Oregon
CHAPTER

Oregon's Cardiac News - December 2003

The Governor's Page

By: Stuart E. Trenholme, MD, FACC - Chapter Governor

This will undoubtedly be my last column as Oregon Governor for the American College of Cardiology as my term ends in March 2004. Dr. Tony Furnary will be taking the helm at that point. I have enjoyed the last three years and learned a great deal about medical politics and the challenges that lie ahead for all those who will practice cardiology in the years to come. I want to thank Tony for stepping in and assuming the leadership responsibilities after the tragic loss of Bruce Shively.

In terms of our accomplishments during the three years, I can say that we now have an excellent executive director in Alan Morasch, who has worked tirelessly on our behalf and continues to do so. We have this newsletter and we are in the process of forming a meeting of the state Councilors to focus the Chapter efforts in appropriate ways to help us all for the next three years. The web site is being reconstructed and is up and running-- you will hear more about this in the near future. We are also planning a symposium, the first, under the sole sponsorship of the Oregon Chapter of the ACC on April 30 and May 1, 2004. We will be using members of the Chapter as speakers as well as inviting national guest speakers. If any of you are interested in participating, please let Tony or myself know of your interest. The symposium will be directed to all practitioners in the hopes of reinforcing the practice guidelines.

For the remainder of this column I want to focus on two urgent challenges that affect us all at the state and national levels. They relate to advocacy and the first centers around the medical liability issue.

There is a great push in the state by the OMA to get liability relief for the physicians. However, the legislature cannot get the job done and thus we need a constitutional amendment to see any changes. This means that we must go to the voters (our patients) for their support. Polls have indicated that the public is sympathetic to our plight but in order to push the initiative along the OMA needs money. I will personally be writing a check to the OMA for $1000.00 to aid in this effort and I would hope that every cardiologist and cardiac surgeon in the state would do the same. This is an investment in your future practice and there may not be another opportunity to force the issue until at least 2005 or later. The OMA plans to put the initiative on the November 2004 ballot. The time is right and the money is needed. It is my opinion that there will not be a national medical liability reform law and we will need to have a state law much as has been recently passed in Texas. Please spend your money now in an effort to insure future stable malpractice premiums and end the medical liability crisis in this state. The OMA also has information, posters, and pamphlets, which you can make available in your offices for your patients---WHO WILL BE VOTING ON THIS ISSUE!!

(Continued on page 2)

BECOME A PART OF THE PLANNING TEAM
"OREGON CARDIOVASCULAR SYMPOSIUM"
SPONSORED BY THE OREGON CHAPTER OF THE ACC
PORTLAND MARRIOTT HOTEL
APRIL 30 - MAY 1, 2004

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The Governor's Page.... (*cont. from page 1*)

The second challenge relates to the ACC PAC contribution, which is optional with your yearly dues statement. Here again, there are national issues, which need to be addressed. The ACC, in conjunction with other specialty societies, has formed an alliance to promote Medicare fee schedule reform and other issues, which aim to improve our reimbursement. These have been well outlined in Cardiology, which you all receive. It is only recently that the ACC has assumed a strong advocacy role at the national level and they are making a significant difference. I have given $250.00 to the PAC contribution and hope you would all do the same.

Thank you all once again for allowing me to serve you over the last three years-it has been a real pleasure. I hope you will continue to support your Chapter and the ACC both locally and nationally. I will be most happy to send any of you a copy of my cancelled checks to demonstrate my resolve in supporting our current challenges.

ACC Chapter Dinner and Annual Meeting

April 29, 2004

Portland Marriott Downtown Hotel

(More Details to Follow....)

Save the Date!

April 30 - May 1, 2004
Oregon Cardiovascular Symposium

Sponsored by the Oregon Chapter of the ACC
Portland Marriott Downtown Hotel Grand Ballroom
Portland, Oregon

This day and a half educational event will provide cardiologists and physicians providing primary care, as well as nurse practitioners and other medical professionals, cardiac care training with the most current information on the diagnosis, treatment and prevention of common cardiac problems.

Invitations to the symposium and supplier exposition will be sent to medical professionals throughout Oregon and SW Washington.

Notices will be distributed to industry suppliers shortly requesting their sponsorship and exhibition support.

Your attendance, participation and support of this event will help to ensure that the patients in our region receive the best cardiac attention and care from the medical community.

The Update on the Heart Failure GAP Project

By: Mark Huth, MD, FACC

The project aims to improve quality of care of Oregonians with Heart Failure (CHF) by increasing the application of ACC/AHA guidelines for Heart Failure management.

Oregon, like much of the U.S., is experiencing a marked increase in reported diagnosis of heart failure and in hospitalizations for heart failure (CHF). The projected increases are staggering and the current costs and anticipated costs are huge. In many respects this increased incidence appears to be a consequence of improved therapies of heart disease. Patients are surviving myocardial infarction and other acute cardiovascular events and are left with a damaged left ventricle leading to CHF. In this context, advances in the understanding and in the management of CHF have greatly improved care of these patients, improved their functional capacity, and improved their survival.

However, in many respects as a consequence of the rapid growth of knowledge in this area, application of now standard measures and optimal care are spotty. Practitioners often lack a systematic way to apply the new thinking and guidelines for CHF care, and lack the systems necessary to do so consistently for all patients. Some Oregon data illustrate these dilemmas. In a 1997 sample of Medicare patients (1) there were 1347 discharges from Oregon hospitals for CHF over a six month period (July 1-December 31, 1997), (2) 16% (216) were readmitted within six months for the same diagnosis.

Our hope was that the cardiologists of Oregon could join together in a project that would improve congestive heart failure care in Oregon. We'd hoped to improve the lives of patients with heart failure, to develop tools and techniques to make our lives easier and to develop a model for the treatment of heart failure in our communities.

The project was conceived as a multi-phase effort predominantly set in the outpatient arena (where most CHF care should be accomplished). We proposed to first engage the leaders in this field, the cardiologists, by beginning the project in the offices of several (7) cardiology groups geographically dispersed in Oregon. This initial phase provided the forum for developing tools for system enhancement, measurement techniques, data collection and reporting, and for testing training materials and implementation strategies, and communication methods among participants and other practitioners. In addition, we intended to develop and begin to use an electronic registry. The intent was to compare the participant cardiologists with their peers in a number of measures, including documentation of systolic dysfunction, use of ACE inhibitors, Beta Blocker usage, evidence based Beta Blocker Use, appropriate use of anticoagulation, blood pressure control, documentation of functional status, and registry use.

At this point, tools for physician, nurse, and patient use have been developed and are actively being utilized in the participant cardiologists' offices. The electronic registry is complete and in production in the cardiologists' offices, and baseline and interim data collection is complete. The participant cardiologists and nurse practitioners have just completed our 4th meeting and expect to submit the data for publication and the tools for general release in short order. For updates on the Heart Failure GAP Project, visit the GAP web site at http://www.acc.org/gap/gap.htm or email gap@acc.org.

Advocacy in Review

By: Ron Schutz, MD, FACC

The advocacy committee of the Oregon chapter of the American College of Cardiology functions to link our chapter's efforts with those of the national organization. This is a two-way interchange of information and resources. On a practical basis, this means that our chapter provides input to the national organization in order to help develop coherent and effective national policies with regard to cardiovascular medicine. We also provide financial support with our membership dues. We are represented nationally by our Oregon chapter governor as well as any other individuals who may serve on national policy-making committees. Flowing in the opposite direction, policies that are agreed upon nationally are funneled through the chapter in order to facilitate their implementation on a local level. At times we coordinate with other specialty societies and/or the Oregon Medical Association. This can include working with the local media to inform them about important topics, lobbying our representatives at all levels of government, and increasing public awareness through our own offices.

Most recently much of the activity in the chapter has been devoted to the liability insurance crisis which affects all of us directly and therefore our patients as well. On July 2nd, Dr. Stuart Trenholme and I represented the chapter at a meeting with Senator Gordon Smith at his office in Portland. We were there together with representatives of many other medical specialty societies in order to impress upon the Senator the gravity of the situation and to illustrate to him how it is affecting patients' access to needed medical care. There was strong unanimity amongst all the doctors at the meeting that tort reform legislation, including caps on awards were necessary to help restore stability to our practices and our ability to deliver care. The Senator expressed that he was sympathetic to our plight and had been a key supporter of caps on medical malpractice damage awards while he was in the state legislature (which was subsequently reversed by the courts). Senator Smith stated that the political realities, however, were that the trial lawyers organization was extremely powerful and that it was unlikely that either at the state or national levels a meaningful legislative tort reform package would be achievable within the foreseeable future.

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Advocacy in Review *(continued from page 3)*

Also, Drs. Trenholme, Furnary and I have been attending regular meetings at the OMA where representatives of all the specialty and sub-specialty organizations are represented. These meetings were initially for us each to get to know the issues that the other groups face and find areas of common ground on which to base appropriate responses. Together with the OMA we are supporting their statewide efforts on tort reform which have resulted in the submission of four specific ballot measures which will be put before voters in order to address this issue. These measures include proposed caps on non-economic damages and on plaintiff's attorneys' contingency fees. Based on the financial analysis prepared by a consulting group, it is clear that for any of these measures to have a chance of success, each of us, in addition to all of our medical colleagues in this state will need to make a significant monetary contribution to support what will undoubtedly be a hard fought campaign, primarily against the heavily funded trial lawyers' organization. More on this will be forthcoming directly from the OMA, but suffice it to say this will be a real test of our individual and collective commitments to solving this insurance and malpractice award crisis. We urge you to support both the OMA and the ACC with your monetary contributions. Our fate is in our hands and we will have no one to blame but ourselves if we fail to make our case known to the public.

Special Thanks to Our 2003 ACC Chapter Sponsors!

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Guest Contributor:

Recent Update to the ACC/AHA Guidelines for the Management of Patients with UA/NSTEMI

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More than 1.4 million patients every year in the United States are admitted to the hospital with unstable angina and non-ST-segment elevation myocardial infarction (UA/NSTEMI). To help improve the treatment of UA/NSTEMI, American College of Cardiology (ACC) and the American Heart Association (AHA) developed and just updated in October 2002 clinical guidelines for diagnosis and management of these patients.(1)

The evaluation of patients with UA/NSTEMI begins with the clinical history, ECG and cardiac biomarkers to make an assessment of 1) the likelihood of coronary disease, and 2) the patient's risk of death or recurrent cardiac events. Patients with a low likelihood of having UA/NSTEMI should undergo, a "diagnostic pathway" evaluation via serial ECGs, cardiac biomarkers, and early stress testing to evaluate for coronary disease. This can frequently be accomplished in an Emergency Department observation/chest pain unit.

For patients with a clinical history strongly consistent with UA/NSTEMI, antithrombotic therapy with aspirin, clopidogrel, heparin, or low-molecular weight heparin, beta-blockers and nitrates are recommended as initial management for all patients. The 2002 update added clopidogrel based on data from CURE and PCI-CURE trials, (2,3) and these recommendations were further supported by recent data from the CREDO trial. (4) Recent cost-effectiveness data have found it to be very cost effective when used in ACS patients. The guidelines also make a Class IIa recommendation for the use of enoxaparin as preferred over unfractionated heparin. The use of GP IIb/IIIa inhibitors is recommended for patients being treated with an invasive strategy, or in those who are high risk. With regard to an invasive vs. conservative strategy, the latter recommendation is based on 9 randomized trials that have assessed the merits of an invasive strategy involving routine cardiac catheterization, with revascularization if feasible, versus a conservative strategy where angiography and revascularization are reserved for patients who have evidence of recurrent ischemia either at rest or on provocative testing. Of these, six have now shown a significant benefit of the invasive strategy, especially in higher-risk patients.(5-7) Accordingly, the 2002 ACC/AHA guideline has added ST-segment changes and positive troponin to the list of high-risk indicators which would lead to a Class I recommendation for an early invasive strategy.(1)

Long-Term Medical Therapy and Risk Factor Modification-The new 2002 guidelines put greater emphasis on the importance of multifaceted risk factor modification, which is the responsibility of the in-hospital cardiologist, but later of the primary care provider. There are 5 key long-term medications that have strong evidence of benefit in reducing cardiovascular events in patients with recent UA/NSTEMI, and thus are included in the Class I recommendations of the new 2002 ACC/AHA Guidelines: Aspirin, clopidogrel, beta-blockers, ACE inhibitors and statins. Risk factor modification is also critical, with good control of blood pressure, diabetes, and providing smoking cessation counseling. With all these multifactorial approaches, it is estimated that tens of thousands of lives can be saved by applying the guidelines into practice, as recently highlighted in the ACC GAP program.(8) It is thus hoped that all of us will work to apply the guideline recommendations to try to improve the outcomes of our patients with ACS.

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OREGON CARDIOVASCULAR SYMPOSIUM

PORTLAND MARRIOTT DOWNTOWN HOTEL
APRIL 30 - MAY 1, 2004
PRELIMINARY AGENDA

FRIDAY, APRIL 30, 2004 (7:00 am - 6:45 pm)
SATURDAY, MAY 1, 2004 (7:00 am - noon)

CORONARY ARTERY DISEASE AND THE ACUTE CORONARY SYNDROMES*

Pathophysiology of Atherosclerotic Heart Disease
What is High Sensitivity CRP and How do I Use It?
Primary Prevention of Coronary Artery Disease and Modification of Risk Factors
The Metabolic Syndrome - The Tip of the Iceberg
New Lipid Markers in Coronary Artery Disease
Diagnosis and Current Treatment of Stable Angina Pectoris
Unstable Angina and the Acute Coronary Syndrome - How Has The Therapy Changed?
The Acute Myocardial Infarction-Current Therapy
Risk Stratification Following an Acute Myocardial Event
Secondary Prevention of Future Coronary Events

THE FAILING HEART

The Pathophysiology of the Failing Heart
How to Use BNP in Clinical Practice
Current Management of the Heart Failure Patient
New Therapy for the Failing Heart
Prevention of Heart Failure in Valvular Heart Disease: Mitral and Aortic Regurgitation
Hybernating Myocardium
Biventricular Pacing in the Failing Heart
The Oregon GAP Trial in Congestive Heart Failure

* We are still seeking speakers for the session programs that are *italicized.* Any Fellow in the Chapter who is interested in presenting - please contact Dr. Trenholme (503-292-4485)

Are you.....

**** Willing to assist as a volunteer for the Symposium?***
**** Willing to distribute invitations to your referring PCP and Family Practice physicians?***
**** Willing to notify your suppliers of this event for either sponsorship or exhibiting opportunities?***

Please send the Chapter office an e-mail @ imc360@comcast.net and let us know how you can help.

QUALITY

Kirk W. Walker, MD, FACC

We can all agree that we want high quality cardiologic care. But how does one measure quality and who is responsible for it?

Let's take smoking for the sake of argument. Smoking should be an easy issue. Everyone except for the tobacco companies and the politicians they employ agree that the world would breathe easier if the tobacco industry evaporated in a puff of blue smoke. I am hard pressed to find much argument among physicians with regard to the merit of smoking cessation. Then why don't the insurance companies help pay for smoking cessation prescriptions and try to make it easy for me to do what I know is best? Why don't the employers who pay the premiums demand "high quality" smoking cessation programs for their workers?

The simple answer, of course, is that the insurance companies haven't figured out how to make a buck on smoking cessation so they don't invest in it. The same with employers, when they sit down and do the analysis, spending money to promote smoking cessation is a cost without return on the investment.

This fundamental economic problem sets up an irresolvable dissonance between the payers and to providers. They would like to provide "high quality" care because that is what the patients want, but they do not want to pay for it. The best situation for them would be to have someone else do the extra work for free.

Unfortunately, physicians do not have a lot of spare time for extra little activities. When I past through the hospital late last Friday night to discharge a patient, I didn't see a single physician leaning on his stethoscope, passing time until his shift was over. I for one do not long to spend unrecompensed time to develop quality initiatives focused on improving corporate margins.

However, at the same time it is important that we recognize the source of the dissonance. I just want to take care of my patient and then go home to take care of my family. If I choose to discuss smoking cessation with the patient at that time it is a personal thing between me and my patient-I'm not getting paid to do it. The payers on the other hand have little incentive to help me out with smoking cessation programs or prescriptions-it doesn't pay for them to do it either.

This problem would not be so annoying if we all just identified it and worked through it. However, the payers feel a need to differentiate themselves in the marketplace and have an incentive to do so on the cheap. A way for them to prove that they are better than "Brand X" is to tout their "high quality". Unfortunately, rather than actually paying for smoking cessation, they typically resort to the inexpensive but arcane art of auditing clinical indicators. Unfortunately, clinical indicators are surrogate endpoints, not outcomes. In the business world they are termed "metrics". The advantage of "metrics" is that they can be measured with precision. Their disadvantage is that they can be as true as an Enron executive. In a corporate world divorced from the patient, even irrelevant metrics acquire an aura of reality. In the surreal world of quality metric analysis it becomes important that the physician writes in the chart, "smoking cessation discussed with patient" and irrelevant if the patient actually quits.

Still, quality is important. The process of quality improvement can indeed be the rising tide that raises all boats. However, as we engage the process, we as physicians have both the right and the responsibility to examine the process with educated skepticism and to remember primum non nocere.

Ideas, Solutions, Comments about the Chapter?......Let Us Hear From You!
Please e-mail the Chapter Office at imc360@comcast.net

Are you planning to attend the 2004 ACC Annual Scientific Session in New Orleans, March 7 - 10?
Please let the association office know if you plan to attend.
Perhaps we can all connect somehow while we are there!

To get more information about the event, visit the ACC web site at www.acc.org

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The Governor and Councilors
of the Oregon Chapter of the ACC
wish you a safe and enjoyable
holiday season.