OCTOBER 2006 VOLUME 3 NUMBER 10

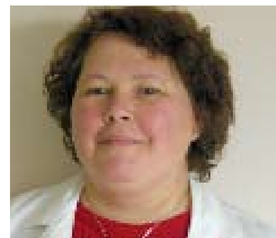
Cardiac Care

FOR NURSES
NURSE PRACTITIONERS
CLINICAL NURSE SPECIALISTS
AND PHYSICIAN ASSISTANTS

EHR in Cardiology

By Jacqueline Gannuscio, N.P.

Imagine seeing a patient in the hospital or your office and having immediate access to data at point of care that improves your ability to make clinical decisions. The dream of a seamless Electronic Health Record (EHR) is a reality for providers at the Veterans Health Administration Medical Centers (VHAMC) nationwide. The benefits of continual access to important health data seem intuitive, but our measurable improvements have included improved time management, quality, access and cost savings, as well as fewer deaths from medical errors.



Jacqueline Gannuscio, N.P.

In 1978 the Veterans Health Administration (VHA) began incorporating patient data into the Decentralized Hospital Computer Program (DHCP) in an effort to improve efficiency and patient care. This system was fully functional nationwide by 1989. The current system, the Veterans Health Information System and Technology Architecture (VistA), includes computerized patient records (CPRS), computerized physician order entry, pharmacy, lab and test information including graphic imaging. In addition, home telemonitoring systems and web-based access called My HealtheVet allow data to be collected outside of the VA facilities and integrated directly to CPRS.

Before describing the impact of EHR on the care we provide to patients at the Washington, D.C., Veterans Medical Center, it's important to understand the different types of records used in health care.

Electronic medical records (EMR) contain documents and perform functions. EMRs include demographic data, history and examination, progress notes, medication lists, lab test access and ordering, graphic image displays of x-rays, MRI and other imaging studies, medication ordering, appointment scheduling, claims and payment processing and patient reminders. These records are usually developed and maintained at a single provider location.

Continued on page 16

EHR in Cardiology *Continued from page 15*

EHRs contain all patient information from multiple sources and are accessible from any location by any provider caring for the patient. They are continually updated and current. In addition, quality improvement, resource management and chronic disease surveillance can be done through data tracking within an EHR system.

Specific Values for Cardiology

The system is invaluable in providing cardiology care on a daily basis. For example, when a new hospital consult order is received for the CHF Program (entered through CPRS), these various steps and elements are available because of the system:

- a provider can be notified electronically and the patient seen within 24 hours
- the patient's record, which includes text and images, is then reviewed
- past medical history can be reviewed through the use of a comprehensive, continually updated Problem List
- the patient's medication orders are reviewed and patient compliance can be determined by seeing when medications were last filled
- templates for consult notes and procedure reports are integrated into CPRS
- orders can be entered electronically and results obtained, including lab results; digital x-ray images; EKGs, echo, cardiac MR and nuclear stress images and their relevant reports; cardiac cath reports; pacer interrogation reports; EP procedure reports and others
- access to Clinical Practice Guidelines within CPRS facilitates decision making

Proven Value Nationwide

The system's utility does not end in providing direct patient care at individual facilities. The Veterans Administration has more than 1,400 health care facilities nationwide and because of access to data, care of patients does not need to be interrupted because the patient has changed locations.

The system proved its worth last year after hurricanes Katrina and Rita displaced many veterans. Records for at least 40,000 veterans from the affected areas were available throughout the country wherever they relocated. This meant that care was able to continue, and medications were refilled because records were immediately available.

Improving Patient Outcomes

One additional benefit of EHR is the potential to improve patient outcomes. With access to the database aggregate, performance measures can be tracked and performance improvement plans implemented. For example, at the D.C. center, we have been tracking blood pressures in CPRS since 2000. Our data show that the percentage of patients with systolic blood pressures greater than 160mmHg has decreased from 70 percent to fewer than 30 percent of the patients. The credit for the decrease goes to efforts to educate providers and the establishment of nurse-led hypertension clinics. Many other performance measures are tracked through CPRS for chronic diseases and preventive health maintenance.

In recognition of the development and expansion of the VistA EHR system, the VHA received the Innovations in American Government Award in 2005.

Gannuscio is Heart Failure Nurse Practitioner at the VA Medical Center, Washington, D.C.

Science Advisory on Influenza Vaccination Posted Online

An AHA/ACC science advisory on Influenza Vaccination as Secondary Prevention for Cardiovascular Disease was posted on *www.acc.org* and *www.cardiosource.com* and will be published in the October 3 issue of JACC. All members are encouraged tto order flu vaccines for their offices as early as possible. The three manufacturers are GlaxoSmithKline (call Flurix Service Center at 1-866-475-8222 and choose option 1), Novartis (formerly Chiron) (call 1-800-244-7668 and choose option 2 to receive a list of vaccine distributors in your area), and Sanofi Pasteur (set up a provider account and then place order at *www.vaccineshoppe.com*).

Cardiac Care

October 2006 Vol. 3, No. 10

Publisher
Steve Erickson
Director, Corporate Communications

Editor
Anne Dees

Design
Tony Ciccolella

Cardiac Care is published monthly by the American College of Cardiology, 2400 N Street NW Washington, DC 20037-1153.

Telephone:
(800) 253-4636
or (202) 375-6000

Fax:
(202) 375-7000

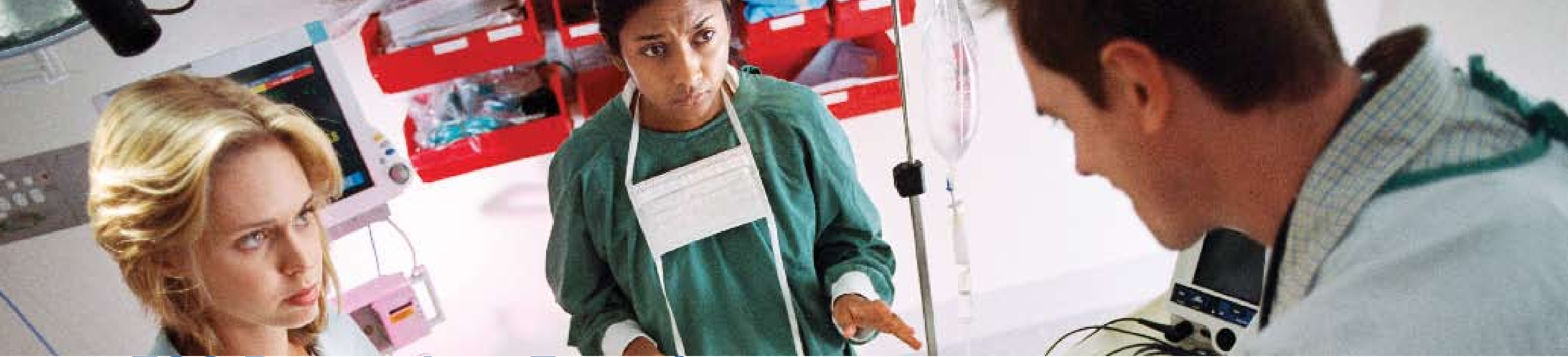
E-mail:
cardiologyeditor@acc.org

Web site:
www.acc.org

To subscribe or report a change of address, call (800) 253-4636, ext. 8603.

All contents © 2006. American College of Cardiology.

Send correspondence and letters to the editor to *cardiologyeditor@acc.org*.



ESC Recognizes Team Impact

By Brenda Garrett, R.N.

At the recent European Society of Cardiology meeting, results from a large European-wide prevention cardiology project, EUROACTION, proclaimed the effectiveness of the cardiovascular team approach in addressing risk factor and lifestyle targets. Results showed that a nurse-led multidisciplinary approach along with support and family involvement generates more effective prevention outcomes with coronary patients and those who are at risk of cardiovascular disease.

This statement is not of the magnitude that one might expect, at least not to the medical force of today's clinical management. Nor is this a nuance to the ACC. The ACC recognized this truth when it initiated the Cardiac Care Associate membership category. ACC's population now includes approximately 3,000 non-physician cardiac care team members, representing nurses and physician assistants who consider the College to be their professional home.

Additional Study of Team Effect

Improved patient care comes as the result of informed and deliberate patient care strategies that include a multi-disciplined approach to disease management. It goes without saying that multi-disciplined equals multi-team members. A clinical trial called Multi-Fit demonstrated this same theory when it compared the physician-only arm to the nurse-team arm in terms of patient compliance after one year. The nurse-team arm did better than (p value <0.01)* with a rate of compliance of 95 percent to prescribed medications. The usual care or physician-only arm achieved 5 percent.

Team care of heart disease equates to improved patient care and efficient and proper use of clinical staff. In essence, it is a critical survival tool to anyone who chooses to practice medicine today.

CCA Role Increases at ACC

I was honored recently, as a representative of ACC's non-physician medical team members, to be invited to join the ACC Board of Governors. When I made a presentation to this prestigious board last month, I asked each of them to look beyond me as the presenter and envision instead an individual back at their institutions who has made it possible for them to practice in their everyday clinical world. There is no doubt in my mind that each of them immediately envisioned one or more of the non-physician professionals on their care teams who contribute to patient care and who are instrumental in their clinical worlds.

This is how cardiovascular medicine will forever be etched — as a team of dedicated professionals working and learning together. None of us reach our goals alone. Our patients will either recover or die from heart disease, but they will do so knowing not just their physician but the whole team that cared for them, too.

Our team will continue to grow and contribute to the mission of the American College of Cardiology. CCA members need to look for ways in which they can become more active members of the ACC team, enhancing their professional growth and that of others on their clinical team.

Garrett is clinical coordinator, Piedmont Hospital Center, Marietta, Ga., and CCA representative to the ACC Board of Governors.

Brenda Garrett, R.N.

Joining the ACC Cardiac Care Team

Cardiac Care Associate Members serve not only on CCA member committees or as State Liaisons, but they also serve on several standing ACC committees, including, but not limited to: publications, continuing education, cardiac catheterization and intervention committee, accreditation steering committee, and the heart failure and transplant committee. They serve on various working groups and task forces, too.

CCA Liaison Roles and Responsibilities

CCA Liaisons work with the ACC Governor and/or Chapter Executive to represent the needs and opinions of CCA members in the area. They keep CCAs informed about activities and programs that are relevant to cardiac care team members. They encourage cardiac care team members to apply for CCA membership by discussing the benefits of membership.

Also, as the prime contacts for CCAs, they forward relevant information from local area to national headquarters and relay any concerns or issues. They participate on the listserve for CCA Local Network Liaisons and lead discussions on the CCA Bulletin Board. Of course, they attend local meetings or programs to educate participants on the benefits of the ACC Cardiac Care Associate membership.

Since the CCA category was initiated in 2003, the activities and outreach of the membership have grown. The more that individual members contribute to CCA programs and working groups, the more benefits will be added for the whole membership.

If you are interested in joining in any of the activities, contact your state liaison. For a full listing of liaisons, go to *www.acc.org/membership/cca/home/home.htm*. Read also about other activities and members.

The support and activities of the CCA Committee members (See box) have also been crucial to the development of the CCA membership.

CCA Committee Members 2006

Mary Walsh, M.D., F.A.C.C., Co-Chair
Brenda Garrett, R.N., Co-Chair
Claire Call, R.N., CCA Member
Kathleen Dracup, R.N., CCA Member
Barbara Fletcher, R.N., CCA Member
Theodore Fraker, M.D., F.A.C.C.
Beth Friday, R.N., CCA Member
Nelson Schiller, M.D., F.A.C.C.
Roy Small, M.D., F.A.C.C.
Janet Wright, M.D., F.A.C.C.

Physicians face a
5.1%
payment cut on
Jan. 1, 2007
We're fighting the battle but need your help!
TELL CONGRESS TO STOP THE CUTS AND FIX THE PROBLEM
ACT NOW:
www.acc.org/CAN