these patients with poor long-term outcome may represent a significantly opportunity to improve their prognosis.

Table.

<table>
<thead>
<tr>
<th>Medications at within 6 hours of Admission, (%)</th>
<th>Diabetic Patients</th>
<th>Non-Diabetic Patients</th>
<th>Adjusted Odds Ratio Diabetic/ Non-Diabetic (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>69/78</td>
<td>0.71 (0.61, 0.84)</td>
<td></td>
</tr>
<tr>
<td>Beta Blockers</td>
<td>25/33</td>
<td>0.77 (0.64, 0.92)</td>
<td></td>
</tr>
</tbody>
</table>

Things to Note: Medications at within 6 hours of Admission, (%)

Aspirin: 69/78, 78 (0.61, 0.84)
Beta Blockers: 25/33, 0.77 (0.64, 0.92)

*Adjusted for age, sex, hospital characteristics.

**T77777** Implementation of Acute Myocardial Infarction Guidelines in Community Hospitals Without Cardiac Catheterization Labs: Are We There Yet?

David M. Larson, Scott W. Sharkey, Barbara T. Unger, Timothy D. Henry, Minneapolis Heart Institute Foundation, Minneapolis, MN, Ridgeview Medical Center, Waconia, MN

Background

In order to reduce delays to treatment for ST Elevation Myocardial Infarction (STEMI), the National Heart Attack Alert Program, in 1993, recommended that emergency department protocols for STEMI and monitor quality measures starting 30 days prior to their treatment intervals. The ACC/AHA guidelines on STEMI recommend specific protocols to rapidly assess and treat STEMI patients. The goal of this study was to obtain information regarding the current use of STEMI protocols, adherence to guidelines and quality assessment practices in hospitals without catheterization labs in Minnesota.

Methods

In March 2003, we mailed surveys to ED medical directors or nurse managers in 111 Minnesota hospitals that did not have cardiac catheterization labs. In addition to hospital size and distance to nearest cath lab, the survey asked the questions regarding protocols, standing orders, quality assurance, decision making and indications for transfer of pts with STEMI.

Results

103 (93%) of hospitals surveyed responded (10 to 173 beds; mean 42) located from 12 to 300 miles (mean 74) from the nearest cardiac cath lab. Only 64% of hospitals had STEMI protocol/guidelines and 45% had standing orders in the ED; 32% had neither. Of those hospitals that had specific guidelines, only 6% addressed criteria for transfer to a tertiary hospital. Decisions addressed in guidelines: indications and dose of thrombolytics (58%), indications and dose of beta blockers (48%), use of aspirin (62%), indications and dose of heparin (54%), and low molecular weight heparin (23%). Only 50% of hospitals have a formal Quality assessment process for STEMI. Door to drug intervals are monitored in 53% of hospitals; use of aspirin in 46% and beta blockers in 35%.

Conclusion

Despite recommendations from the NHAAP and ACC/AHA to develop hospital specific guidelines and protocols for STEMI, only two thirds of community hospitals in Minnesota have these in place. These guidelines are incomplete and rarely address transfer criteria to hospitals with PCI capability. Quality performance measurement was lacking in one half of hospitals surveyed. Programs to help community hospitals develop and implement guidelines should be encouraged.

**T7777** The Association Between Care and Outcomes in Patients With Acute Coronary Syndrome: National Results From CRUSADE

Eric D. Peterson, Matthew T. Roe, Barbara L. Lytle, L Kristin Newby, Elizabeth S. Fruolo, W Brian Gibler, E Magnus Ohman, Duke Clinical Research Institute, Durham, NC, University of North Carolina at Chapel Hill, Chapel Hill, NC

Background: Demonstrating the association between adherence to ACC/AHA guidelines and better outcomes is an important step in motivating their adoption in clinical practice.

Methods: Using data from the CRUSADE Initiative, we studied 45,987 high-risk ACS patients (ischemic ST changes and/or positive cardiac markers) treated at 403 US hospitals between 4/00-4/03. We evaluated hospitals’ use of 9 ACC/AHA Class I care indicators among eligible patients without contraindications. Hospitals were divided into quartiles based on overall guidelines adherence, calculated as % of guidelines consistent care out of total care opportunities. Results: There were significant performance gaps for each of the 9 indicators between the leading and lagging hospital quartiles: from narrow (97 vs 88% for aspirin <4 hrs, p=0.0001) to wide (60 vs 28%, p=0.0001 for GP IIb/IIIa inhibitors <4 hrs). Compared with lagging, leading centers tended to be larger (mean bedsize 388 vs 321), more likely academic (34 vs 21%), and have CAGB/PCI facilities (81 vs 55%, p<0.001). The Figure displays average in-hospital mortality for each hospital performance quartile after adjusting for patient and hospital features. Conclusion: Adherence to ACC/AHA Guidelines varies markedly among US hospitals.