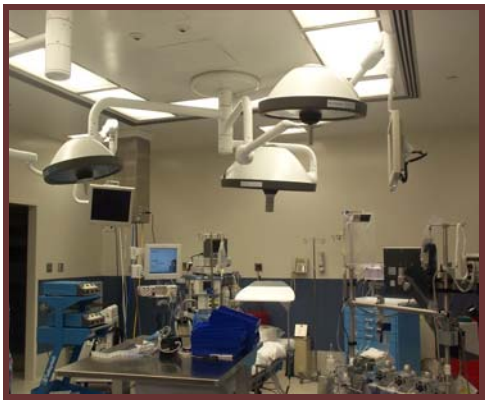
Health Care Visions News
From The Cardiovascular Specialists

3RD QUARTER 2005

OHS/PCI 5 Year Vision Becomes A Reality

Landmark Medical Center located in Woonsocket, Rhode Island received state approval to design and implement a Comprehensive Cardiac Service Program in August 2000. Phase I of this program was implementation of a diagnostic cardiac catheterization program which they successfully put into operation in November 2001. Phase II was implementation of percutaneous coronary interventions and open heart surgery. On May 17, 2005 Phase II was successfully completed when the first open heart surgery was performed at the hospital.



Landmark Medical Center OR

Responsibility for the overall management and supervision of the program was provided by an Executive Oversight Committee. The committee membership included individuals from various disciplines from Beth Israel Deaconess Medical Center, Harvard Medical Facility Physicians and Landmark Medical Center. The committee met monthly to develop and execute the plans for program development and will continue to meet to assess its progress.

The hospital based implementation teams were lead by Betsy Haker, RN, Cardiac Program Administrator. Betsy's leadership skills were instrumental throughout the project. She devoted countless hours on program development, including staffing plans, budgets, interdepartmental requirements, staff education, etc. Her enthusiasm and hard work moved the project along to meet the targeted implementation date.

The hospital was fortunate to have Dr. Divakar Mandapati, Chief of Cardiothoracic Surgery as part of the team. His guidance, skills and insight were pivotal to the program development.

An intense investment of time and hard work was dedicated to developing the program. Nearly every hospital department was involved in the project. Each department's roles and responsibilities for providing care to the patient, including pre and post hospital care, were delineated. Policies and procedures were developed, patient flows were outlined, and the staff was educated. Towards the end of the project multiple dry run scenarios were conducted to validate all processes.

The open heart surgery program opened utilizing the One Stop Post Op™ model. Rather than move from room to room or department to department, patients stay in a single unit throughout their entire post operative hospital stay. Eight rooms in the existing ICU were renovated to accommodate this new patient population. This patient care model was a good match for the community's expectations. The residents of northern Rhode Island and neighboring Massachusetts now have accessible cardiovascular care with advanced technology and skilled professionals at Landmark Medical Center.

Landmark's Cardiac Center

Congratulation to Landmark Medical Center's management team and staff! Health Care Visions, Ltd. was honored to work with such a dynamic group, supporting their efforts to build a quality program.

Message From The President

Have You Taken Score of Your "Heart" Risk?

Barb Sallo

The University of Pittsburgh Medical Center has received a $4,000,000 grant from the Pennsylvania tobacco suit settlement to study community heart disease risk. They have named the study SCORE, and I have become a willing participant. It included an excellent screening process and provided a coronary ultra fast CT for those identified at the initial visit with an intermediate risk.

I am fortunate that I scored in the low risk category and did not qualify for the CT. I did want to experience the ultra fast CT as I have been curious about this test--a very easy way to get a look at my arteries. I was impressed with the comprehensive screening (beside the usual BP, etc.) they measured the width of my brachial artery, body fat, C-reactive protein and a detailed analysis of all cholesterol (with a special test to tell whether I had the "sticky" type). All of the tests are repeated next year so I can judge any improvements.

As health care providers/ consultants specializing in heart disease, shouldn't risk assessment start with us? There is an assessment tool designed for people who haven't had a coronary event or developed diabetes.

Researchers crafted the tool out of information from the Framingham Heart Study. Since 1948, doctors have tracked the health of thousands of adults from Framingham, a Boston-area community. Years of analysis have established connections between medical history data and heart disease.

You can calculate your Framingham score by going to the web and searching for: http://hin.nhlbi.nih.gov/atpiii/calculator.asp?usertype=pub. You do need to know your total cholesterol, your HDL and your BP. Interesting, the only other question is whether you are a smoker or not.

A review of the "classic" risk factors includes:

- Smoking
- Abnormal cholesterol
- High blood pressure
- Diabetes
- Obesity

Researchers consider these factors "independent" because when they hold other risk factors constant as they analyze data, changes in these factors alone lead to greater or lesser disease.

In the real world, if you are able to positively influence one of the classic risk factors, it is likely that one or more of the others will be affected. The researchers tell us that the benefits flow in equal measure to people with or without heart disease.

You may not have access to a research study in your city, but you should assess your own risk. Good luck with starting a prevention program based on your specific risk factors.

"Door to Balloon" Time

The generally accepted benchmark for "door to balloon" is 90 minutes.

The national hospital average is 78 minutes.

H&HN May 2005

Disposable Equipment Reprocessing: HCV Survey Results

Rose Czarnecki

Marsha Knapik

Reprocessing of single use devices (SUD) has been a concept that has brought several issues to the forefront: patient safety and infection control concerns as well as the financial savings implications. Several agencies including the ACC and NAPSE have weighed in on the issue and do not disagree with reprocessing, provided stringent guidelines are followed. The federal government has approved numerous items for reprocessing in several areas including invasive cardiology, surgery, orthopedics and gastroenterology.

HCV conducted an on line survey in April and May of 2005 of hospitals nationwide to gather information regarding current levels of participation in reprocessing of disposable equipment in cardiac services. The survey goal was to determine: prevalence of reprocessing, the most common items reprocessed, and cost savings realized with reprocessing. Eighty-one hospitals responded to the survey and an abbreviated summary of the results is listed below.

- Of the hospitals responding to the survey 30.9% (N=25) were academic or teaching facilities while 69.1% (N=56) were non-teaching hospitals.
- Of the hospitals surveyed 53.1% (N=43) performed electrophysiology studies as well as cardiac catheterization.
- Catheter-based procedures (diagnostic and PCI) volumes ranged from a low of 50 procedures to a facility that performs over 6,500 procedures per year. The average number of procedures performed was approximately 2,188 annually.
- Of those that performed EP, annual volumes ranged from 150 to over 2,500 procedures with an average of approximately 850 procedures.
- Of great interest was that more than three quarters of the facilities that responded (75.5%, N=61) did not reprocess single use devices.
- Of those who did reprocess (N=20), 60% or 12 of those facilities reprocessed items that were expired or open and not used.
- The most common items reprocessed were diagnostic EP catheters and pacer cables while the less common items mentioned were guidewires, femostops and femoral sheaths.
- Of those who reprocessed, the range of cost savings to the facility was as little as $1,500 to a high of $250,000. The overall average saving to the facilities was approximately $63,923.
- Note that of the facilities that reported they did reprocess equipment, more than half of them were unable to estimate cost savings due to either:
  - Just implementing or trailing reprocessing and have not done it long enough to realize the savings
  - Hospital reprocesses items for several departments and does not break out individual department cost savings
  - Three facilities reported that they felt their cost savings were minimal
  - Do not have mechanism in place to determine cost savings

From this survey several interesting points were identified. Immediately apparent was the low percentage of facilities that are using reprocessing for cardiac equipment. It was also evident that EP services have the majority of reprocessed items and the facilities that performed larger volumes of EP had the highest potential cost savings. Cost savings was less clear at the facilities that did not perform EP. Finally, many facilities were not tracking and monitoring the savings related to reprocessing, making it difficult to determine a cost/benefit analysis in all cardiac settings.

HCV looks forward to exploring the topic of equipment reprocessing in greater detail in an upcoming publication that will discuss regulations and guidelines for reprocessing, identify items appropriate for reprocessing and methods to safely and cost efficiently accomplish reprocessing.

Specialty Hospitals—Can They Still Exist? Start Up? Will CMS pay?

FACT SHEET

For Immediate Release: Thursday, June 9, 2005
Contact: CMS Office of Public Affairs
202-690-6145

For questions about Medicare please call
1-800-MEDICARE
or visit: www.medicare.gov.

Mark McClellan, MD is the head of the Center for Medicare and Medicaid which controls about 7 percent of the U.S. economy. On June 8, 2005, Dr. McClellan, a Harvard-trained physician and MIT-trained economist extended the moratorium on specialty hospitals until year-end.

There are about 130 physician-owned specialty hospitals; most of them focused on heart, orthopedic or other types of surgery.

CMS OUTLINES NEXT STEPS AS MORATORIUM ON NEW SPECIALTY HOSPITALS EXPIRES

Overview: The Centers for Medicare & Medicaid Services will, over the next six months, conduct a review of its procedures for enrolling specialty hospitals in the Medicare program. In addition, CMS will undertake a series of steps to reform rules governing Medicare payments that may provide specialty hospitals with an unfair advantage over other providers such as community hospitals and ambulatory surgical centers. Specialty hospitals are those with limited focus and generally treat only cardiac, orthopedic or surgical cases. Physicians who refer patients to these specialty hospitals often have a limited ownership interest in them.

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