



# NC Chapter of the American College of Cardiology

## Spring 2011 Newsletter

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## Should we be teaching bystander cardiac arrest response to our patients and their families?

*Dustin Letts, MD, FACC  
Councilor, Southwestern Region  
Mid Carolina Cardiology*

In 2010, the [American Heart Association](#) implemented two important changes to the CPR guidelines. The order of interventions was changed from airway, breathing, chest compressions (ABC) to chest compressions, airway, breathing (CAB). This placed a larger emphasis on chest compressions.

More importantly, recommendations for bystander CPR have been modified to recommend chest compressions only, 100 per minute with 2 inches of compression. The emphasis on uninterrupted chest compressions has shown a higher success rate than standard CPR in patients with out-of-hospital cardiac arrest when performed by the untrained public. Additionally, compression only CPR seems to be a more favorable way for the public to get involved.

An article published in JAMA in the past year showed adults who experienced cardiac arrest in a non-hospital setting were 60% more likely to survive if they received compression-only CPR than if they received traditional CPR or no CPR until an emergency medical services crew arrived at the scene. This study suggested compression-only CPR may be easier to learn and remember and avoids the stranger anxiety when confronted with issues of mouth-to-mouth breathing. Many feel the public is more likely to get involved when compression-only CPR is an option.

In the above study, 13.3% of those who received compression-only CPR survived to hospital discharge

### Quick Links

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compared with 7.8% of those who received traditional CPR, and 5.2% who received no CPR from bystanders. Although these findings also emphasize the extremely poor outcomes with out of hospital arrest, this clearly shows a significant benefit. Additionally, the number of bystanders who performed compression-only CPR instead of traditional CPR increased during the study period.

Over the next five years, North Carolina Chapter of the American College of Cardiology will focus on doubling survival from out of hospital cardiac arrest. We will start with the first link in the "chain of survival," bystander recognition and response.

Currently, only 17% of cardiac arrest victims in our state receive bystander CPR, and the rate of bystander automatic external defibrillator application is 2%. Through our leadership, we hope to engender a culture of emergency cardiac care. Many of our patients are most likely to suffer from cardiac arrest and benefit from prompt and correct intervention.

During our leadership meeting in Cary, NC, we considered the possibility of routinely teaching our patients and their families cardiac arrest resuscitation as a routine part of the hospital discharge process. The simple components of such training would include recognition of an arrest, activating 911, calling for an AED, performing chest compression only CPR, and application of an AED.

Suggestions for extending this training to the outpatient setting included video assisted teaching being played in waiting rooms, night classes offered in the offices, and encouraging the cardiac rehab staff to offer this as a form of support. Clearly our patients have the most to gain from this educational initiative.

*Sources:*

JAMA 2010 Oct 6; 304(13):1447-54.  
American Heart Association [website](#)

**NC/SC Chapters of the ACC**  
**18th Annual Meeting**  
**September 23-25, 2011**

***Register Today!***

Take advantage of the discounted hotel and

conference registration rates. You may conveniently register for both online by clicking on the links below, so please take a moment now to secure your space with us!

[Online Meeting Registration](#)

[Click here](#) to download the registration brochure as a PDF. Use this version if you pay by check. [View the agenda](#)

Rooms are being held for the nights of September 23 and 24 at the discounted rate of \$229 per night. To ensure you receive this special rate, book your room by **August 23**. You may also call 800-438-5800 to reserve your room. Be sure to identify yourself with the group code (68U9UX). Reserve your room early as The Grove Park books quickly this time of year!

## Objectives

*Upon completion, participants should be able to:*

Discuss issues impacting the diagnosis and management of cardiac arrest and hypothermia at the completion of the meeting.

Discuss interventional and surgical approaches to patients with valvular heart disease at the completion of the meeting.

Discuss new approaches to the treatment of congestive heart failure at the completion of the meeting.

Understand new targets for management of lipids at the completion of the meeting.

Discuss sleep apnea, cardiovascular genomics and radial cath.

## Cardiology Case of the Year Presentations

We are soliciting applications for Cardiology Case of the Year presentations - both interventional and imaging cases. Judging will be based on uniqueness of the clinical presentation or treatment, quality of the graphics/visuals and/or the ability of the case to provide teaching points. Applications are due by **August 1** and the winners will be announced by August 31.

The winning interventional and imaging cases will be presented Sunday morning. To apply, please email your case summaries with graphics/visuals to:

[bdenny@nccacc.org](mailto:bdenny@nccacc.org)

*Credit: MAHEC designates this activity for a maximum of **6.5 AMA PRA Category 1 Credits TM***

## FIT Day

The NCCACC second Fellows-in-Training (FIT) Day will be held on **Friday, September 23** in conjunction with the annual meeting. The FIT Day program will be held from 1:00 - 5:00pm. The [FIT Day agenda](#) covers important and timely topics such as: *Finding the Right Practice, Medical Contracting and Financial Planning*. If you are a fellow and would like to find out more information including how to qualify for a complimentary stay, contact [info@nccacc.org](mailto:info@nccacc.org).

Questions? Contact [info@nccacc.org](mailto:info@nccacc.org)

*NCCACC looks forward to seeing you in Asheville!*

## ACC Associate Designation for Cardiac Care Associate Members: *Why would you want to become an A.A.C.C.*



*Allison Dimsdale, MSN, NP, A.A.C.C.  
Duke University Department of Cardiovascular Medicine*

### ***What is an A.A.C.C.?***

The Associate of the American College of Cardiology (A.A.C.C.) is a professional designation that was established by the Board of Trustees in 2009 to recognize [Cardiac Care Associate \(CCA\) members](#)

who have proven their commitment to providing quality cardiovascular care through advanced education, training and professional development. The process for advancement from CCA member to [A.A.C.C.](#) mirrors the course for physician members who become Fellows of the ACC.

### ***Why pursue A.A.C.C. designation?***

If you are a CCA member of the ACC, chances are excellent that you care deeply about the practice of cardiovascular medicine and about the wellness of your patients. You may attend the annual meetings, read the journals, collaborate with your team members, and provide high quality cardiovascular care for your patient population. You may participate in clinical trials, write articles, teach others, and certainly complete enough CME to keep current (both your knowledge and your certification!). You are a licensed and board certified professional, and also may be a part of other professional organizations to participate in educational and advocacy endeavors. If this indeed describes you, and you have worked in cardiovascular practice for 5 years, and have been a CCA member for 2 years, the A.A.C.C. designation is available to you.

The A.A.C.C. designation is recognition of your involvement and your commitment to excellence, professional development, and to patient outcomes. It declares that you are the kind of person who goes the extra mile to continually improve your knowledge and skills, and to be the best you can in order to benefit your cardiovascular patients. Importantly, it is a vote of confidence from the physician collaborators who write your recommendations. Will it make you more marketable in the job field? Likely. Will it increase the confidence of those around you in your work, dedication and ethic? Also likely.

### ***How do I apply for the A.A.C.C.?***

Criteria for the application are straightforward. The complete list and application form can be found on the [Cardiosource website](#).

The A.A.C.C. designation represents recognition of what many of us already do every day. The [ACC](#) would like to recognize your effort to attain the ideals of the College: *promoting excellence in cardiovascular care*.

## Cardiovascular Care Associate Program

This year, the NCCACC is proud to announce a CCA program will be held on Friday, **September 23 from 1:00 - 5:00**. Free registration and one night hotel room will be covered by NCCACC. This is limited to the first 20 CCA applicants.

*Qualifications are:*

- Must be a current ACC member - proof of membership is required
- Must be a current NCCACC member - proof of membership is required
- Must live farther than 50 miles away from meeting location.

The hard copy of the [registration form](#) must be completed and submitted with home address and proof of memberships to NCCACC.

Questions? Contact [info@nccacc.org](mailto:info@nccacc.org)

## A Call to Fiscal Responsibility

*Linda Calhoun, MD, FACC  
Councilor, Southeastern Region  
Cape Fear Heart Associates*

I am incredibly irritated and offended by requests for authorization of ordered services. I feel that whoever is requesting these authorizations just doesn't know me, and the depth of thought and appropriateness of our requested services. But the cruel realities are that there is a finite amount of money appropriated to healthcare, that there are going to be surges in healthcare costs due to maturing baby boomers, and that there are examples of fraud and abuse that have dirtied our reputations, and raised the antennae of those policing us. We also have partners and extenders, who work with us who may not know the patients as well as we do who may order a study that was recently done or one that we may not think necessary. We can save time as well by understanding and teaching our fellow physicians and extenders the necessary documentation to support appropriateness of requested studies in our

notes so the requests do not boomerang back to us for "authorization" (and don't let me get started on challenges of documenting with electronic medical records). We are called to organize ourselves to police ourselves, and be fiscally responsible.

So, have you noticed the "realignment" of physicians with different groups or Healthcare organizations? Accountable Care Organizations (ACOs) have arrived. The Centers for Medicare and Medicaid Services have published the draft guidelines for the formation of ACOs. An ACO is a network of physicians and hospitals that shares responsibility for providing care to patients. Under the new law, an ACO would agree to manage all of the health care needs of a minimum of 5000 Medicare beneficiaries for at least 3 years. The premise is that an ACO would bring together the different components of care for the patient-primary care, specialists, hospitals, home care, etc, and "ensure that all those components work well together." There are obvious downsides for physicians, but CMS is establishing a "pilot" to give physicians/providers the "opportunity" to share in the cost savings with this approach. For ACOs to work, Healthcare providers involved in the network must have seamless access to information. One obvious risk for those involved is the cost of investments in personnel, such as nurse case managers, and information software systems that would be necessary to achieve savings goals that would not be paid for by traditional fee for service payments. These costs must be paid for with other "reward payments" for job well done. There is a lot of theory here, and unclear specifics.

Another concept to review is "Physician Designation Programs" or "Provider Tiering." Due to soaring healthcare costs, certain large companies, who buy insurance for their employees, are requesting these insurance companies to control costs. Quality is of course considered, but the reality is that most physicians try to meet quality expectations. For the insurance companies, the factor that will help "tier" physicians is the "cost efficiencies of the physician or physician group." So our cost/patient/disease state is being profiled. We may be second or third tiered if we spend more money on our management of common disease states, i.e. chest pain, acute myocardial infarction or acute coronary syndrome, or heart failure. This is already being done.

So we need to be fiscally responsible in ordering tests, to be aware of what data is being collected on us and how it is reported, to work together with our hospitals and with the other physicians that our

patient is seeing, and to be mindful of the politics and bureaucracy that these changes entail. Incidentally, there is actually a current bill in Congress, recommending that a physician requesting a diagnostic test may not be involved in anyway with the interpretation. Sounds like a political turf battle to me. Just imagine if you brought your car for repairs, and the shop owner told you that he would have to outsource diagnostics before he could service you. Where is the cost and time efficiency of that strategy?

## Message from the North Carolina ACC Governor

*James G. Jollis, MD, FACC  
Chapter Governor  
Duke University Medical Center*

I know that I share a similar memory of many colleagues in North Carolina of discovering the field of cardiology in medical school. The excitement of finding the ultimate medical specialty... expertise backed by randomized controlled trials; the ability to help patients and save lives through just about every scientific and technological advance available to medicine; amazing clinicians and amazing technology. This great pleasure continues today for most of us and provides the underlying foundation to our daily pursuit of medicine.

Much has changed since that first rotation on cardiology, most for the better. My first admission to the cardiology service, a man in his 60s with an anterior myocardial infarction, progressed from amiable conversation to an obtunded state and death as his shock progressed without the benefit of coronary reperfusion. That same man would have likely survived in 2011.

Some of the most striking changes are political and economic, forces that seem somewhat outside the formidable armamentarium of traditional cardiology. Faced with declining technical revenues and increased administrative burden, the past five years have witnessed the purchase of most large cardiology practices by hospital systems. Legislative challenges are increasing in pace and scope, most recently involving H.R. 1476, the "*Integrity in Medicare Advanced Diagnostic Imaging Act of 2011*"

introduced by Representative Jackie Speier, Democrat from California in April 2011. This act would add diagnostic imaging services to the federal self-referral prohibition (Stark laws). Intensely supported by the American College of Radiology and strongly opposed by the American College of Cardiology, this bill would prohibit physicians in practice from providing office imaging. Violations would be subject to civil penalties up to \$15,000, exclusion from Medicare, and liability under the Federal False Claims Act. Imagine the likelihood of a technologist completely unfamiliar with your patient or your practice extending an echocardiogram to differentiate constriction from restriction according to slower cursor sweep mitral inflow pulsed Doppler with concomitant respirometer recording. The chance of being able to efficiently view the images and interpret them from the perspective of your clinical exam are even more remote.

The array of political and economic forces that may potentially alter our ability to care for our patients, the advanced medical imaging and electronic prescribing portions of the Medicare Improvements for Patients and Providers Act of 2008, Wellpoint American Imaging Management, the Physician Quality Reporting Initiative, and increasing patient co-pays according to physician resource use ranking. My most recent striking conversation involved the calculation by an administrator of the number of new or return patients required to generate a bypass surgery. Such calculations are far removed from the needs of our patients and reflective of severe and unsustainable economic distortions in health care financing.

Despite these challenges, cardiology comes from a position of great strength and long tradition to work with our partners in health care to provide the best and most cost effective approaches to heart disease. With detailed disease registries like [CathPCI](#) and ACTION, we are one of the few medical specialties and health care organizations in possession of adequate clinically detailed information to identify and extend quality care.

Combining these registries with medical evidence compiled from 30 years of large scale randomized trials and highly trained and experienced cardiovascular care teams across the state, we will remain a valuable and increasingly effective asset to victims of cardiovascular disease. A marvelous example of our strength involves the [RACE](#) (Regional Approach to Cardiovascular Emergencies) system.

Cardiology colleagues across the state have voluntarily organized the largest and most effective regional ST elevation myocardial infarction system in the United States. Largely attributable to these efforts, in hospital STEMI mortality in North Carolina has dropped by 15% over 3 years, length of stay averages 3 days, and mortality for patients treated within guideline goal times is only 2.4%. The statistics are remarkable, yet the greatest thrill comes from direct involvement in coordinated STEMI care from paramedic activation, sub 60 minute device activation, and sincerely grateful patients and families returning to their loved ones fully capable of resuming normal lives. Our coordinated efforts were described as "a thing of beauty" by a nurse from Frye Regional, and this thing of beauty extends to much of cardiology practice.

How does one resolve the discordance between our continued love of the greatest of medical field and the ever mounting political, economic, and administrative burdens. My approach is to continue to "breathe in" the gratification provide by the wide array of opportunities available in cardiology practice. At the same time, there has never been a more pressing need for us to join together as a single voice to advocate for our patients and our profession. While our numbers and resources are far outspent by much larger forces in healthcare, our skills and abilities are second to none. The [RACE](#) project and numerous other successful collaborations with colleagues from many fields demonstrate that our best opportunities reside in constructively engaging and working with colleagues across the health care spectrum. We must face the challenges of delivering timely and quality care in the face of overstretched resources, providing strong leadership and solutions that embrace medical evidence, the outstanding traditions of cardiology, and the best interests of our patients.

First steps include active involvement in the [American College of Cardiology](#) and renewed support for advocacy efforts. For those wishing to become more involved, we have numerous opportunities including plans to meet with your legislators in Washington, DC September 11-13, 2011. Please feel free to contact [Beth Denny](#) or [myself](#) for more details.

**Deadline to Avoid E-Prescribing  
Penalty is June 30**

*News from the ACC*

Starting in 2012, practitioners will be penalized if they have not successfully participated in the federal e-prescribing program in the preceding year. Unfortunately, the 2012 penalty will be determined based on services provided from Jan. 1 to June 30, 2011.

It is critical that eligible physicians for whom certain specified office visits total at least 10 percent of their Medicare charges report the E-Prescribing Incentive Program e-prescribing measure in conjunction with 10 unique office visits between Jan. 1 and June 30, 2011 to avoid having all of their 2012 Medicare payments reduced. The one percent cut will be to all professional covered services.

The ACC has prepared a number of resources to help CV professionals navigate the e-prescribing requirements in general and most importantly not be caught with a penalty come January 2012. Practitioners are urged listen to the archived webinar, read the FAQ, share the slides and take part in the e-prescribing blog series on the ACC in Touch Blog. For more information visit [CardioSource.org/HealthIT](http://CardioSource.org/HealthIT).