SA Heart® Committee and SA Heart® Project reports 2019

Full reports with photos are available in the SA Heart Newsletter 2019 issue 3

https://www.saheart.org/newsletters/viewFile/77

Education and Fulltime Salaried committees

Education committee members

Ashley Chin, Jens Hitzeroth, Ebrahim Hoosen, Hopewell Ntsinjana, Shaheen Pandie, Alfonso Pecoraro, Timothy Pennel and Nqoba Tsabedze.

Fulltime Salaried committee members

Antoinette Cilliers, Anupa Patel, Jacques Scherman, Timothy Pennel, Risenga Chauke, Nqoba Tsabedze, Makoali Makotoko and Adele Greyling

The role of the education committee continues to evolve. Where the committee previously directed most educational activities, it now plays more of an oversight role, ensuring equitable support for all interest groups that fall under the banner of SA Heart®. Many successful education activities have been organised over the past year and have been well attended by society members. ISCAP in particular, continues to grow from strength to strength. The biggest challenge, however has been the changing interaction with our industry partners. As you will all be aware, the new MedTech rules came into effect in January 2018 and have changed the landscape of financial support for educational activities in a very drastic way. The pilot project for implementation of these rules was the annual Africa PCR Congress held in March 2018 in Cape Town. Attendance of this Congress fell significantly, particularly in terms of allied healthcare professionals, who did not manage to secure support to attend the meeting under the new rules. Similarly, with Euro PCR and ESC, the number of South African delegates attending these meetings has fallen sharply. This has occurred despite many reassurances from our industry partners that the degree of support for these independently sponsored congresses would not be significantly affected. Clearly, more has to be done between SA Heart® and our industry partners to ensure that the new rules do not result in the death of further education and training in cardiology, particularly for the South African medical community. This will continue to be a challenge not only for the education committee, but for the SA Heart® executive as a whole together with the executives of all the special interest groups.

An exciting new project is taking shape that should add significant value to membership of SA Heart®. We are still in the process of establishing an online platform where videos can be accessed by SA Heart® members through our society website. The SA Heart® Journal has now been CPD accredited and members have free access to this CPD opportunity via the MPC platform.

Lastly, may I once again take the opportunity to encourage all society members to actively participate in our
educational activities? Without member participation, our collective knowledge begins to stagnate which impacts the quality of care we provide our patients.

*Tawanda Butau and Blanche Cupido*
Chairpersons of the Education and Fulltime Salaried committee

**Ethics and Guidelines Committee**

The Committee has reviewed a few matters over the past year:

- Prepared and submitted a report on Counterpulsation;
- Terms of Reference of the SA Heart® E&G Committee were submitted for discussion; and
- Complaint received from a patient concerning the treating cardiologist was resolved by discussion and to the satisfaction of all parties.

*Les Osrin, Chairman, Ethics and Guidelines Committee*

**SASCI Private Practice Committee**

The SASCI PPC (including SA Heart®) under the leadership of Jean Vorster initiated the process of developing a CPT cross walk. The PPC contracted Karen van der Westhuizen to assist with the cross walk together with David Jankelow, Andrew Thornton and Dave Kettles. We would like to thank Dr Tom Mabin for his willingness to actively work with SASCI PPC to address various issues, including consulting on CPT coding and funder engagements. Meetings have been set up with SAMA and major funders as part of the process.

SASCI PPC has been involved in addressing coding “issues” raised by, for example, Discovery Health (practice audits) and Medihelp on behalf of our members as well as the issue of Vascular Codes not being reimbursed. Members are requested to bring issues to our attention to allow us to minimise the impact on your individual practice.

Elsabe Klinck Associates is on a retainer to advise on ongoing legal, statutory and policy matters, including submissions on the HPCSA Global fee issue, CMS PMB process, HMI Outcomes Measures, TAVI Medihelp, and HMI Tariffs. A major focus area going forward will be the National Health Insurance. Please see the separate report from Elsabe Klinck.

**Update on Law, regulation and Policy in the health sector (18 September 2019)**
The following matters occurred in the period from April 2019 and merit consideration by all practitioners:

**Update on TAVI / TAVR**
Bestmed Medical Scheme: Bestmed funded the member in full at cost for all expenses incurred. The payment was made to the member’s bank account as an ex gratia payment. Bestmed still insists that the initial funding
decision was correct. However, they settled the payment as a way forward and that this act of kindness should not be regarded as precedent setting.

Bonitas Medical Scheme: Post the initial full decline of payment toward the entire TAVI procedure, Bonitas changed the funding decision and funded the claim up to an alleged cost of SVR. However, Bonitas still maintained a prosthesis limit of R$0 000. It therefore entailed that, the biggest part of the claim, the TAVI, was regarded as a prosthesis. The cost of TAVI was approximately R$299 000, leaving the member with an almost R$250 000 co-payment. EKA approached once again, the office of the Principal Officer, currently being Mr Lee Callakoppen. We understand that the claims have been sent for a second opinion to Dr Ivan Sherwood, a cardiologist. We await feedback accordingly and will update once it is received. Armed with the Registrar’s Ruling as per below, we will approach the office of the Principal officer once more, should the claims be declined.

Medihelp Medical Scheme: The long-awaited Ruling of the matter between SASCI and Medihelp Medical Scheme was received. The matter was that Medihelp was unlawfully limiting the funding of TAVI procedures in respect of patients suffering from Aortic Valve Stenosis, which is a Prescribed Minimum Benefit (PMB) condition. The said funding limitation is implemented by way of a prosthesis limit on TAVI for all members registered on all of Medihelp’s benefit options, and, by so doing, Medihelp members could not access the full PMB benefit they were entitled to.

The Registrar ruled that the use of benefit option rules and vascular prosthetic limits to curb Medihelp’s funding liability in TAVI procedures is “found to be offensive to the Act and the Regulations in that it is both restrictive”.

Whilst this is a victory to be celebrated, EKA is cognisant of the fact that Medihelp has 90 days from 11 September 2019 within which to lodge an appeal to the Appeals Committee challenging the decision of the Registrar. Once Medihelp has lodged the Appeal, the decision of the Registrar will be suspended. This lodging of an appeal (s48 of the Medical Schemes’ Act), will suspend the order by the Registrar that Medihelp must, within 90 days of the date of this ruling, align its rules and funding model for TAVI procedures with the Mabin Appeal Board ruling to ensure that it funds the average cost funded for open heart procedures, inclusive of all the necessary components applicable to the PMB entitlement. The appeal will have the effect that, Medihelp will not be obligated to implement the remedial actions requested by the Registrar.

EKA has arranged a meeting between SASCI and Dr Lee Moses from Medihelp on 15 October 2019. EKA seeks to probe Dr Moses in order to gather intelligence on whether Medihelp seeks to appeal the decision of the Registrar. However, the final decision will be noted post the expiry of the appeal period. EKA will closely monitor the events herein and update accordingly.

**NHI Bill, 2019**

The NHI Bill has been introduced in Parliament, and will now follow parliamentary processes – namely a call for
comments by the Portfolio Committee on Health, followed by verbal presentations. There will also be provincial processes, whereby provincial parliaments will obtain input from the public to inform their mandates sent to the National Council of Provinces, which will also deal with the Bill.

It is important that practitioners look at the implications of the Bill for themselves, and their patients. These are, from our point of view, largely practical, i.e. relating to what is indeed possible, and what is feasible in the short, medium and longer term.

The Bill envisages a re-organisation of the public and private healthcare sectors:
In the public sector, all regional, tertiary and central hospitals will no longer fall under provinces, but under the National Department of Health (NDoH). This would include academia, and will be complex from constitutional and labour law perspectives, as health science facilities and medical schools, which are in part governed by the specific university’s Act, and in part by labour law with the specific province as the employer, but also the entity that sets availability of types of care. Hospitals are described as “semi-autonomous” for central hospitals (with cost centres) and “autonomous legal entities” for regional and tertiary hospitals. Hospitals will get budgets from the NHI Fund (“NHIF”) based on diagnosis-related groups (DRG) for the population it serves.

Primary healthcare will be organised in so-called “Contracting Units for Primary Health Care” (“CUPs”) – being subject to oversight by District Health Management Offices (“DHMOs”), which will also not be part of the provinces, but form a “component” of the NDoH. The DHMOs will also be responsible, through an amendment to the National Health Act, for the District Specialist Support Teams, although the relationship with, or in the NHI, is not clear (e.g. will the capitated fee paid to the CUPs include the work of the District Specialist Teams?).

There is very little in the Bill on the details around private sector specialist care, and how its re-organisation is expected to take shape. The Bill states that the NHIF will contract CUPs, emergency services and “hospitals”. Under the payment clause, it merely states that payment for specialist and hospital services must be “all-inclusive and based on the performance of the health care service provider, health establishment or supplier of health goods”. Although providers will not claim from the NHIF in the way one does from a medical scheme, the Compensation Fund or RAF, providers are expected to stick to the “national pricing regimen” for services. It is not clear when this will, in fact, apply.

There will be an Office of Health Products Procurement (“OHPP”), which will facilitate the procurement of “high cost devices and equipment”. All procurement must be done in line with the OHPP’s Formulary, which will be based on the Essential Medicines List (EML) and the Essential Equipment List (EEL). It is unclear how existing equipment in practices, which may not be included in the EEL, will be handled. As a condition of contracting, practitioners will be expected to adhere to the Formulary. Mention is made of a “complementary list”, which will have to be approved by the Minister of Health. Unlike the Medical Schemes Regulations, which requires formularies and protocols to be set on the basis of evidence-based medicine, and for exceptions to be made for deviations from those in
cases of ineffectiveness in treatment, harm or potential harm, and adverse effects, no such principles appear in the NHI Bill.

The most controversial aspects of the NHI, and not addressed in the Bill, relates to the funding of the system ("money in"), and the payment of providers ("money out"). The National Treasury paper on the funding of the NHI is still awaited.

Although the shifting of funds from medical scheme contributions through a special payroll tax will lead to an increase in the pool of money available to the NHIF, and increase the amount available per patient per annum in the public sector, the annual amount available for a patient who was, but no longer can afford, medical scheme cover will be significantly less. This assumes that there is a possibility to, through increased volume, lower pricing of all services and goods in the private sector. It is unclear whether the willingness and feasibility of industry-wide price reductions have been modelled. Particularly pertinent is the fact that basic practice costs (e.g. salaries, rental, already-procured goods and equipment) will not change, unless there is a large-scale physical and structural re-organisation in practices.

**The Davis tax committee, in March 2017, found as follows in relation to the feasibility of the NHI:**

Given the current costing parameters outlined in the White Paper, the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth.

There are also aspects on which the NHI Bill is silent, such as the role of the NHLS and private pathology, the provision of blood and blood products by SANBS, research and development (and post-trial access). It is also not clear how provincial departments of health debts and liabilities, e.g. for malpractice lawsuits and unpaid suppliers, will be handled in the transition into an NHI system.

**The PMB review**

In spite of uncertainty as to the exact nature of the “complementary cover” medical schemes would be able to provide under the NHI, and the certainty that the NHI will provide primary care (PHC), the CMS is pressing ahead with the inclusion of a PHC portion to the PMBs. The process is currently with a priority-setting committee, to engage on the draft PHC package that was issued earlier this year.

Dr Kabana, Registrar of the CMS, said in an interview on Business Day TV, that as benefits are included in the NHI, they will be removed from medical scheme cover. Practically, it would be difficult for a patient to enter the NHI system, receive professional services and to then exist again to access, for example, innovative technologies not available in the NHI.
Section 59 Inquiry

The CMS has initiated an inquiry into allegations of racial discrimination during the conduct of medical scheme forensic inquiries (section 59’s). Although there has been mixed reaction as to whether there is indeed racial profiling, there was remarkable commonality in the testimonies of provider groups and advisors on how forensic investigations are undertaken. One of the key matters raised, was the lack of common understanding on the coding system, and that it creates room for claw-backs to occur. Such coding issues do not necessarily mean that fraud had been committed.

Jean Vorster, Chairman, SASCi Private Practice Committee

Update on Law, regulation and Policy in the health sector provided by Elsabé Klinck and Associates

SA HeArt® REgistry – SHARE

Committee members

Mpiko Ntsekhe (Chairperson), Erika Dau, Elizabeth Schaafsma, Karen Sliwa, Francis Smit, Jacques Scherman, Hellmuth Weich, Ashley Chin and Martin Mpe.

SHARE has now run as a SA Heart® prospective registry programme for 3 years, and the model for independent funding and functioning can be considered successful. The primary aims for the year 2018 - 2019 included consolidation of the progress from the previous year and recruitment of 2 new registries, as well as improving patient care through providing local data showing outcomes, and transparent presentation of data from the registries.

The SHARE-TAVI registry is now running very well. All TAVI sites in the country are active with the overall case capture rate exceeding 92%, which is a great achievement for a voluntary participation registry. Over 850 TAVIs have been captured to date, and over 1180 patients have been evaluated for TAVI and entered into the registry. More than 150 patients still await funding decisions regarding their TAVI procedures. However, looking at the data for 2019 only, the average number of days for a funding decision to be made has dropped to 72 days, from +180 days when the registry was first initiated – so the high number of patients awaiting decisions reflects that a greater number of patients are being referred for TAVI evaluations, rather than that decisions remain outstanding for a lengthy period.

In line with SHARE’s commitment to disseminate the data and information generated from the projects through publication and presentation of abstracts and papers, abstracts have been accepted and presented at EuroPCR
2019, ESC 2019 and locally at this year’s SA Heart®/PCR combined Congress. TAVI participants have been invited to feedback meetings at the SA Heart® Congress, as a forum to gather participants together conveniently for dissemination of information. With 45% of TAVI patients having completed their 1-year follow up, we are now in a position to offer more substantive data for publication, and are busy with the first manuscript on the SA TAVI data.

Prof Karen Sliwa of the Hatter Institute at UCT, and Dr Priya Soma-Pillay lead the SHARE Cardiac Disease and Maternity Registry (CDM), which has come to the end of its life cycle. Data entry has been closed on this project and as Prof Sliwa’s responsibilities at WHF have increased, she has handed over the lead in reporting on this registry to Dr Ferial Azibani, who is now in the process of preparing the first manuscript on this patient cohort.

The new Atrial Flutter/Fibrillation registry, SHARE-SAFFR, led by Dr Martin Mpe and Prof Ashley Chin, has been developed and tested by the Investigators, and ethics approval has been obtained for the initial sites. A further 12 sites have been identified and are in the process of obtaining ethics approval. Data capture will begin synchronously at all sites once the ethics approval for the remaining sites has been obtained. There will be an Investigator meeting at the SA Heart® Congress for all site personnel to attend – to be briefed on developments and to discuss registry-related queries.

In addition to the initiation of SHARE-SAFFR, 3 additional device and drug registries are in contention to come on board pending ongoing evaluation and registration process at SAHPRA. The draft dataset for the ICD registry led by Drs Klug and Moses, has been developed, and will shortly be circulated to the HEFFSA and CASSA members for comment.

Fundraising remains a priority for the continued development and running of all the registry programmes. We are tremendously grateful to Medtronic, Edwards Life Sciences and Pfizer for the very generous support of the SHARE registry programmes. This continued support enables the maintenance of the registries over the next 2 years, and allows for extended follow-up data to be collected, as well as supporting the continued analysis and publication of the outcomes – which has been one of the cornerstone aims of the SHARE registries.

We look forward to continued growth in 2019 - 2020 as we generate the type of local data and information that will influence and improve clinical practice, patient care, and public policy in the future. The committee remains thankful to individual members of SA Heart®, the SA Heart® Exco, industry partners, funders and hospital groups for their continued interest and support of SHARE, and of course most importantly to the participants at all our sites.

*Elizabeth Schaafsma and Prof Mpiko Ntsekhe, Chairperson, SHARE Committee*
**STEMI SA**

**International arena**

**STENT - SAVE A LIFE! Initiative**

This year marks the 10th anniversary of the Stent-Save a Life! global initiative, whose aim is to reduce morbidity and mortality from acute coronary syndrome on a global level. Japan, Taiwan and Uruguay have now joined the initiative and the number of participating countries has risen to a total of 32.

The project’s objective is to develop a STEMI network guide (Blueprint) aimed at helping countries set up their own efficient networks. This is based on the Hub and Spoke model that has successfully implemented in India. Representatives for 4 countries (Argentina, China, Portugal and South Africa) compiled the Blueprint. Rhena Delport represented South Africa. A round table discussion was held at the Forum Meeting during which participants brainstormed on communication processes and indicators of effective deployment of the Blueprint in regions. This guideline will shortly be published and it will be employed not only in South Africa but across the continent to strengthen national initiatives to optimise STEMI care across regions.

Adriaan Snyders chaired a session on: Regional synopsis – Where are we and what are the next steps? and Rhena Delport served as panel member for the STEMI Network Blueprint project.

**Stent – SAVE A LIFE! Project managers meeting**

Rhena Delport participated as a member of the working group as national Project Manager for SASCI/STEMI SA, and led the discussion on the complexities of data collection.

Valuable insights were obtained relating to the challenges of and solutions for STEMI networks for patient referrals that the new member countries experience.

**STEMI India collaboration**

Meetings and informal discussions were held with members from African countries as well as industry partners, during the Conference. The Pan-African meeting with the steering committee and international experts on systems of care for STEMI is depicted on the left, and on the right is a photo of the Faculty with whom STEM SA had fruitful discussions. Thomas Alexander, our host, stands in the centre of the group. He is co-investigator for the STEMI SA research project and has provided valuable input and support thus far. This is acknowledged and fully appreciated.

**Education project**

Standardisation of care in acute management of ACS

The Guardian initiative (Guard your Heart), which is similar to the Angles Stroke Initiative run by Boehringer Ingelheim (BI), will be launched shortly. It is a training programme that focusses on the management of ACS at first medical contact and results from joint collaboration between Emergency Physicians for Wits, STEMI SA, the Resuscitation Council, representatives from hospital groups, and EMS providers. The development was
supported by BI and Medtronic.

We plan quarterly meetings in metropolitan cities, but will also make the material available to any hub hospital cardiologist who is prepared to arrange training sessions on a smaller scale either in their hospital or at their referral centres – provided that the user assists us in improving the material. We are particularly looking for case studies focusing on the time lines and correct and incorrect management.

**STEMI data collection**

The upgraded STEMI SA data platform will be available shortly and Dave Kettles, with the assistance of the SASCI office, will drive the data collection process among cardiologists in collaboration with STEMI India. Rhena Delport will continue collaborating with hospital groups regarding data collection and is primarily responsible for the data analysis.

**Mapping of STEMI networks in regions**

We are making progress with the process of defining a national network for referrals of STEMI patients in South Africa. Dr Eamon Mare will contact each Cath Lab Hospital to:

- Determine who will act as contact person for the hospital at each Cath Lab hospital;
- Request information to more clearly define the national network which should/could be available by determining the:
  - Number of Cath Labs in each PCI-capable hospital;
  - Number of Cardiologists in the centre;
  - Number of Catheterisations performed per period/year;
  - Number of STEMI patients per period/year;
  - 10 Main Referral Centres and classifying whether they are a hospital/clinic/practice, emergency room or other;
  - If possible, number of STEMI patients transferred from each referral centre.

Should the requested information not be available, we will recommend/request that each Cath Lab centre reply as such and then collect the data required for a period of 3 months and then submit to Dr Eamon Mare.

**STEMI SA non-Profit Company (NPC)**

The present Board includes Adriaan Snyders, Rhena Delport and Len Steingo. The next Board will be elected at the beginning of 2021 by members actively involved in the programme. The STEMI SA NPC has opened an account and the account is managed by an independent accountant who will give 2-monthly feedback reports to all contributors. All financial support will be used for the specified purpose it was donated for, with a zero commission or handling fee.

Industry members are invited to:

- Register as a SUPPORTER of the STEMI SA Project with a yearly contribution of R15 000. This will be used for admin and local meeting expenses and a financial statement will be made available.
- Contribute toward running costs (R50 000 p.a.) for the STEMI SA Software for data collection.
- Adopt or participate in a metropolitan half day training session (100 attendees) or a referral site (20-50 attendees) evening training session.
- Support 1 or 2 STEMI SA representatives to attend SSL and other related meetings at STEMI India; EuroPCR; ESC; AfricaPCR; SAHeart®; Project Managers Meeting; STEMI Africa and other Africa Meetings; and Local steering committee meetings.
- Contribute towards a SSL Africa Round Table Dinner Discussion during a SA Heart®/AfricaPCR Meeting for not more than 20 attendees.
- Employ a research assistant for 20 hours per month for 1 year that will greatly enhance our data collection efforts.
- Consider playing a major role in the STEMI SA Forum 2020 Meeting.
- Discuss any options with Adriaan Snyders.

*Adriaan Snyders, Champion/Chairman, STEMI SA and SSL Africa*