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Nebraska ACC

SUPPORTING PHYSICIANS, TRAINEES, AND CARDIOVASCULAR TEAM MEMBERS WITH EDUCATION, ADVOCACY, & NETWORKING OPPORTUNITIES

Chapter News

Go ahead: Fall for the Nebraska ACC!

Andrew M. Goldsweig, MD, MS, FACC, FSCAI, FSVM, RPVI
Governor, Nebraska ACC

- **Nebraska ACC elections** for governor (term 2023-2026) and secretary-treasurer will be held in September-October 2021. You will receive separate e-mails with instructions for voting in each election.
- Attend the **ACC Legislative Conference** and tell Nebraska's congressional delegation about what matters to cardiologists and our patients. The ACC Legislative Conference is now **all virtual** from October 3-5. Join our advocacy team and participate in virtual visits with legislators on Tuesday, October 5. Register at https://cvent.me/8wd3O5.
- The Nebraska ACC 4th **Annual Meeting** will take place on Wednesday, October 20, 2021 at the Omaha Marriott from 4:30 to 8:30 pm. We are thrilled that **ACC President Dr. Dipti Itchhaporia** will travel to Omaha to deliver the keynote address. Register now at nebraskacardiology.org/events/annual-meeting-2021. All are invited, whether or not you are an ACC member: cardiologists, nurses, NPs, PAs, pharmacists, and technologists.
- The Annual Meeting will also feature the 3rd annual **FIT Poster Competition** including podium presentations of the top 4 posters and cash prizes. Thanks to Nebraska ACC Education Committee Chair Dr. J. William Schleifer and FIT Section Chairs Drs. Swethika Sundaravel, Brett Van Briggle, Abhishek Thandra, and Kashif Shaikh for their hard work in planning the event. More information and submission instructions at nebraskacardiology.org/fit-abstract-competition-2021.
- Planning will soon begin for the Nebraska **ACC 2nd Annual Cardiovascular Team Meeting** to be held in spring 2022. E-mail CVT Representative Jessica Livingston, MSN, AAAC to get involved in future CVT events.
- The Nebraska ACC Advocacy Committee **met with State Senator John Arch** (District 14), chair of the Health and Human Services Committee, on June 14th to discuss his support for a candy and soda tax, telehealth coverage, and pharmacy benefit pricing regulation.
- We want to hear from YOU! Contact Dr. Anu Tunuguntla if you would like to **write for this Newsletter**. The Newsletter features four brief articles quarterly: Chapter News, Cardiology Update (by a cardiologist), FIT Corner (by a fellow in training), and CVT Corner (by a CV team member).
- Please **follow us** on Twitter and Facebook!

Nebraska CHAPTER

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CARDIOLOGY UPDATE

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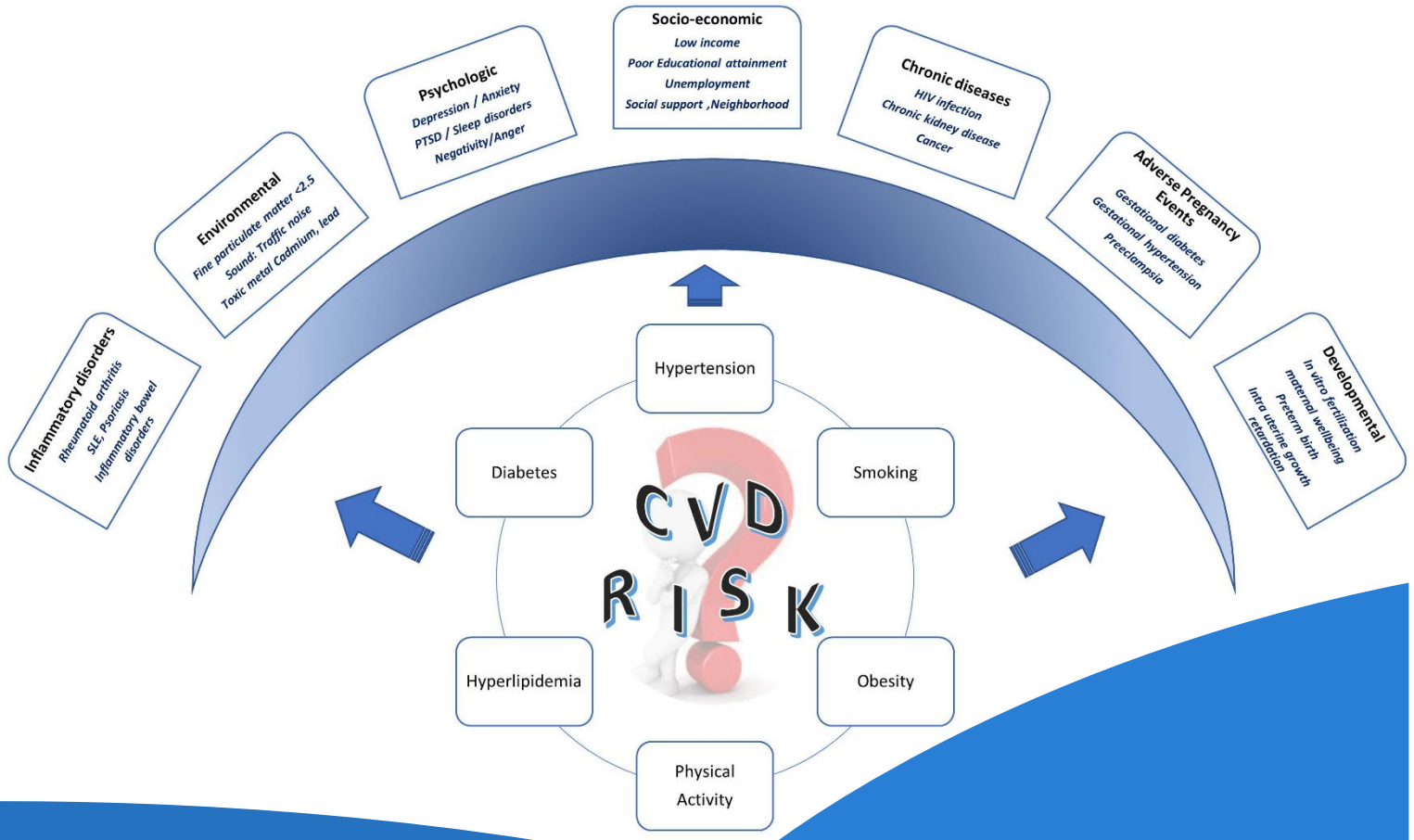
EMERGING RISK FACTORS AND THE NEED FOR A NOVEL CARDIOVASCULAR HISTORY TAKING PARADIGM!

Pioneering work in the mid twentieth century based on the Framingham cohort has led to our understanding of hypertension, smoking, physical inactivity and dyslipidemia as important predisposing factors for atherosclerotic cardiovascular disease (CVD) and the popularization of the term "risk factor". This traditional risk-factor based model centered around age, gender, diabetes, hypertension, dyslipidemia, smoking and lifestyle factors (diet and physical activity) has been the backbone for cardiovascular risk evaluation and is ingrained into every medical student and resident's training as an integral part of cardiovascular history taking. However, in the last two decades, our understanding of atherosclerosis has evolved from one that is passively driven by lipid deposition in arterial wall to a more complex and dynamic process that results from an interplay of lipid dysmetabolism, vascular injury and inflammation. While the traditional risk factors rightfully remain the preeminent focus for risk evaluation and treatment, abundant data now supports the important role of several novel risk factors / modifiers beyond the traditional risk factors, some of which are already included in the most recent ACC AHA guidelines for cardiovascular risk assessment.

An extensive body of research now supports the excess risk of CVD events in patients with rheumatoid arthritis which is associated with a 68% excess risk of myocardial infarction and 40% excess risk of stroke. A similar excess risk of CVD has been demonstrated across a wide spectrum of chronic inflammatory diseases such as systemic lupus erythematosus, psoriasis, and inflammatory bowel disorders. Notably, this excess risk is independent of underlying traditional risk factors. Similarly, cancer and cancer therapeutics, chronic kidney disease and chronic HIV infection have all been recognized as risk factors for CVD. The strong links between mental health, stress and CVD are well recognized though they are not part of any current CVD risk prediction tools. Numerous psychiatric disorders have been shown to increase risk of ischemic heart disease with major depression and post traumatic disorder demonstrating the strongest association. Furthermore, the



CARDIOLOGY UPDATE (CONTINUED)

importance of social, economic and environmental factors on the incidence and outcomes of CVD is increasingly evident potentially leading to a number of ethical and moral obligations for the cardiologist. Our role as physicians would naturally extend beyond treating individuals as our core mission is to promote cardiovascular health and not just treat cardiac disease. The WHO has declared that outdoor air pollution is the world's largest environmental health risk {Fine particulate matter <2.5 mm (PM2.5)} and accounted for > 4 million deaths in 2015, the vast majority of which were cardiovascular. Beyond this, indoor air pollution, metallic toxins such as lead, arsenic and cadmium exposure are all associated with excess risk of CVD. Finally, in the context of women, there is now wide appreciation of common pathophysiologic underpinnings between adverse maternal reproductive health, adverse pregnancy outcomes and CVD. Therefore, these can serve as markers of future CVD risk in women and provide a potential opportunity for screening and intervention long before the onset of clinical CVD.
In conclusion, an increased appreciation of these novel risk factors by patients, physicians and policy makers is critical for sustaining the progress and ensuring continued success in decreasing cardiovascular disease burden and improving outcomes. It is therefore time for us to reimagine the way cardiovascular history is taken in a way that encompasses the wider spectrum of risk factors and better prepare our younger physicians!

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FIT CORNER

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THE DEVASTATION OF PHYSICIAN BURNOUT

There is an epidemic of physician burnout challenging our happiness, personal relationships, career satisfaction, and patient care. In a survey of over 15,000 physicians, 42% of these individuals reported that they are burned out.[1] Burnout is included in the 11th revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon originating from chronic workplace stress, manifesting as feelings of emotional depletion, mental distancing from or cynicism for one's job, and reduced professional efficacy and efficiency.[2] Burnout is **not** a medical condition we face, nor a marker of physician inadequacy.

Coping strategies have largely targeted physicians, proposing that burnout can be conceptualized as a battery.[3] For our occupational tasks, we withdraw energy from this source, and we are challenged to learn to deposit energy intentionally by taking time to rest and recharge.[3] Healthcare organizations inadequately attempt to fill this gap by offering relaxation techniques, exercise classes, or social hours; yet 42% of physicians report that they would not utilize these wellness programs.[1] Individualized strategies to combat burnout advocate for the intentional separation of work and life through forming calendars to not just schedule work tasks, but to intentionally schedule time for

FIT CORNER (CONTINUED)

family, friends, and individual reflection – stressing the need to say "no" to any engagement that conflicts with this time.[4] While these strategies may be helpful, they do not address the underlying problem: a profound destruction of physician motivation by the current health care system.

Seminal work by Porter and Lawler examined concept of motivation in the workplace.[5] Intrinsic motivation is driven by spontaneous satisfaction from the activity itself, and extrinsic motivation arises from a tangible award given for the completion of an activity.[5] There has been a misguided attempt by the healthcare regulating system to increase external motivation by utilizing relative valve units and patient satisfaction scores to dictate reimbursement, without realizing that this undermines intrinsic motivation. In reality, over one third of physician's report that they would give up at least $20,000 of their annual salary to improve their work-life balance.[1]

Gagné and Deci pose that there are three integral components of intrinsic motivation which have been stripped from the modern healthcare system: autonomy, competence, and relatedness.[5] Autonomy involves acting with a sense of volition and the ability to experience choice.[5] Physicians are trained for over a decade to be independent thinkers and to critically analyze situations. In practice, this is reduced to following algorithms for patient care and reimbursement. Clinical competence was once heralded as the ability to utilize one's repertoire of medical knowledge to solve complex clinical situations. Under the current healthcare system, competence has been redefined as compliance with checking meaningless boxes in electronic health records.[6] Relatedness is the extent to which a person feels connected with and valued by other individuals.[5] Most physicians enter this field with a high level of altruism, with a desire to closely work with their patients. While the healthcare regulating system claims this achievement through the pronouncement of "patient centered care," physicians are penalized for not following metrics focusing on cumbersome electronic health records while limiting time for patient interactions.

The devastation of burnout will not be solved without revitalizing physician intrinsic motivation by addressing autonomy, competence, and relatedness. This will require purging the healthcare regulating system of unnecessary metrics dictating patient care and reimbursement. We must redefine value as clinical competency focusing on truly patient centered care: concentrating on patient interactions and medical decisions stemming from both evidence-based medicine and clinical judgment.

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CVT CORNER

IMPLEMENTATION OF CLINICAL PHARMACY SERVICES IN THE CARDIAC CATH LAB

Research suggests that multi-disciplinary teams benefit from the addition of a pharmacist.1-3 However, pharmacy representation in the cardiac cath lab (CCL) is not currently a well-established practice. In November of 2020, Nebraska Medicine implemented clinical pharmacy services in the CCL with the goal of improving patient care, expanding available medication resources, and serving as a clinical resource for all staff.

The responsibilities of the pharmacist range from typical duties such as order verification and medication reconciliation to emergency response, patient education, and protocol development. The addition of pharmacy services in the CCL has allowed for the collaboration and implementation of numerous process improvement initiatives. Some highlights

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CVT CORNER (CONTINUED)

include:

- Expansion of discharge medication review to include all patients
- Implementation of a discharge flag for any patient with new stents who does not have DAPT appropriately prescribed
- Implementation of a discharge flag for any patient with new stents who does not have DAPT appropriately prescribed
- Creation and implementation of "Protect Your Stent" education for all patients with new cardiac stents
- Collaboration and implementation of a heparin nomogram for use during PCI
- Creation of a new cangrelor algorithm to guide dosing for use in periprocedural bridging
- Establishment of a novel workflow for the use of intra-coronary acetylcholine to induce vasospasm

There continues to be opportunities for growth and there are many areas in which pharmacy services can provide value. Potential future directions include exploring options for expanding transitions of care and working with our outpatient partners to ensure all patients are optimized on guideline directed medical therapy. Other ideas include developing a pharmacist managed insulin protocol and working with our infectious disease colleagues to implement a periprocedural antibiotic protocol addressing erroneous allergy concerns to utilize optimal antibiotic selection.

The successful implementation of clinical pharmacy services could not have been accomplished without the positive reception and inclusion from all members of the multi-disciplinary staff. With this support, the pharmacy team looks forward to continuing work to find ways to improve care in this unique practice location.

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ACC CV TEAM NEWSLETTER

Did you know? The ACC has a monthly newsletter for CV Team Members. Click on the link below to learn more about what is happening on the national stage!

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NEBRASKA ACC ANNUAL MEETING INVITATION

ACC LEGISLATIVE CONFERENCE NOW VIRTUAL!

ACC's Legislative Conference 2021, scheduled for Oct. 3-5, is moving to an all-virtual experience. With the continued surge of COVID-19 across the U.S. and new travel restrictions being imposed by some health care institutions, the difficult decision was made to move the live portion of the meeting to the virtual stage.

Planning for virtual congressional visits was already underway given ongoing U.S. Capitol restrictions, and those visits will continue as planned on Oct. 5. The ACC HeartPAC event featuring Olympic gymnast Dominique Dawes will also take place virtually. Contact Meg Novak (*mnovak@acc.org*) for additional details.

Learn more and get answers to questions about the virtual experience, *here.* **Registration for the conference is still open – save your spot now!** Stay tuned to @Cardiology and *#ACCLegConf* on Twitter and the *ACC Advocate* newsletter for updates and news. Questions? Contact advocacyleg@acc.org.

Check out highlights from ACC's 2020 Legislative Conference *here*.

ACC'S REVAMPED PEER-TO-PEER MENTORSHIP COMMUNITY IS NOW LIVE!

Visit MemberHub.ACC.org for more information!

NEW PHYSICIAN WELLBEING PROGRAM AVAILABLE TO ALL NEBRASKA PHYSICIANS

LIFEBRIDGE NEBRASKA—NEBRASKA'S PHYSICIAN WELLNESS PROGRAM

The Nebraska Medical Association has launched their peer-to-peer physician coaching program LifeBridge Nebraska. LifeBridge Nebraska was developed by physicians, for physicians. It is a FREE coaching program available to all Nebraska physicians, regardless of NMA membership. The NMA hopes Nebraska physicians will reach out as a normal response to acute and chronic stress rather than just "powering through."

Confidential appointments are self-referred without medical diagnoses, insurance billing, or electronic records. Notification is not given to employers, NMA, or the board of medicine. Program participants can expect complete confidentiality –information and/or identity is never disclosed to others without written consent.

Physicians can connect with LifeBridge Nebraska by calling a confidential third-party call center at 1-888-569-2036. To learn more and to view coach profiles, please visit nebmed.org/lifebridge. Questions? Please contact Lindsey Hanlon at lindseyh@nebmed.org.