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HDSP CONNECTION

Connecting programs, events, resources, research and people in the Minnesota heart disease and stroke prevention community.

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Improving CAD Care through Systems Change

Dr. Tom Kottke, HealthPartners Research Foundation

"Occupational organization . . . constitutes a dimension quite as distinct and fully as important as its knowledge."
- Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* [1]

Eliot Freidson, a pre-eminent sociologist of the second half of the 20th Century, reached this conclusion after studying a group of New York physicians. He observed that the practice environment is a more powerful predictor of physician behavior than are attributes like personality, beliefs, knowledge, or education [1].

Taking this observation to heart over the past 25 years, we have focused on building a physical and social environment that supports the care team to deliver the desired services rather than expecting

"CAD Care" *Continued on Page 2*

From the Editor:

System change involves changes made to the rules and mores within an organization. It is a way to effectively improve the health in a community by going beyond individual behavior change. I'm pleased to showcase two projects that are improving systems for heart disease and stroke care.

~ Mary Jo Mehleich

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CAD Care *Continued*

that more education and improved awareness alone will be sufficient to increase the delivery of preventive services.

We have found that an environment that supports the delivery of preventive services must have 5 components: Mutually agreed-upon goals; public reporting of the goals; resources to achieve the goals; stakeholder incentives, imperatives and sanctions that are aligned with the goals; and, leadership to keep the goals on the agendas of all stakeholders [2].

Supported by the CDC and the MDH, we have developed a method to easily identify evidence-based opportunities to improve outcomes for populations of patients at risk of or with heart disease, and we have demonstrated that nearly all patients who are hospitalized at Regions Hospital receive nearly all of these evidence-based therapies [3]. However, we also documented in this same study that there are still opportunities to improve the outcomes of patients through secondary prevention by addressing the optimal care goals: tobacco-free, daily aspirin, blood pressure control, and LDL control [4].

Our current MDH-supported efforts at HealthPartners Medical Group (HPMG) focus on developing tools in the electronic health record that allow care teams to assess whether patients with heart and other vascular diseases are meeting the four goals. We have also developed an electronic health record order, "HealthPartners Connect" that makes it easy for the clinic team to refer patients who might benefit from more intensive services like smoking cessation support, dietary change support, physical activity programs, or medication team management.

Recently HPMG has begun to give individual primary care physicians and cardiologists' reports on their patients who are not meeting the optimal care goals. Performance will be reviewed periodically with the expectation that each physician will meet performance targets.

In the coming year and beyond we will be continuing our work in HPMG and will be seeking to work with other medical groups in the state to help them implement these same tools in their practices and use them to reduce heart disease events by 3,000 per year in Minnesota—our part in making the Million Hearts Initiative [5] a success. This is a big job, but working together, we can do it.

References

[1] Freidson E. Profession of Medicine. A study of the sociology of applied knowledge. . New York: Dodd, Mead & Company; 1970.

[2] Kottke TE, Pronk NP, Isham GJ. The simple health system rules that create value. Prev Chronic Dis. accepted for publication.

[3] Baechler CJ, Kottke TE. Identifying Opportunities for a Medical Group to Improve Outcomes for Patients with Coronary Artery Disease and Heart Failure: An Exploratory Study. The Permanente J. 2011;15(2):4-14.

[4] Minnesota Health Scores. Minnesota Health Scores. Minneapolis: Minnesota Community Measurement; 2011 [cited 2011 October 14]; Available from: http://www.mnhealthscores.org/.

[5] Frieden TR, Berwick DM. The "Million Hearts" initiative--preventing heart attacks and strokes. N Engl J Med. Sep 29;365(13):e27.

DEVELOPMENT OF A STATEWIDE STROKE SYSTEM

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You're enjoying a weekend at the cabin when your spouse suddenly becomes dizzy, numb on one side, confused, can't see or speak—they have had a stroke. What do you do? Call 9-1-1 immediately!

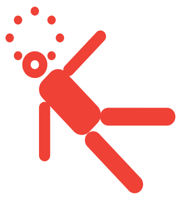
If you were home in the Twin Cities, Rochester or St. Cloud, emergency medical services (EMS) would assess and triage the stroke and transport you to the best equipped hospital—a certified Primary Stroke Center (PSC)—which would be less than an hour away. However, you are at the cabin in rural Minnesota and the nearest hospital is more than 60 minutes away and is not certified PSC.

This lack of coordination among Minnesota's communities, EMS and hospitals is unnecessarily costing us lives and increasing healthcare costs, when the solution is relatively simple—to coordinate and communicate between ambulance systems, hospital systems and communities so stroke patients, especially those in rural Minnesota, can be triaged and transferred quickly to the hospitals best equipped to treat them.

Far too many Minnesotans die or are disabled from stroke because they do not get brain-saving emergency treatment in time and don't ultimately end up at the best facility to fully treat their acute stroke. Timely and expert treatment can mean the difference between returning to work or becoming permanently disabled; living at home or living in a nursing home. It can be the difference between life and death.

"STROKE SYSTEM" *Continued on Page 4*

STROKE SYSTEM *Continued*

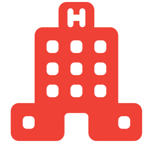


According to the American Heart Association, nearly 795,000 people suffer a stroke each year in the United States. In Minnesota, stroke takes the life of over 2,000 people each year and is the primary reason for nearly 12,000 hospital admissions every year with direct annual hospitalization costs of over $350 million.

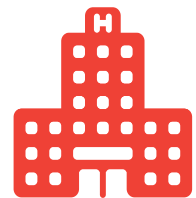
Thankfully the solution is in progress—getting ambulance systems to use uniform protocols to assess and triage stroke patients, getting rural hospital systems to coordinate resources and expertise; and getting more hospitals to become acute stroke-ready – meaning they can provide both expert emergency intervention before transferring to a tertiary care facility – and, if necessary, follow on admission for stroke care.

More than one-third of Minnesotans live over 60 minutes away from a PSC. Rural areas of Minnesota have the highest population of seniors; the group most impacted by stroke; but have the longest travel times to PSCs. With stroke, time lost is brain lost. Nearly 1 in 3 stroke victims arrive first at a small, rural hospital, which highlights the need to make sure that every community hospital emergency room is equipped to treat acute stroke patients. This is not to say they can't receive good stroke care in greater Minnesota, but currently there is no system to coordinate the resources each hospital and community brings to the table.

To coordinate, we first need to adopt standard protocols for ambulances and emergency medical services. Standard protocols allow EMS to better assess and triage stroke patients in the field, and to know the best-equipped facility to take them. We can advance care and stroke patient outcomes by identifying hospitals in every corner of the state that can best treat acute stroke patients for immediate intervention and provide follow-up on care, and encouraging these hospitals to collect and submit data to a database so we can track and implement quality improvements.



Thankfully, the process to develop a system-based approach to treating stroke in Minnesota is already underway with the leadership of the American Heart Association/ American Stroke Association and the Minnesota Department of Health. Under the new Minnesota Heart Disease and Stroke Prevention State Plan, a statewide Minnesota Acute Stroke System Council has been established and charged with developing and implementing a comprehensive stroke system of care for Minnesota. The Council has been meeting monthly since March of 2011 and includes expert representation from across the state and across areas of medicine and health policy. The goal will be to develop a framework for the system by early 2012 and launch voluntary participation in the system later next year. Join us in the effort to develop a system that works for everyone (EMS, hospitals, and especially our residents) in the entire state.



For more information, please visit the HDSP website: http://www.health.state.mn.us/divs/hpcd/chp/cvh/learn_stroke.htm ■

State Plan Update

State Plan Website Coming Soon!

Sueling Schardin, MPH, RD, Minnesota Department of Health, HDSP

By year end, the HDSP unit will have the State Plan 2011-2020 website up and running. The website will include the most current inventory of progress of state plan objectives, strategies and tactics. It will also show where we are at with our global and objective indicators. These numbers will be updated once per year. We will also have a mechanism for the public to submit activities around our state plan strategies and tactics.

SPOTLIGHT *Upcoming Events*

February is American Heart Month

Heart disease is the leading cause of death in the United States. Learn about heart disease and heart disease prevention at these websites.

Centers for Disease Control and Prevention
http://www.cdc.gov/features/heartmonth/

American Heart Association, Go Red for Women
http://www.goredforwomen.org/

Minnesota Department of Health, Heart Disease & Stroke Prevention
http://www.health.state.mn.us/divs/hpcd/chp/cvh/index.htm

Please direct any comments, questions or suggestions for newsletter content to Mary Jo Mehelich at (651)201-5419 or mary.mehelich@state.mn.us

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