Expecting Success: Excellence in Cardiac Care
An RWJF National Program

SUMMARY

*Expecting Success: Excellence in Cardiac Care* was a national program of the Robert Wood Johnson Foundation (RWJF). From 2004 to 2008, it aimed at improving the overall quality of cardiac care while reducing racial, ethnic and language disparities. The 10 participating hospitals developed and shared tools for improving care for all heart attack or heart failure patients. (Heart failure is a condition in which the heart cannot pump enough blood to meet the body's needs.)

Teams within each hospital worked together via a learning network (which included technical assistance, meetings, conference calls and a password-protected website). They used evidence-based guidelines to improve and track the quality of inpatient cardiac care and also worked on community demonstration projects to improve care as heart patients transitioned from inpatient to outpatient care.

Key Results

Program Director Bruce Siegel, MD, MPH, reported the following results in *Expecting Success: Excellence in Cardiac Care: Results from Robert Wood Johnson Foundation Quality Improvement Collaborative* (November 2008) and to RWJF:

- The *Expecting Success* hospitals institutionalized, or "hardwired," the collection of self-reported patient race, ethnicity and language data and tracked core measures of care for patients who had a heart attack or heart failure. "We showed you can collect data on race and ethnicity and use it to improve quality, and you can do it relatively easily," said Siegel.

"*Expecting Success* provided a model for using performance data stratified by race and ethnicity to improve quality. Prior to that, many hospitals were doing quality improvement, but I'm not aware of any that were stratifying the data by race and ethnicity and using them to improve care overall and for specific populations," said Pamela S. Dickson, MBA, assistant vice president of RWJF who served as the program officer.

- The *Expecting Success* hospitals improved their quality of care. Within one year, every hospital that participated in the program had increased its percentage of patients
receiving all core measure of care for heart attack and heart failure. This improvement continued throughout the program.

**Key Findings**

From 2005 to 2010, evaluators at the Center for Health and Public Service Research in New York University's Robert F. Wagner Graduate School of Public Service evaluated *Expecting Success*. John Billings, JD, led the evaluation team. Among its findings were the following:

- The experience of the *Expecting Success* hospitals indicates that it is quite feasible for a diverse group of hospitals to implement systematic, internally standardized methods to collect race, ethnicity and language data from patients. As increasing numbers of hospitals are required to collect race, ethnicity and language data, standardization will become more essential. Because the sites did not achieve full standardization, there are challenges for comparing hospitals or using the data for cross-site research or evaluation.

- *Expecting Success* hospitals improved their performance during the intervention period (September 2005 to May 2008) and in the following year, but they fared no better than a comparison group of similar hospitals that did not participate. This may reflect the strong government incentives that were created for all hospitals to improve their reporting, including penalties for not submitting core process measures to the Centers for Medicare & Medicaid Services (CMS) and the public availability of these data.

- Implementing the community demonstration projects proved challenging for most hospitals. Many of the community demonstrations were significantly scaled back, often focusing solely on post-discharge follow-up.

**Program Management**

The Center for Health Services Research and Policy in the School of Public Health and Health Services at George Washington University, where Siegel is a research professor, served as the national program office for *Expecting Success*. Siegel directed the program.

**Funding**

In November 2004, the RWJF Board of Trustees authorized *Expecting Success* up to a total of $13.2 million through 2008.

**Afterward**

The model used in *Expecting Success* has been incorporated into *Aligning Forces for Quality*, RWJF's signature effort to lift the overall quality of health care in 17
communities, reduce racial and ethnic disparities and provide models of national reform. Begun in 2006, Aligning Forces for Quality builds on Expecting Success by:

- Collecting self-reported race, ethnicity and language data
- Stratifying performance data by race, ethnicity and language data
- Guiding the Hospital Quality Network, a hospital quality improvement collaborative

**CONTEXT**

**Health Care Disparities Between Minorities and Whites**

Health care disparities—differences in the use of health care services and health outcomes—between minorities and Whites have received widespread attention. In 2002, the Institute of Medicine (IOM) report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care noted that:

- Minorities are less likely than Whites to receive the health care services they need in many disease areas.
- Racial and ethnic disparities in care were especially likely in the treatment of heart disease. For example, Blacks and Hispanics are less likely than Whites to receive appropriate heart medicines (e.g., aspirin and beta-blockers) or to have coronary artery bypass surgery.

(Beta-blockers help relax the heart, slow the heartbeat and decrease blood pressure and thus can limit the amount of damage to the heart and prevent future heart attacks. Coronary artery bypass surgery is a procedure to restore blood flow to the heart by diverting the flow of blood around a blocked artery.)

The IOM report also recommended the use of evidence-based guidelines to provide more consistent and equitable care for all patients. The theory is that focusing on overall quality improvement could improve care for all patients while reducing or eliminating disparities.

**The Increased Burden of Heart Disease on Minorities**

Partly as a result of these disparities, Blacks and Hispanics are more likely than Whites to be seriously affected by heart disease, according to researchers at the George Washington University School of Public Health and Health Services. For example:

- Blacks are much more likely than Whites or Hispanics to die from heart disease. Among individuals 35 or older:
  - 662 deaths from heart disease occur per 100,000 Blacks
— 559 deaths from heart disease occur per 100,000 Whites
— 348 deaths from heart disease occur per 100,000 Hispanics

- Blacks and Hispanics are more likely than Whites to die prematurely from heart disease. Heart disease causes:
  - 31.5 percent of all deaths among Blacks
  - 23.5 percent of all deaths among Hispanics
  - 14.7 percent of all deaths among Whites

- More than 40 percent of Black men and women suffer from cardiovascular disease, compared to 34 percent of White males and 32 percent of White females.

- Blacks and Hispanics are more likely than Whites to have risk factors for heart disease. For example, 42 percent of Black men have high blood pressure, compared to 31 percent of White men.

**RWJF Interest in the Area**

In response to *Unequal Treatment*, RWJF established a disparities team to direct grants to address this area. In developing the best approach for disparities work, the team considered quality improvement in hospitals, which was becoming a mainstream process.

"We came to an 'ah ha!' feeling that it wasn't going to be as effective to treat disparities as a problem," said RWJF's Dickson. "If some people in minority populations were not receiving the best care, it was a quality problem, period. It meant this hospital didn't give good care across the board."

RWJF adopted the strategy that reducing disparities should be a central part of quality improvement agendas at hospitals, health plans and other organizations involved in health care. RWJF's approach also followed the IOM's recommendation that health systems "promote the consistency and equity of care through the use of evidence-based guidelines.”

Subsequently, RWJF consolidated and reorganized its teams, merging disparities into a new Quality/Equality Program Management Team in 2005.

**Using Quality Improvement to Improve Health Care**

A national program that began in 2001, *Pursuing Perfection: Raising the Bar for Health Care Performance*, informed the Quality/Equality team's quality improvement focus. "Pursuing Perfection helped us see the value of using quality improvement methods to improve care," said Dickson. During this $25.6 million, national demonstration program
(2001 to 2008), seven health care organizations worked to improve their care processes and patient outcomes (see Program Results Report).

Another national program, Hablamos Juntos: Improving Patient-Provider Communication for Latinos (2001 to 2006), showed the Quality/Equality team the limits of focusing only on reducing disparities. This program sought to help health care organizations provide language services, including:

- Interpretation for spoken encounters and translation for written documents
- Informational materials in Spanish
- Easy-to-understand signage within health facilities

Carving out language services was less effective than efforts to improve overall quality, said Dickson (see Program Results Report).

THE PROGRAM

Based on this earlier work, in 2004 RWJF funded Expecting Success: Excellence in Cardiac Care aimed at improving the overall quality of cardiac care; finding out where racial, ethnic and language disparities exist; and developing targeted approaches to deal with these disparities. It ran to 2008.

RWJF saw hospitals as a logical place to focus efforts to reduce disparities since many of the procedures that have formed the evidence base for disparities in cardiac care are done there. Also, hospitals typically have the most advanced information systems and quality improvement processes.

RWJF focused the program on cardiac care because the recommended standard of care is clear and accepted by doctors nationwide. Validated measurement tools to determine whether patients receive the recommended care are available, and strong evidence of racial and ethnic disparities existed.

"There's a lot of evidence about the proper approach and how you treat people with cardiac disease, how you know when you're doing well and what the problems were," said Dickson.

Ten hospitals participating in Expecting Success worked together in a learning collaborative to improve care for heart attack or heart failure patients. (Heart failure is a condition in which the heart cannot pump enough blood to meet the body's needs.)

The program had four goals:

- To improve cardiovascular care for Blacks and Hispanics by improving care for all patients
- 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 policy-makers.

*Expecting Success* used evidence-based guidelines to improve the overall quality of care for all heart attack and heart failure patients. "If we follow simple guidelines for every patient, we will eliminate disparities and improve care for everyone," said Siegel, the program's director.

**Building on Urgent Matters**

*Expecting Success* used the collaborative learning model and rapid improvement techniques developed in *Urgent Matters*, another RWJF national program Siegel directed at George Washington University. *Urgent Matters* aimed to relieve emergency department overcrowding, improve patient care and increase patient satisfaction in 10 hospitals. The program also sought to use emergency departments as an example to help communities understand the interdependence of the health care safety net and the rest of the health care delivery system. See [Program Results Report](#).

**Choosing Diverse Hospitals With Large Minority Populations**

RWJF, the *Expecting Success* national program office and an advisory committee invited 380 hospitals with substantial populations of Black and Hispanic patients to apply; 122 hospitals did so. Ten hospitals from across the country were selected to participate:

- Del Sol Medical Center (El Paso Healthcare System), El Paso, Texas
- Delta Regional Medical Center, Greenville, Miss.
- Duke University Hospital, Durham, N.C.
- Montefiore Medical Center, Bronx, N.Y.
- Mount Sinai Hospital Medical Center, Chicago, Ill.
- Sinai-Grace Hospital, Detroit, Mich.
- University Health System, San Antonio, Texas
- University of Mississippi Medical Center, Jackson, Miss.
- Washington Hospital Center, Washington, D.C.
See Appendix 1 for members of the advisory committee. See Appendix 2 for hospital contact information.

Participating hospitals were intentionally diverse in terms of size, geographic location, patient mix and type (e.g., teaching, community, for profit, private nonprofit and public) so that similar hospitals nationwide could adapt their work.

The hospitals also shared:

- A willingness to discover where and how disparities were occurring
- A proven track record in quality improvement initiatives
- A readiness to serve as "learning laboratories" for other hospitals nationwide
- Leadership committed to improving heart care for all patients, particularly minorities

Each hospital had a multidisciplinary team that included medical staff, such as the chiefs of cardiology and emergency department and frontline nurses, and administrative staff, such as the directors of quality improvement, information systems and patient registration or admitting.

The teams worked within their hospitals to improve and track the quality of care and to collect race, ethnicity and language data. They also worked together via a learning network managed by the national program office. The CEOs of the hospitals were required to attend several meetings of the learning network.

The hospitals received grants of about $200,000 beginning in September or October 2005 and ending in May 2008.

Two of the hospitals also received additional RWJF grants to extend and disseminate their work:

- Sinai-Grace Hospital (Detroit)
- University of Mississippi Medical Center

**Improving and Tracking the Quality of Inpatient Care**

The hospital teams developed interventions and systems to ensure that their cardiac patients would consistently receive all of the recommended inpatient care for heart attack or heart failure. Each hospital chose the interventions it wanted to test and apply.

The program used 21 performance measures, based on evidence-based guidelines from CMS, the American College of Cardiology and the American Heart Association to assess the quality of care provided. These included eight core measures of care for heart attack
and four core measures for heart failure, as defined by CMS. Examples of these core measures are:

- Aspirin and beta-blockers at arrival and discharge for heart attack patients. (Aspirin thins the blood; beta-blockers help relax the heart, slow the heartbeat and decrease blood pressure. They can limit the amount of damage to the heart and prevent future heart attacks.)

- Evaluation of left ventricular systolic function for heart failure patients.

- Smoking cessation advice/counseling.

The hospitals also tracked two Measures of Ideal Care, "all-or-none" measures that indicated whether a patient had received all of the core CMS components of care for heart attack or heart failure. "These were envisioned as 'stretch' measures that reflect the national move towards simplifying measurement while focusing on the totality of the patient experience," according to the national program office in a report to RWJF.

For a complete list of performance measures, see Appendix 3.

The hospitals reported monthly on their care performance measures, stratified by patient race, ethnicity and primary language. The national program office analyzed the data and developed detailed, individual reports for each hospital. Hospitals also could see aggregate data for all hospitals on the program's password-protected website.

**Standardizing Collection of Race, Ethnicity and Language Data**

In order to stratify the data by race, ethnicity and primary language, the participating hospitals adopted a standardized approach to data collection. Before Expecting Success, registration staff generally looked at the patient and guessed what to include for race and ethnicity. During the program, the hospitals asked patients about their race, ethnicity and preferred language, using:

- The U.S. Office and Management and Budget's standard categories for race and ethnicity
- The U.S. Census Bureau's language categories
- Categories added by the national program office for patients who declared more than one race or language; were unable to provide race, ethnicity or language data; or declined to respond

For the race, ethnicity and language categories, see Appendix 4.

Experts from the Health Research and Educational Trust (HRET), a division of the American Hospital Association, provided on-site technical assistance to help the hospitals
collect these data, using the HRET Disparities Toolkit. The toolkit includes information about how to collect the data and resources for training staff, such as sample scripts.

When Expecting Success started, the hospitals were worried about collecting these data and especially concerned that patients might think they would receive less care based on their race. "We expected a lot more resistance and push-back," said Siegel. "We were worried that people just wouldn't want to do it because it's politically sensitive."

Instead, hospital team members overwhelmingly reported that implementing the new data collection procedures was far easier than they had expected it to be, largely because the process took place within a single department (the registration department), which in many cases was headed by an experienced administrator who had received clear direction from management. Moreover, hospital registration departments are already accustomed to implementing procedural changes (as they have done by adding questions about living wills and smoking cessation to the registration process).

Siegel also credited the training Expecting Success provided with facilitating the collection of these data. "We spent a lot of time training people, going on-site, answering questions. We gave people the time and ability to process all of this," said Siegel. He also noted that people were more used to answering these kinds of questions in their daily life than expected.

**Developing and Sharing Tools and Techniques**

To improve the use of core measures of cardiac care, the hospitals developed and implemented a variety of techniques and tools:

- Visual reminders for staff to provide the core measures, such as post-it notes or brightly colored paper on the patient's chart or door
- Chart reviews to determine whether core measures were met
- Performance reviews of providers and reporting
- External and internal communications programs
- Standardized order sets
- Discharge orders or contracts
- Patient education materials

The learning network provided a structure through which the hospitals could exchange strategies. "It was an open network sharing of ideas, tools and strategies across the 10 hospitals. Part of the sharing is seeing, 'Wow, somebody else can do this, maybe I can too,'" said Siegel.
For example, one hospital developed a new form for admitting patients and another assigned a cardiac care manager responsibility for ensuring that every patient got the recommended care. Other innovations shared among the project sites included:

- Sinai-Grace Hospital in Detroit developed universal patient discharge instructions, available online, to help hospital staff meet discharge guidelines for heart patients.
- University of Mississippi Medical Center in Jackson developed weekly chart review report cards for staff for heart attack and heart failure care, available online.

**Designing a Community Demonstration Project**

Each hospital also developed a community demonstration project to improve care as heart attack and heart failure patients transitioned from inpatient to outpatient care. Most of the hospitals had problems implementing these projects and had to scale back their plans significantly, often focusing only on post-discharge follow-up. For more information about these challenges, see Lessons Learned and Evaluation Findings.

**Management**

**National Program Office**

The Center for Health Services Research and Policy in the School of Public Health and Health Services at George Washington University served as the national program office for Expecting Success. Siegel directed the program.

The national program office facilitated the learning network by providing the hospitals with:

- The opportunity to work together through meetings; monthly conference calls; and a password-protected website, which included clinical guidelines and quality improvement tools.
- Technical assistance, including:
  - Cardiovascular care market assessments of each hospital's community to inform its work
  - Site visits by national program staff and experts to help guide quality improvement, collection of race and ethnicity data, evidence-based practices and survey and sampling methodologies
- Creation and facilitation of three work groups produced educational and training tools and resources for hospital staff and heart failure patients.
The work groups, composed of representatives of the participating hospitals, focused on common issues:

- **The need for materials that communicate the importance of collecting race, ethnicity and language data.** This work group developed a "We Ask Because We Care" poster and tent card to explain why the hospital collects this information and how it will be used.

- **The need for tools to help educate heart failure patients on how to manage their disease after being discharged from the hospital.** This work group created a "You Can Live with Heart Failure—Healthy Habits for Life Calendar" and the "You Can Live with Heart Failure—Patient Teaching Guide Calendar Companion," for use by nurses in teaching heart failure patients about managing their condition.

- **The need to define more clearly the role of nurse practitioners in the care of heart failure patients.** This work group formulated the elements necessary to develop a successful nurse-led heart failure program.

**National Advisory Committee**

The national advisory committee helped the national program office and RWJF choose the hospitals that participated in *Expecting Success*. For a list of members, see Appendix 1.

**PROGRAM RESULTS**

Program Director Siegel and national program staff reported the following results in *Expecting Success: Excellence in Cardiac Care: Results from Robert Wood Johnson Foundation Quality Improvement Collaborative* (November 2008) and to RWJF:

- **Expecting Success hospitals improved the quality of their care.** Within one year, every hospital that participated in the program had increased its percentage of patients receiving all core measures of care for heart attack and heart failure. This improvement continued throughout the program.

However, an evaluation found comparable improvements in similar hospitals that did not participate. (See *The Evaluation and Its Findings.*

- **The Expecting Success hospitals became more aware of disparity in disease treatment.** Through data collected by the hospitals and analyzed by national program staff, hospital managers and clinicians recognized the potential for racial and ethnic disparities at their institutions and became more committed to identifying disparities and addressing them promptly.

"All of these hospitals were sure that they did not have any disparities and that they treated everybody the same," said RWJF's Dickson. "It was a very positive experience for them to go through the process of collecting the data and to understand that they
had problems across the board. It was clear that as a group Blacks and Hispanics were receiving poorer care."

"Health care providers assume they provide high-quality care to everyone but they don't," said Siegel. "They're often shocked when they find what the reality is. Seeing the data is a powerful impetus for change in these organizations."

- **The Expecting Success hospitals implemented systems to collect patient data routinely by race, ethnicity and primary language and tracked core measures of care for patients who had a heart attack or heart failure.**

"Expecting Success provided a model for using performance data stratified by race and ethnicity to improve quality. Prior to that, many hospitals were doing quality improvement, but I'm not aware of any that were stratifying the data by race and ethnicity and using them to improve care overall and for specific populations," said Dickson.

For example:

- Montefiore Medical Center in the Bronx, N.Y., redesigned its patient registration system and trained 600-plus registration staff in collecting data on race, ethnicity and preferred language from patients and in using the system. "We were very careful to explain how getting the information would improve patient care," said Caryl Greaves, MPA, RHIA, director of Health Information Management.

  Read the Grantee Profile on Montefiore's work under Expecting Success.

- In Durham County, N.C., the Duke University Health System (Duke University Hospital, Duke Raleigh Hospital and Durham Regional Hospital) used the Get REAL (Race, Ethnicity and Language) campaign to help registration staff learn how to ask patients to identify their race, ethnicity and primary language. The health system also trained registration staff, upgraded information systems and informed patients and families about the purpose of collecting this information.

  "Figuring out why disparities exist depends on having consistent, reliable data about the populations we serve, on understanding their culturally specific needs and on identifying patterns in care," said Eric Velazquez, MD, the cardiologist who was the principal investigator for Expecting Success at Duke.

  Read the Grantee Profile on Duke's work under Expecting Success.

- **The Expecting Success hospitals implemented quality improvements to ensure that all patients consistently received the right care.** For example:

  - The Code Heart program at Memorial Healthcare System in Broward County, Fla., reduced door-to-balloon time (the amount of time from arrival at the emergency department to receiving angioplasty) by immediately alerting the
emergency department and cardiac teams when a heart attack patient arrived at
the hospital.

(Angioplasty, also called percutaneous coronary intervention, or PCI, is a
procedure used to open clogged heart arteries by temporarily inserting and
blowing up a tiny balloon to help widen the artery.)

"It used to be that potential heart attack patients arriving in the ED would first be
given a chest X-ray. Then we'd do the lab work, followed by an EKG. Now the
EKG is our very first step, which tells us immediately whether we need to activate
the cath lab. Doing things the old way cost us 10 or 15 minutes, sometimes more.
Now we're saving time and saving heart muscle, which potentially saves lives,"
said Melinda Stibal, RN, CEN, administrative director of emergency and trauma
services.

— Washington Hospital Center in Washington, D.C., also focused on reducing door-
to-balloon time by doing simulated percutaneous coronary intervention exercises.
Staff took volunteer "patients" through every step of the process—from the
emergency room door to the catheterization lab. These simulations identified
areas for improvement that might not have been captured by traditional pen-and-
paper operational reviews.

"The learning simulations have helped our emergency cardiac care teams become
more of a finely tuned machine. By examining ourselves in action, these exercises
improved operations and ensure that 100 percent of the cardiac patients that need
PCI receive it within the 90-minute standard that CMS looks for," said Elizabeth
Wykpisz, RN, MBA, vice president of heart and vascular services.

— Del Sol Medical Center in El Paso, Texas, initiated standardized procedures for
diagnosing and treating heart attacks and other cardiovascular problems. The
hospital hired a nurse with a strong cardiology background to review charts and
determine whether heart attack patients were receiving care in compliance with
evidence-based guidelines.

This "real-time" review "gave us the opportunity to make a difference in the care
we were providing," said Jennifer Suitonu, MBA-HCM, MSN, RN, NEA-BC,
administrative director of cardiovascular services.

Read the Grantee Profile on Del Sol's work under Expecting Success.

— Mount Sinai Hospital Medical Center in Chicago implemented a comprehensive
cardiology admission order set to replace three separate order sets previously
used. This reduced provider confusion and helped the hospital regularly reach 90
percent to 100 percent compliance with evidence-based cardiac care measures.

"The comprehensive order set has been a powerful tool in our efforts to meet
documentation requirements for core heart measures," said Christopher Cornue,
MSHSA, FACHE, vice president of physician services. "Physicians now have
access to a single, simple form that includes all of the required information, instead of our previous three-form system that caused a lot of confusion. As with all paperwork, this just goes to show that simpler is always better."

Read more about Mount Sinai Hospital Medical Center’s work under Expecting Success and get the comprehensive cardiology admission order set.

- **The Expecting Success hospitals became more engaged in discharge and outpatient care to reduce readmissions.** Transitions from the hospital to outpatient care were closely tied to many of the disparities encountered during Expecting Success. The hospitals worked to improve discharge transition processes and give patients better resources to maintain their health. For example:
  
  — Sinai-Grace Hospital in Detroit developed a system-wide universal discharge instruction form, merging general discharge instructions with cardiac-specific instructions.

    "With this integrated discharge form, we have come close to perfecting our compliance rates for the discharge of cardiac patients. It has helped ensure that all of our patients receive the best possible care from start to finish and has simplified the discharge process for our busy staff," said Conrad Mallet Jr., JD, president and CEO of Sinai-Grace Hospital.

    Read more about Sinai-Grace Hospital's work under Expecting Success and get the universal discharge instructions.

  — Del Sol Medical Center in El Paso, Texas, developed standardized cardiovascular discharge orders on a single form that guides clinicians in dispensing aspirin and beta-blockers, reviewing additional medication needs and offering smoking cessation counseling and other patient education. The document also includes perforated prescription forms.

    Previously, the process for discharging heart patients had been fragmented, requiring nurses and physicians to remember everything they were supposed to do.

    "With the new patient discharge and prescription tool, our team has been able to implement a low-cost and highly effective intervention that helps our staff perform better and reduces the possibility of documentation errors. Now our cardiac patients are receiving the best discharge instructions possible, while our staff enjoys a more productive work environment," said Jennifer Suitonu, administrative director of cardiovascular services.

  — In response to data showing higher readmission rates for Spanish-speaking patients, Montefiore started a discharge phone call program to reinforce compliance with discharge medications and follow-up appointments for heart patients. The service now is used throughout the hospital. Knowing the patient's
preferred language also enabled the medical center to use patient education materials and to print consent forms in the appropriate language.

Read the Grantee Profile on Montefiore's work under Expecting Success.

— An Expecting Success work group developed a heart failure calendar in English and Spanish to help patients take care of themselves and for nurse educators to use to teach heart failure patients about their condition. These tools are available online.

- **The learning network created collegiality among participants and fostered opportunities for leadership.** "One of the advantages of doing a collaborative was that it really allowed leadership in these institutions to emerge," said evaluator Sue Kaplan, JD. "We saw powerhouse people pop up through this program. It gave the hospitals recognition and the individuals in the hospitals recognition."

- The Expecting Success hospitals developed community demonstration projects to improve care as heart attack and heart failure patients transitioned from inpatient to outpatient care. However, many of these were difficult to implement and had to be scaled back (see Evaluation Findings and Lessons Learned).

Examples of projects:

— The University of Mississippi Medical Center in Jackson, Miss., created a nurse-led heart failure clinic a few miles from the hospital to help patients manage their disease after leaving the hospital.

At hospital discharge, a nurse schedules the patient for frequent follow-up appointments at this clinic. During these visits, a nurse practitioner does an exam and counsels the patients on lifestyle changes. All patients also meet with a pharmacist to discuss their medications and ensure that they can get and afford them. The clinic closely monitors and tracks patient outcomes and quality indicators.

"The clinic is helping our patients better self-manage their heart disease and better transition from the hospital to the ambulatory setting so that they don't need to return to the emergency department or be readmitted. This signifies better patient outcomes and lower health care costs," said Michael Winniford, MD, medical director of cardiovascular services and professor and vice chair of the Department of Medicine and Surgery.

Read more about the University of Mississippi Medical Center's work under Expecting Success and get the Heart Failure Encounter Form.

— Delta Regional Medical Center in Greenville, Miss., established a health ministry among local churches serving the Black and Hispanic communities to provide cardiac education and support for chronically ill patients through trained local parishioners. The health ministry is linked to the Good Samaritan Health Center,
source for primary care and health education for the uninsured, and Delta Regional Medical Center's Medication Assistance Program, a source for immediate financial help with prescription medications.

"People who are active in their church often want to make a contribution of their time, like joining the choir or teaching Sunday school classes, but not all of us have those talents. Improving congregation members' physical health, which also benefits one's spiritual well-being, is a way for us to contribute meaningfully," said Florence Jones, MSN, chief nursing officer at Delta Regional Medical Center.

Read more about Delta Regional Medical Center's work under Expecting Success.

- **The national program office developed the *Expecting Success Toolkit*, which provides tips for hospitals on improving quality of care and reducing disparities.** The toolkit has an overview of the program, and chapters with descriptions and tools for:
  - Getting buy-in from hospital executives
  - Thinking about disparities
  - Assessing the community
  - Creating awareness of the effort among patients and potential patients in the community
  - Collecting patient data
  - Analyzing the data
  - Innovations that work (10 promising practices from the participating hospitals)
  - Transitioning care from the hospital to outpatient setting

Sample tools include:
  - *Expecting Success* quality performance measures
  - A wall poster on collecting race, ethnicity and language data; available online
  - Categories for patient race, ethnicity and language preferences; available online
  - A tool to track a heart patient's status and movement from the emergency department to the catheterization laboratory, developed by Memorial Healthcare System in Broward County, Fla.
  - Universal discharge instructions, developed by Sinai-Grace Hospital in Detroit; available online
— A Learn to Quit Smoking brochure developed by the University Health System in San Antonio.

- **Sinai-Grace Hospital** spread *Expecting Success* beyond cardiac care under additional RWJF grants to extend and disseminate its work, and the University of Mississippi Medical Center planned to do so as well.

  — Sinai-Grace Hospital used *Expecting Success* tools and strategies in other areas of care: stroke, community-acquired pneumonia and surgical care.

  Project staff implemented a measurable metric of "perfect care" to evaluate evidence-based standards in each of these areas. Staff also created "electronic core measure dashboards," placed onto patient orders at admission, to remind the health care team about the care that was to be provided.

  — The University of Mississippi Medical Center planned to create a toolkit to disseminate lessons learned and program innovations from its nurse practitioner-led Health Failure Disease Management Clinic. Staff planned to help Delta Regional Medical Center in Greenville, Miss., implement the clinic there. The grantee had not reported any results to RWJF as of November 2010.

- **The National Quality Forum endorsed the Health Research and Educational Trust Disparities Toolkit for universal use in 2009.** This was part of the National Quality Forum's endorsement of 45 practices to guide health care systems in providing culturally appropriate and patient-centered care. (The National Quality Forum is a nonprofit organization that endorses and builds consensus on health care performance measures; RWJF has been a major supporter of its quality improvement work.\(^1\))

  *Expecting Success* was the first multihospital demonstration program to use the HRET Disparities Toolkit. The National Quality Forum's endorsement is a direct result of that experience, according to Siegel.

- **Hospitals in New Jersey replicated *Expecting Success*.** The Health Research and Educational Trust of New Jersey, an affiliate of the New Jersey Hospital Association, worked with New Jersey hospitals to improve the quality of the patient race and ethnicity data they report to the state Department of Health and Senior Services. The *Expecting Success* national program staff provided tools and technical assistance to support this effort.

  RWJF funded this activity with a separate grant through its New Jersey Health Initiatives, which is charged with improving health care for New Jersey residents through creative, community-based health services. See Program Results Report.

\(^1\) See Program Results on its quality improvement work in nursing care, ambulatory care, palliative care, efficient care, substance abuse and mammography centers.
Communications

Along with the *Expecting Success Toolkit*, now available on RWJF's website, the national program staff created a website (no longer active) and published several reports and journal articles about the program. GYMR Public Relations (Washington, D.C.), under a contract with RWJF, helped the staff of the national program and the participating hospitals with communications work. This included developing the style and tone of communications products and working with the hospitals to publicize the program.

See the Bibliography for more information.

THE EVALUATION AND ITS FINDINGS

From 2005 to 2010, evaluators at the Center for Health and Public Service Research in New York University's Robert F. Wagner Graduate School of Public Service evaluated *Expecting Success*. John Billings led the evaluation team.

The evaluation goals were to:

- Assess progress toward improving the quality of cardiac care provided to Black and Hispanic patients within and across sites
- Assess the spread of quality improvement techniques for minority populations to other clinical areas within each hospital
- Identify and analyze factors in the quality improvement processes that influenced the capacity of individual grantees to meet their goals
- Assess the take-up of program findings by other providers and policy-makers

Evaluation methods included:

- Interviews with hospital staff
- Collecting data from hospitals
- Observing meetings and listening in on conference calls
- Reviewing program documents
- Analyzing care performance measures

The evaluation included a comparison of *Expecting Success* hospitals with a control group of similar hospitals.

For more information about the components and methods of the evaluation, see Appendix 5.
Throughout the evaluation, the evaluators attended Expecting Success meetings and communicated their observations and findings both informally and formally through several reports. "The national program office was always interested in hearing from us. [It was] always trying to take what we found and improve the program," said Billings.

For example, early in the program, the evaluators pointed out that the hospitals had been working for years on improving cardiac quality, and that Expecting Success had to build on that. "We became much more sensitive to what the hospitals had in place and working with that rather than trying to drop in something completely new," said Siegel.

**Evaluation Findings**

Evaluators reported the following findings in reports to RWJF.

**Findings About Collecting Race, Ethnicity and Language Data**

- **The experience of the Expecting Success hospitals indicates that it is quite feasible for a diverse group of hospitals to implement systematic, internally standardized methods to collect race, ethnicity and language data from patients.** In general, hospitals of all types were able to implement the new system successfully within 18 months after their grants began, despite considerable trepidation at the outset.

- **Explaining the rationale for collecting race, ethnicity and language data to staff and patients, combined with good staff training, strengthened the hospitals' capacity to collect these data.** Although implementing the changes necessary to collect data proved easier than anticipated, a few hospitals encountered barriers that were not trivial. In particular, some of the hospitals initially had difficulty with the information technology involved, although these issues were eventually resolved.

- **The continuing discomfort among both staff and patients about the distinction between ethnicity and race for Hispanics was an ongoing issue with significant implications nationally.**

  According to the U.S. Office of Management and Budget's categories for race and ethnicity, which Expecting Success followed, Hispanic is a designation of ethnicity, not race. With this terminology, someone who is Hispanic can be either Black or White.

  All hospitals with Hispanic patient populations reported this as an ongoing source of controversy for which they had not developed entirely satisfactory responses. "No one is comfortable with the standardized way we ask. Selecting a race once you've said you're Hispanic doesn't make sense to people," said Sue Kaplan, a member of the evaluation team. Many Hispanic patients were unwilling to provide information about race.

- **The standardization of data collection needs to be improved, especially as more hospitals are required to collect race, ethnicity and language data.**
Standardization was an important goal for *Expecting Success*. Although the sites created tools and protocols that worked well internally, they were not completely successful at "rolling up" to standard federal categories, suggesting that challenges remain in comparing hospitals or using the data for cross-site research or evaluation purposes.

- **Race, ethnicity and language data gathered by observation and through patient report were very similar.** The presumed accuracy of patient reports, compared to observation by staff, and the potential to reduce missing data often are cited as reasons for collecting patient-reported race, ethnicity and language data, but these may be less critical than assumed.

However, there are many other benefits of asking the question, including increasing awareness of disparities and a dramatic increase in the use of race, ethnicity and language data in quality improvement efforts. Some of the sites also discovered subpopulations they might not have recognized through observation alone (such as a group of Ethiopians in one community).

"Asking shows a level of respect and raises sensitivity around these issues," said evaluator Kaplan.

**Findings on the Inpatient Projects**

- **Some hospitals used formal rapid cycle testing techniques to improve cardiac care, but most modified the process to be less highly structured.** Rapid cycle testing is a quality improvement process for making change in real-world settings "by planning it, trying it, observing the results and acting on what is learned," according to the Institute for Healthcare Improvement (IHI), which refined and widely disseminated this process. Rapid cycle testing uses systematic empirical data to test discrete changes in processes quickly.

An important theme among the *Expecting Success* sites was that formal rapid cycle testing was not applicable for all situations. Sites made modifications in response to problems with data collection or the complexities of working across multiple providers with patients located on different floors.

Nonetheless, the evaluators reported that over the course of the project, there was growing clarity about rapid cycle testing. "This is an effective way to make change," said evaluator Kaplan. "You can make it in one place and it can spread to other parts of the institution." Culture shifts resulting from the use of this technique included:

- Less discussion and more action
- A license to test out new ideas
- Great interdisciplinary cooperation
- Enhanced use of data
Findings on Care Performance Measures

Although measures of cardiac care improved, it was difficult to assess performance related to racial and ethnic disparities.

— Virtually all Expecting Success hospitals improved on every heart attack and heart failure care performance measure, without much variation and with high levels of compliance. (The list of measures is in Appendix 3.)

— All Expecting Success hospitals improved on measures of ideal care for heart attack, with some achieving stronger results than others.

— There was more variability on measures of ideal care for heart failure, with some hospitals achieving remarkable improvements, and one declining somewhat in the final quarter.

— Racial and ethnic disparities in performance were difficult to assess due to data limitations. Ideally, it would have been useful to look at non-Hispanic Whites, non-Hispanic Blacks and Hispanics separately. However, the collected data allowed comparisons only between Blacks and Whites (whether or not they were Hispanic) and Hispanics and non-Hispanics (regardless of race).

Across most CMS core measures for heart attack and heart failure, small differences were seen between Whites and Blacks, with measures among Blacks often slightly lower. For the composite measures of ideal care, consistent and somewhat larger differences persisted throughout the initiative.

Small differences between Hispanic and non-Hispanic patients were eliminated during the project (largely reflecting improvements at a single Expecting Success hospital with a large Hispanic population).

— Expecting Success hospitals improved their performance during the intervention period (September 2005 to May 2008) and one year later, but they fared no better than a comparison group of similar hospitals that did not participate in Expecting Success.

— For five CMS heart attack core measures combined, compliance with the standards by the Expecting Success hospitals and the comparison group was virtually identical at the beginning and end of the program, and one year afterward.

— There were no statistically significant differences between the two groups on two CMS measures of heart failure.

The findings may reflect the financial incentives created by the federal government for all hospitals to submit core quality process measures data to CMS beginning in 2004 and make the data publicly available. This created strong incentives to improve
performance and made it difficult to tease out the impact on quality of *Expecting Success*.

**Findings on the Community Demonstration Projects**

- **Implementing the community demonstration projects proved challenging for most hospitals, and many were significantly scaled back, often to focus solely on post-discharge follow-up.** The challenges were similar across hospitals and included:
  - The precedence of patients' nonmedical needs over medical management
  - The time-consuming and complicated process of developing and sustaining relationships with community organizations and providers, often exacerbated by turf issues
  - The fragility and limited resources available to community organizations, which hampered their ability to partner effectively

Two examples are informative:

  - One hospital went from an ambitious community-wide outreach program to a modest educational program for cardiac discharges, to an even more modest educational program focused only on Medicaid managed care patients.
  - Another hospital planned to send a cardiac nurse educator to community clinics to train staff in post-discharge care for cardiac patients. Because it proved difficult to engage staff in busy community clinics, the hospital eventually decided to focus on educating patients in self-management instead.

"These hospitals are not used to the idea that their responsibility for managing patients goes beyond discharge. The knowledge and skills around how to improve discharge and reduce readmissions are at a very early stage in America," said Siegel.

- **Sites that had the greatest success with their community demonstration projects used existing structures that were controlled by the hospital.** Sites that chose to forge new relationships or attempted to expand services often faced the greatest challenges and in many cases had to modify their programs.

- **Regardless of their degree of success, the community demonstration projects helped many respondents learn more about their patients and their organizations and enabled them to identify opportunities for improvement.**

**Findings on the Learning Collaborative**

- **Most sites valued the collaborative aspects of the program, and many reported sharing tools and lessons learned with other grantees.** This increased over the life of the project, facilitated by the working groups that were formed around specific issues, which were productive and widely praised, by the networking at national
meetings and by national program staff site visits in which ideas from other sites were shared and contacts facilitated.

Individuals and institutions have developed relationships that they believe will continue beyond the life of the grant-funded project.

**Findings on the Enduring Impact of Expecting Success**

- **By the end of the funded projects, the Expecting Success teams, staff and activities had been integrated into larger quality improvement/performance improvement teams and processes at most sites.** As a result, Expecting Success practices were institutionalized or "hardwired" into hospital structures.

**LESSONS LEARNED**

Unless otherwise indicated, these lessons are drawn from an interview with Program Director Siegel and the national program office report submitted to RWJF.

**Overall Lessons**

1. **Recognize the importance of talking about disparities.** Acknowledging that inequities in care may exist within an institution is the first step to addressing them.

   "A lot of folks we talked to said they didn't believe disparities existed or [occurred] only because people didn't have health insurance. They rejected the idea that a Black person and a White person who both had health insurance might get different care," said Siegel, who gave a "Disparities 101" talk at the program's first meeting and repeated this information to all team members at site visits.

2. **Understand the importance of data collection and reporting.** Expecting Success reaffirmed what the national program staff had previously experienced on a smaller scale with Urgent Matters: It is vital for hospitals to use a standardized approach to collecting clinical and demographic data so that hospital staff members can assess the quality of care provided to patients of various races and ethnicities.

   "Without a standardized approach, half the time questions don't get asked or the registration clerk makes assumptions about the patient that may not be true," said Siegel.

3. **Maintaining momentum for a long-lasting program requires special attention.** The hospitals participated in Expecting Success for 29 months, longer than most hospital collaboratives, according to Siegel. Although enthusiasm was high, at times national program staff detected some fatigue and some hospital project directors reported difficulty in continuing to make Expecting Success an organization-wide priority.

   To counter this, national program staff communicated directly with senior leaders to reinforce the significant resources RWJF was devoting to improving the hospital's
quality of care. Sharing performance data among the participating hospitals was an additional motivator. National program staff also worked with GYMR Public Relations to provide motivational tools thanking front-line hospital staff members for their work to improve health care quality.

**Lessons About Improving Hospital Quality**

4. **Get buy-in from hospital executives.** *Expecting Success* required participation by CEOs who could convey to staff that the initiative was a priority.

"Hospitals are really busy places. Unless the executives are on board to clear away the obstacles, then this project will get lost among 100 projects," said Siegel. "For example, at a couple of hospitals, collection of data was held up because the information systems people couldn't make changing the registration fields a priority. It took the CEO saying this is important to get it done."

5. **Use data to develop a compelling case for improving quality.** To gain the support of hospital CEOs and other senior leaders, *Expecting Success* provided reliable data from participating hospitals and community assessments demonstrating that the hospital did not always meet evidence-based care metrics.

6. **Be creative in experimenting with many approaches to improve hospital quality and address disparities.** The national program office designed *Expecting Success* to allow the hospitals to implement a wide range of self-selected interventions. Trying a variety of strategies enabled the institutions and the national program staff to identify effective approaches.

7. **Engage all stakeholders in hospital quality improvement efforts.** Improving health care quality is everyone's issue, and improvements can happen when all stakeholders are engaged. *Expecting Success* showed that including senior leadership, quality improvement staff, all levels of clinical staff, information technology staff, registration staff and others in planning efforts to improve quality and address disparities is the right strategy.

"You need very broad input, from the computer people to parts of the medical staff to the emergency department, to people in dietary and housekeeping," said Siegel. "You really need a cross-cutting team to do this."

8. **Build community awareness of quality improvement efforts.** Providing information to the community about changes in hospital procedures that impact staff and patient interactions should be part of the ongoing communication with the population the hospital serves.

*Expecting Success* hospitals built community awareness through town hall meetings, television interviews and a wall poster about collecting race, ethnicity and language data.
9. **Nurses are critical to hospital quality improvement efforts.** Nurses spend more time with patients than doctors and can ensure that patients receive required care. "We found the nurses to be vital champions of change in these organizations. A lot of quality improvement has tended to focus on what doctors do. That's not enough," said Siegel.

10. **Forming and sustaining hospital quality improvement teams require ongoing attention.** Some hospitals, especially the larger ones, had problems forming a cohesive team and maintaining effective communication. These problems stemmed from turnover at some hospitals and project directors who were "relatively disengaged" at others. National program staff had to reorient new team members to a complex project.

   When projects directors were disengaged, national program staff communicated directly with other hospital team members and the CEO during site visits and collaborative meetings. This problem lessened over time as project expectations became clearer.

   Siegel noted that he has seen similar problems in other hospital-based quality improvement collaboratives.

**Lessons About the Community Demonstration Projects**

11. **Consider alternatives to relying on hospitals to reduce readmission rates.** The challenge that the program's community demonstration projects faced is a "sobering signal" of what to expect nationally as efforts to reduce hospital readmissions rates intensify under health reform, said Siegel.

    He added, "This is really hard. Everybody is focused on this, but nobody knows what to do. Maybe the center for control needs to be in the primary care or patient-centered medical home. I'm worried we're making a mistake by counting on hospitals to improve this measure."

12. **Teach hospital staff about community dynamics and how patients behave in the real world.** Executives of the hospitals participating in *Expecting Success* thought that just creating community demonstration projects would ensure their success. "They thought, 'If we build it they will come.' They didn't understand, for example, that patients don't show up for their appointments," said evaluator Kaplan.

13. **Provide technical assistance and allow time to help hospital staff develop and sustain relationships with community organizations and providers.** One reason for the difficulty in establishing community demonstration projects was the time and effort required to work with community entities. (Program Results Report Writer/ De Milto)

14. **Consider providing some funding to community organizations and providers to work with hospitals on improving the transition from inpatient to outpatient**
Limited resources made it difficult for some community organizations to participate in these projects. (Program Results Report Writer/De Milto)

**AFTERWARD**

The model used in *Expecting Success* has been incorporated into the national program, *Aligning Forces for Quality*, RWJF's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models of national reform.

*Aligning Forces for Quality* began in 2006 and by November 2010 was underway in 17 communities with almost 38 million residents in 15 states. Teams of stakeholders representing the people who get care, give care and pay for care are working together in alliances to create sustainable models of high-quality, patient-centered, equitable care within their regions.

The School of Public Health and Health Services at George Washington University serves as the national program office. Siegel was director until October 2010, when he left George Washington University. Katherine Browne, MBA, MHA, became the interim director/chief operating officer.

**Aligning Forces for Quality Evolves**

The first phase of *Aligning Forces for Quality* helped four pilot communities build health care systems where none had previously existed.

In 2008, the program expanded to include inpatient care, as well as a focus on reducing disparities in care and enhancing the central role of nursing. RWJF used *Expecting Success* as the model for its focus on equity—reducing racial, ethnic and linguistic disparities—and incorporated this goal into the program's other focus areas:

- Performance measurement and public reporting
- Consumer engagement
- Quality improvement

The communities participating in *Aligning Forces for Quality* encourage physicians and providers to collect patient-reported race, ethnicity and language information and to begin stratifying performance data by these patient characteristics. The model for collecting data, training staff in data collection and using these data in performance measures is based on *Expecting Success*. "We tried to use our experience in *Expecting Success* to develop a faster, quicker, leaner model in *Aligning Forces for Quality*," said Siegel.
Expecting Success also provided a template for hospital quality improvement work. In 2010, Aligning Forces for Quality launched the Hospital Quality Network, in which 140 hospitals (about one-third of those in the 17 participating communities) are working on initiatives to increase the role of nurses; reduce disparities in care; and provide equitable, high-quality care for all patients.

**Expecting Success Helps Aligning Forces for Quality and Spreads Its Own Work**

As Expecting Success ended, RWJF awarded the national program office another grant (ID# 064126 from August 2008 to May 2009) to provide consulting services to Aligning Forces for Quality and to spread its own successful strategies and disseminate findings.

Consulting services to Aligning Forces for Quality included:

- Developing and implementing an equity-focused hospital quality improvement collaborative, the precursor to the Hospital Quality Network, composed of 17 of the 140 Aligning Forces for Quality hospitals and based on Expecting Success
- Revising several quality performance measures and developing new performance measures for Aligning Forces for Quality hospitals

The grant also allowed Expecting Success to disseminate its own findings by:

- Drafting two articles for research journals. As of April 2011, one was under review at the Journal of Healthcare Quality. The other has not been submitted.
- Developing content on promising practices for RWJF's website.
- Making many presentations about the program.

**For Further Information**

To learn more about Aligning Forces for Quality, see the program's website.

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RWJF Team: Quality/Equality
APPENDIX 1

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Jackson Heart Study
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APPENDIX 2

Hospitals Participating in Expecting Success

Del Sol Medical Center (El Paso, Texas)
ID# 053829 (September 2005 to May 2008)

- 336-bed community hospital
- Patient population is 75 percent Hispanic

Project Director
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Delta Regional Medical Center (Greenville, Miss.)
ID# 053830 (September 2005 to May 2008)

- 398-bed, county-owned hospital serving five counties within the Mississippi Delta
• Population served has a high prevalence of heart disease
• More than two-thirds of the area's residents are Black

**Project Director**
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**Duke University Hospital** (Durham, N.C.)
ID# 053831 (September 2005 to May 2008)
• 398-bed, not-for-profit hospital and the flagship hospital for Duke University Health System, an academic medical center
• Serves Durham County, where almost half of the residents are Black (40%) or Hispanic (8%)

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**Memorial Healthcare System** (Hollywood, Fla.)
ID# 053832 (September 2005 to May 2008)
• 690-bed flagship hospital of a public, not-for-profit, health care system and home to the system's Cardiac and Vascular Institute
• Serves south Broward County, where half of the area's population is either Black or Hispanic

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**Montefiore Medical Center** (Bronx, N.Y.)
ID# 053833 (September 2005 to May 2008)
• 1,491-bed, not-for-profit, academic medical center and a fully integrated health care delivery system
• Some 79 percent of the area's residents are Hispanic (48%) or Black (31%)
Project Director
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Mount Sinai Hospital Medical Center (Chicago, Ill.)
ID# 053834 (September 2005 to May 2008)
● 291-bed, not-for-profit teaching hospital
● Almost all hospital patients are Black (56%) or Hispanic (38%)

Project Director
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Sinai-Grace Hospital (Detroit, Mich.)
ID# 053838 and 065126 (September 2005 to May 2008 and October 2008 to September 2009)
● 404-bed, not-for-profit, community-based teaching hospital
● Patient population is 90 percent Black

Project Director
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University Health System (San Antonio, Texas)
ID# 053836 (September 2005 to May 2008)
● 498-bed, publicly owned, academic medical center
● More than half of all patients are Hispanic (61%)

Project Director
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University of Mississippi Medical Center (Jackson, Miss.)
ID# 053837 and 065125 (September 2005 to May 2008 and October 2008 to March 2010)

- 598-bed, teaching hospital, serves as Mississippi's principal diagnostic and referral center
- Two-thirds of patients are Black

Project Director
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Washington Hospital Center (Washington, D.C.)
ID# 055670 (October 2005 to May 2008)

- 926-bed, not-for-profit, major teaching hospital operating one of the largest cardiovascular programs in the nation
- Serves a large Black and Hispanic population

Project Director
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APPENDIX 3

Quality Performance Measures for Heart Attack and Heart Failure

Centers for Medicare & Medicaid Services’ Measures of Care

Core Heart Attack Measures

- Aspirin at arrival
- Aspirin at discharge
- Angiotensin converting enzyme (ACE) inhibitor or angiotension receptor blocker (ARB) for left ventricular systolic dysfunction
- Smoking cessation advice/counseling
- Beta blocker at arrival
- Beta blocker at discharge
● Thrombolytic agent received within 30 minutes of arrival
● Percutaneous coronary intervention (PCI, or angioplasty) received within 90 minutes of arrival

Heart Failure Measures
● Discharge instructions
● Evaluation of left ventricular systolic function
● ACE inhibitor or ARB for left ventricular systolic dysfunction
● Smoking cessation advice/counseling

Noncore Heart Attack Measures
● Lipid-lowering therapy at discharge
● Dietary counseling during hospital stay
● Standardized heart attack/acute coronary syndrome orders present in record
● Discharge document for heart attack/acute coronary syndrome present and signed in the record

Noncore Heart Failure Measures
● Standardized heart failure orders present in the record
● Discharge document for heart failure patients present and signed in the record

Measures of Ideal Care
● Heart attack composite measure: Patient received all appropriate evidence-based measures
● Heart failure composite measure: Patient received all appropriate evidence-based measures

Outpatient Measure
● 30-day heart failure readmission rate

How the Measures Were Revised
Earlier versions of the Expecting Success performance measures included 23 measures instead of 21. In those versions, two measures related to cholesterol:
● Cholesterol testing within 24 hours
● Lipid-lowering therapy at discharge
These were condensed in the later version to "lipid-lowering therapy at discharge."

There also were two measures related to heart failure readmissions:

- Readmission for any reason within 30 days of discharge
- Readmission for heart failure within 30 days of discharge

These were condensed in the later version to "30-day heart failure readmission rate."

**APPENDIX 4**

**Race, Ethnicity and Primary Language Categories**

**Race Categories**

Categories from the U.S. Office of Management and Budget:

- White
- Black or African-American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander

Categories added by the national program office:

- Multiracial
- Declined
- Unavailable

**Ethnicity Categories**

Categories from the U.S. Office of Management and Budget:

- Hispanic or Latino
- Not Hispanic or Latino

Categories added by the national program office:

- Declined
- Unavailable
Primary Language Categories
Categories from the U.S. Census Bureau:

- English
- Spanish
- Other

Categories added by the national program office:

- Declined
- Unavailable

APPENDIX 5

Evaluation of Expecting Success

Components of the Evaluation

- A qualitative implementation evaluation.

- An in-depth assessment of the change in methodology for collecting race, ethnicity and language data. This included both the qualitative component and a data analysis of impact.

- An assessment of the impact of Expecting Success on the hospitals' compliance with (1) the core measures for cardiac care that the CMS collects and publicly reports and (2) additional measures established by the program.

- A comparison of Expecting Success hospitals with a "control" group to assess compliance with the core measures. The control group hospitals were similar in size, type and patients served.

Evaluation Methods

- Structured interviews with key personnel at each site

- Observing meetings of quality improvement teams, steering committees and cardiovascular departments

- Reviewing materials submitted by the hospitals, such as proposals, plans and monthly progress reports

- Observing learning network grantee meetings and listening in on conference calls

- Reviewing data collection forms completed by project directors and staff for the evaluation
• Analysis of the care performance measures reported by the hospitals to CMS and available publicly on its website

• Data on CMS quality of care measures and other Expecting Success measures reported by the hospitals to the national program office

BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Articles

Journal Articles


Reports or White Papers

Fact Sheets


Reports or Monographs


Education or Toolkits

Curricula, Material or Software


Evaluation Tool


Toolkit, Toolbox or Primer


Robert Wood Johnson Foundation's Quality/Equality Promising Practices website had several hospital vignettes contributed by the Expecting Success national program office:

- "Improving Self-Care and Reducing ED Visits Through a Health Ministry Program." Delta Regional Medical Center, Greenville, MS, August 2009. Available online.


Meeting or Conference

Presentations or Background Materials

Bruce Siegel, "Expecting Success: Quality, Measurement and Disparities," at the


Marsha Regenstein, "Disparities in Cardiac Care: A Preview from 10 Communities," at the AcademyHealth 2006 Research Meeting, June 26, 2006, Seattle.


Communication or Promotion

Grantee Promotion & Communication


GRANTEE PROFILE LIST

- "Collecting Data to Identify Disparities and Measure Heart Care Quality." Duke University Hospital, Durham, N.C. Available online.
- "Improving Heart Care through Better Data and Communications." Montefiore Medical Center, Bronx, N.Y. Available online.