# CARDIAC CARE

FOR NURSES, NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS *and* PHYSICIAN ASSISTANTS

**In This Issue:**

Approaching P4P in Quality Terms

i2 and You

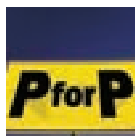
CCA Network

Discover Cardiosource

To the Cardiac Care Team

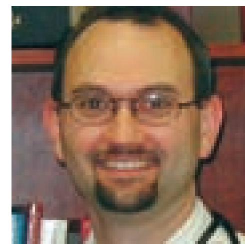
## Approaching P4P in Quality Terms

***By Jeffrey Fox, P.A.-C., M.Sci.***




If you search for pay for performance (P4P) on the Internet, you may be surprised to find that medicine does not appear in the top ten list. What you will find is a well-established list of major businesses that use P4P to ensure quality.

When medicine is added to the search variables, a Spring 2005 *Dartmouth Medicine** article about P4P appears. The article reviews the three-year "pay for performance initiative" being conducted by The Centers for Medicare and Medicaid Services (CMS). The Dartmouth-Hitchcock physician group is one of 10 groups participating in the project. Interestingly, participating physicians approach the project with skepticism despite acknowledging that the project will most likely result in better care and improved patient outcomes.


Jeff Fox

How should we approach the pay-for-performance in medicine? We all hope for an improvement in outcomes. All cardiac care team members on cardiology and cardiovascular surgery teams share this responsibility. But we need to ensure that the metric used to guide P4P is evidence-based, sustainable and non-punitive with equal representation by all groups.

We are seeing improved outcomes. Time from the emergency room to the Cath lab is decreasing. Postoperative wound comorbities are on the decline due in part to better surgical techniques and tighter diabetic control. Postoperative atrial fibrillation is down. Overall, we are seeing that patients have decreased lengths of stay.

We have achieved these goals through multidisciplinary cooperation, using good evidence-based methods. Conceptually, we have created a total heart care environment in which all cardiac care members play an intricate part.

Pay for performance is here to stay. With it, we have the opportunity to practice safer, more efficient medicine for our patients. However, we must embrace and take ownership of the metrics used in the quality controls set up with P4P, or we will fail both our patients and ourselves.

**Jeffrey Fox is chief physician assistant, thoracic surgery and transplantation, Midwest Heart Surgery Institute, Milwaukee, Wis.**

***www.dartmed.dartmouth.edu/spring05/html/disc_performace.php**

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# i2 and You:

## An Interventional Session Designed for CCA Members

You've heard the buzz about i2 Summit, the brand new interventional meeting taking place alongside ACC.06 in Atlanta. But have you heard about the special one-day Spotlight Symposium at i2 designed specifically for nurses and technologists in interventional cardiology?

The Nurse/Tech Spotlight Symposium takes place Sunday, March 12, 2006, at the Georgia World Congress Center during Innovation in Intervention: i2 Summit. The focus is on integrating the latest interventional science into practice, and content is designed for nurses and technologists who work alongside physicians on clinical and genetic research, emerging invasive technologies, and surgical advances.

The faculty will cover —

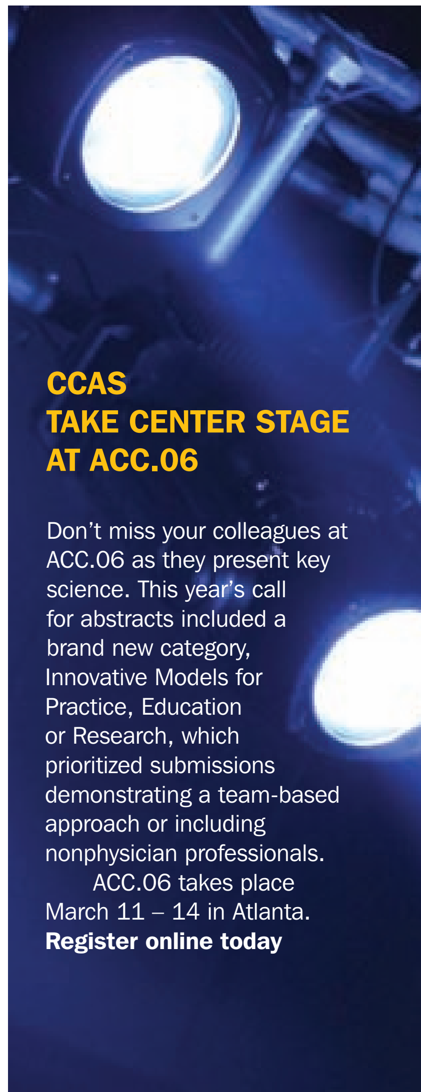
Novel tools and procedures, including new drug-eluting stent platforms, CT angiography in the cath lab, PFO closure devices, percutaneous heart valve therapy, carotid artery stenting and treatment of PAD.

Management of interventional complications, such as acute stent thrombosis, coronary artery perforation, bifurcation devices and vascular complications. Attendees will also discuss how to prep high-risk patients for interventional procedures.

Current debates on issues like vascular closure devices and anticoagulant therapy.

Real world issues, including cath lab economics and quality improvement efforts.

This session is approved for continuing education credit for RNs, LPNs, LVNs and NPs. CCA members enjoy special discounts to attend i2 Summit, and registration includes the Monday session for nurses and techs, as well as access to all ACC.06 sessions and the massive Exposition. Register today at *www.acc.org.*



# CCA Network

**An opportunity to exchange ideas and information**

**Topic:** My six colleagues and I, all physician assistants work in a Cath Lab. We have three main responsibilities. First, we perform procedures in the cath lab including gaining arterial and venous access, right and left heart catheterizations, closing groin sites with angioseal or perclose, coronary interventions and some peripheral interventions.

Second, we have a PA cath service. Roughly 70 percent of same day admissions and transfers that are cathed are admitted to our service. The last part of our job is to cover the recovery room that houses patients that are pre- and post-procedure. We work them up, consent them, assess them for conscious sedation, etc.

We are a teaching hospital and have a lot of CME. However, we have a few topics that we wish someone would talk about. For example, regarding post ACS patients and statins, with a patient who is on 20mg a day pre-procedure with total cholesterol level at 90 and an LDL of 54, how should we handle post-procedure. Do we still put them on 80mg QD? How low is too low?

**Response:** Great question! It's a situation that may not occur often, but when it does, it's a puzzler. Fortunately, there are some sources that can help. The PROVE IT TiMI 22 trial looked at the benefits and safety of going below the guidelines. It seemed to show there is a benefit with LDLs <40.

Also, a Cardiosource e-mail issue, sent out Nov. 3, 2005, reviewed the issue of ACS and low LDLs. If you don't have it in your email any longer, go to *www.cardiosource.com*, under Clinical Collections on the left, place your arrow on General Cardiology. There you will find three choices; select Acute Coronary Syndromes. Under the ACS menu, go to Basic Review. The first four contain additional information on this topic.

Now for the real world! Since we know that the components of the lipid profile all decrease 24 hours after the event, I assume your lipid profile is from before the event, correct? You might increase the statin dose to 40mg, not 80mg. You might want to look over the rest of the lipid profile, also. Ask yourself, would the patient benefit from the addition of niacin or fibrates instead? Due to the higher risk of liver side effects mixing these with statins, it's better if the statin dose is lower anyway. ■

## ABOUT CCA NETWORK

CCA Network is a new feature in Cardiac Care. We encourage you to send questions or topics related to your practice for discussion and comment. December's topic was provided by Donald Parlin, P.A.-C., and his colleagues at Brigham and Women's Hospital, Boston, Mass. The response was provided by Janet Wyman, M.S.N., C.N.P., a CCA Liaison. Send your suggestions to *adees@acc.org* .

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## Discover Cardiosource
### Disparities in Care and Outcomes

*By Suzanne Hughes, M.S.N., R.N.*

The pay-for-performance issue is similar to the concept of disparities in quality outcomes related to gender and race. The November 15, 2005, issue of *JACC* includes two papers related to disparities and an editorial addressing both.

In the first paper, John Spertus, M.D., F.A.C.C., and colleagues[1], examined the health status of 1,159 patients (963 white patients and 196 black patients) one year after acute coronary syndrome (ACS).

The researchers demonstrated that although the mortality rates were similar — 7 percent vs.7.1 percent — between whites and blacks, quality of life indicators differed significantly between the two groups. Using the Seattle Angina Questionnaire and the Short Form 12 Physical Component Score, the study demonstrated that blacks have more angina, poorer quality of life, and a lower level of physical function one year after ACS.

The second study[2] used data from the Clopidogrel in Unstable Angina to Prevent Recurrent Events (CURE) Trial to assess whether gender differences in management of ACS are associated with prognosis. In this trial, women underwent less intervention and fewer surgical and catheter-based interventions. Although women did not have higher mortality or recurrent events, they had more refractory symptoms and rehospitalization rates.

In a related editorial[3], Rita Redberg, M.D., F.A.C.C., explored the reasons for the differences and reinforced the importance of the inclusion of minority groups and women in clinical trials and the analysis and reporting of trial results by race and gender.

To access full text of the above, visit Cardiosource at *www.cardiosource.com* and follow the links to *JACC*. For more information on gender differences in treatment and outcomes, see the Cardiosource clinical collection on women and heart disease. ■

**Suzanne Hughes is with Women's Heart Advantage, Akron Health & Wellness Center, Ohio.**

1. *Spertus J, Safley D, Garg M, Jones P, and Peterson E. The Influence of Race on Health Status Outcomes One Year After an Acute Coronary Syndrome. JACC, Nov. 15,2005;46.*

2. *Anand S, Xie C, Mehta S, Franzosi M, Joyner C, Chrolavicius S, Fox K, Yusuf,S. for the CURE Investigators. Differences in the Management and Prognosis of Women and Men Who Suffer From Acute Coronary Syndromes. JACC, Nov. 15,2005;46.*

3. *Redberg,R. Gender, Race, and Cardiac Care: Why the Differences? JACC, Nov. 15,2005;46.*

## To the Cardiac Care Team

Thanks to the following members of the Cardiac Care Team for their contributions to *Cardiac Care* newsletter this year. We encourage more CCA members to contribute in 2006.
**Send your ideas and contributions to *adees@acc.org***

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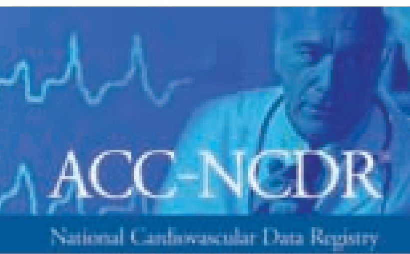


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