



Health Care Visions News

From The Cardiovascular Specialists

1ST QUARTER 2007

“STATE OF THE ART” CV PROGRAM

In January 2005, the McKenzie Willamette Medical Center (MWMC) located in Springfield, Oregon engaged Health Care Visions, Ltd. to conduct a market assessment and demand analysis to



Rose Czarnecki

determine if there was a need to expand their cardiovascular (CV) services. The services considered for this expansion included interventional cardiology and cardiac surgery procedures. The absence of advanced cardiovascular care was cited as a large gap in McKenzie Willamette Medical Center's services. Since cardiovascular disease is the leading cause of death in MWMC's service area, they decided to move forward with the expansion.

Work officially began on October 6, 2005. An implementation team was put together and was lead by Becky Bellingham, RN. Becky brought a wealth of knowledge and experience to the project. Her guidance and insight were instrumental throughout the program's development. The team was composed of administrative, management and clinical staff members as well as experienced cardiac surgeons and cardiologists.



Throughout the next 13 months the team worked diligently planning for both interventional cardiology and cardiac surgery. Almost every department was involved in the project. Each department's roles and responsibilities for providing care to the patient were delineated. Policies and procedures were developed, patient flows were outlined and processes were implemented. Intensive staff education was also completed, including didactic instruction, off-site training and equipment vendor in-services. No stone was left unturned as this implementation team strived to ensure that their program would be state of the art.

New construction was included in the project plan. A cardiovascular operating room, a two bed holding area and an eight bed cardiovascular intensive care unit were built. These areas are located in the same suite on the first floor of the hospital. The close proximity of these units facilitates a

specialized approach to patient care. Having pre/post and intra operative staff working in the same area will contribute to continuity of care by enhancing communication.

McKenzie Willamette Medical Center will utilize the One Stop Post Op™ patient care delivery model. One staff will provide care to the cardiac surgical patient pre and post operatively. Patients who undergo a percutaneous coronary intervention will also be cared for by this staff. This model has gained wide acceptance in cardiac programs throughout the United States and will definitely differentiate this program from others in the community.

In November 2006, multiple dry run mock scenarios were conducted to test staff knowledge and system efficiencies. All systems proved to be ready and in the next month or two McKenzie Willamette Medical Center will open its doors to their first cardiac surgical patient, followed shortly after by the first interventional cardiology patient.

Congratulations to McKenzie Willamette Medical Center! Health Care Visions, Ltd. enjoyed being a part of their implementation team and wishes them continued success with their cardiac program.

WHOSE CATH LAB IS IT ANYWAY? (PART II)



Marsha Knapik

As discussed in the last installment of “Whose Cath Lab is it Anyway?” the cardiac

catheterization laboratory (being called the

cardiovascular laboratory in many institutions) is now the domain of multiple physician specialists. Not only are the types of physicians in the lab expanding, but so is the diversity and mix of the support staff in that area. A busy cardiovascular laboratory today will usually still have some mix of radiology technologists, registered nurses or CV techs, but may also have ancillary support staff, specialty coders/billers, inventory managers or physician extenders (such as a nurse practitioner or clinical nurse specialist) involved in the day to day operations.

Radiology technologists and registered nurses have long been the mainstay core staffing for cardiovascular



rooms, with scrub, monitor and circulating roles being shared at times

based on the hospital’s job descriptions, policies and state regulations on scope of practice. The core responsibilities of these positions have not changed much, however, this staff is constantly being challenged to integrate new equipment, introduce new procedures and utilize new medication therapies or infusions.

The positions that are newer to the cardiovascular laboratory and are used in a wide range and mix include the inventory managers, coder/billers and physician extenders. This article will provide an overview of the roles and usefulness of these positions.

Certainly the cath lab size (number of procedure rooms and pre/post care beds) as well as procedure volume and type play a role in determining the number and skill level of staff that are indicated. Smaller facilities that perform a limited range of procedures in a single room may not require any support staff, while larger laboratories may use these personnel (patient care assistants) to assist with room restocking, room turnaround, patient transport, etc. Likewise, larger laboratories with higher volumes and more diverse procedures are more likely to enlist dedicated personnel for inventory management and coding/billing of procedures. This allows those laboratories to dedicate the RT’s and RN’s time directly to procedures and patient care. Dedicated inventory managers and coders/billers allow for increased inventory and revenue tracking, and provide expertise in reconciliation of inventory and charges. This is imperative to monitor and do correctly and efficiently to maintain the revenue generating benefits of a busy laboratory. The large array of equipment, supplies and interventional devices (balloons, stents, pacers, ICDs, etc.) are

expensive as well as space and resource consuming. Managing this inventory to limit hospital cost outlay, while insuring the items are available when needed can be a daunting task in and of itself. The inventory manager may deal directly with the vendor to determine par volumes, types of devices kept, replacement of stock as used and rolling inventory when outdates are eminent. This position, like the dedicated coder/biller, can pay for itself in terms of preventing lost revenue. A dedicated coder in the cardiovascular laboratory allows for an individual to be able to review and verify all charges (procedural as well as supply), reconcile cases as well as maintain current coding initiatives which can be very complex and rapidly changing for catheter based procedures. Correct coding and billing initiatives will allow for earlier payment and less denials.

Physician extenders, typically a nurse practitioner, physician assist or the clinical nurse specialist, can provide physician support in various ways. Nurse practitioners typically complete history and physicals pre procedure, perform pre/post patient assessment, complete typical orders for follow up. Clinical nurse specialists often provide patient education, patient assessment and may assist in staff orientation and competency assessment. Physician Assistants are most often involved in the

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MESSAGE FROM THE PRESIDENT



Barb Sallo

Happy New Year! This is a special January for Health Care Visions, Ltd. We have completed a decade in business and look forward to many more

years of helping our clients with cardiovascular program assessment and implementations, as well as strategic planning and program evaluations.

Trying to predict the future is hard, but one thing that is foreseeable is the continuation of the trend for outcomes reporting. Full disclosure is being advocated for both clinical care and financial information.

An interesting article in the Cleveland Clinic Heart Advisor, "200 Hospitals Pledge To Create Shortcuts To Care" states that according to a presentation at the American Heart Association's Scientific Sessions meeting in

November, more than 200 hospitals have joined an initiative to shorten the time it takes for patients to get "heart attack" treatment after entering a hospital. The goal is to help ensure that at least three quarters of patients in these hospitals undergo angioplasty within 90 minutes or less of hospital arrival. Currently, only about one in five hospitals in the U.S. has been able to attain this gold standard. Research indicates that just a handful of inexpensive strategies can cut the "door-to-balloon" time.

A web site that can help you compare how your hospital measures up to other hospitals on "heart attack" treatment is available to the public:

www.hospitalcompare.hhs.gov/hospital

I recently read a book by an interventional cardiologist, Mimi Guarneri, M.D., FACC.

Dr. Guarneri is founder and medical director of Scripps Center for Integrative Medicine. She practiced traditional cardiology when she became an attending physician in cardiovascular disease in 1995 at that hospital. Along the way she had a revelation and in the book she "reveals the secret language of healing."

The book tells her story and her patients' stories and reports on non traditional approaches that she applies. *The Heart Speaks* was published in 2006.

I probably would not be writing about this book in our newsletter, but in December I was in two conversations with hospital administrators who brought up the topic of alternative treatment for heart disease. I felt that providing them with a copy of Dr. Guarneri's book was called for.



Health Care Visions, Ltd. Celebrates Ten Years in Business

Thank you all for being friends and clients.

We look forward to serving our hospital clients for many more years.

The most rewarding aspect of our consulting, is the friends we make along the way.

DREAMS DO COME TRUE: TELEMONTITORING FOR CRITICAL CARE PATIENTS



Cyndi Havrilak

Hospitals have been utilizing on-site remote patient monitoring for many years. This typically consists of monitor technicians sitting in front of multiple EKG displays continuously observing the patients' EKG wave forms and alerting the proper individuals of any changes or problems. This type of continuous patient monitoring still occurs, but what if it could be taken to a higher level? Improvements, such as real time access to the patients' clinical data, ability to observe and communicate with the patient and 24/7 staffing by advanced critical care personnel, may seem like a dream; but for many hospitals this is a reality.

The timing could not be better to investigate telemonitoring in light of:

- The aging population that increase critical care needs
- National patient safety standards emphasizing the importance of "intensivists" managed intensive care units
- National quality initiatives of pay for performance

Telemonitoring can assist hospitals in meeting the above listed

demands. Remote critical care specialists add an additional layer of protection for the critically ill. The intent is not to reduce the current number of nurses or physicians staffing the intensive care units but provide continuous monitoring, trending of patient data and continuous access to critical care specialists. Patient data trending has been successful at detecting subtle patient changes facilitating early interventions to avoid life-threatening emergencies. Hospitals utilizing advanced telemonitoring list impressive improvements averaging:

- 25% reduction in mortality
- 15% reduction in ICU stay
- 35% reduction in expenditures

The financial return is obtained from improved patient outcomes and not from reimbursable services. Literature suggests that there are approximately 6,000 intensivists actively practicing in the United States, enough to cover just 13% of ICU beds. It is predicted that due to the aging population, four times as many intensivists will be needed. It is conservatively estimated that intensivist managed ICUs would save 53,850 lives each year in the United States. This is significant since most telemonitoring services provide intensivist-led care.

The rewards of advanced

telemonitoring for intensive care patients are realized in both tertiary centers and community based hospitals. Tertiary centers provide care to the highest acuity patients who benefit from data trending with continuous access to critical care specialists. Community based hospitals reap the same rewards while access to critical care specialists builds confidence in providing care to the critically ill. In both settings a technology infrastructure is needed to offer these remote services.

Reimbursement incentives, termed pay for performance, are directed at improving patient outcomes. Organizational reimbursement is anticipated to be tied to the hospitals' compliance with established quality care standards. Cardiology measures are timing of reperfusion, percentage of aspirin, beta blocker and ace inhibitors given to acute myocardial infarction patients. Constant surveillance and data trending by the critical care specialist for acute cardiology patients should increase compliance with these established standards of practice.

Providing 24/7 access to critical care specialists for your critical care patients and staff may seem unobtainable but today's technology can make it a reality and one worthy of investigating.

WHOSE CATH LAB IS IT ANYWAY? (PART II)

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procedure area, freeing up physician time by performing arterial sticks, sheath insertions, sheath removal and/or closure device deployment.



They may also perform follow up rounds. In some laboratories the RT or RN may perform some of these functions, however, state regulations and scope of practice may limit their ability to independently perform these functions. In some hospitals, the physician(s) may have their own extenders that become credentialed to perform these functions for that

particular physician or physician group, while other hospitals employ the extenders and they perform the functions for all medical staff who work in the cardiovascular laboratory. The use of extenders can increase room throughput by eliminating delays from incomplete history and physicals, waiting for physician arrival for procedure start time (as sheath insertion can be initiated while waiting) and expediting outpatient discharge. In some instances it can also enhance the ability to keep the physician's time dedicated to procedural aspects and make the "day in the lab" more productive and appealing to him/her. The extenders typically also insure that documentation for medical necessity is complete and thorough and that the report is dictated in a timely fashion. This assists in prompt coding and billing, decreasing the chance of denials related to incomplete documentation.

As you can determine from the discussion, the need for the additional positions in the cardiovascular laboratory will vary from facility to facility and depends on the volumes and types of cases performed, the number of cardiologists working in the laboratory and how staff roles and responsibilities are organized. Each cardiac catheterization laboratory manager should periodically examine the staffing and staff mix to determine if changes in cath lab volumes, case types and scope of care dictate a need for a revision in the complement of staff.

Part I of "Whose Cath Lab is it Anyway?" as well as back issues of all of our newsletters are available on our website. Log onto: www.hcvconsult.com and follow the link for Newsletters (4th Quarter 2006 issue).

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