



Michigan Outpatient Cardiovascular Association *December Edition*

DECEMBER: Healthy Holiday Living and Giving



"Heart attack deaths more likely during winter holiday season than any other time of year." Keep these tips in mind while you celebrate:

Know the symptoms and take action: Heart attack signs may vary in men and women and it's important to catch them early.

Celebrate in moderation: 'Tis the season for unhealthy changes in diet and higher alcohol consumption. Eating healthfully during the holidays doesn't have to mean depriving yourself, there are still ways to eat smart.

Plan for peace on earth and goodwill toward yourself: Make time to take care of yourself during the busy holiday. Reduce stress from family interactions, strained finances, hectic schedules, and other stressors that tack on this time of year.

Keep moving: The American Heart Association recommends at least 150 minutes of physical activity per week; this number usually drops during the holiday buzz.

Stick to your meds: Busy holidays can make way for skipping medications, forgetting them when away from home, or not getting refills in a timely manner." [www.heart.org](https://newsroom.heart.org/events/december-healthy-holiday-living-and-giving-20211122)

Legislative Speaking Series

Individuals from various leadership positions will be speaking to the association on important healthcare topics and issues.

Next, *State Representative*

Bronna Kahle: Representative

Kahle was first elected in 2016 to represent the 57th district. Rep. Kahle serves as chair of the House Health Policy Committee. She also serves as a member of the Judiciary Committee and Insurance Committee.

Breathlessness With 'Long COVID' May Point to Heart Damage

"Shortness of breath in people with "long COVID" might not just be about the lungs — it may indicate heart damage from the disease, new research suggests.

"The findings could help to explain why some patients with long COVID still experience breathlessness one year later and indicate that it might be linked to a decrease in heart performance," explained study author Dr. Maria-Luiza Luchian, of the University Hospital Brussels in Belgium.

Her team presented the findings Thursday at a virtual meeting of the European Society of Cardiology (ESC).

The new study included 66 patients, average age 50, who had no history of heart or lung disease before being hospitalized with COVID-19 between March and April 2020 at Luchian's hospital in Brussels.

One year after leaving the hospital, 35% of the patients still experienced shortness of breath during physical activity.

All of the patients underwent imaging of their lungs and heart, including a new imaging technique called "myocardial work," which provides more precise information on heart function than previous methods, the researchers said.

The results revealed poorer heart performance in people with shortness of breath compared to those without shortness of breath. There was also a significant and independent association between abnormal heart function and persistent shortness of breath ("dyspnea"), the study authors noted.

"Our study shows that more than a third of COVID-19 patients with no history of heart or lung disease had persistent dyspnea on effort a year after discharge from hospital," Luchian said in an ESC news release.

"When looking in detail at heart function by cardiac ultrasound, we observed subtle abnormalities that might explain the continued breathlessness," she noted. Two experts based in the United States said the new findings were interesting, but more study is needed."

<https://www.usnews.com/news/health-news/articles/2021-12-09/breathlessness-with-long-covid-may-point-to-heart-damage>

FYI:

- **Quality of Intervention Equals Quality of Life | JACC: Cardiovascular Interventions**
- **Coronary Revascularization the Focus of New ACC/AHA Clinical Guideline | American College of Cardiology**

CMS Releases Final 2022 Medicare Physician Fee Schedule

"The Centers for Medicare and Medicaid Services (CMS) on Nov. 2 released the 2022 Medicare Physician Fee Schedule (PFS) final rule, addressing Medicare payment and quality provisions for physicians in the next fiscal year. Under the rule, the conversion factor will decrease by \$1.30 on Jan. 1, 2022, going from \$34.89 to \$33.59. CMS estimates payments to cardiologists will decrease by about 1% from 2021 to 2022 through updates to work, practice expense and malpractice relative value units (RVUs). This estimate is based on the entire cardiology profession and can vary widely depending on the mix of services provided in a practice. Highlights from the final rule include:

2022 Medicare Physician Fee Schedule:

- A revised and finalized plan to update clinical staff labor inputs in the direct practice expense formula, which takes into account some comments from the ACC and other groups, will be phased in over four years, starting in 2022. Increases for the cost of clinical staff in the **office setting** require reductions elsewhere in the formula to supplies and equipment. The ACC and others expressed concerns about the severity of the cuts at a time when clinicians are needed on the front lines of the COVID-19 pandemic. As a result of the phased-in approach, **office-based services** with high supply costs (lower-extremity revascularization) and equipment (imaging) are estimated to see reductions of roughly 1% to 6% in 2022 and 4% to 24% after full implementation absent changes in future rulemaking."

<https://www.acc.org/Latest-in-Cardiology/Articles/2021/11/02/21/53/CMS-Releases-Final-2022-Medicare-Physician-Fee-Schedule>

OBL: In praise of the office-based interventional lab

"Initially, most interventions were done in the operating room (OR), where we were most familiar with the conduct of that environment. But it did not take long to realize that there were fundamental limitations in imaging equipment and personnel expertise.

As time progressed, many cases began to migrate down to the cardiac catheterization lab. This created other issues, as we were now in competition with cardiologists for the limited resources of the lab. In many institutions, the cardiology service line created a tremendous financial windfall, which was hard to ignore. This meant that vascular surgeons were not the most "favored nation," and oftentimes our cases were pushed to later times in the day if they were being done at all.

At an institutional level, there was a contemporaneous increase in consolidation, and an overall net reduction in available procedure rooms. With an increasing number of cases and no place to do them, something had to give.

It became clear that most endovascular cases could be done on an outpatient basis. With development of effective femoral artery closure devices, recovery times were brief after endovascular interventions. This led to the realization that these cases could be done in a different venue than the hospital—such as an ambulatory surgery center or even in an office.

In 2008, the Centers for Medicare & Medicaid Services (CMS) recognized that endovascular procedures could be done in an office setting (site of service 11) at a significant savings compared to hospital-based procedures. Available data supported the idea that procedures done in an office were as effective as those done in the hospital and did not compromise patient safety." <https://vascularspecialistonline.com/obl-in-praise-of-the-office-based-interventional-lab/>

December 9th, 2021: Discussion on the CON Review Standards for Hospital Beds for CON Commission Final Action took place. See below for more information:

- [MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES: 3 CERTIFICATE OF NEED \(CON\) REVIEW STANDARDS FOR HOSPITAL BEDS](#)

Update: Certificate of Need (MI)

On **September 22, 2021**, new Certificate of Need (CON) Cardiac Catheterization Review Standards took effect in Michigan. These standards are requirements for approval of the initiation, replacement, expansion, or acquisition of cardiac catheterization services, and the delivery of these services. To view the new standards, please visit: [CC Standards 204884 7.pdf \(michigan.gov\)](#).

To begin the application process, the first step is the Letter of Intent (LOI), just please make sure you meet the requirements in the above Review Standards. LOI instructions can be found here: [MDHHS - Submit a Letter of Intent \(michigan.gov\)](#). The "agent" will go to the MiLogin system and submit the LOI electronically. If whomever is submitting the LOI does not have access to MiLogin, instructions on how to gain access can be found here: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5106-165238--,00.html.

Once the LOI is submitted, the Department has 15 days to process it. Once it is processed, an email will be sent to the "agent" letting them know the assigned CON number and that an application can be submitted. The applicant/agent has one year to submit the application before the LOI expires and the process would have to begin again. No application, forms, or documents will be accepted until after the LOI is processed. As part of processing the LOI, all required forms and documents are assigned. These can be found under the CON Application link after the LOI processing, at [MDHHS - Submit a CON Application \(michigan.gov\)](#).

Please note, if you are applying for both an FSO/ASC and CCL, they will have to be submitted separately.

For questions regarding the LOI and application, please contact (517) 241-3348 or visit the Certificate of Need website at www.michigan.gov/con.

Randomized Trial of Metoprolol in Patients with Obstructive Hypertrophic Cardiomyopathy

Cardiomyopathy “The use of β -adrenergic receptor blocking agents in symptomatic patients with obstructive hypertrophic cardiomyopathy (HCM) rests on clinical experience and observational cohort studies.

This study aimed to investigate the effects of metoprolol on left ventricular outflow tract (LVOT) obstruction, symptoms, and exercise capacity in patients with obstructive HCM.

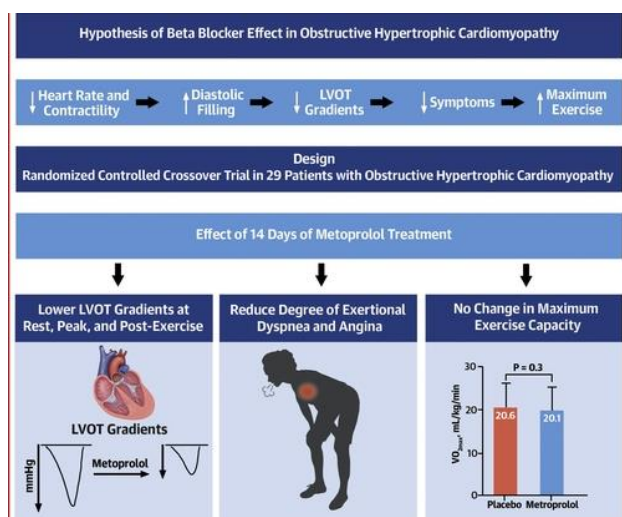
This double-blind, placebo-controlled, randomized crossover trial enrolled 29 patients with obstructive HCM and New York Heart Association (NYHA) functional class II or higher symptoms from May 2018 to September 2020. Patients received metoprolol or placebo for 2 consecutive 2-week periods in random order. The effect parameters were LVOT gradients, NYHA functional class, Canadian Cardiovascular Society (CCS) angina class, Kansas City Cardiomyopathy Questionnaire Overall Summary Score (KCCQ-OSS), and cardiopulmonary exercise testing.



Dr. Justin Elijah Trivax graduated from the Wayne State University School of Medicine in 2003. Dr. Trivax completed his residency in internal medicine, and fellowships in both cardiovascular disease and interventional cardiology at Beaumont Health.

Dr. Trivax currently works in Farmington Hills, MI and 3 other locations where he specializes in Cardiovascular Disease, Internal Medicine, and Interventional Cardiology.

Dr. Trivax is affiliated with St. John Macomb-Oakland Hospital Warren Campus and William Beaumont Hospital.



Compared with placebo, the LVOT gradient during metoprolol was lower at rest (25 mm Hg [interquartile range (IQR): 15-58 mm Hg] vs 72 mm Hg [IQR: 28-87 mm Hg]; $P = 0.007$), at peak exercise (28 mm Hg [IQR: 18-40 mm Hg] vs 62 mm Hg [IQR: 31-113 mm Hg]; $P < 0.001$), and postexercise (45 mm Hg [IQR: 24-100 mm Hg] vs 115 mm Hg [IQR: 55-171 mm Hg]; $P < 0.0001$). During metoprolol treatment, 14% of patients were in NYHA functional class III or higher compared with 38% of patients receiving placebo ($P < 0.01$). Similarly, no patients were in CCS class III or higher during metoprolol treatment compared with 10% during placebo treatment ($P < 0.01$). These findings were confirmed by higher KCCQ-OSS during metoprolol treatment (76.2 ± 16.2 vs 73.8 ± 19.5 ; $P = 0.039$). Measures of exercise capacity, peak oxygen consumption, and N-terminal pro-B-type natriuretic peptide did not differ between the study arms.”

https://www.jacc.org/doi/10.1016/j.jacc.2021.07.065?_ga=2.153953712.926597995.1639508995-1071968131.1639508995

