Health Care Visions News
From The Cardiovascular Specialists

4TH QUARTER 2005

A "Unique" Partnership

Cyndi Havrilak

The community of Waterbury, Connecticut has a reason to be delighted with the initiation of advanced cardiovascular services operating at both Waterbury Hospital and St. Mary's Hospital. Both hospitals are operating under one program, the "Heart Center of Greater Waterbury."

The program is set up as a unique partnership between three facilities: Waterbury Hospital, St. Mary's Hospital and University of Connecticut Health Center/John Dempsey Hospital (UCONN). An advisory board of representatives from all the hospitals provided oversight for the implementation of new services at Waterbury and St. Mary's Hospitals. Staff education and on-site training for both open heart surgery and interventional cardiac catheterization was completed at UCONN under the guidance of Dr. Paul Preissler's cardiothoracic practice and interventional cardiologists Drs. Steve Widman and Kevin Kett.

Ms. Loraine Shea was hired as the Executive Director and coordinated the development of the Heart Center.

The individual hospitals collaborated through a multi-hospital cardiac services implementation (CSI) committee providing a depth of hospital leadership who collectively and individually labored to complete the project within a compressed nine month timeline. The program coordinators were:

- Mary Prybylo, COO and Sandi Iadarola, Director of Nursing-Waterbury Hospital
- Sandy Roosa, VP Patient Care Services-St. Mary's Hospital
- Jeanne Lattanzio, Associate VP of Operations-UCONN

Health Care Visions enjoyed the opportunity to work with all of these individuals and the CSI committee members.

Both hospitals successfully began open heart surgery and interventional cardiac catheterization during the week of July 18th. With 350,000 people in their primary and secondary markets, their program has continued to flourish as expected. Waterbury Hospital and St. Mary's Hospital serve as the community's provider of health services with approximately 70,000 visits per year through their emergency departments. It makes good clinical sense that their community should also be able to select these facilities for advanced cardiology care.

Both facilities implemented the One Stop Post Op™ patient care delivery model for their open heart surgery and PCI patients. This approach to care provides patients with the benefits of remaining in the same department with their care coordinated by an advanced trained nursing staff throughout their stay. The hospitals are the first to offer this patient care delivery model in their area. Health Care Visions believes this is just another example of why their program will be a success over the years to come.

Congratulations to the Heart Center of Greater Waterbury. It was a pleasure to assist you with all of your implementation efforts!

Survey Results for the One Stop Post Op™

Health Care Visions, Ltd. recently conducted a survey of the issues surrounding the "One Stop Post Op™" patient care delivery model . This method of care delivery provides patient focused care in a single clinical setting. Health Care Visions has been teaching the concepts of the model to our clients and assisting in implementing this care delivery model for several years. The One Stop method of care delivery has been a great match for cardiovascular patients and for our clients who are initiating new cardiovascular services. Our clients who have implemented this care delivery model continue to provide favorable testimonials of its benefits. It has become evident through increased interest for implementing this patient care model and specific requests from clients for additional details that the healthcare community is seeking specific information on issues surrounding this method of patient care delivery.

There was a total of one hundred and thirty four responses to our survey but only twenty one responders are actually using the model. The sample sizes vary from 17 to 22. Although, the sample size is small the survey does serve as a source of useful information on this increasingly popular subject.

Below are the results from the survey:

1. **Are you using the One Stop Post, Universal Bed, or Uni Bed patient care delivery model?**

   Total sample size = 132

   13.6% (18) are using the model

2. **If you are not using the One Stop Post Op model, are you considering implementing the concept?**

   Total sample size = 114

   58% (66) answered yes

3. **How long have you been using the model?**

   Total sample size = 19

   The longest use of the model has been for 5 years, with four sites just starting this year

4. **How many beds do you have in the unit?**

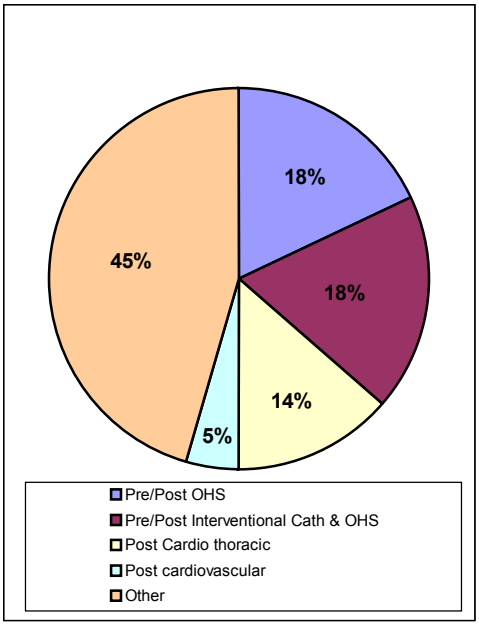
   Total sample size = 22

   The range was from one site with 64 beds to one site with 3 beds; the most common was 8 beds

5. **What type of patients do you have in the units?**

   Total sample size =22

   The responses were arranged into five categories. The "other" category includes a mix of patient types primarily with a cardiovascular focus or listed as both medical and surgical .



6. **Do you change the accommodation code to reflect patient acuity? If so, how often?**

   Total sample size = 20

   45% (9) - Change accommodation with a change in patient acuity
   35% (7) - Do not change the accommodation code
   20% (4) - Have two levels an initial higher rate and a lower step-down rate

7. **Have you been able to document cost savings by using the One Stop Post Op model compared to the traditional two step transfer model?**

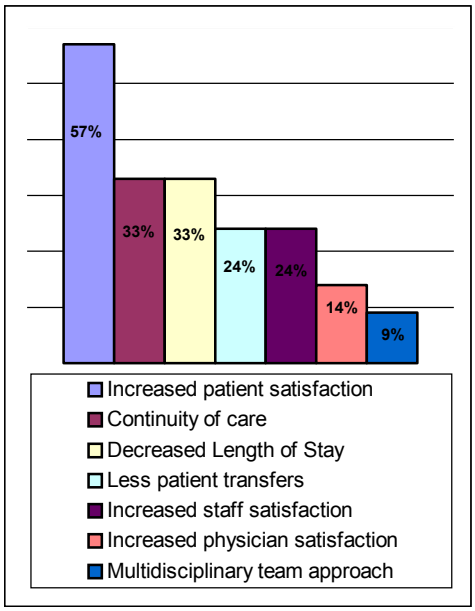
   Total sample size=22

   68% (15) stated no
   32% (7) stated yes

8. **What have you found to be beneficial about the model?**

   Total sample size = 21.

   57% (12) - Increased patient satisfaction
   33% (7) - Continuity of care
   33% (7) - Decreased Length of Stay
   24% (5) - Less patient transfers
   24% (5) - Increased staff satisfaction
   14% (3) - Increased physician satisfaction
   9% (2) - Multidisciplinary team approach



9. **What are the disadvantages of the model?**

   Total sample size =18

   28% (5) - Having enough beds to accommodate during higher volumes
   16% (3) - Requires frequent oversight of nurses/patient ratios
   11% (2) - Obtaining staff acceptance for mixed acuity and changing nursing ratios
   11% (2) - Difficult to maintain model when there is hospital need for critical care beds
   11% (2) - Maintaining staff competency
   11% (2) - None

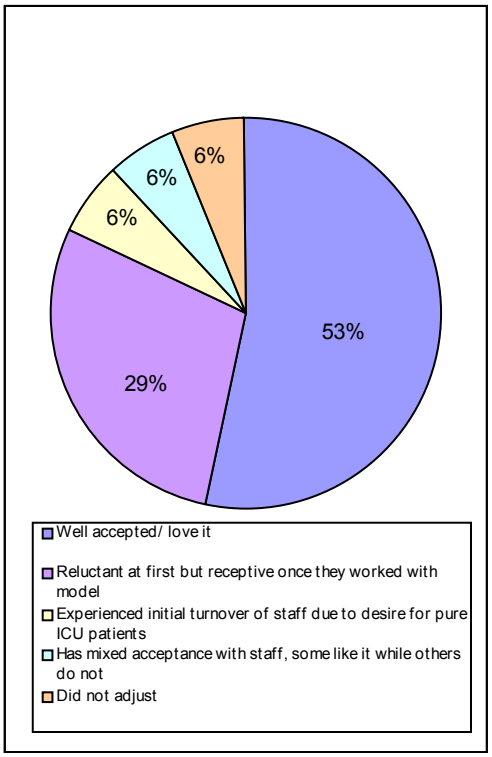
Also mentioned: Can be difficult to recruit since nurses do not understand the model. Smaller units are less efficient. Only unit trained to provide care to these patients.

Survey Results for the One Stop Post Op™ - *Continued*

10. How has the nursing staff adapted to the patient care model?

Total sample size = 17

53% (9) - Well accepted/ love it
29% (5) - Reluctant at first but receptive once they worked with model
6% (1) - Experienced initial turnover of staff due to desire for pure ICU patients
6% (1) – Has mixed acceptance with staff, some like it while others do not
6% (1) – Did not adjust



11. Are the physicians satisfied with the model?

Total sample size = 16

94% (15) - Yes, with 3 very satisfied
6% (1) - Their physicians have never known any other model, and have some frustration with the lack of trained open heart nurses

12. Have you found patient satisfaction to be higher on this unit?

Total sample size = 19

89.5% (17) – Yes
10.5% (2) - No

13. Have you incorporated any healing concepts with the model?

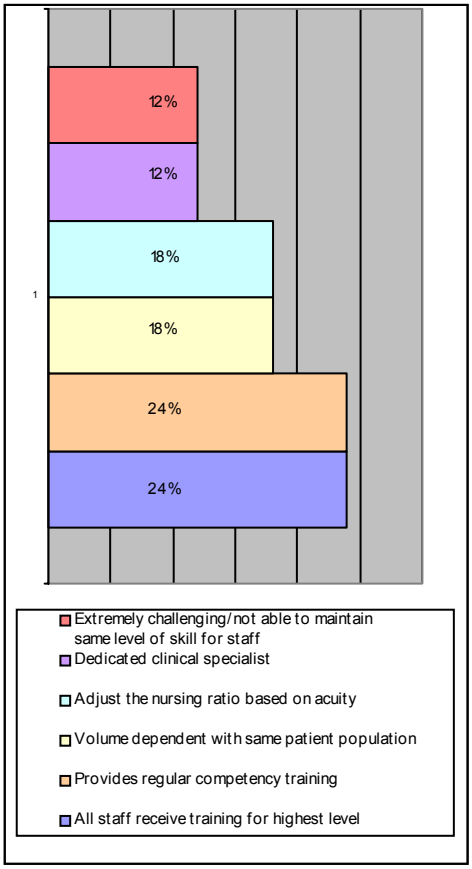
Total sample size = 19

15.8% (3) - Yes
84.2 % (16) - Have not

14. How do you maintain higher level nursing skills with varying patient acuity?

Total sample size = 17

24% (4) – All staff receive training for highest level
24% (4) - Provides regular competency training
18% (3) - Volume dependent with same patient population
18% (3) - Adjust the nursing ratio based on acuity
12% (2) – Dedicated clinical specialist
12% (2) – Extremely challenging/not able to maintain same level of skill for staff



15. Are all staff members able to provide care to all acuity levels of patients?

Total sample size = 21

71.5% (15) - Yes
28.6% (6) - No

16. What is the skill mix of your care providers such as RN's, LPNs, and aides?

Total sample size = 20

55 % (11) - Utilize RNs with CNAs, PCTs, or unit sec.
40 % (8) -Have an all RN staff
5 % (1) - Have RNs, LPNs, and CNA

Health Care Visions will provide more detailed information addressing this innovative patient care delivery model at our next Audio Conference on November 3rd, at 3:00 pm ET.

Circle your calendar—Health Care Visions next audio conference is November 3, 2005 at 3:00 pm Eastern Time

Health Care Visions Audio Conference

"One Stop Post Op™ Cardiovascular Unit Design"

Register by e-mail: hcv@hcvconsult.com or call (412) 364-3770

CMS Makes Major Changes

New DRG's and ICD-9 Codes for 2006

Marsha Knapik

CMS has made some major changes to cardiac inpatient coding for 2006 with the creation of twelve (12) new DRG's which will replace nine (9) currently existing DRG's. These changes become effective October 1, 2005. In addition to the DRG changes, three (3) ICD-9 codes have been deleted and nine new ICD-9 codes have been created to replace them. The reference tables provides a summary of these changes.

Several of the eliminated DRG's did not consider a patient's cardiovascular co-morbidities. The new codes have been divided into DRG's reflecting these co-morbidities by categorizing the patients into those "with" or "without" major cardiovascular diagnosis. The major CV diagnosis list is extensive (approximately 111 diagnoses) possibly permitting many patients to be coded at the higher level of acuity.

DRG's 535 (ICD implant with cath with AMI) and 536 (ICD implant with cath without AMI), were expanded to include not only patients with acute MI, but also heart failure and shock. This could also create the potential for more patients to fall into the higher acuity DRG of 535. The caveat is that although some patients may now fall into the higher acuity DRG, payments for most of the DRG's have been decreased and those hospitals that perform a higher percentage of low risk, non-acute patients will have more patients in the lesser acute DRG (which has a lower payment accordingly). Facilities performing these procedures will need to review the types of patients they typically see to determine how these new DRG's will affect overall revenue received from CMS.

Three ICD-9 codes related to single/multi-vessel PTCA have been deleted. In their place, CMS has created nine (9) new codes to use for PCI procedures. They include 00.66 as a base code to be used for all PTCA/Atherectomy procedures, along with four (4) codes that are used to indicate the number of angioplasty vessels and four (4) to indicate the number of stented vessels. There is still a need to use modifiers for vessel location (Left Anterior Descending, Left Circumflex or Right Coronary Artery). When coding a PCI procedure, the new base code for the procedure must be used as well as the new code for the number of vessels either ballooned or stented. If stented, the appropriate new code for non-drug eluting or drug eluting stent (36.06 for non- drug eluting and 36.07 for drug eluting stent) must also be indicated. Therefore, a stent case may have a total of three codes and a modifier to represent the procedure (base code, number of vessels stented, type of stent and the modifier for the vessel stented). If the procedure used more than a single stent and one was non-drug eluting and one was drug eluting, an additional code would be added to represent the two types of stents used. Currently these codes will have no impact on reimbursement and will be used for data tracking only, but may be used for future reimbursement changes.

Although these are considered 2006 changes, the old codes become invalid and the new DRG's and ICD-9 codes should be used as of October 1, 2005.

Currently Existing DRG's that will be invalid in 2006	Replacement DRG's for 2006
107- Coronary Bypass with Cath divided into:	**547**- Coronary Bypass with Cath with Major CV Dx
	548- Coronary Bypass with Cath without Major CV Dx
109- Coronary Bypass without Cath divided into:	**549**- Coronary Bypass without Cath with Major CV Dx
	550- Coronary Bypass without Cath without Major CV Dx
115- Permanent Pacemaker with AMI, HF or Shock or ICD Lead or Generator	**551**- Permanent Pacemaker with AMI, HF or Shock with Major CV Dx or ICD Lead or Generator
116- Other Permanent Pacemaker Implant	**552**- Other Permanent Pacemaker Implants without Major CV Dx
478- Other Vascular Procedures with CC divided into:	**553**- Other Vascular Procedures with CC and with Major CV Dx
	554- Other Vascular Procedures with CC and without Major CV Dx
516- PCI with AMI	**555**- PCI with Major CV Dx
517- PCI with Non-DE Stent without AMI	**556**- PCI with Non-DE Stent without Major CV Dx
526- PCI with DE Stent with AMI	**557**- PCI with DE Stent with Major CV Dx
527- PCI with DE Stent without AMI	**558**- PCI with DE Stent without Major CV Dx

ICD-9 Codes	
Deleted ICD-9 Codes	**36.01**- Single Vessel PTCA or Atherectomy w/o Thrombolytic
	36.02- Single Vessel PTCA or Atherectomy with Thrombolytic
	36.05- Multi Vessel PTCA or Atherectomy with or without Thrombolytic
New ICD-9 Codes	**00.66**- Base code to be **used for all** Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
	00.40- Procedure on a single vessel
	00.41- Procedure on two vessels
	00.42- Procedure on three vessels
	00.43- Procedure on four plus vessels
	00.45- Insertion of single stent
	00.46- Insertion of two stents
	00.47- Insertion of three stents
	00.48- Insertion of four plus stents
Change in ICD-9 Code Use	**37.36**- Cardiac electrophysiologic stimulation and recording studies- **can no longer be used with DRG's 535 and 536, can only be used with DRG 515**

Message From The President

Barb Sallo

"Nuts" to Your Heart Health

It is not as nutty as it sounds: Eating nuts promotes cardiovascular health. Two studies from Harvard Medical School and the Harvard School of Public Health have examined how eating nuts affects the cardiovascular health of men and women.

One study, the *Physician's Health Study* evaluated 21,545 men. None of the participants were diagnosed with heart disease. The nut portion of the study showed that over a year period, men who ate nuts two or more times a week enjoyed a 47% lower risk of sudden cardiac death and 30% lower risk of dying from coronary artery disease than men who eschewed nuts.

To support these findings, consider an earlier Harvard nut study on women who were free of cardiovascular disease and between 34 and 59 years old when the research began. During a 14 year period, women who ate at least five ounces of nuts per week, were 35% less likely to suffer a heart attack than women who ate less than one ounce a month.

While these studies involved doctors or nurses who may be more energetic heart disease "risk avoiders", scientists in California evaluated diet and heart disease in 31,208 Seventh-Day Adventists. After six years of observation, researchers found that people who ate nuts at least four times a week had suffered 51% fewer heart attacks than those who did not eat nuts. The study could not find any trends/risk factors that could subtract the protective power of nuts.

If nuts can reduce a healthy person's risk of developing heart disease, can they also help patients with documented heart disease? To find out, doctors in India randomly divided more than 500 heart attack survivors into two groups. One group received standard care and a low-fat diet; the other group got the same care but ate a diet supplemented by extra portions of nuts, grains, and vegetables. The nut eaters had better cholesterol levels, fewer recurrent heart attacks, and a lower death rate.

Does all this information make you hungry? Reach for that nut snack and reduce your own risk of heart disease.

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