = Observed, T = Target

Quarter	Quarter	Quarter	Quarter

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Physicians and Reporting

"That's the hospital's problem…"

- "Patients can not differentiate the hospital from the physicians when it comes to outcomes!"
- "If you want to work in a hospital with great outcomes, you have to help make it that way"
- Physicians are attracted to facilities with a reputation for excellence
- Physicians will gain by working at a hospital known for excellence
- Work on improving clinical processes can add efficiency

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Practical Realities

- Current outcomes and performance measures are just the beginning
- The current infrastructure will support reporting at the practitioner level
- It is only a matter of time until physician outcomes and results will be publicly available
- Good preparation for physicians is to get involved, understand the process and support improvements now

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Physician Partners

- Physician Executive Leadership
- Physician Champion partners
  - In the specific discipline
  - Advocates for improvement and has a reputation for excellence
  - Will genuinely partner with team members to achieve necessary improvements
  - Is willing to commit the time – consider compensation for documented work
  - Will have the critical conversations

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Physician Partners

- Physician and Clinical/Analyst team members work closely
- Prompt response to questions/concerns
- Regular communication
- Review everything ahead of time
- Collaborative preparation for meetings
- Physician to lead the meeting
- Develop a professional relationship for change

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Physician Partners

"Help me be successful…"

- Prompts and reminders
- Protocols and order sets
- Care plans that support improvement
- Concurrent review if possible
- Prompt (if not immediate) feedback
- Recognition for successes
- Physicians like recognition too!

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November 6, 2008

John Feelgood, MD
Hospital Boulevard
Our Town, NC

Dear Dr. Feelgood,

Thank you for doing a great job in promoting the best care for your patients. As you know Presbyterian Healthcare is aggressively promoting good hand hygiene to prevent the spread of infection in healthcare facilities, offices and public places. You were observed to consistently use proper hand hygiene technique at Presbyterian Hospital Charlotte on November 2, 2008.

Studies have demonstrated that when physicians practice good hand hygiene, nursing and other support staff will follow their example. We appreciate your support in making the hospital environment safer for our patients by your example and leadership in practicing good hand hygiene.

Thank you again for your support in this very important initiative.

Sincerely,

Stephen Wallenhaupt

Stephen Wallenhaupt, MD

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Physician Partners

"You would be amazed by what can be achieved when you are not concerned about who gets the credit."

Wayne Corpening

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CMS Public Reporting

- It's everyone's responsibility to succeed!
- Physician champion on point
- Educate medical staff often
- Design for success
- Involve coders for details/advice
- Concurrent review is significant
- Provide prompts and reminders
- Frequent communication for best results
- Prompt feedback and education on misses
- Work first on solutions and support, then work on the outliers

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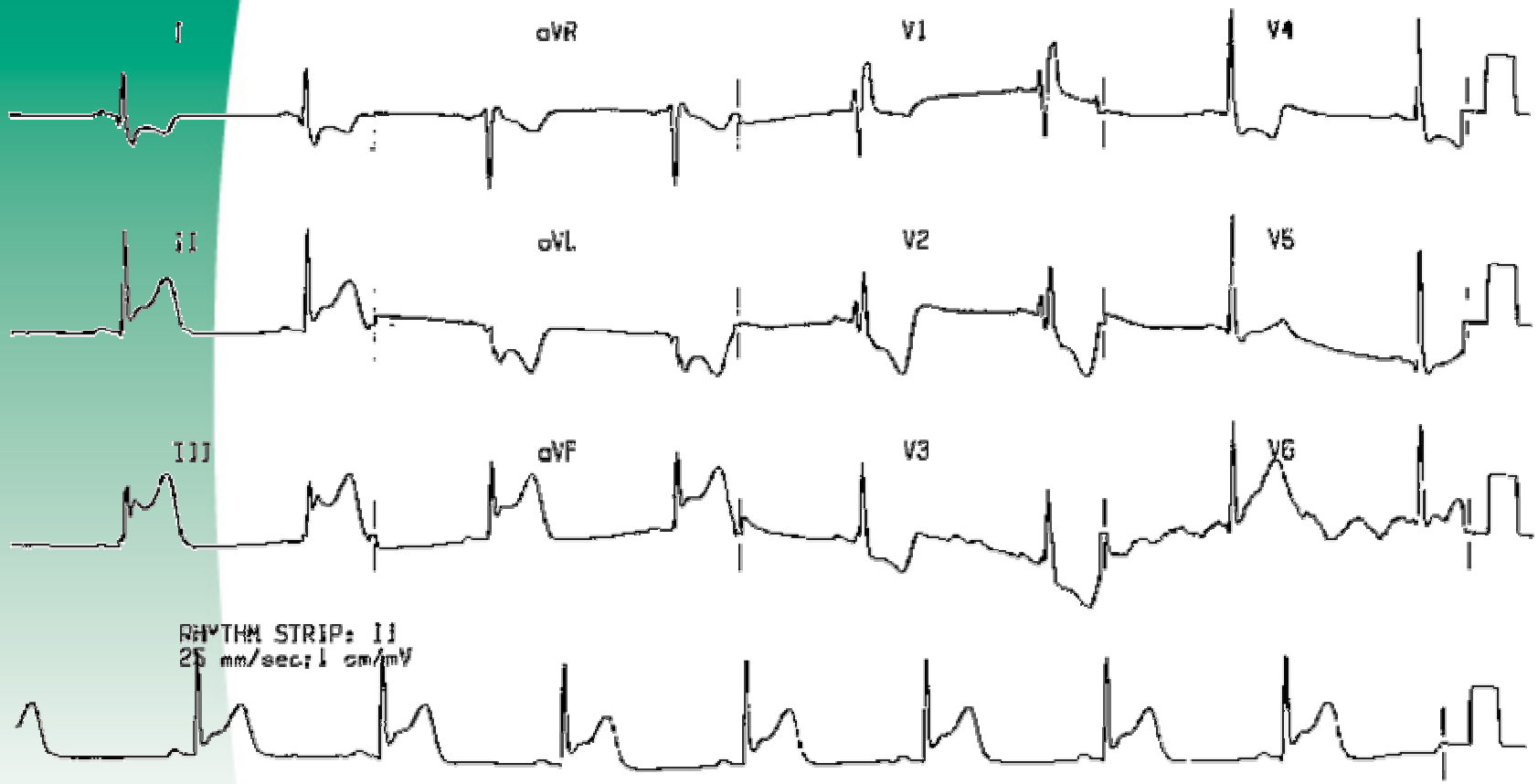
Cardiac Measures: Acute MI and Heart Failure



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Friendly Reminders

AMI Core Measures

- ASA & Beta Blocker at Arrival (within 24 hrs)*
- ASA & Beta Blocker at Discharge*
- Documentation to stop Smoking
- ACEI at discharge for low EF*

CHF Core Measures

- Documentation of Diet, Wt., Activity, Worsening Symptoms, & Rx Instruction at Discharge*
- Documentation to stop Smoking
- ACEI at discharge for low EF*

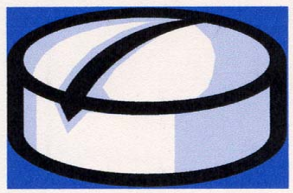
*Or documented reason for not implementing

Pocket Card

Core Measure:

Aspirin

Acute Coronary Syndrome Patients



Dose or Document!

ED Poster

Attention Physicians, PA's & NP's

Reminder:

AMI and CHF patients will NOT be allowed to be discharged without the ACS or CHF Discharge Instruction Sheet being filled out completely.

You will be called to address any incomplete areas.

Thank you for your help in meeting core measures

Discharge Poster

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ACS/AMI Admit Order Set

Oral anti-platelet therapies

Aspirin must start day of admission. If not ordered, MD please document contraindication in progress notes

- Aspirin, Chewable 324 mg PO STAT (**unless allergic**)
- Aspirin 325 mg PO daily

❒ Clopidogrel (Plavix):
- ❒ Clopidogrel 300 mg PO STAT x1 (unless already taking daily clopidogrel)
- ❒ Clopidogrel 600 mg PO STAT x1 (unless already taking daily clopidogrel)
- ❒ Maintenance dose: Clopidogrel 75 mg PO daily

Beta Blockers

Must start day of admission. If not ordered, MD please document contraindication in progress notes.

❒ **Beta blocker contraindicated due to: _____**

- **Do not administer beta blockers if SBP < 100 mm Hg, heart rate < 55, active CHF, or active wheezing**
- Metoprolol tartrate (Lopressor) 5 mg IV q5min x 3 doses (**DO NOT GIVE** if already administered in ED. If patient admitted to 4C, must be administered by 4C stepdown RN)
- Metoprolol tartrate (Lopressor) 25 mg PO q6h, start 15 minutes after the last IV metoprolol dose given (do not enter if alternate beta blocker ordered)

❒ Metoprolol tartrate (Lopressor) _____mg po q ____ hours
❒ Atenolol (Tenormin) _____mg po daily
❒ Other: _____

Angiotensin Converting Enzyme Inhibitor (ACEI)

If patient has Left Ventricular Systolic Dysfunction (LVSD) and ACEI not ordered, MD please document contraindication in progress notes

❒ **ACE inhibitor contraindicated due to: _____**

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CMS Public Reporting

> 90th %ile
> 50th, <90th %ile
< 50th %ile

Presbyterian Hospital Charlotte Quality Measures		Jan 08	Feb 08	Mar 08	Apr 08	May 08	June 08	July 08	Aug 08	Sept 08	Oct-08	Nov-08	Dec-08	Top 10% All Hospitals Reporting in US	Avg All Hospitals Reporting in US
Acute Myocardial Infarction (AMI)															
AMI-1 Aspirin w/in 24hrs of hospital arrival		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%
AMI-2 Aspirin at discharge		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%
AMI-3 ACE/ARB at discharge for LVSD		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	88%
AMI-4 Smoking Cessation Advice/Counseling		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%
AMI-5 Beta Blocker at discharge		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%
AMI- 6 Beta Blocker w/in 24hrs of hospital arrival		100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%
AMI-8 Median Time to Primary PCI		61"	66"	57"	58"	64"	49"	64"	28"	37"	46"	44"	38"	N/A	N/A
AMI-8a Primary PCI received within 90" hospital arrival		100%	100%	85%	89%	100%	100%	100%	100%	100%	89%	100%	100%	92%	67%
AMI-9 Inpatient Mortality	@	0%	0%	3%	4%	5%	4%	0%	3%	5%	0%	4%	0%	N/A	N/A
AMI- ACM Appropriate Care Measure	%			99%			99%			100%			99%	Pending	Pending
Heart Failure (HF)															
HF-1 Discharge Instructions		94%	93%	98%	95%	96%	95%	95%	96%	92%	93%	92%	94%	97%	69%
HF- 2 Left Ventricular Function Evaluation		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	87%
HF-3 ACE/ARB at discharge for LVSD		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	87%
HF-4 Smoking Cessation Counseling		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%
HF- ACM Appropriate Care Measure	%			96%			96%			95%			94%	Pending	Pending

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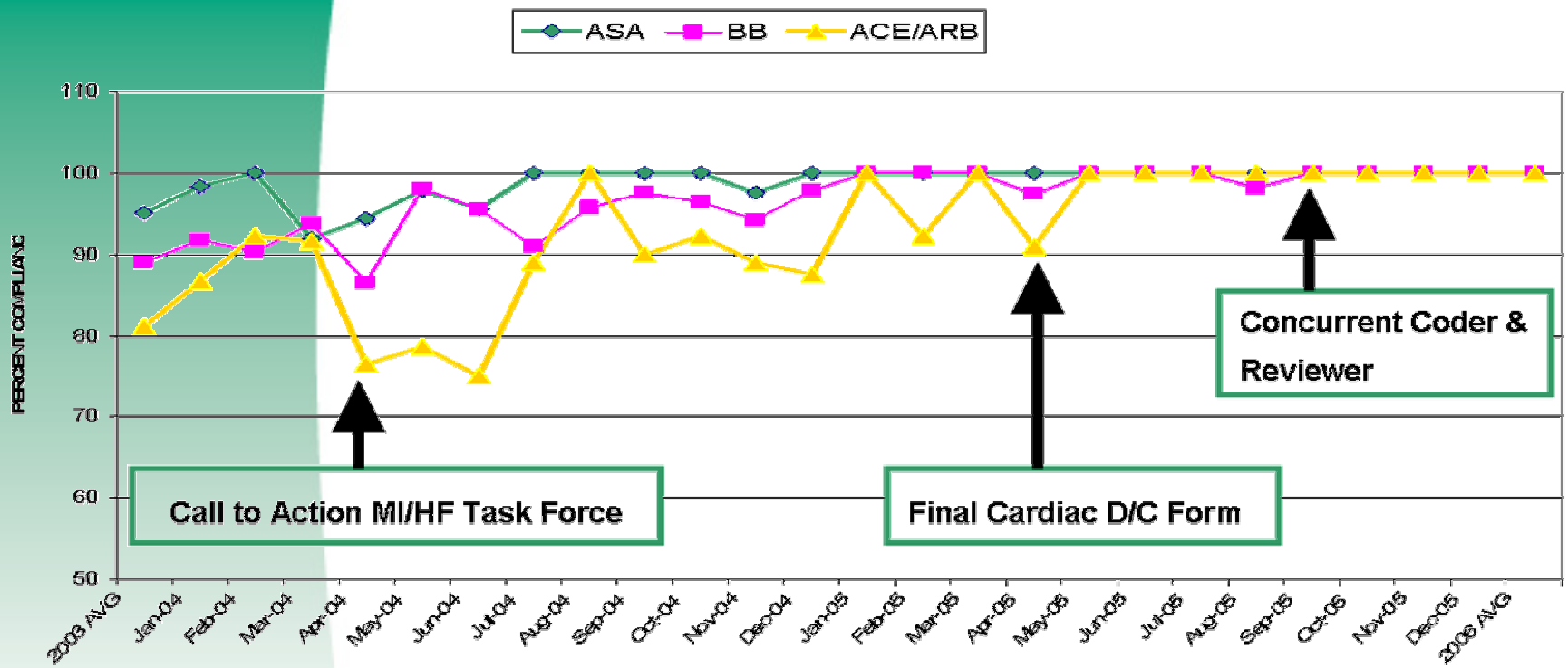
AMI Results for Discharge

Discharge Aspirin, Beta Blocker and ACE/ARB



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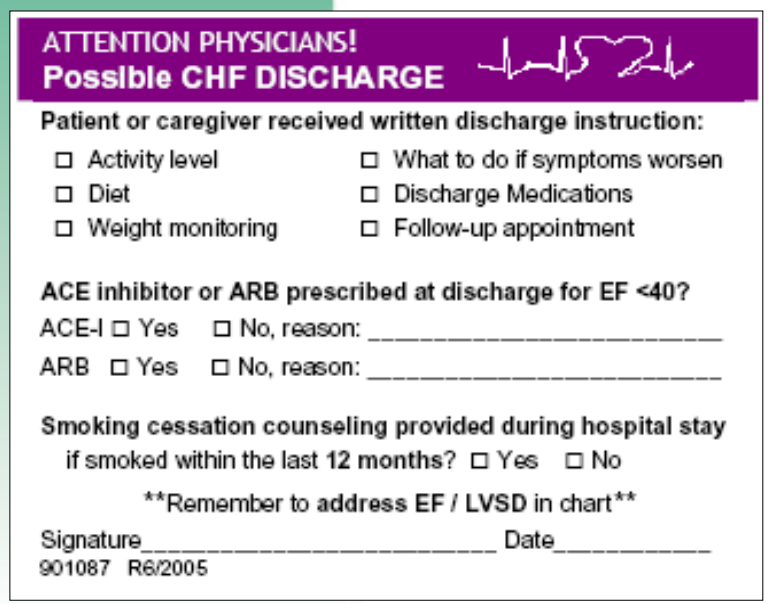
Lab and Progress Note Alerts

- Elevated BNP level generates alert that prints on appropriate unit, placed in chart
- Nurse Manager receives email with all elevated BNP values on unit
- List monitored by analysts and reviewers
- Easily recognized by physicians



ATTENTION PHYSICIANS!
Possible CHF DISCHARGE

Patient or caregiver received written discharge instruction:

- ☐ Activity level
- ☐ Diet
- ☐ Weight monitoring
- ☐ What to do if symptoms worsen
- ☐ Discharge Medications
- ☐ Follow-up appointment

ACE inhibitor or ARB prescribed at discharge for EF <40?

ACE-I ☐ Yes ☐ No, reason: _____

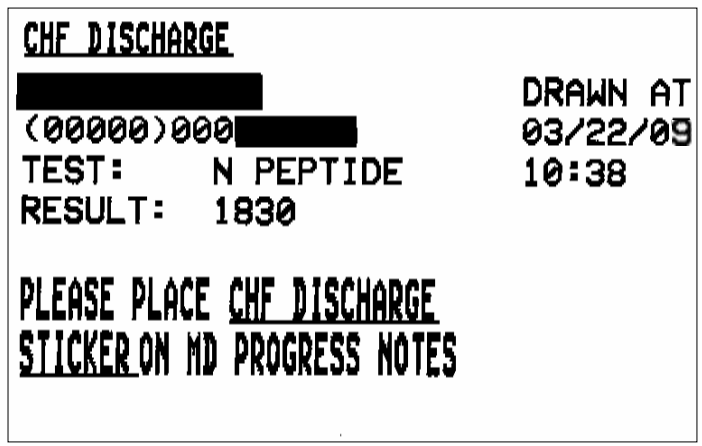
ARB ☐ Yes ☐ No, reason: _____

Smoking cessation counseling provided during hospital stay if smoked within the last 12 months? ☐ Yes ☐ No

Remember to address EF / LVSD in chart

Signature_____ Date_____

901087 R6/2005



CHF DISCHARGE

[redacted]

(00000)000[redacted]

TEST: N PEPTIDE

RESULT: 1830

DRAWN AT
03/22/09
10:38

PLEASE PLACE CHF DISCHARGE STICKER ON MD PROGRESS NOTES

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Physician Education Updates

- Physician documentation in the progress notes and D/C summary about the primary diagnosis is crucial. Clear and unambiguous chart information is extremely helpful for the coders. The coders depend upon this information in deciding whether CHF is an appropriate diagnosis. The coders can ***not*** infer a CHF diagnosis from Chest Xray reports, BNP levels, the administration of Lasix in the ED, or other secondary sources.

- It is very important to specify, whenever possible, the cause of a fluid overload in order to guide the coders about the presence or absence of CHF. For example, if a patient is admitted with pulmonary edema, please specify whether it is non-cardiogenic. Or, for a patient with anasarca, please specify the reason such as ESRD, cirrhosis, etc.

- The order in which the discharge diagnoses are listed on the discharge summary does ***not*** necessarily influence the priority of order for coding purposes. However, if you write or dictate, **"Primary diagnosis is exacerbation of COPD,"** that will be regarded as such in the coding. For a patient with a ***history of*** **CHF** admitted for some other reason such as a COPD exacerbation, please specify that the primary diagnosis is COPD. This is especially important when the CHF is compensated and incidental to the admission.

- Patients receiving biventricular pacemakers are coded as heart failure even if they are stable due to the indication for implantation of these devices.

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CMS Public Reporting

- Immediate feedback to practitioners involved in missed measures
- Physician committees or MEC to address standards and expectations related to specific CMS measures
- Peer review committees from reactive to proactive to address ongoing behaviors resulting in CMS measure deficiencies
- Demonstrate willingness to work cooperatively with physicians for best clinical care

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Physicians Support SCIP

Pre-operative Prophylactic Antibiotic Regimens for Selected Procedures – ADULTS

Approved by the SPR OR Committee and the SPR Medical Board

Pacemakers / AICDs:	
NO β-lactam allergy - *choose 1 of the 2 options provided* Cefazolin Vancomycin[1]: significant MRSA risk	If β-lactam allergy - *choose 1 of the 2 options provided* Vancomycin[2] Clindamycin[2]
Cardiothoracic Procedures:	
NO β-lactam allergy - *choose 1 of the 2 options provided* Cefazolin Vancomycin[1]: significant MRSA risk	If β-lactam allergy - *choose 1 of the 2 options provided* Vancomycin[2] Clindamycin[2]
Gastrointestinal:	
Laparoscopic appendectomy	
NO β-lactam allergy - *choose 1 of the 3 options provided* Ampicillin/sulbactam Cefoxitin Cefazolin **PLUS** Metronidazole	If β-lactam allergy - *choose 1 of the 4 options provided* Clindamycin **PLUS** Gentamicin Clindamycin **PLUS** Ciprofloxacin Metronidazole **PLUS** Gentamicin Metronidazole **PLUS** Ciprofloxacin
Laparoscopic cholecystectomy - Required if age ≥ 70 years; at surgeon's discretion if age < 70 years	
NO β-lactam allergy: *choose 1 of the 2 options provided* Cefazolin Cefoxitin	If β-lactam allergy: *choose 1 of the 2 options provided* Clindamycin (Cleocin) **PLUS** Gentamicin Clindamycin (Cleocin) **PLUS** Ciprofloxacin
Colon	
NO β-lactam allergy: *choose 1 of the 3 options provided* Cefoxitin Ampicillin/sulbactam Ertapenem	If β-lactam allergy: *choose 1 of the 5 options provided* Clindamycin (Cleocin) **PLUS** Gentamicin Clindamycin (Cleocin) **PLUS** Ciprofloxacin Clindamycin (Cleocin) **PLUS** Aztreonam Metronidazole (Flagyl) **PLUS** Gentamicin Metronidazole (Flagyl) **PLUS** Ciprofloxacin
PEG placement	
NO β-lactam allergy - *choose 1 of the 3 options provided* Cefazolin Vancomycin[1] (significant MRSA risk) **PLUS** Gentamicin Vancomycin[1] (significant MRSA risk) **PLUS** Ciprofloxacin	If β-lactam allergy - *choose 1 of the 4 options provided* Clindamycin **PLUS** Gentamicin Clindamycin **PLUS** Ciprofloxacin Vancomycin **PLUS** Gentamicin Vancomycin **PLUS** Ciprofloxacin

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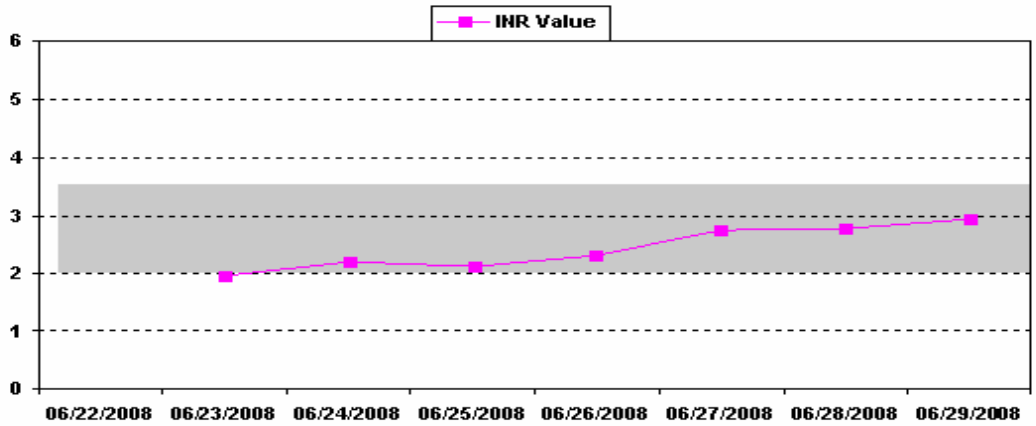
Support for SCIP measures

Current daily warfarin dose_____



	06/22/2008	06/23/2008	06/24/2008	06/25/2008	06/26/2008	06/27/2008	06/28/2008	06/29/2008
Dose Give (mg)	5	5	5	5	5	5	5	None
INR Value		1.96	2.21	2.11	2.31	2.75	2.77	2.93

PHARMACY:

Warfarin Dose PO	Frequency at 1700	Starting Date
_____ mg	❒ Daily ❒ X 1 Dose	❒ Today ❒ Other:_____

OR

Alternating Warfarin Dose PO Daily at 1700	Mon	Tue	Wed	Thur	Fri	Sat	Sun
_____ mg	❒	❒	❒	❒	❒	❒	❒
_____ mg	❒	❒	❒	❒	❒	❒	❒

DISCHARGE warfarin dose							
Date							
Dose _____ mg							

Labs:_____

_____

_____

MD: _____ *Date:* _____ *Time:* _____

Phone / Verbal Order: _____

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CMS Public Reporting

”Most importantly, a willingness by administration to dialogue with the medical staff about some of the requirements of the CMS measures. If based on applicable medical literature and sound clinical judgment, the most appropriate care for an individual patient is out of compliance with a specific CMS indicator, administration supports the clinical staff in its decision, even if it means not meeting the CMS requirement. This demonstrates to the medical staff a level of cooperation by administration that helps garner support from the medical staff around CMS indicators.”

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Care Plan Support

Nursing Care and Treatment:

- Telemetry
- O_2 sat now; ABG if less than 91%
- Intake and output q shift
- Weigh on admission and daily
- ❑ Foley catheter
- Vital signs per unit routine
- BRP with assistance
- Head of bed greater than 45 degrees as tolerated
- OOB to chair and increase activity as tolerated
- Assess and document date of last pneumococcal vaccine and influenza vaccine. Document in physician progress notes
- Document smoking cessation education
- Activate/ document Heart Failure Patient Education
- **Place Cardiac Discharge Instruction sheet on chart**
- Review and distribute Living with Heart Failure Book
- Weigh at discharge and place weight on discharge form
- Fax copy of discharge instructions to follow-up physician's office

Phone/Verbal		**RN**		**MD**	
Transcribed by	Time	**Verified by**	**Time**	**Orders Processed**	**Shift**

Date: _____

DIAGNOSIS:

- ☐ ACS (Acute Coronary Syndrome)
- ☐ MI (Myocardial Infarction or "Heart Attack")
- ☐ CAD (Coronary Artery Disease)
- ☐ HF (Heart Failure)
- ☐ Hypertensive Heart Disease
- ☐ Irregular Heartbeat _____
- ☐ Other: _____

PROCEDURES ☐ **Diagnostic Cath** ☐ **Coronary Intervention** ☐ **ICD/Pacemaker** ☐ **Other** _____

EJECTION FRACTION (MI / HF Core) **%** **or** ☐ EF ≤ 40% (Moderate to Severe Dysfunction)

DISCHARGE MEDICATIONS	**Dose / Frequency**	**Does not apply because:**
☐ List of medications to be taken after discharge was reviewed with patient/ family. Copy of list given to patient.		
DO NOT stop taking Plavix or Aspirin without discussing it with your HEART doctor first!		
Aspirin (MI Core)		☐ Allergic ☐ Other _____
Plavix		☐ Allergic ☐ Other _____
ACE Inhibitor: (MI / HF Core if EF < 40%)		☐ Allergic ☐ Low BP ☐ Cough ☐ Renal ☐ Other _____
ARB: (MI / HF Core if EF < 40%)		☐ Allergic ☐ Low BP ☐ Renal ☐ Other _____
Beta Blocker: (MI Core)		☐ Low pulse ☐ Lung disease ☐ Low BP ☐ Other _____
Lipid Lowering:		☐ Allergic ☐ Will start as outpatient
Aldosterone Antagonist (Aldactone)		
Anticoagulant:		
Diuretic:		
Nitrate:		
Potassium:		

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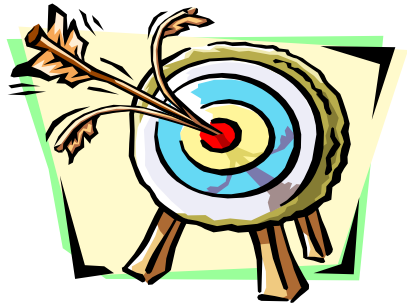
Excellent!

Code STEMI – 35 minutes

Wednesday March 7 @ 0857 – By EMS



ED: Dr. Nelson

Cardiologist: Dr. Johnson

Cath Team: Maria Schenoni, Chip Connor, Barry Horsey and Gary Huckaby

Arrival: Wednesday 3/7 @ 0857 MEDIC

Door to ECG: 0 min

ECG to Code STEMI: 0 min, Activated Prior to Patient Arrival
Cath Team Response: Cath Team Here

Door to Depart ED: 0 min (goal 30 min); Fast Track to Cath Lab Process Used

Depart ED to Lesion Treatment: 35 min (goal 30 min)
Note: Time includes enrollment into the Horizons Trial

Total Door to Lesion Treatment: 35 min (goal 60 min)

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Summary

- It's everyone's responsibility to succeed!
- Partner with physicians for improvement
- Identify key physicians as champions
- Provide useful and reliable data
- Educate medical staff often
- Communicate results at every opportunity
- Prompt feedback and education for misses
- Support results with protocols and order sets
- Understand physicians' time constraints
- Help physicians to be successful


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