Update From the California Chapter of The American College of Cardiology

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I am using this issue's column to reach out to our cardiovascular colleagues throughout the United States and to review the events at our most recent CA ACC Board Meeting, which was held in April 2015 in Sacramento.

A fully engaged and energized group of 35 attendees included cardiologists from academic institutions, private practice, and integrated practices, and a brilliant nurse practitioner (NP). The agenda for the meeting touched on issues that affect us on a national scale, such as Maintenance of Certification (MOC) and Medicare reimbursement; state level issues, such as the Scope of Practice Legislation for Nurse Practitioners; and issues that affect many practitioners on a personal level, such as the flawed "peer" review system of authorization (or rather, "peer" review deniers), and the electronic medical record (EMR). Also discussed was our state-level effort to brand FACC to both our membership and our patients. FACC indicates the achievement of a high level of training, certification of that achievement, and a continued commitment to excellence. Please take a moment and visit our website (http://www.caacc.org/) to hear William Shatner thank our FACC-certified cardiologists.

Our goal was not only to provide information to the attendees, but to motivate them to become more involved in the activities of the CA ACC and to become more effective points of contact for the greater membership. I think we succeeded.

Dr. Paul Teirstein, from the Scripps Clinic (San Diego, CA), presented his views on MOC. Dr. Teirstein's journey began after hearing many of his colleagues complain about the MOC process as mandated by the American Board of Internal Medicine (ABIM). This prompted Dr. Teirstein, a person of action, to organize an effort to counter what most of us agree MOC is—a financial bonanza for ABIM. Per recent ACC polling, the vast majority of ABIM-certified cardiologists find the process deeply flawed and out of control. With ABIM resistant to changing their process and with the threat of MOC mandated not only for certification but possibly for licensure, it was clear to Dr. Teirstein that another certification option was needed. With this option, from The National Board of Physicians and Surgeons (NBPAS.org), cardiologists receive initial certification from the ABIM and continue with high-quality, lifelong learning that is relevant their practice and interests. To date, the NBPAS has had almost 2000 applicants. We all know that competition is a good thing; as President Herbert Hoover said, "Competition is not only the basis of protection to the consumer, but is the incentive to progress." I'd like to thank Dr. Teirstein for speaking at the meeting.

We conducted a state legislative roundtable and were privileged to

have Assembly Members Kristin Olsen and Matt Dababneh, State Senator Ben Allen, and a representative of Senator Richard Pan in attendance. The discussion included Scope of Practice legislation and access to patient care. With regard to the Scope of Practice issue, it was agreed by all that NPs are an important part of the healthcare team and compliment the efforts of physicians. It was also agreed that there was a clear difference in the scope and intensity of training among physicians and NPs, including the certification process and postgraduate medical education. Unfortunately, it seems that efforts to have NPs fill gaps in areas of physician shortage have not been successful, as NPs seem to show a preference for urban areas. NP training was designed to include physician supervision and the scope of practice is decided in partnership with the supervising physician, determined on an individual basis based on the experience and skills of the NP. The CA ACC has a deny position on SB-323, which, if enacted, would allow for NPs to determine their scope of practice.

Following the roundtable discussion, we were fortunate to have a presentation from Dr. Arthur Lurvey, the Contractor Medical Director (CMD) contact at Noridian Healthcare Solutions, LLC (Fargo, ND). A CMD is a physician with expertise in medicine and Medicare who is primarily responsible for clinical coverage determinations, such as Local Coverage Determinations (LCDs), determinations regarding Investigational Device Exemption (IDE) requests, and collaborates with medical societies and peer groups to share information and provide education. This was a timely discussion as the sustainable growth rate (SGR) was just recently repealed by Congress and the ICD-10 compliance date is rapidly approaching. With the repeal of SGR, physicians were spared the 20%+ cut in Medicare reimbursement. However, we await the unintended consequence of this legislation that, at a later date, would define new methods for physician reimbursement that would replace a reduced "fee for service" with a system that "is focused on quality, value, and accountability" within the next 5 years.

Those of us who have lived with evolution of healthcare delivery over the past few decades know that the government has a hard time getting it right, especially when those sitting at the table and affecting policy exclude practicing physicians and patients. This is the best reason to contribute to your national and state political action committees (ACCPAC and Cardio PAC, respectively).

A lively discussion took place regarding the process of insurance company peer review. The highlights of this discussion included:

- How we can be sure a peer review is actually a peer review? The so-called peers who we engage in the peer-review process are not really our peers. They are often licensed in other states and may not be cardiologists or internists who have knowledge of the issues being reviewed and can just be "parroting" the company line.
- Are there data showing how often a peer-review interaction leads to an authorization of a denied activity? How do insurance companies vary in their rate of peer-review authorization?
- Should the CA ACC develop a website open to consumers and physicians that would compare the performance of third-party payers?

An animated discussion on the EMR followed, with excellent points being raised on both sides of the issues. Points against EMR systems included the following:

- EMR systems were not engineered with clinical practice in mind and therefore not very effective or efficient.
- They create a financial burden on practitioners due to the cost of the systems, transition from written records (analog) to digital records, and the significant 18- to 24-month reduction in practice efficiency.
- Different systems cannot communicate with each other.
- Once a system is in place, it is very difficult to get good customer service from the EMR vendor; some vendors do little to upgrade their systems and others go out of business.
- It reduces the patient-physician face-to-face experience.

Points for EMR systems included the following:

- EMR systems are becoming easier to navigate.
- Within health systems, EMR systems enhance the quality of care by allowing improved access to a patient's medical record by practitioners.
- Improved access to medical records reduces unnecessary testing.

We encouraged our membership to become more involved with politics at a state level by encouraging the development of relationships with individual legislators, but there is no substitute for supporting our CA ACCPAC. Our goal for 2015 is 100% support by our Executive Board and Committee members via contributions. We also encouraged our leadership to engage the greater membership and keep them better informed of the value that the CA ACC provides for them. ■