Expecting Success: Excellence in Cardiac Care

First–Year Achievements Signal Big Improvements in Heart Care for Minority Patients

MARCH 2007

The 10 hospitals taking part in *Expecting Success* have improved performance on national measures of heart care and are ensuring that cardiac patients get *all* the care they should receive.

Participating hospitals have not only significantly improved overall heart care, but have begun to look closely at how they provide care to patients of different racial and ethnic backgrounds. These hospitals are systematically collecting information by patients' race, ethnicity and primary language —a critical first step towards improving quality of care for minority patients that may have major implications for improving care for all patients.

"This program demonstrates that hospitals serving our minority communities can make strong improvements in their performance measures in a relatively short period of time," says Bruce Siegel, M.D., who directs the *Expecting Success* program nationally and is a professor of Health Policy at The George Washington University. "Often, these are institutions that struggle to operate with fewer resources than other hospitals. Their progress has been amazing, and we think the changes they have implemented are going to be sustainable over the long term."

OVERVIEW

Each of the 10 *Expecting Success* hospitals is identifying, testing and adopting interventions and strategies to deliver better inpatient care, coupled with efforts to improve care in communities that support patients once they leave the hospital. The program has four specific goals:

- To improve cardiovascular care for African Americans and Latinos;
- To develop effective, replicable quality-improvement strategies, models and resources;
- To encourage the spread of those strategies and models to clinical areas outside of cardiac care;
- To share relevant lessons with health care providers and policymakers.

While all of us understand that there are certain characteristics that make a hospital just like any other, hospitals have important differences in mission, size, services offered and communities served. A small hospital in a rural area, for example, will obviously look and operate differently than a large teaching hospital in a major urban area. The Robert Wood Johnson Foundation (RWJF) supports many collaborative projects with very diverse types of hospitals to prove that no matter what the circumstances, the quality of treatment provided at every facility can and should be improved.

*RWJF took the learning collaborative model one step further with a national initiative to improve the quality of cardiac care for minority patients. The program, called **Expecting Success: Excellence in Cardiac Care**, is a RWJF project directed by experts at The George Washington University. Although the program has been operating for only a year and a half, it is already yielding gains in quality at the participating hospitals.*

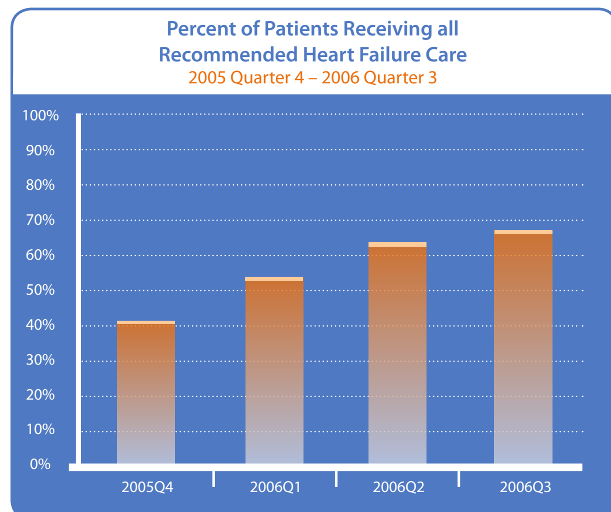
Robert Wood Johnson Foundation

THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

"Reducing racial and ethnic disparities in the quality of care is a tough problem. Our hospitals are consistently working on providing care to patients in a more focused manner," says Dr. Siegel. "*Expecting Success* is breaking new ground. We have not seen another hospital collaborative designed to improve care for minority patients and reduce disparities—and certainly none has used performance measures in a focused way and achieved solid results in such a short period of time."

Most hospitals participating in the program—spread across the country from the University of Mississippi Medical Center in Jackson, to Washington Hospital Center in the nation's capital, to the University Health System in San Antonio—provide care for mostly African-American and Hispanic patients.

"In developing this program, we specifically selected hospitals that could be learning laboratories for other institutions," says Pamela Dickson, M.B.A., deputy director of the Health Care Group at RWJF. "CEOs of the participating hospitals are telling us that the collection of race, ethnicity and language data has not been as hard as many expected, which is an important early success that will help us spread lessons to other institutions. We are now watching how these hospitals improve the care of their minority patients. We think the results from this initiative will be very relevant and important for other hospitals, and we intend to disseminate them widely."



Expecting Success *hospitals raised the median percentage of their patients receiving all recommended heart failure care from 41 percent to 68 percent in the first year of the collaborative.*

Reporting on Performance Measures of Ideal Care

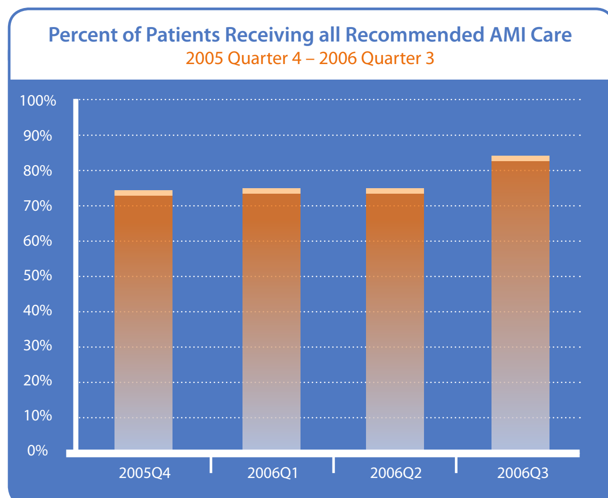
On a monthly basis, *Expecting Success* hospitals report on 23 care performance measures by patient race, ethnicity and primary language. These include the seven core performance measures of care for heart attacks or acute myocardial infarction (AMI) and the four core measures for heart failure (HF) that the U.S. Centers for Medicare and Medicaid Services (CMS) collects and publicly reports. Most of these measures reflect quality of inpatient care. For follow-up outpatient care, participating hospitals are using the 30-day readmission rate as a performance measure.

Performance on Measures of Ideal Care

Overall performance in cardiac care for the 10* Expecting Success *hospitals showed strong improvement during the first year (fourth-quarter 2005 through third-quarter 2006).

In addition, participating hospitals are reporting on key composite measures—known as Measures of Ideal Care (MIC)—that show whether a patient gets all of the core components of care recommended by the American College of Cardiology and the American Heart Association as evidence-based guidelines for treatment of heart failure or heart attacks.

"This is a perfect test of care. If a patient arrives in the hospital having a heart attack, we look to see if that patient got all of the care for which he was eligible. If the hospital doesn't pass any one core measure, for that patient, it has failed," says Dr. Siegel.



The median percentage of patients receiving all recommended AMI care increased from 74 percent to 82 percent in the first year of the collaborative.

Interventions Vary by Hospital

Expecting Success hospitals are using a range of interventions to improve performance on the care measures. Other than requiring the use of the core measures and the collection of data by race and ethnicity, the program did not require the hospitals to test and apply the same interventions.

"We provide guidance, not mandates," says Marcia Wilson, M.B.A., deputy director of the program. "The *Expecting Success* hospitals were responsible for developing their own work plans and strategies for how to achieve their goals. We exposed them to best practices and made it possible for them to share their experiences with each other."

There are some interventions that almost all hospitals are using, although even these are often customized to meet the needs of the individual hospital. All, for example, are working to standardize paperwork, such as admission and discharge forms. Most are helping doctors use standardized order sets that simplify procedures, such as ordering the appropriate medications in the proper dosage, as a way to continually improve patient care.

"Most hospitals are also using tools that provide a visual reminder for staff caring for each patient. When clinicians handle a patient's chart, it reminds them that the patient has to have specific care according to the performance measures," says Wilson. "Ultimately we will collect all the materials that the hospitals are using, as well as outline their best practices, and share these resources with other hospitals."

Data Collection Drives Improvement

Almost all U.S. hospitals collect and report data on quality of care performance. Very few, however, have a uniform system for asking patients their race, ethnicity and primary language. Even fewer track the quality of care they provide by patient race, ethnicity and language and subsequently use their data to promote improvement and reduce disparities.

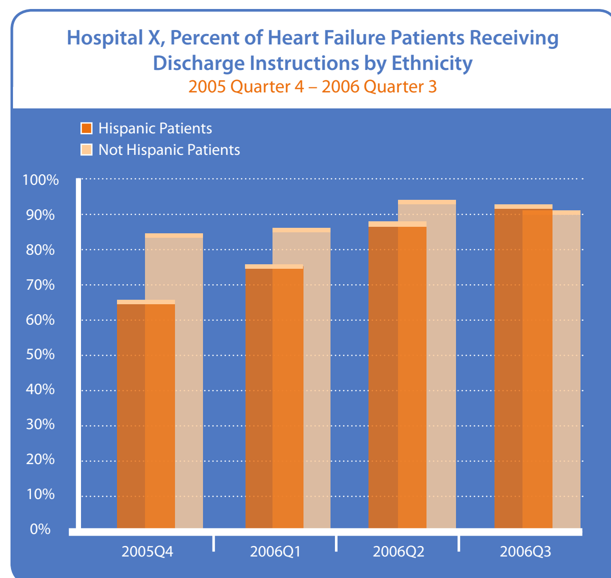
"We all want to think that all patients receive the same level of high-quality care, but if we aren't brave enough to gather data and look at the evidence in our own hospitals, we will never know if that is really the case, or if we need to take action," says Dr. Siegel. "We've learned that collecting racial and ethnic information uniformly can be done, but it requires commitment. We had to go in and train our hospitals' staff to do this and then find interventions that will impact performance."

Expecting Success is helping hospitals identify gaps in care and make changes that will result in reduced disparities and higher quality of care for everyone. But Dr. Siegel says the first and most-critical step for reducing disparities is gathering data based on patient race, ethnicity and primary language in order to accurately assess the situation.

"In *Expecting Success*, we collect data every month to help hospitals move to real-time consideration of how they are doing, so they can take these data back to clinicians and discuss how they can do things better. Some data are being reviewed on a daily basis. Once clinicians make a change, the data show them whether it has made a difference."

Dr. Siegel says that standardized collection provides a wealth of reliable data throughout a hospital—that can be used in all departments or units. "This is data they can trust, data that they can work with, and it helps in the spread of interventions that improve the quality of patient care," he says.

For example, when staff began collection of language data at one hospital, they discovered how many patients prefer to communicate with their health care providers in Spanish that verified the need for Spanish-speaking staff for their patient base.



To address health care disparities, one hospital has closed the gap that existed between its Hispanic and non-Hispanic patients receiving heart failure discharge instructions from 17.7 percent to 1.3 percent.

While all 10 *Expecting Success* hospitals are now uniformly collecting patient data based on race, ethnicity and language, the ease with which hospitals in the project have learned to collect data on race, ethnicity and language has been variable. One hospital had to train only a dozen or so staff; another faced training 600 registration staff.

Challenges Remain

While *Expecting Success* hospitals have made strong gains improving cardiovascular care and collecting data to document disparities in care, the program faces clear challenges in the coming year. These include:

- Maintaining momentum in the face of competing demands and attention. “Some of our hospitals have trouble seeing their successes,” says Wilson. “Because they are in the trenches working very hard every day, they don’t always see the truly amazing progress they have made. We have learned the incredible importance of outside validation. On site visits we are able to tell them that many other *Expecting Success* hospitals face the same challenges—so they realize that they do not work in isolation. Conference calls and our grantee meetings are also good for providing outside validation. It’s absolutely critical for them to remain enthusiastic about their efforts.”
- Understanding that not everything works. “At one hospital we found that out of 100 interventions, maybe 50 work and 25 are sustainable—that means you are going to fail three out of four times. This is a little discouraging, but I believe the program gives hospitals the flexibility to find out what works and the time to make it work,” Dr. Siegel says.
- Sustaining improvement efforts once the project ends. Most hospitals are expected to continue to work on improving care, because performance on core measures is publicly reported and will likely be linked in the future to Medicare and Medicaid reimbursement. The length of the program also allows time for hospitals to experiment and develop effective interventions that will spread to other units in the hospital. But many hospitals will face pressure to justify spending their own resources once grant funding ends.

“The sites will have to begin to look at the business case for continuing these activities. They will have to look at what the gains are—financially and non-financially—in relation to expenses,” says Dr. Siegel. “But when these hospitals go back and look at what they have accomplished in terms of improving care for minority populations, that’s a strong case for sustaining the efforts.”

Many hospitals participating in *Expecting Success* are finding that reducing disparities related to inpatient cardiovascular care is far easier than eliminating disparities patients face in follow-up outpatient care. Some are seeking to focus their resources on bridging this gap in the second half of the program.

For a list of participating hospitals, an explanation of ‘ideal care’ for Expecting Success *institutions or for other information on the program, see* www.expectingsuccess.org.

What were some of your most successful interventions?

We really struggled with ensuring discharge instructions documented patients' prescriptions and performance on all of the ideal care measures, so we created a standard set of discharge orders with a copy that stays in the medical record. We also developed a recognition program for staff members who provide the right care quickly. We designed a button that says 'I saved a life today,' and an award for 'Heart Doctor of the Month.' It's posted where patients can see it and has sparked competition between the doctors.

Why are you educating patients about collecting information on race and ethnicity?

We were initially concerned that patients would be offended if we asked these questions, but the registration staff developed a tool—a flier in English and Spanish to give patients. It explains why we are asking for this information, and that we are studying disparities in health care in order to ensure high-quality care for everyone.

What lessons have you learned?

One of the most important things we have learned, and this is useful for any quality improvement initiative, is for our staff to document exactly what we are doing and what is going on in our program, so that anyone can come in and follow the process. The program, is what needs to be ingrained into our processes, regardless of the people who are running it.

Are physicians on board with the *Expecting Success* program?

In the beginning, there was some resistance. When we started trying to implement changes like standard orders, they wanted to do what they always had done in the past. But now that they have seen our measures improve, the physicians have become very possessive of those standard order sets. They feel pride and ownership.

How has this program changed the way you improve care?

We have raised awareness that everyone has a role in providing quality care, and we better understand that quality improves with teamwork. We have created post-it notes on cardiac measures with a check-off list pasted on each patient chart. As each core measure is met, it's checked off so the next person knows what to focus on. The post-it notes serve as reminders to do it right as you go along. This has spread throughout the hospital.

Del Sol Medical Center

Del Sol Medical Center in El Paso, Texas, increased its performance on the Measures of Ideal Care for heart failure from 13 percent of patients in fourth-quarter 2005, to 78 percent in third-quarter 2006. Ideal care for heart attack patients at Del Sol during this period increased from 20 percent to 72 percent.

"Our 2006 fourth-quarter data showed all but one of our core measures are above the national average. This program has captured the attention of physicians and other front-line staff, who are now working together to improve quality of cardiac care."

*Jennifer Suitonu,
M.B.A.-H.C.M., M.S.N., R.N.
Administrative Director for
Cardiovascular Services
Del Sol Medical Center*

Which interventions have made the most difference on core measures?

For AMI we were already doing well — over 90 percent on meeting both the CMS and Joint Commission goals for most measures. On heart failure we were in the low-80s to mid-80s. Using the rapid cycle improvement process, we implemented a number of interventions, and we have brought the numbers for many measures up over the 90 to 95 percent mark.

We have fine-tuned the use of standard order sets and incorporated them throughout the entire hospital system. We are one of eight hospitals in the system, but the only one participating in *Expecting Success*. The other hospitals are using the order sets the way we prepared them, and they are seeing their quality scores go up as a result.

Has working on *Expecting Success* on heart care begun to spread through the hospital?

Yes, definitely — especially on core measures related to community-acquired pneumonia and surgical care improvement. Within a couple of months, our pneumonia measure scores shot up.

Has the community outreach program been effective?

We put together the 'Healthy Heart' program, a community-based health education program that helps schedule discharged patients for classes in nutrition, exercise, medication management, stress release and diet — so we can continue to show patients how they can keep themselves well, with the goal of keeping them out of the hospital. The program also educates physicians and asks them to refer their patients to Healthy Heart education classes as an extension of what they already provide in their offices.

We also developed the 'People's Medical College' — where we have physicians speaking to the public about how the heart works and problems you can have with heart disease. We're getting 100 to 150 people coming to these courses every Saturday.

All of these initiatives have really enhanced our patient volume, as well as physician and patient satisfaction. This program has helped revitalize our institution within the community.

What do you get out of the *Expecting Success* collaborative meetings?

We all walk out rejuvenated and educated about something new, and we come back excited and eager to adapt it and see if it works for us. We have realized that if we can make improvement processes part of everybody's day-to-day practice, that's how we will sustain performance. If an intervention becomes routine, then it will be sustained.

What's your goal for the second half of the program?

To get to 100 percent for all our performance measures and sustain it.

Sinai-Grace Hospital

Sinai-Grace Hospital in Detroit, Michigan, improved its performance on the Measures of Ideal Care from 77 percent of patients receiving perfect care for heart attacks in fourth-quarter 2005 to 92 percent in third-quarter 2006. Care for heart failure dropped slightly (86 percent to 83 percent) during this period.

"Participating in the project has created a stronger culture of safety and process improvement within the institution. It has brought greater collaboration into our group. Now, everybody is working together for a common goal."

Paru Patel, Pharm D.
Administrative Director,
Quality/Clinical Resources
Sinai-Grace Hospital

What have been some evidence-based keys to your success so far?

We developed standardized tools for physicians and clinical staff—including physician order sets. We also have a discharge tool that prompts clinical staff and physicians on key points for discussion before a patient is released. We standardized our educational materials. We created a consistent transfer form with a heart symbol on any performance measure related to *Expecting Success*. We also provide physicians with their own data, so they get feedback on core measures and benchmark them against their colleagues. That was not done before.

What impact has this program had on physicians?

Physicians by nature are highly competitive, and they want to try to see what they can do to increase their scores of key measures. Our next cut of the data will look at those physicians using the standardized order sets and the tools—to see if their performance is better than those who don't.

What lessons have you learned from this process?

Rapid cycle testing really does work. That was new for us. In the past, we tested an intervention for months. Now we can see if something works in a short period of time and if it does, we make it standard practice.

What have you been doing on the outpatient side?

My colleague, Dr. Jacqueline Ennis, is managing that aspect of the *Expecting Success* program. She is seeing improvement in outpatient care, but frankly, there are many barriers to providing good outpatient care. We now have case managers who help patients with admissions to the hospital for heart failure, and we also work with patients to make sure they have outpatient physicians.

How have you structured interventions to deal with this situation?

Dr. Janis Orlowski is working through community clinics where our case managers meet regularly with patients to follow up, and she is working to put in place structures, such as the free pharmaceutical program offered by the D.C. government. We are beginning to find effective ways to deal with the gap, but we are obviously not there yet.

Washington Hospital Center

At Washington Hospital Center in the nation's capital, the percentage of patients receiving all recommended care for heart failure improved from 30 percent in fourth-quarter 2005 to 59 percent in third-quarter 2006. The percentage of patients receiving ideal care for heart attacks went from 79 to 87 percent in the same period.

"Our data do not show disparity of care in the hospital, but there are real disparities that arise when patients of different races are discharged. There is no doubt that the overall quality of inpatient and outpatient care provided to minority patients in America needs to improve."

Elizabeth Wykpisz, R.N., M.B.A.
Vice President for Heart and Cardiac Services
Washington Hospital Center