

# Rhode Island Chapter of the American College of Cardiology

"THE MISSION OF THE RHODE ISLAND CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY IS TO BE AN ADVOCATE FOR ACCESSIBLE, HIGHEST QUALITY, COST EFFECTIVE CARDIOVASCULAR CARE FOR THE PEOPLE OF RHODE ISLAND AND TO ACTIVELY SUPPORT CARDIOLOGISTS IN THEIR EFFORTS TO ACHIEVE THESE GOALS."

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## Executive Council Opens Dialogue with Department of Health and Attorney General's Office to Tackle Reimbursement and Quality of Care Issues

This has been a tumultuous quarter in the delivery of health care in Rhode Island. With Harvard Pilgrim Health and Tufts Health Plan both leaving the state, the future landscape of RI health care financing is coming under question. Not only has the number of insurers operating in the state declined, but also those remaining insurers face difficult ethical and financial challenges.

The RI ACC council wishes to add our thanks to the Almond administration and especially to Tom Schumpert, Rhode Island's director of business regulation, for obtaining a pledge from Harvard Pilgrim Health Care to pay back in full all RI health-care providers owed money by the defunct RI unit. The ACC council was very pleased when Dr. Patricia Nolan, director of the Rhode Island Department of Health addressed the council. Dr. Nolan affirmed the Governor's commitment to maintaining choice and highest quality health care in Rhode Island. In addition, Maureen Glynn, Health Care Advocate and Assistant RI Attorney General, attended a council meeting. Ms. Glynn reiterated the Attorney General office's position that insurers operating in the state reimburse physicians for all services that are medically beneficial. We particularly addressed reimbursement for tilt-table tests and ambulatory blood pressures monitors, and are actively pursuing a resolution.

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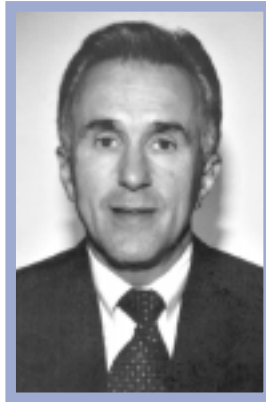
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# The President's Message: Shaping Policy and Developing Recognition

In March, I had the opportunity to attend the Board of Governor's general session held prior to ACC 2000 in Anaheim, California.

In two major respects, this was a historic occasion. First, there was a joint meeting of the ACC Board of Trustees (BOT). This was an unprecedented meeting and recognizes the increasing influence the governors and respective chapters have on shaping policy within the ACC. Several former governors are now

force, a larger percent of the ACC budget will be designated for advocacy and will include increased support for chapters, legislative and regulatory advocacy, public



relations and practice management resources.

The ACC leadership recognizes the importance of strengthening state chapters as an effective means for bridging the

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members of the BOT and the newly elected National Vice President, Bruce Fye, MD, a past Wisconsin Governor, BOT member will be our national leader in 2002-2003.

Secondly, the results of the task force for the 21st century were reported to the Board of Governors. This is, in essence, a blueprint that will guide the College through the early part of the 21st century. The details of this report are beyond the scope of the message but will be included in the May, 2000 issue of Cardiology. As a result of this task

leadership-membership gap. They also recognize that it is at the state and local level that ACC can have the greatest impact in terms of fighting adverse legislation, passing important regulations, and negotiating with third party payers, etc.

March also represents the first anniversary of our state chapter and our united efforts and successes were recognized by Michael Nocera, MD, Chairman of the Chapter Relations Committee. The Executive Council and chapter members can be proud of its accomplishments.

Our membership ranks highly in participation in all areas including dues payment, governor-elect voting and annual meeting attendance. I appreciate this enthusiasm and support. The chapter website will be on-line by May 1st and will be a dynamic and timely source of information for our members and the general public.

I believe it will take some time, perhaps 2-3 years, for the Rhode Island Chapter to be recognized and respected as representing cardiologists in the state. To this end, the Executive Council has concentrated on dialogue with representatives of RIMS (I am a voting representative on the RIMS Council), executive government (RI Department of Health and the Attorney General's office), and insurers (we are represented on the Medicare Carrier Advisory Committee and the Blue Cross Specialty Advisory Committee). The State Government Relations Committee will identify issues or legislation for which we can advocate independently or participate jointly with RIMS. This process, by its nature, is slow and deliberate but we are increasingly being recognized for our efforts.

I was appointed by George Beller, MD to serve on the Private Sector Relations Committee and attended my first meeting prior to ACC 2000. This committee heard reports regarding the Pennsylvania experi-

# RI Chapter ACC Supports Take Care Rhode Island

ence with ‘contact capitation’ and the Pennsylvania chapter’s efforts to prevent implementation of this BCBS plan which in essence forces a surreptitious rationing of care. Discussion at the committee emphasized the importance of cooperation between state chapters and the national ACC on such issues and sought to identify protocols to address such issues.

Lastly, I recognize that our members are very busy and there never seems to be enough time to communicate with leadership. This is your organization and I urge you to call, e-mail, or talk with me or any council member so we can represent you and your patients’ needs. Thank you.

—*Frederic V. Christian, MD FACC*

**G**one are the days when physicians could get certified and be done with proving how much they know. Today physicians are increasingly required to demonstrate their skills by quantifying their performance to patients, boards, insurers and hospitals.

The RI ACC Chapter recognizes the importance of physician performance as a factor in patient outcome and is a member of the Take Care Rhode Island Coalition.

Take Care Rhode Island is an effort of Rhode Island Quality Partners (RIQP), the peer review organization (PRO) for RI. This coalition hopes to reduce the different data collection requirements in use across the state and to facilitate the development of a uniform, systematic

approach to measure quality in the hospital setting. For example, the coalition will be using ACC/AHA guidelines for treatment of myocardial infarction, congestive heart failure and atrial fibrillation. This is an opportunity for members to share information and experiences about quality improvement efforts that will provide our patients with quality cardiovascular care. David R. Gifford, MD, MPH, Clinical Coordinator, will be a guest of the Executive Council at its April meeting.

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## Executive Council

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The council discussed the importance of an informed consumer in choosing health plans. Members of the council voiced concern that consumers do not understand that under capitated plans there are financial incentives to limit subspecialty referral. Finally, we heard an informative presentation from Dr. Joel Spellum, a RI gastroenterologist, on the concept of subspecialty networks and subspecialty specific contracting.

These remain difficult times in the evolution of health care policy in the United States and particularly in Rhode Island. The RI ACC chapter reaffirms the need to maintain a partnership and dialogue with insurers and state government to continue to improve cardiovascular care for all citizens of Rhode Island.

—*Alan S. Katz, MD FACC*

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# Clinical Briefs from *Journal Watch Cardiology*

*Journal Watch Cardiology has graciously allowed us to reproduce selected articles from their publication that we feel are of special interest.*

## Defibrillators Reduce Sudden Death

The randomized, controlled Multicenter Unsustained Tachycardia Trial tested the hypothesis that antiarrhythmic therapy (drugs and implantable defibrillators, as indicated), guided by electrophysiologic testing, reduces the risk for sudden death and cardiac arrest among patients with coronary artery disease, left ventricular systolic dysfunction, and spontaneous unsustained ventricular tachycardia. Of 704 patients with inducible, sustained ventricular tachyarrhythmia, 351 received electro-physiologically guided therapy and 353 received no antiarrhythmic therapy.

Forty-five percent of the patients assigned to electrophysiologically guided therapy were discharged with antiarrhythmic drugs (class I agents, 26%; amiodarone, 10%; and sotalol, 9%), and 46% were given defibrillators. Median follow-up was 39 months.

The 2-year rates of cardiac arrest or death from arrhythmia and overall mortality were lower for those receiving electrophysiologically guided therapy than for those not given antiarrhythmic therapy (12%

vs. 18% and 22% vs. 28%). Patients who received electrophysiologically guided therapy and defibrillators had a lower 5-year rate of cardiac arrest or death from arrhythmia than those without defibrillators (9% vs. 37%).

Defibrillator use was associated with a 60% reduction in overall mortality risk, even after adjustment for prognostic clinical factors.

**Comment:** This remarkable trial suggests that electrophysiologically guided antiarrhythmic therapy with implantable defibrillators may dramatically reduce risk for sudden death in patients with coronary artery disease. These are profound implications given that the vast majority of patients in the U.S. who would meet the inclusion criteria for this trial currently are not receiving this therapy. It will be interesting to see whether these results are integrated into clinical practice guidelines because the most significant finding (the importance of defibrillators) was not part of the randomization scheme.

—HM Krumholz

*Buxton AE et al for the Multicenter Unsustained Tachycardia Trial Investigators. A randomized study of the prevention of sudden death in patients with coronary artery disease. N Engl J Med 1999 Dec 16; 341:1882-90.*

## Dexfenfluramine and Valve Regurgitation

Previous studies have indicated an association between dexfenfluramine and valve regurgitation. However, the reported prevalence and severity of regurgitation vary significantly.

This multicenter U.S. study attempted to determine the true prevalence of valve disease and other contributing factors in 172 dexfenfluramine patients compared with 172 unexposed matched controls and 68 unmatched subjects who met the entry criteria (51 treated with dexfenfluramine and 17 controls).

Three echocardiographers independently interpreted each study participant's echocardiogram. Mean treatment duration for dexfenfluramine patients was 6.9 months, and mean interval between treatment discontinuation and echocardiogram was 8.5 months.

Dexfenfluramine-treated patients had at least mild aortic or at least moderate mitral regurgitation more often than controls (7.6% vs. 2.1%), a difference primarily due to the increased prevalence of mild aortic regurgitation (6.3% vs. 1.6% in controls).

The amount of sclerosis and range of mobility did not differ between groups for either the aortic or mitral valve. Importantly, the 223 dexfenfluramine-treated patients

had no instances of severe mitral regurgitation or moderate-to-severe aortic regurgitation, although 1.3% of these patients did have moderate mitral regurgitation. Older age, higher diastolic blood pressure, and shorter time from drug discontinuation to echocardiogram were independently associated with at least moderate mitral or any aortic regurgitation.

**Comment:** This carefully performed study confirms that dexfenfluramine is associated with increased prevalence of abnormal valvular regurgitation, particularly that of the aortic valve. These results also provide important evidence that dexfenfluramine-associated valve regurgitation may regress after drug discontinuation. —H Calkins

*Shively BK et al. Prevalence and determinants of valvulopathy in patients treated with dexfenfluramine. Circulation 1999 Nov 23; 100:2161-7.*

### **New Insights into Aortic Dissection**

Aortic dissection is an uncommon but often rapidly fatal disease that presents diagnostic and therapeutic challenges. Recent advances in imaging and surgical techniques prompted investigators at 12 major centers in 6 countries to examine the diagnosis and management of aortic dissection in the modern era. In this case series of 464 patients with diagnosed dissection, 289 (62%) had type A dissection.

The most common presenting symptom was severe pain (91% of patients), which patients described more frequently as sharp rather than tearing (64% vs. 51%). Chest pain of any type was reported by 73% of patients, and was most often anterior (61%). Only 15% of patients showed a pulse deficit. Chest x-rays showed mediastinal widening in only 62% of patients; more than one fifth had neither a widened mediastinum nor an abnormal aortic contour. Computed tomography was the most commonly used imaging procedure, but most patients underwent multiple imaging studies.

The in-hospital mortality rate was 26% among patients with type A dissection who had surgery, and 58% among those who did not.

Among patients with type B dissection, 11% of those treated medically died in the hospital, compared with 31% of those treated surgically.

**Comment:** This important study shatters the conventional wisdom about aortic dissection. Investigators

found that patients often do not present with tearing pain and that pulse deficits are distinctly uncommon. Furthermore, chest x-rays are often unrevealing, and multiple imaging modalities are needed frequently. Finally, despite advances in imaging and surgery, in-hospital mortality rates remain very high.

—MS Lauer

*Hagan PG et al. The International Registry of Acute Aortic Dissection (IRAD): New insights into an old disease. JAMA 2000 Feb 16; 283:897-903.*

### **Beta-Blockers Are Underused for Acute MI**

Although extensive evidence supports the use of beta-blockers soon after acute MI, there is concern that they are being underused in clinical practice. Yale University investigators reviewed medical charts for 140,653 Medicare patients who survived at least one day of hospitalization for acute MI in 1994 and 1995.

*continued on page 7*

**Reserve This Date:  
October 18, 2000**

**2nd Annual Meeting of the Rhode Island Chapter  
of the American College of Cardiology**

**Metacomet Country Club, East Providence, RI  
Topical and Informative Program to Follow**

# Local and National ACC News Briefs

## **The College has endorsed a joint AMA statement on the uninsured**

The statement, developed by the AMA and six other physician organizations, is an attempt to unify physician organizations around one main objective: providing all Americans with health care coverage. The statement does not recommend specific policy initiatives for reducing the number of uninsured, rather it outlines three concepts that should guide the health system reform agenda:

- 1) All Americans must have health care coverage;
- 2) Health care coverage should contain a benefits package that provides quality care; and
- 3) Medical necessity decisions made under the benefit package should reflect generally accepted standards of medical practice. A copy of the statement can be found at <http://www.ama-assn.org/ama/basic/article/0,1059,204-446-1,00.html>

## **States Earmarking Tobacco Settlement Monies for Health-Related Issues/Projects**

In New Mexico, both legislative houses will be acting on recommendations of the Senate Tobacco Settlement Committee that \$19.8 million be earmarked for various health and education programs beginning July 1, 2001. A public health initiative of comprehensive tobacco cessation and prevention

programs would receive \$5.75 million.

In Indiana, an initial spending plan for the state's share of the national tobacco settlement easily passed the House Ways and Means Committee with only minor tweaking. The committee made only two changes to that plan, agreeing to a \$7.5 million appropriation for addiction services and \$2 million for hospice programs.

In Pennsylvania, Gov. Ridge recently proposed a plan to spend its \$11 billion pot of tobacco settlement monies entirely on health initiatives. Up to 40 percent of the money would be earmarked to provide low-cost insurance for uninsured adults, 10 percent would go to hospital charity care and 45 percent of the total would be used for tobacco control programs, home care for seniors, health care research and capital development. Across the river in New Jersey, Gov. Whitman unveiled her plan for two-thirds of the state's annual \$300 million tobacco settlement allocation to be directed towards health-related programs with the remainder for school renovation and construction.

Beginning in 2001, \$100 million would be used to subsidize low-income adults through a new health insurance program. Another \$92 million would be set aside for other health initiatives including tobacco control programs. A one-time expenditure of \$50 million would pay

health care providers for services to patients insured by the two HMOs that became insolvent in 1999.

In Maine, Gov. Angus King and House Speaker Steven Rowe introduced competing bills to allocate the state's tobacco settlement money. At the core of much of the debate is whether to pay off current Medicaid bills or expand the program. While both measures focus most of the money on smoking prevention and other health incentives, the governor would like to spend \$18 million to wipe out the state's Medicaid shortfall and fund a "healthy community initiative" that would encourage people to live healthier lifestyles. Speaker Rowe's bill would spend new Medicaid money to expand health access to low-income parents, pregnant women and uninsured babies.

## **ACC's Department of Legislative Affairs is available to help ACC Chapters and members in promoting their respective state legislative agendas and priorities**

Please contact Enzo Pastore at either 800.435.9203 or [epastore@acc.org](mailto:epastore@acc.org) to find out about the College's resources and how we can help you.

## **ACC on Capitol Hill February 4 educating congressional staff about the issue of medical device reprocessing**

Representing both the College and the North American Society of Pacing and Electrophysiology, Dr. Bruce Lindsay met with several

House and Senate staff to talk about the reuse of electrophysiology (EP) catheters. Dr. Lindsay explained to staff that the reuse of EP catheters is safe, effective and cost efficient. The purpose of the meetings was to convince members of Congress that legislation to require reprocessed devices to go through the pre-market approval process is unwarranted. There are currently two bills pending in Congress that could restrict the use of reprocessed devices ñ S. 1542 introduced by Sen. Richard Durbin, D-Ill., and H.R. 3148 introduced by Rep. Anna Eshoo, D-Calif. Dr. Lindsay will

testify on the issue before the House Commerce Subcommittee on Oversight and Investigations on February 10. A copy of the ACC's fact sheet on medical device reprocessing is available online.

### **ACC Chapters planning to hold their inaugural state legislative conferences this year and participate in grass-roots lobbying**

While the Ohio Chapter's conference is scheduled for April, the New Jersey Chapter is planning its meeting for sometime in the fall. The Pennsylvania Chapter is also planning to hold its second legislative conference this year.

The Virginia Chapter is coordinating its Lobby Day schedule for ACC members in the commonwealth. The chapter expects the following topics to be addressed by the legislature this year: Licensing Medical Directors/Liability of Third Party Payers; Certificate-of-Public-Need; Licensure of Physician Offices and Tobacco Settlement Dollars. The chapter will arrange for ACC members to be briefed on the issues and on the chapter's positions on these issues. Virginia members will be meeting with their legislators this month and in February.

## **CLINICAL BRIEFS**

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After exclusion of patients with common contraindications to beta-blockers (heart failure on admission, 37%; history of heart failure, 24%; history of asthma or chronic lung disease, 20%; pulmonary edema, 12%), 58,165 patients were considered "ideal" candidates for beta-blocker therapy during early hospitalization. However, only 49% of these patients received beta-blockers during the first two days of hospitalization.

Patients who did not receive beta-blockers were more likely to be women, older, nonwhite, and residents of states outside New England; Kansas, Mississippi, and Oklahoma had the lowest rates of

beta-blocker use. Early beta-blocker therapy was associated with a lower in-hospital mortality rate, even after adjustment for demographic and clinical variables, other treatments, and geographic region (adjusted odds ratio, 0.81).

**Comment:** These disturbing data suggest underuse of beta-blockers in the early post-MI period among elderly U.S. patients, which may lead to unnecessarily high mortality rates. Clinicians should carefully and consistently prescribe beta-blockers for all patients who are hospitalized with acute MI and withhold the agent only when clearly contraindicated. —MS Lauer

*Krumholz HM et al. Early b-blocker therapy for acute myocardial infarction in elderly patients. Ann Intern Med 1999 Nov 2; 131:648-54.*

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# WWW.RIACC.ORG

## The Rhode Island Chapter of the ACC interactive web site



- Including Chapter, State and National Information and Links
- Calendar of Events
- Communication to Executive Council and Committees
- Membership Directory
- Current Announcements/Issues
- Current and Newsletter Archives

*More to come as construction continues.....*

SUBMISSIONS, SUGGESTIONS OR COMMENTS REGARDING THE RIACC CHAPTER NEWSLETTER SHOULD BE E-MAILED TO ROBERT H. SCHWENDEL, MD FACC AT [RSCHWENDEL@HEARTRI.COM](mailto:RSCHWENDEL@HEARTRI.COM)

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