Happy Holidays from your California Chapter of the ACC!

Congratulations to our 2011 Award Winners!

Cardiac Care Associate of the Year:
Cher Hagaman, MSN, RN, CNS

Future Leader Award: Brad G. Angeja, MD FACC

Advocate of the Year: Raymond S. Yen, MD, FACC

Elliot Rapaport Cardiologist of the Year:
Ralph Brindis, MD, M.P.H., MACC

Congratulations to Our Past Presidents!

Dipti Itchhaporia, MD, FACC has been recognized as a co-winner of the 2012 American Academy of Nurse Practitioners’ Nurse Practitioner Advocate of the Year Award.

Gordon Fung, MD, FACC was elected Incoming Governor Northern California for the American College of Physicians.

Upcoming Events

Check out our website at www.caacc.org for details on all these events.

Dec. 15: PINNACLE Webinar “Enhance your Practice & Make Quality Count: Invest in Health IT”
Dec. 15: Fellows-In-Training Career Dinner Program, San Francisco
Dec. 16: 28th Annual Advances in Heart Disease, San Francisco
Dec. 17: Lipoprotein Management in ACS Improving Outcomes in Patients with Complex Lipid Disorders, San Francisco
Jan. 20 -22: Advances in Nuclear Cardiology & Cardiac CT: Case Review with the Experts CME Conference, Los Angeles
Feb. 11: Mid-Valley Cardiovascular Symposium, Modesto
Feb. 11: 12th Annual UCSD Heart Failure Symposium for Primary Care & Internal Medicine Physicians Conference, La Jolla
Feb. 25: San Diego Cardiology Conference, San Diego
President’s Corner
George Smith, MD, FACC,

December 2011

The State of the State

As in all other states, California cardiologists are facing much uncertainty in our future care of patients, and in our livelihood. Although national issues of efficiency of care, costs and reimbursements are the focus of much of our attention, it seems worthwhile to outline how California cardiologists have dealt with this changing environment.

1. Several of our councilors have stepped forward this year to attend critically important fundraisers both for state elected officials and for members of Congress. We have an active state PAC which has donated to members on both sides of the aisle who have been receptive to good ideas regarding the delivery of good patient care to the people of California. Involvement with local legislators is critically important for ongoing issues which we always have with trial lawyers. There are yearly efforts to repeal our MICRA legislation, which has kept malpractice premiums in California some of the lowest in the country. There have been several scope of practice bills which would allow other providers of medical care to encroach on areas which should be reserved for physicians. We have teamed with the California Medical Association to successfully oppose these.

2. Our Cardiac Care Associates have spearheaded our hospital coordination in the H2H project, whose purpose is to minimize the too early rehospitalizations which add substantial burden to medical costs. Our chapter members have worked hard with Mission Lifeline, in accord with our close cooperation with the American Heart Association. Our colleague in emergency medicine, Dr. Ivan Rokos, is now a fellow in our College, and has been an exceptional partner over the past four years in the D2B project which has been so successful in California, as in the U.S. as a whole.

3. We have again either partnered with or sponsored more than 40 educational programs in the state this year. A sampling of these includes: “Advances in Nuclear Cardiology and Cardiac CT”; “An Update on Therapy: Heart Failure, Hypertension, Arrhythmias and Valvular Disease”; “Women and Ischemic Heart Disease Symposium”; “Diagnostic and Therapeutic Modalities in Heart Failure”; and Interventional Cardiology 2011. In these we have partnered with hospitals, universities, private practices, and pharmaceutical companies. These have been well attended both by FACC’s, CCA’s, and by our FIT members. It has been especially heartening that our FIT members have become far more engaged in these programs and have come to recognize how important the ACC will be for their future lives in cardiology.

4. In terms of membership, we have grown considerably both in our associate nursing members, and practice administrators. Both have proven to be extremely valuable in their respective spheres, our Cardiac Care Associates in being partners in excellent patient care, and our administrators in sharpening the attention of their groups’ members to issues of critical importance which they might otherwise overlook because of the daily pressures of the 12 plus hour work days. We are all in debt to our national leaders who recognized these non traditional additions to the ACC as being exceptionally valuable.
5. California chapter activities have been extensive. Twinning with our British colleagues continues to be highly successful, with our attendance at each others’ national meetings, participating as speakers and panel members in these meetings, and learning much from one another. At our yearly chapter meeting in Beverly Hills, three eminent BCS speakers shared with us their ideas about congestive heart failure, progression of aortic valve disease, and health care transformation. A most valuable part of our partnership has been the preceptorships which have been arranged for our FITS between the Brompton Hospital and Cedars Sinai, in imaging. The quality of the British FITS has been exceptional, and they have been laudatory in their descriptions of their experiences.

California is one of the ongoing pilot states for the ACC with the Medical Directors’ Institute, a committee set up to work with insurers to find pathways of patient care which improve outcomes, reduce administrative hassle, and ultimately reduce costs. We have had one major meeting this past summer with the major insurance company medical directors, and another is planned during our Las Vegas meeting in January. We continue, however, to have considerable skepticism that the carriers are committed to using established AUC criteria to lessen many of the onerous requirements for appropriate testing of our patients.

We published our fourth printed-edition California membership directory this fall. This was a huge effort, and the cross pollination of member data between national and California ACC has created a far more accurate member base for more than 10% of the cardiologists in the country. This will pay great dividends in the future.

Finally, our lobby day in Sacramento was once again a great success, with positive interactions between about 30 of us and our legislators. They seem to understand, whatever their political party, how hard we are all working for both excellence and affordability in our care of patients.

Our chapter accomplishments this past year have focused on improving the awareness of councilors and members about the great value of the ACC to practicing cardiologists, especially in this rapidly changing and challenging landscape. We are reenergizing our committee structures. We have had great success in encouraging our FITS to become a contributing part of the ACC at the very onset of their careers, something that has been most uncommon in the past. We are also working to encourage national to offer more value to our practice administrators through support of billing, coding, and other critical activities. They are the newest members of the ACC team and will be a most important part of our future.

The single most important concern for our Council and our members is communication. The ACC and Chapter Communication with members is ineffective and as leaders we need to be proactive to find a solution to get the valuable work of the ACC into our members’ hands.
PLANTS IN CARDIOLOGY
Arthur Hollman MD FRCP FLS
Archivist of the British Cardiovascular Society
Curator of the Physic Garden of the Worshipful Company of Barbers of London
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Plant derived medicines have been discovered in several ways. Folk medicine, trial and error in the community, has been very important, and starting with the folk remedy scientific endeavour has produced new and better synthetic analogues, such as amiodarone and verapamil. But folk medicine is not the only path of drug discovery. Veterinary medicine led to oral anticoagulants, academic chemistry gave lignocaine, a patient’s experience led to quinidine and an American doctor found a treatment for eclampsia. Let us have a look at some of these drugs in more detail.

Foxglove, Digitalis purpurea, was identified in 1775 by William Withering from an old herbal remedy and now digoxin is extracted from Digitalis lanata. Quinine was the discovery in 1912 of a patient who found it halted his paroxysms of atrial fibrillation and the better isomer Quinidine is extracted from the bark of the Cinchona tree.

In 1859 a family doctor in Eufala Alabama treated a woman with pregnancy eclampsia with the American plant Veratrum viride, and the veratrine alkaloids were used to treat eclampsia and hypertension until 60 years ago. They have a unique mode of action via the von Bezold reflex. But the first really acceptable drug for high blood pressure was reserpine in 1949, derived from the Indian plant Rauvolfia serpentina.

In 1945 G V Anrep, a pharmacologist in Cairo, noticed that a colleague’s angina pectoris got better when he took the local folk remedy to treat an attack of renal colic. This was Khella from Ammi visnaga and Anrep showed it to be a selective coronary vasodilator. Many analogues were made and one of them was amiodarone.

Papaverine, an alkaloid in the opium poppy Papaver somniferum, was once a popular anti-spasmodic. The German firm Knoll made a synthetic analogue in 1959 which Albrecht Fleckenstein showed to act by calcium antagonism. It is now named verapamil, the first ever calcium channel blocker.

An investigation into genetically different strains of barley Hordeum vulgare led to the isolation of a local anaesthetic called Gramine, of which Lignocaine is a synthetic analogue. Purely academic chemistry gave us a valuable medicine.

Acetyl salicylic acid, Aspirin, is named after the plant formerly called Spiraea ulmaria (now Filipendula ) from which salicylic acid was first isolated in 1835. A for acetyl, spir for the plant and in for the compound salicin found in the willow tree. Aspirin was synthesised via phenol, not from a plant compound.

Dicumarol, our first oral anticoagulant drug, was discovered after a Canadian veterinary surgeon noted that cattle died from haemorrhage after eating mouldy hay made from sweet clover, Melliotus officinalis. It was isolated in Wisconsin where Warfarin was later introduced.

Finally we should remember the use of plants in cardiological research. Pulmonary arterial disease was produced by feeding Crotalaria seed to rats, by JJ Lalich in Madison, and pulmonary hypertension was demonstrated in rats after feeding Senecio jacobae. Cardiac arrhythmias were studied in dogs by David Scherf and Myron Printz metal by putting aconitine from Aconitum napellus onto the heart.

FDA Approves SAPIEN Transcatheter Heart Valve
The Food and Drug Administration (FDA) has announced approval of the Edwards Lifesciences SAPIEN Transcatheter Heart Valve. This is one of several devices in development for use in the emerging field of transcatheter aortic valve replacement (TAVR). In announcing the decision, the FDA also noted that Edwards Lifesciences will continue to evaluate the outcomes of the SAPIEN transcatheter heart valve through a national Transcatheter Valve Therapy (TVT) Registry that will track patient safety and real world outcomes related to emerging TAVR procedures. The American College of Cardiology and the Society of Thoracic Surgeons have been working with the FDA and the Centers for Medicare and Medicaid Services in the development of this new registry, called the TVT RegistryTM, which is scheduled to launch in late 2011. It will be the first national program to evaluate safety and efficacy of a TAVR option for patients who are otherwise considered to be high-risk or non-operable for conventional valve replacement surgery. For more on the announcement and what this means for TAVR, click here.

2012 Physician Fee Schedule Final Rule Released
The Centers for Medicare and Medicaid Services released the final 2012 Medicare Physician Fee Schedule on Nov. 1. This final rule, which sets payment levels and other associated policies for next year, includes a number of issues important to cardiology. On a broad scale, the rule cuts payments to cardiologists by an average of 2 percent depending on the mix of services provided. It also includes the mandated 27.4 percent cut in overall Medicare payments as a result of the sustainable growth rate formula, or SGR. This cut will take effect on Jan. 1, 2012 without congressional action. Other payment adjustments of note: a 29 percent reduction in payment rates for the replacement of pulse generators on pacemakers and ICDs, as well as a 25 percent reduction in payment rates for the professional component of advanced imaging services provided by the same physician on the same day. CMS had initially proposed slashing the imaging payment rates by 50 percent, but changes its mind as a result of advocacy efforts by the ACC and others. To Learn more information about the Final Rule, including policy implications relating to e-prescribing and the physician quality reporting system visit www.cardiosource.org. Providers can pre-order the 2012 CPT Reference Guide for Cardiovascular Coding and save 10 percent.

Final Rule on Accountable Care Organizations (ACOs) Released
CMS recently issued its final rule on ACOs, which make it easier for doctors and hospitals to participate by cutting in half the number of performance measurements, removing the electronic health records requirement and eliminating financial risks for some groups. Theca supported many facets of the proposed rule that was released earlier this year but expressed concerns that the requirement for ACOs to take on financial risk would make it difficult if not impossible for physicians to form together with hospitals to form an accountable care organization. While the ACC is supportive of the focus on quality of care and the particular focus on cardiovascular care within the final rule, there must be continued flexibility for physicians and other providers to improve care.
American College of CardiologyLaunches PINNACLE-AF
The American College of Cardiology (ACC) is expanding the PINNACLE Registry, with a new platform focusing on atrial fibrillation and including the next generation of anticoagulants. The new platform, PINNACLE-AF, will operate within the existing PINNACLE Registry, the largest cardiovascular outpatient database in the U.S., and part of the ACC’s National Cardiovascular Data Registry (NCDR). NCDR is the most comprehensive, outcomes-based cardiovascular patient data registry for quality improvement in the United States. PINNACLE currently has 2.1 million patient records representing valid patient encounters from hundreds of outpatient practices nationwide. Of those patients, over 100,000 have atrial fibrillation. Participation in the Registry is free to all cardiology practices. For more information about the PINNACLE Registry and PINNACLE-AF, visit www.PINNACLEregistry.org.

PINNACLE All Member Webinar
Click here to access You may access the archived recording of the December 1, 2011 PINNACLE All Member Webinar.

The next PINNACLE webinar, “Enhance your Practice and Make Quality Count: Invest in Health IT” will take place Thursday, December 15, 3-4pm ET. Tune in to learn about the evolving role of health information technology within the healthcare industry and how Electronic Health Records (EHR) can impact your medical practice. Additionally, the panel will discuss current key issues under consideration for Stage 2 Meaningful Use. Please join Michael Mirro, MD, FACC, Joshua Seidman, PhD, Office of the National Coordinator, Robert Anthony, Centers for Medicare and Medicaid Services, and Janet Wright, MD, FACC, Million Hearts Campaign for this informative webinar. Register now at http://accwebinars.cardiosource.org/session.php?id=8052.

November ACC Update Looks at TAVR, Mended Hearts and More!
The November ACC Update video looks at a new program founded by an ACC member that helps patients live a better heart healthy lifestyle and the landmark summit on non-communicable diseases held recently in New York and attended by ACC leaders including president-elect William Zoghbi. The update also highlights a new industry training program for medical and device representatives to learn more about cardiovascular care. There is also an interview with ACC senior vice president Kevin Fitzpatrick who discusses the collaboration between the College and the patient-centered organization, Mended Hearts. Watch the video.
Caring for California

December 2011

Medi-Cal Electronic Health Records Incentive Programs Begin for Providers in 2011
By Larry L. Dickey, MD, MPH, Medical Director, Office of Health Information Technology, California Department of Health Care Services

In recognition of the importance of moving health care delivery from paper-based records into the digital age, beginning in 2011, the federal government is providing financial incentives to Medi-Cal and Medicare providers to adopt and use ONC-certified electronic health records (EHRs) through the HITECH Act. The Medi-Cal and Medicare EHR incentive programs for eligible providers are similar, but each has its own rules and incentive payment schedules. Eligible providers may only participate in one program, but may switch once during the course of their participation. Both programs represent an unprecedented opportunity for providers to obtain financial assistance to adopt and utilize electronic health records.

The Medi-Cal EHR Incentive Program is administered by the California Department of Health Care Services. During the first year of the program, eligible providers who adopt, implement, or upgrade an EHR in their practices will receive $21,250. In subsequent years, providers who demonstrate “meaningful use” of their EHRs, by reporting on a set of objectives and clinical quality measures, will receive $8,500 yearly, for up to 5 years. Eligible providers can receive up to a total of $63,750 in incentive payments from Medi-Cal over the life of the program. To be eligible, providers must satisfy all of the following:

- Provider type: doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, nurse practitioner, certified nurse midwife, or physician assistant practicing in a physician assistant-led, federally qualified health center or rural health center. Doctors of optometry may be eligible, but this is currently undergoing federal review.

- Practice setting: outpatient (cannot provide more than 90% of services in a hospital inpatient or emergency room setting).

- Medi-Cal volume: 30% or more of patient encounters must be fully or partially paid by Medi-Cal. Pediatricians may qualify with 20%-29% Medi-Cal encounters, but will receive incentive payments reduced by 33.3%. Providers practicing predominantly in federally qualified health centers may count Healthy Families, sliding scale, and uninsured patients (in addition to Medi-Cal patients) toward the 30% volume requirement.

Registration for the Medi-Cal EHR Incentive Program will open in late spring. Providers should first register with CMS at www.ehrincentives.cms.gov. After this, providers should register with Medi-Cal at www.medi-cal.ehr.ca.gov to complete the registration process. Registration for the program will end in 2016. Questions can be e-mailed to: Medi-Cal.EHR@dhcs.ca.gov.

For more information about the Medicare EHR Incentive program, which is administered at the federal level by CMS, please visit: www.cms.gov/EHRIncentivePrograms.