

## Acute Myocardial Infarction (AMI) Excess Days in Acute Care (EDAC) Measure (CBE #2881)

The Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI) measure evaluates post-discharge acute care utilization within 30 days for Medicare beneficiaries aged 65 and older. It quantifies the total days spent in emergency department visits resulting in discharge, observation stays, and unplanned readmissions following an index AMI hospitalization. This measure captures the quality of care transitions by aggregating all of these acute care events into a single outcome measure. Risk adjustment accounts for age and comorbidities, and exposure time is incorporated for patients who do not survive the full 30-day period. The measure is specified at the hospital level using administrative claims data from Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) beneficiaries and is intended to support quality improvement by providing a comprehensive assessment of post-discharge outcomes.

Inputs	Activities	Outputs	Outcomes	Impacts
<ul style="list-style-type: none"> <li>Performance data from multiple sources, including CMS's tailored reports that include key patient-level information to target quality improvement efforts, Electronic Health Records (EHR), and data collection systems for real-time tracking of AMI hospitalizations</li> <li>Capacity to identify patients at highest risk for EDAC as well as infrastructure, for data analysis and reporting</li> <li>Technological capacity to provide post-discharge patient monitoring</li> <li>Standardized training manuals, protocols, and competency checklists to ensure personnel are equipped and help accountable for using</li> </ul>	<ul style="list-style-type: none"> <li>Applying evidence-based approaches to create patient care processes that address readmission and post-discharge acute care utilization (including but not limited to improving clinical management and discharge processes, including patient communication and engagement with care team)</li> <li>Patient use of remote blood pressure monitoring and telehealth visits</li> <li>Implementing strategies to increase Patient enrollment in cardiac rehab and provision of other evidence-based self-management programs.</li> <li>Implementing a process to identify</li> </ul>	<ul style="list-style-type: none"> <li>Improved and standardized AMI discharge and follow-up protocols, such as individualized post-discharge patient education and self-management support (e.g., cardiac rehab referrals); ensure timely referrals to outpatient cardiology and AMI specialists</li> <li>Primers on recognition by patients of symptoms and signs of adverse outcomes of cardiac interventions with a mechanism in place for patients to seek immediate care in an ambulatory setting</li> <li>Increased use of technology (e.g., telehealth remote monitoring and check-ins, apps with wearable health trackers, smartphone applications) and in-home assistance (visiting nurses, community health workers) for high-risk patients with AMI</li> <li>Patient engagement tools (e.g., mobile apps, blood pressure monitors, symptom trackers) to support self-</li> </ul>	<p><b>Short-term:</b></p> <ul style="list-style-type: none"> <li>Improved provider communication with patients regarding AMI care and self-management at discharge</li> <li>Increased provider use of telemonitoring, follow-up calls, or visits to support post-discharge AMI care</li> <li>Increased adherence by hospital staff to evidence-based discharge planning protocols</li> <li>Greater utilization of standardized discharge checklists for patients with AMI</li> <li>Better coordination between inpatient and ambulatory teams around transition of patients</li> </ul> <p><b>Intermediate-term:</b></p> <ul style="list-style-type: none"> <li>Increased number of patients receiving timely outpatient AMI care post discharge</li> <li>Increased patient adherence to outpatient AMI management (medications, diet, exercise, cardiac rehab, etc.)</li> <li>Improved overall patient healthcare experience including ease of care navigation, timely follow up, and satisfaction with the continuity and quality of care received post-discharge</li> </ul>	<ul style="list-style-type: none"> <li>Improved patient quality of life</li> <li>Lower healthcare costs associated with AMI-related hospitalizations</li> <li>Potential for improved continuity and sustainability of AMI care programs through better care transitions</li> <li>Improved care delivery processes that support risk factor control and reduce risk of recurrent AMI and future AMI hospitalizations</li> <li>Broader impact (spill-over effect) across all clinical areas (reduced readmission and EDAC for multiple conditions)</li> <li>Better integration between hospital and outpatient settings</li> </ul>

<p>quality improvement tools</p> <ul style="list-style-type: none"> <li>• Highly trained and invested staff (clinical, quality improvement (QI), and leadership), as well as infrastructure, for data analysis and reporting</li> <li>• Resources to support timely cardiac catheterization and bypass surgery including lab protocols, and door-to-door balloon tracking</li> <li>• Clinical guidelines for AMI management (AHA, ACC, etc.)</li> <li>• Resources to support guidelines around procedure-based interventions (e.g. timely cardiac catheterization and bypass surgery interventions)</li> <li>• Transition of care program with built-in capacity for iterative refinement</li> <li>• Care transition programs and case management staff (to close the loop on discharge instructions and perform medication recommendations)</li> </ul>	<p>patients at highest risk for EDAC</p> <ul style="list-style-type: none"> <li>• Integrating patient voice and lived experience to inform personalized self-management training for both staff and patients</li> <li>• Implementing structured medication reconciliation and adherence counseling as a standard part of discharge planning, recognizing current gaps in practice, and ensuring follow-through before patient discharge</li> <li>• Adopting a culture of safety throughout the hospital including team huddles and flowcharts in cardiac care and telemetry units</li> <li>• Understanding patient social needs by performing a social needs screening prior to discharge, which would assess needs/barriers for linking to community resources post-discharge (e.g., access to transportation, medications, healthy foods, exercise, and telemedicine), including both access</li> </ul>	<p>management and behavior change</p> <ul style="list-style-type: none"> <li>• Dashboards or other forms of reports (for leadership, QI staff, and care teams) to track and communicate performance on post-discharge acute care utilization by AMI patients</li> <li>• Utilization of data to develop processes for iterative feedback loops for QI improvement (along with measuring effectiveness of new processes)</li> <li>• QI committee meetings to review iterative PDSA cycles introduced during QI activities</li> <li>• Medication reconciliation post-discharge by pharmacist and assistance with copays and formulary exceptions to ensure uninterrupted adherence to dual anti-platelet (and other) medications</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease in number of patients using acute care (inpatient admission, observation stay, ED visit) after hospital discharge</li> <li>• Improved patients' self-management and optimization of lifestyle</li> </ul> <p><b>Long-term:</b></p> <ul style="list-style-type: none"> <li>• Reduction in days spent in acute care within 30 days of discharge following an inpatient hospitalization for AMI (including ED visits, observation stays, and unplanned readmissions)</li> <li>• Improved quality of care transitions for patients hospitalized for AMI, as measured by the AMI EDAC outcome</li> <li>• Enhanced use of outcomes data to inform hospital-specific quality improvement strategies for AMI care transitions</li> <li>• Improved patient experience with interpersonal aspect of care including clearer communication from staff, better communication about medications, and more effective discharge instructions</li> <li>• Decreased morbidity and mortality related to cardiovascular disease</li> </ul>	
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## Logic Model for the AMI EDAC Measure

<ul style="list-style-type: none"> <li>• Multidisciplinary team (cardiologists, primary care, case managers, pharmacists, cardiac rehab specialists, nurses, social workers)</li> <li>• Evidence-based hospital-based interventions known to reduce post-discharge acute care, such as transitional care excellence programs</li> </ul>	<p>to and aptitude with telemedicine technology</p> <ul style="list-style-type: none"> <li>• Analyzing hospital data, tracking, and QI meetings to identify root causes for readmission and post-discharge acute care utilization by patients with AMI overall or for subsets of patients (such as gaps in hospital discharge planning)</li> <li>• Engaging relevant stakeholders in the QI process; staff training materials targeting best practices in AMI care and discharge transitions for AMI patients</li> <li>• Training staff on implementation and use of new care processes as identified and developed by QI teams with an accountability structure and incentives within team and hospital sites</li> <li>• Joining available AMI registries to receive data, trends analysis, benchmarking guidance, and QI resources</li> <li>• Implementing robust clinical coordination</li> </ul>			
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	efforts to ensure seamless timely follow-up with ambulatory cardiologists			
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Feedback Mechanisms
<ul style="list-style-type: none"> <li>Utilization of real-time monitoring and data analytics</li> <li>Routine dissemination of performance reports on AMI care outcomes and adherence to best practices</li> <li>Collection of patient-reported feedback on care quality and transition post-discharge</li> <li>Regular multidisciplinary review meetings to analyze performance data and address gaps in AMI care delivery</li> </ul>
Assumptions
<ul style="list-style-type: none"> <li>Investment in healthcare infrastructure to support high-quality care, including staff, money, time, space, adequate services, etc</li> <li>Hospitals and healthcare providers have the necessary resources to implement AMI-specific discharge planning and follow-up interventions.</li> <li>Investments are made to meet the diverse needs of patients, including language and literacy adaptations, transportation access, and community-based support services</li> <li>Healthcare providers adherence to evidence-based clinical guidelines for AMI management, including discharge planning, follow-up protocols, and medication reconciliation.</li> <li>Patients will have access to outpatient cardiology services, medication refills, and rehabilitation programs following discharge.</li> <li>Patients and caregivers are willing and able to engage in self-management activities, including lifestyle changes and adherence to care plans.</li> <li>Telehealth, remote monitoring, and related technologies are accessible and usable by patients post-discharge.</li> <li>For patients with limited digital access or more acute post-discharge needs, home health RN visits or community-based follow-up options are feasible and available.</li> </ul>
External Factors
<ul style="list-style-type: none"> <li>Variability in insurance coverage and reimbursement for post-discharge services, including cardiac rehabilitation and telehealth</li> <li>Healthcare staffing shortages can affect the implementation of QI programs and follow-up coordination</li> <li>Regional differences in healthcare infrastructure affect the availability of outpatient services and follow-up care</li> </ul>

### Summary:

This AMI EDAC logic model provides a structured approach to improving post-discharge care for AMI patients, reducing preventable hospital acute care visits. It lays out a plan to improve how hospitals discharge AMI patients by using clear protocols, ensuring medication reconciliation, and setting up follow-up appointments before they leave. High-risk patients receive additional support through telehealth, remote monitoring, home health RN visits, and enhanced coordination between hospital teams and outpatient providers. This model helps patients stay on track with their recovery, which can lead to better cardiovascular health, fewer complications, and lower healthcare costs. Ultimately, it creates a more connected system where hospitals, healthcare professionals/providers, and patients work together to improve patient outcomes while reducing the overall burden on hospital resources.