Same-Day PCI: Guidelines & Best Practices for In-N-Out Procedures

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North Shore LIJ Health System
New York
I, Michael Guiry, DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.
Overview

• How do we define patient status; inpatient vs. outpatient?
• Does shortening length of stay after PCI have an impact on patient safety and quality of care?
• What patients qualify for early discharge?
• How do we implement a same day PCI discharge program?
“Inpatient care, rather than outpatient care, is required only if the patient’s medical condition, safety, or health would otherwise be significantly and directly threatened if care was provided in less intensive setting.”

“The physician or other practitioner responsible for patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.”
Defining Outpatient vs. Inpatient

• **Outpatient**
  - Duration of hospitalization is NOT the qualifier.

  **What’s the 2 Midnight Rule?**
  - *Defined:* decision to admit as “Inpatient” based on expected stay of at least 2-midnights
  - Limits use of inpatient and “observation” stays (latter grew from 3 in 2006 to 8% in 2011)
  - Effective date delayed until March 2015

• **Same-day** (aka “Day case”)
  - Would by definition qualify as outpatient
  - Discharge the same calendar day as the PCI
Shift from Inpatient to Outpatient

1. Elective admissions dropped during recession and have been slow to recover.
2. Health reform pressure on hospital readmissions and avoidable admissions.
3. The growth of observation status.
4. Long-term continuing movement towards outpatient models of care.
5. Shift toward fee-for-value away from fee-for-service.
6. Growth of technology, particularly when it comes to imaging, surgery and anesthesia.
7. An ongoing birth rate decline.
## NY State PEPPER Reports - NYP specific data

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>NYP 1 D Stays to Total D/C’s</th>
<th>National 1 D Stays to Total D/C’s</th>
<th>Hospital Avg LOS for DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>254</td>
<td>Other vascular procedures w/o CC/MCC</td>
<td>78.9%</td>
<td>37.8%</td>
<td>1.6</td>
</tr>
<tr>
<td>247</td>
<td>Perc cardiovasc proc w drug-eluting stent w/o MCC</td>
<td>71.8%</td>
<td>35.0%</td>
<td>1.7</td>
</tr>
<tr>
<td>251</td>
<td>Perc cardiovasc proc w/o coronary artery stent w/o MCC</td>
<td>65.3%</td>
<td>35.0%</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Medicare RAC and ADR Audits on One Day Stay Encounters

• Purpose of ADR process
  – Prevent improper payments before they are made

• Medicare started requesting prepayment documentation January 1, 2012
  – 3 steps before final disposition (initial review, appeal, administrative law judge decision)
  – If case is denied IP and not re-billed as ambulatory surgery within one year of DOS no opportunity to bill case

• Procedures being targeted
  ➢ Angioplasty, Uncomplicated stent placement

• Providers have 30 days to send additional documentation requests (ADR)
  – If documentation not received within 30 days admission will be denied
Documentation for Inpatient

Documentation Points to uphold an inpatient decision:

➢ Severity of the signs and symptoms exhibited by the patient

➢ Medical predictability of something adverse happening to the patient

➢ Complications during/after an amb surg procedure

➢ Treatment plan for a specific medical condition/ monitoring
Overview

• How do we define patient status; inpatient vs. outpatient?

• Does shortening length of stay after PCI have an impact on patient safety and quality of care?

• What patients qualify for early discharge?

• How do we implement a same day PCI discharge program?
Preparation of Patients for Intra Vascular Catheterization

Patient should be prepared emotionally and psychologically...

The patient is given a cleansing enema the night before...

&

..250 mg V penicillin t.i.d. the day of catheterization to prevent the possibility of any local or general infection


Slide courtesy of Ian Gilchrist MD
Risks of PCI

- Death
- MI
- Overall, PCI has become a lower risk procedure.
- Elective patients typically discharged within 24 hours of PCI
- Same Day PCI occurred as early as 1997
- Contrast reactions
- Renal Failure
- Vascular Complications

Kiemeneij et al. Outpatient coronary stent implantation. JACC 1997;29:323-7
Ziakas et al. Safety of same day discharge radial PCI. Am Heart J 2003;146:699-704.
Same Day Discharge after PCI

Why not?

Possible reasons:

• Medical
• Legal
• Psycho-social/cultural
• Financial
Same Day Discharge after PCI

Medical reasons:
• Cardiac complications
  – Acute stent thrombosis
  – Arrhythmia
• Vascular complications
  – Access site bleedings
  – Other vascular complications
• Other complications
Length of Stay In Patients Hospitalized With Acute Myocardial Infarction

Worcester Heart Attack Study

Saczyński, JS et al, Am J Med. 2010
Early Discharge After Primary PCI for STEMI

Single-center analysis of 2,448 patients, 63% were released early (within 2 days of the procedure) vs. late (after 2 days).

<table>
<thead>
<tr>
<th>Mortality Risk with Early vs. Late Discharge</th>
<th>HR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cox Regression</td>
<td>0.35</td>
<td>0.26-0.48</td>
</tr>
<tr>
<td>Propensity Matching</td>
<td>0.48</td>
<td>0.32-0.71</td>
</tr>
<tr>
<td>Adjustment for Covariates</td>
<td>0.36</td>
<td>0.21-0.62</td>
</tr>
</tbody>
</table>

Conclusion: Discharge within 2 days is feasible and safe in almost two thirds of patients with STEMI receiving primary PCI.
CathPCI Registry

- Patients aged ≥ 65 years
- Underwent first diagnostic or PCI between November 29, 2000 and December 31, 2008
- Linked to Medicare Part A claims
- N = 107,018
- Same-day discharge: 1.25% (n = 1339)
# CathPCI Registry: 2-Day and 30-Day Rates of Death and Rehospitalization

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Same-Day Discharge, % (n = 1339)</th>
<th>Overnight Stay, % (n = 105,679)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death or rehospitalization</td>
<td>0.37</td>
<td>0.50</td>
<td>.51</td>
</tr>
<tr>
<td>Death</td>
<td>0.07</td>
<td>0.02</td>
<td>.10</td>
</tr>
<tr>
<td>Rehospitalization</td>
<td>0.30</td>
<td>0.48</td>
<td>.30</td>
</tr>
<tr>
<td>30-day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death or rehospitalization</td>
<td>9.63</td>
<td>9.70</td>
<td>.94</td>
</tr>
<tr>
<td>Death</td>
<td>0.30</td>
<td>0.22</td>
<td>.53</td>
</tr>
<tr>
<td>Rehospitalization</td>
<td>9.56</td>
<td>9.60</td>
<td>.96</td>
</tr>
</tbody>
</table>

# EPOS: Elective PCI in Outpatient Study

<table>
<thead>
<tr>
<th></th>
<th>Same-Day Discharge, %</th>
<th></th>
<th>Overnight Stay, %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 24 Hours</td>
<td>1-30 Days</td>
<td>&lt; 24 Hours</td>
</tr>
<tr>
<td>Composite primary endpoint</td>
<td>2.2</td>
<td>1.5</td>
<td>4.2*</td>
</tr>
<tr>
<td>Any MACCE</td>
<td>1.5</td>
<td>1.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>MI</td>
<td>1.5</td>
<td>0.25</td>
<td>3.5</td>
</tr>
<tr>
<td>CABG</td>
<td>0.3</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Repeat PCI</td>
<td>0.3</td>
<td>1.0</td>
<td>0.25</td>
</tr>
<tr>
<td>False aneurysm</td>
<td>0.8</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>AV fistula</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Readmission</td>
<td>0.3</td>
<td>4.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Hematoma &gt; 5 cm</td>
<td>5.0</td>
<td>5.7</td>
<td>4.5</td>
</tr>
</tbody>
</table>

*Risk difference, -0.02 (95% CI, -0.045 to 0.004); P < .0001

Same Day Discharge after PCI

Legal reasons:

• Efficacy and safety of outpatient PCI has been demonstrated and described in a large series of publications from different groups in the past 15 years. (largely outside US)

• In several countries outpatient PCI has become clinical routine.
Same Day Discharge after PCI

Psycho-social/cultural reasons:

- Dependent patients
- Elderly patients
- Insecure patients
- Preference for staying overnight
### Same Day Discharge after PCI

**Financial:**

<table>
<thead>
<tr>
<th></th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCI Reimbursement</td>
<td>$18,970</td>
<td>$12,000</td>
</tr>
<tr>
<td>Avg Total Costs</td>
<td>$12,500</td>
<td>$11,300</td>
</tr>
</tbody>
</table>

- Outpatient PCI is reimbursed at 28-38% less than inpatient PCI
- Reimbursement is the same regardless of LOS for outpatient PCI
- Net Margin approximately $6,500 vs. $1,000 for IP vs OP, respectively
- On 250,000 PCI/year = $1.8 Billion decrease in revenue
- However, hospitals experience $600 Million in direct costs savings
  - AND potential for increased revenue due to bed availability

Heyde, GS et al. Circulation 2007
Overview

• How do we define patient status; inpatient vs. outpatient?
• Does shortening length of stay after PCI have an impact on patient safety and quality of care?
• What patients qualify for early discharge?
• How do we implement a same day PCI discharge program?
Defining the Length of Stay Following Percutaneous Coronary Intervention: An Expert Consensus Document From the Society for Cardiovascular Angiography and Interventions

Endorsed by the American College of Cardiology Foundation

Charles E. Chambers,1 MD, Gregory J. Dehmer,2 MD, David A. Cox,3 MD, Robert A. Harrington,4 MD, Joseph D. Babb,5 MD, Jeffrey J. Popma,6 MD, Mark A. Turco,7 MD, Bonnie H. Weiner,8 MD, and Carl L. Tommaso,9* MD

Catheterization and Cardiovascular Interventions 73:847–858 (2009)
SCAI Guidelines for Outpatient PCI

- Stable angina with (-) biomarkers
- No significant comorbidities
- Normal renal function and LVEF
- Successful, uncomplicated procedure
- Appropriate home support and access to emergency care
- Single vessel PCI with < 28mm stent (no POBA and no adjunctive devices)
- Immediate access site stabilization with closure device or radial artery approach or brachial cut down

100 patients discharged the same day after elective PCI – 80% did not meet SCAI criteria. None were readmitted within 30 days

- Gilchrist I, et. al. SCAI 2010
## Same-Day Discharge: Dimensions to consider

<table>
<thead>
<tr>
<th>Patient</th>
<th>Procedure</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively Intact</td>
<td>Successful</td>
<td>Education</td>
</tr>
<tr>
<td>Adequate social support</td>
<td>No post procedure bleeding</td>
<td>24-hour Hotline</td>
</tr>
<tr>
<td>Medically Stable</td>
<td>No need for prolonged antithrombotics</td>
<td>Dual Antiplate therapy RX</td>
</tr>
</tbody>
</table>
Sample Same-Day Discharge Protocol

- Elective PCI
- Successful PCI with stent (<20% residual stenosis, TIMI 3 flow, no dissection or thrombus)
- No recent CHF
- Adequate access site hemostasis
- No requirement for GP 2b/3a Inhibitors
- Pt. resides ≤ 60 miles from PCI center and does not live alone
- No other comorbidity precluding same-day discharge as determined by attending
Sample Same-Day Discharge Protocol

- Recovery area staff provide education
  - Procedure
  - Disease state
  - Secondary prevention
  - Follow-up appointment
  - Educational materials
- Fellow or attending evaluate patient before discharge
- Patient and caregiver MUST have thienopyridine in hand before leaving
Selection of patients for Same Day Discharge after PCI

All ARU patients screened for eligibility (Baseline Screening)

Angiogram

• Left Main
• >6F Guide
• Referred for CABG

Exclusion Criteria

ACS
Troponin (+)
EF<30%
GFR<50%
>60 min away
Bleeding Diathesis
Chronic Anticoagulation
Hb<10

PCI

Exclusion Criteria

• Suboptimal result
• >20% residual stenosis (stent), >40% POBA
• Any Untreated dissection
• Thrombus
• No-reflow
• Persistent Slow flow
• Branch compromise (>1mm)
• Persistent CP (20 min)
• Perforation (including wire)
• >300 cc of dye
• Use of IIb/IIIa Inhibitors
• Complicated hemostasis

Hemostasis

2 hours of Observation if closure device is used
4 hours of observation if manual hemostasis

1 Hour after Ambulation

Discharge

Persistent/Recurrent CP
EKG changes
Hypertension/Hypotension (Excluding vagal)
Any groin complications (hematoma >3cm, new bruit)
Anticipated Discharge after 6 PM
Overview

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SFH PCI 2012: Transition from Inpatient to Outpatient

PCI transition to Outpatient by Quarter
2010 Q1 - 2012 Q4
Same Day Discharge for Elective PCI

New York Presbyterian Hospital
Columbia University Medical Center
Hurdles to clear prior to initiating Same Day Discharge

- Pre-Admission
- Post-Procedure
- Pre-Discharge
- Stakeholder Buy-In
Process – Flow Map

Expected: 50/month

Internal Patient

Est: 60%
1920/yr
160/mo

ER
Patients

Est: 30%
1280
107/mo

Actual
Patients/
month:

70-75%
Internally
referred

Pre-Admission

Post Procedure

Pre-Disposition

Outpatient

Inpatient
## Criteria for Hospital Admission post Percutaneous Coronary Intervention (PCI)

### Pre-Procedural Clinical Criteria

**Major Criteria:**
- Acute Coronary Syndrome
- Clinical Heart Failure within 7 days
- Creatinine greater than 1.5 mg/dL, GFR less than 60 ml/min. Hemodialysis
- Inability to ambulate due to poor coordination, vasmotor instability, dizziness or suspected neurologic issues or events
- Need for therapeutic anticoagulation (i.e. Coumadin)
- Left Ventricular dysfunction (Ejection Fraction less than 30%)
- Antiplatelet or contrast allergy (uncontrolled)
- Prior stent thrombosis

**Minor Criteria:**
- Age greater than 75 years
- Patient lives or will be staying greater than 60 minutes from NYP-Columbia
- Patient does not live with or have the ability to stay with, another responsible adult on the evening of intended discharge
- History of recent ventricular arrhythmia
- Uncontrolled Diabetes (HbA1c > 7% or Fasting Blood Sugar > 180 mg/dL)
- Poorly controlled Hypertension (SBP > 160 mmHg)
- COPD (Home Oxygen dependent or requiring acute treatment)
- Morbidly obese
- Severe valvular heart disease (i.e. Severe AS, Severe MR)
- Prior organ transplant/immuno-suppressive therapy

### Procedure Related Criteria

**Major Criteria:**
- Complex Anatomy
  - Unprotected Left Main
  - PCI performed in 2 or more vessels
  - Bifurcation Lesion or Long Lesion (≥ 28 mm)
  - Support device (i.e. Balloon Pump, Impella)
- Suboptimal angiographic results (i.e. residual dissection)
- Use of GPIIb-IIIa Inhibitors (i.e. Abciximab, Eptifibatide)
- Side branch occlusion
- No-Reflow requiring treatment
- Significant Hypertension or Hypotension during procedure (SBP < 100mmHg or > 160mmHg)
- Total contrast volume/Calculated CrCl (CcrC) ratio > 3
- Intra-procedural access site complication
- Significant brady or tachy arrhythmia requiring treatment
- Coronary Perforation
- Need for staged procedure (during this hospitalization)

**Minor Criteria:**
- Rotablator, Laser
- Chronic Total Occlusion
- Proximal LAD lesion
- SVG PCI
- Fluoro > 60 minutes or > 5 Gy
- Diffuse in-stent restenosis with restenting
- Left Ventricular End Diastolic Pressure > 25mmHg

### INPATIENT Admission

- **(1 MAJOR criteria / 2 or more MINOR criteria)**

  Patient required an inpatient admission due to their co-morbid conditions and complex/high risk nature of their procedure and was considered to be at increased risk of major adverse cardiac and vascular events if discharged.

**Ambulatory Encounter:**
- **SAME DAY DISCHARGE**
- **EXTENDED RECOVERY** (Patient requires overnight recovery)

**Physician Signature:**

**Date:** __/__/__

**Time:** __:__ AM/PM
The following is completed by the Physician/NP/PA in the pre-admission area and follows the patient through to discharge.

<table>
<thead>
<tr>
<th>MAJOR CRITERIA</th>
</tr>
</thead>
<tbody>
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*(To be completed by the Interventional Cardiologist)*

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</tr>
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<td>100mmHg or &gt; 160mmHg)</td>
</tr>
<tr>
<td>Total contrast volume/Calculated CrCl (CCC) ratio &gt;3</td>
</tr>
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Ambulatory Encounter:
- SAME DAY DISCHARGE
- EXTENDED RECOVERY (Patient requires overnight recovery)

Physician Signature:
_____________________
Date ___ /____/_____
Time ___:_____   AM / PM
Pre-Discharge – Flow Map

Transfer patient to Outpatient care area

<table>
<thead>
<tr>
<th>Role</th>
<th>Est Tot Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10/day</td>
</tr>
</tbody>
</table>

Potential post discharge blood work

Clinical Research: Studies may require next day labs/patient review

Draw Labs

<table>
<thead>
<tr>
<th>Role</th>
<th>Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 min</td>
</tr>
</tbody>
</table>

Process labs

<table>
<thead>
<tr>
<th>Role</th>
<th>Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 min</td>
</tr>
</tbody>
</table>

Review Labs

<table>
<thead>
<tr>
<th>Role</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results pass post procedure criteria

Yes

Discharge Patients

Admit Patient

No
## Pre-Discharge

<table>
<thead>
<tr>
<th>RN</th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRE-DISCHARGE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have post-PCI ECG and labwork (CBC, BMP, CPK) been performed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the dedicated caregiver been involved in the discharge teaching and do you feel he/she understands instructions?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the vascular access site without complication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient been ambulatory for 60 minutes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was discharge teaching performed; including medication management, access site management and emergency management of complications post discharge?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Recommendations

• Start slow...pilot with only a few operators
• Examine your own practice.....consider discharging lowest risk patients
• Develop a protocol which fits the culture of your institution
• Patients should feel comfortable going home; if they are not comfortable, keep them
• Patient should have supervision at home
• Geographically close to a medical center.
• Follow up phone call – A way to close the loop.
• Ensure they have their DAPT
Next Phase
Conclusion

- Patient care is increasingly shifting from inpatient to outpatient settings.

- While Same Day PCI has been demonstrated to be safe in select patient populations, it is important to develop a comprehensive same day PCI program.

- Keys to success in developing a program:
  - Careful patient selection
  - Establish guidelines and protocols
  - Involve all stakeholders including patients, families, staff and physicians
Thank You