JUNE 2009 VOLUME 38 NUMBER 6

Cardiology

A MEMBER PUBLICATION OF THE AMERICAN COLLEGE OF CARDIOLOGY

Updated Appropriate Use Criteria for Cardiac Radionuclide Imaging

SOMETIMES, AN OUNCE OF PREVENTION

REALLY IS WORTH A POUND OF CURE

The case for 23 almonds a day.

THE EVIDENCE WEIGHS IN

[illegible] of almonds are giving [illegible] these days. Nine clinical [illegible] almonds can have [illegible]

AN ANTIOXIDANT SUPERACHIEVER

[illegible] and say "almonds." [illegible]

{ Nutrients per ounce }

[illegible]

MAKE THE CASE TO YOUR PATIENTS

[illegible]

California almonds

[illegible]

A Long, Hot Summer

On May 15, as ACC President, I sent a letter to Senate Finance Committee Chair Max Baucus (D-Mont.) and ranking member Charles Grassley (R-Iowa), responding to the Committee's recent policy options paper on delivery system reform. The letter highlights ACC's stance on topics including linking payment to quality outcomes, hospital re-admissions and bundling, health information technology, comparative effectiveness research, transparency and medical liability reform. The full text of my letter is available at *qualityfirst.acc.org/advocacy/documents*. The full text of the Senate Finance Committee's policy options paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs," can be found at *finance.senate.gov*.

Also, in a recent guest editorial on The Lewin Report (*lewinreport.acc.org*), **John Brush Jr., M.D., F.A.C.C.,** discusses comparative effectiveness research. You are asked to respond with your thoughts.

My purpose in mentioning these documents here is not to provide a complete review of what was written. My purpose is to encourage you to be aware of what is happening, what ACC's positions have been and are as we look at what will most likely be major shifts in how medicine is practiced in this country. None of us can ignore the issues and the various ideas being proposed. We must, all of us, provide our ideas and opinions to the ACC, to our colleagues and to our legislative representatives. We must also stay attuned to what is happening.

By the time most of you receive this issue, we will all have a fairly good idea of what the initial health care reform proposals will encompass. The ACC leadership and staff are committed to keeping members posted on these events that will affect us all; however, I ask you to commit to reading the e-mails, blogs and magazine articles that are provided. I ask also that you commit to sharing your thoughts with me (*president@acc.org*) or other members of the Executive Committee and the Board of Trustees. We need to know what you are thinking during this interesting period of our professional lives.

Quality of care is the underpinning of so much commentary that ACC has provided on health care reform, and the introduction of the updated Appropriate Use Criteria for Cardiac Radionuclide Imaging by **Robert C. Hendel, M.D., F.A.C.C.,** and the article on ACC's IC3 Program in this issue of *Cardiology* further support ACC's strong position on quality.

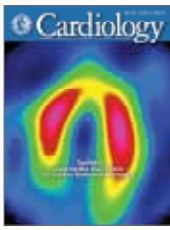
Meeting the needs of ACC's newest members, the fellows in training, is also an important topic in this issue. **Andrew M. Freeman, M.D.,** a representative from the Fellows in Training Committee, writes about the number of certification and board exams faced by most FITs today and the costs in dollars and time. **Rick Chazal, M.D., F.A.C.C.,** responds with a thoughtful commentary on what is a complex issue. We will need to work with others to resolve the concerns raised by the FIT members, but I am sure we will be able to find an equitable way to do it.

This is going to be a long summer. We need to stay attuned to what is happening and keep each other informed.

Alfred A. Bove, M.D., Ph.D., F.A.C.C.
ACC President

Inside This Issue

June 2009



ACC Releases Updated Appropriate Use Criteria for Cardiac Radionuclide Imaging

By Robert C. Hendel, M.D., F.A.C.C.

Last month, the American College of Cardiology Foundation (ACCF), along with key specialty and subspecialty societies, released an updated version of the appropriate use criteria for cardiac radionuclide imaging (RNI). The document is a revision of the original Single-Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI) Appropriateness Criteria, published in 2005. As was true at that time, there is continued interest by clinicians, payers and patients regarding the appropriate use of cardiac RNI.

Appropriate use criteria are intended to be dynamic. Since the first SPECT MPI criteria were released four years ago, the ACC and collaborating organizations have committed to critically and systematically creating, reviewing and categorizing the appropriate use of certain cardiovascular diagnostic tests on a frequent basis. The goal continues to be to provide the medical community with guidance regarding the rational and responsible use of cardiovascular procedures, including imaging.

Update Adds New Clinical Information

The new Appropriate Use Criteria for RNI represent the first attempt to update existing criteria to reflect changes in test use and new clinical data. The new criteria also address gaps that were identified within the original criteria and clarify descriptions of certain clinical scenarios. Some uncertain procedures identified in the original SPECT MPI criteria had also stimulated research over the last few years, resulting in data now being available to help with appropriateness determination.

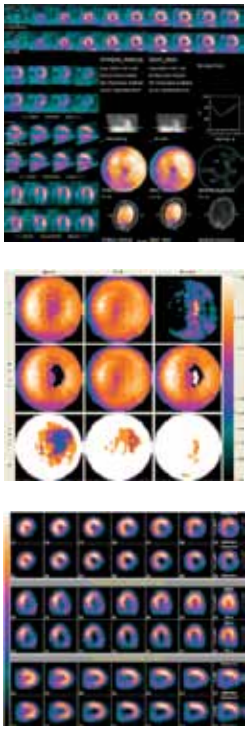
The indications for the updated criteria were drawn from common applications or anticipated uses, as well as from current clinical practice guidelines, including the recently updated perioperative guidelines. The Appropriate Use Criteria Task Force has found it increasingly important to harmonize the appropriate use criteria with clinical practice guidelines and performance measures.

The writing group developed 67 clinical scenarios — up from 52 in the original criteria — which were then reviewed and revised by more than 40 external reviewers. These indications were subsequently scored by a separate technical panel using a scale of 1 to 9 to designate appropriate use, inappropriate use or uncertain use. Technical panel members were asked to rate indications for cardiac RNI in a manner independent and irrespective of the prior ratings for SPECT MPI, as well as the prior ratings for similar diagnostic imaging modalities, such as stress echocardiography, cardiac computed tomography (CCT) or cardiac magnetic resonance.

Four New Assumptions in RNI AUC

In addition to adding new clinical indications and clarifying existing indications, the writing group, technical panel, and/or external reviewers of the RNI document also added these new assumptions —

- **First assumption** addressed accordance with best practice standards as delineated in the imaging guidelines for nuclear cardiology procedures as well as ensuring that procedures are performed in an accredited facility.
- **Second assumption** addressed the use of pharmacologic stress testing versus exercise stress testing in the setting of an ACS.
- **Third assumption** emphasized that in the perioperative setting, the use of RNI would have the potential to impact clinical decision making and to direct therapeutic interventions. This was added to enhance consistency with 2007 ACC/AHA Guideline for Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.
- **Fourth assumption** addressed the category of uncertain indications and clarified the relationship between such a rating and grounds for reimbursement.



Images courtesy *Journal of Nuclear Cardiology*

In general, use of cardiac RNI for diagnosis and risk assessment in intermediate- and high-risk patients with coronary artery disease (CAD) was viewed favorably, while testing in low-risk patients, routine repeat testing and general screening in certain clinical scenarios were viewed less favorably. In addition, use of SPECT RNI for perioperative testing was found to be inappropriate except in highly select groups of patients.

Clarifying Definitions, Assumptions

In addition to adding new clinical indications and clarifying existing indications from the original SPECT MPI Criteria, the writing group, technical panel and/or external reviewers of the RNI criteria also revised specific definitions and assumptions. For example, the new criteria include a revised definition of "chest pain syndrome," which had caused confusion when the original SPECT MPI criteria were applied. The original definition of chest pain syndrome focused only on symptoms and excluded other clinical

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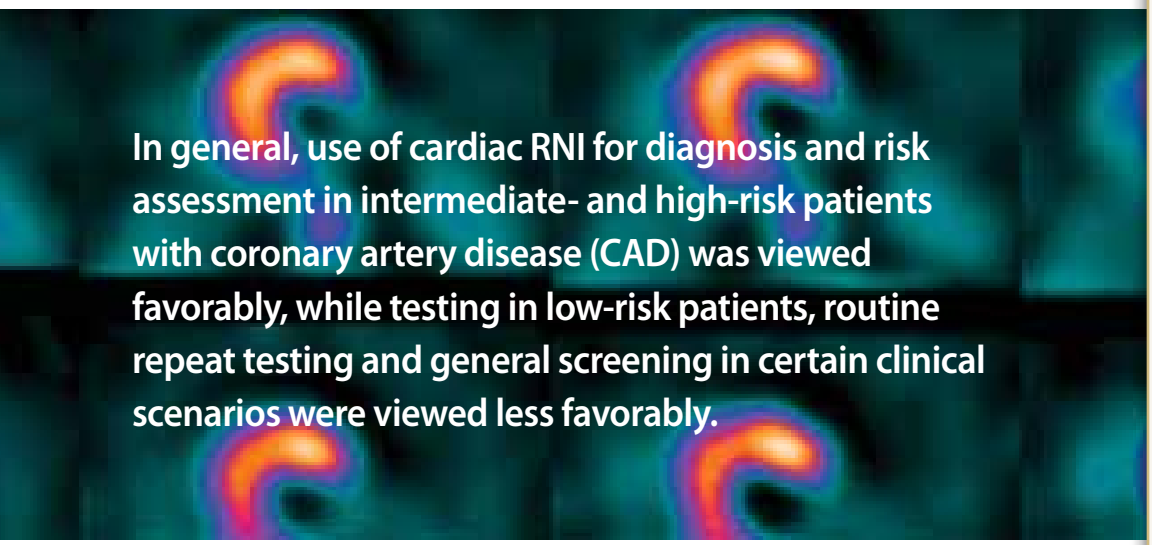

findings, such as new ECG changes that suggest the presence of obstructive CAD that might warrant RNI testing. Therefore, a new term "ischemic equivalent" was developed to encompass chest pain syndromes as well as other symptoms and signs that may be due to obstructive CAD.

Other changes include supplementing the series of tables with a flow diagram, making it much easier to incorporate appropriate use criteria in decision making and computer algorithms. These algorithms provide specific guidance for determining pretest risk assessment for risk stratification as well as pretest probability of CAD "ischemic equivalent" patients.

Moving Forward Important

It is anticipated that the updated RNI criteria will have a significant impact on physician decision making, test performance and reimbursement policy and will help guide future research. As is the case with all appropriate use criteria, the RNI criteria are intended to provide guidance for patients and clinicians and are not intended to serve as substitutes for clinical judgment and practice experience. The ranking of an indication as uncertain should not be viewed as limiting the use of cardiac RNI for such patients or denying reimbursement.

Moving forward, a comparative evaluation of the appropriate use of multiple imaging techniques is underway as part of a joint effort with the American College of Radiology. However, the ACC is proceeding with revisions of modality-specific criteria and an update to the Appropriate Use Criteria for CCT is already underway.

Hendel, who is chair of the Cardiac Radionuclide Imaging Writing Group, is a member of the Appropriate Use Criteria (AUC) Task Force and chair of the Evaluation and Implementation of AUC.

For more information on appropriate use criteria and practice tools, go to *www.acc.org/auc*. The full ACCF/ASNC/ACR/AHA/ASE/SCCT/SCMR/SNM* 2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging was published in the *Journal of the American College of Cardiology*, Vol. 53, No. 23, 2009 (*American Society of Nuclear Cardiology, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the Society of Cardiovascular Computed Tomography, the Society for Cardiovascular Magnetic Resonance, and the Society of Nuclear Medicine)

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Practicing Systematic Quality with the IC³ Program

By David May, M.D., Ph.D., F.A.C.C.

Quality is at the core of our seven-cardiologist practice in Texas. In fact, that commitment to improving the quality of care we offer patients is what led my practice to participate in ACC's IC³ Program®, an outpatient quality improvement program intended to facilitate the practice of evidence-based cardiovascular medicine.

The IC³ Program measures my practice's adherence to ACCF/American Heart Association guidelines and metrics for coronary artery disease, atrial fibrillation, hypertension and heart failure. After learning about the program at the January Board of Governors meeting, I thought participating would be a great way to take a critical view of how my practice performs compared to the national average, as well as examine our current process and see where we could eliminate inefficiencies.

In addition, participating in the program allows me to view our practice data before it is submitted to the Centers for Medicare and Medicaid Services (CMS) for the Physician Quality Reporting Initiative (PQRI). Submitting data through the IC³ Program allows us to use clinical, prospective data rather than claims data, which more accurately represents our adherence to the PQRI measures.

Our IC³ Program System

Although the implementation was not without challenges, we have developed a successful system that has proven to benefit both us and our patients. We began by assessing our workflow and the data elements needed. My IT staff and I developed a system using our electronic health record (EHR) to extract patient demographic and insurance information from office visit registration fields. This information is electronically added to the IC³ Program form, customizing it for each patient.

The form is then used by the physicians and nurses during the patient visit to fill in clinical information. Other data, such as a lab results from a patient's primary care physician, are entered into our EHR in the usual fashion. In many cases this is one to two weeks after the patient visit. At 30 days from the date of service, the IC³ form — including the data populated after the initial date of service — is automatically faxed to the ACC. This means our doctors interact with the form for only about two minutes during the patient visit.

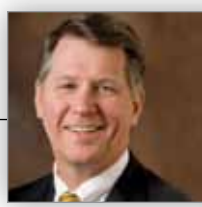
While there were definitely obstacles we had to overcome — including the usual reluctance to do something new — once we were able to streamline into our daily workflow and master the programming necessary to integrate the IC³ Program form seamlessly with our EHR, everyone realized the benefits of participation.

Additional Benefits

Because we can monitor our performance on core measures, our practice has an enhanced awareness of the care we provide to patients. In areas where we do not perform as well as we'd like, we can adjust to improve adherence to the performance metrics. In addition, since the program interfaces with our EHR, we're able to critically examine the usefulness of our vendor selection. The process of implementing the program also served to indentify inefficiencies in our practice workflow and served as a team-building exercise.

I feel strongly that the IC³ Program is the future. As an interventionalist, I am very familiar with collecting data in real time through ACC's National Cardiovascular Data Registry®, and the benefits that collection provides to knowledge of cardiovascular disease and treatment. Wide-scale participation in the IC³ Program has the potential to tell us much more than we know now about care in the ambulatory setting.

My practice's participation in the IC³ Program has been extremely positive, and I hope that other practices make the commitment to quality by joining the program. For more information about the IC³ Program, visit: www.*improvingcardiaccare.org*.



May is the governor-elect for ACC's Texas Chapter.

IC³ Program®

"...once we were able to streamline into our daily workflow and master the programming necessary to integrate the IC³ Program form seamlessly with our EHR, everyone realized the benefits of participation."

Too Many Boards? What ACC is Doing. . .

By Andrew M. Freeman, M.D.

The ACC's Fellows in Training Committee works diligently to help solve issues facing cardiology fellows nationwide. We recently addressed one of the most pressing issues faced by all cardiology fellows when they complete training — the substantial number of board exams that they are expected to take.

Most cardiology fellows expect to face six or more subspecialty boards to prove competency in various subject areas. In addition to the general cardiology boards sanctioned by the American Board of Internal Medicine (ABIM), there are also interventional cardiology and electrophysiology boards. In addition, there are board exams in echocardiography, cardiac/coronary computed tomography (CT), nuclear cardiology and vascular biology. Other exams include heart failure/transplantation, geriatric cardiology and cardiovascular magnetic resonance imaging (MRI).

Time and Financial Costs

The FIT Committee took the time to research the costs and time involved. Our results, seen in Figure 1, are based on 2009 figures.

Obviously, no one is going to take every single board that is offered; however, many FITs would most likely want to take multiple exams depending on their level of training and interests. Yet the cost in terms of dollars and time is overwhelming. For example, an FIT who specializes in non-invasive imaging would probably want to become "board-certified" in cardiovascular medicine, as well as in nuclear, echo, CT and vascular. The costs are estimated at $17,000 with a total time commitment of about 26 days between May and December. This includes exams, review courses and travel. The estimate does not take into account the intensive personal time required to prepare for the exams or even the stress in taking so many exams.

FELLOWS IN TRAINING
American College of Cardiology • Member Section

Do We Need All These Boards?

Looking at this issue from another perspective, many cardiologists are confused about the meaning of "board-certified." Is it necessary to be board-certified in every subspecialty and imaging modality? There is no question that proving competency via an exam has inherent value; however, many FITs now receive substantial training in many modalities during their fellowship. They feel confident and well-versed, and they question the value of taking an exam in every modality in which they have just completed training.

Other questions and issues arise regarding the many subspecialty boards. When should one take such exams? Are these exams required by hospitals to be credentialed or by the insurance companies that will be paying the reimbursements?

Taming the Board Exam Goliath

As a result of these tremendous pressures on newly minted cardiologists and also on established cardiologists needing to recertify, the FIT committee brought the above concerns to the ACC Executive Committee.

In response, the ACC leadership is taking immediate steps to address our concerns. First, as a neutral body with no direct involvement or financial stake in the board exams, the ACC is:

- Asking the administrators of each of the boards to expedite a process that unifies registration and credentialing to make the application and verification processes faster and more efficient — all of which might lower costs
- Forming a committee that will communicate with the respective boards to help facilitate some sort of simplification — or even unification — of exams
- Planning to work with other organizations to develop an ABIM-administered cardiovascular imaging board exam
- Committed to researching the issues surrounding certification questions and help determine which boards a cardiologist needs to take

As the ACC develops the necessary resources and gathers information to help solve the issue of the proliferation of the board and certification exams, we can expect that changes will be put in motion. Unfortunately, changes like this take time, compromise and cooperation among somewhat competitive entities. Most important at this time is that the ACC leadership does not take this issue lightly, and we can expect the situation to improve.

We Want to Hear From You

The FIT Committee needs to hear from FITs on this and other issues. The ACC offers many opportunities for FITs to communicate their ideas and concerns, as well as network with their peers. These are just a few possibilities —

- Check the new Discussions Forum for Fellows in Training at *www.cardiosource.com/forum*
- Need to raise an important issue? E-mail us today at *fellowsintraining@acc.org* or visit *www.acc.org/membership/Fellows/index.htm*
- Want to reach the whole membership? Write an article for *Cardiology*. Send articles or ideas to *adees@acc.org*.

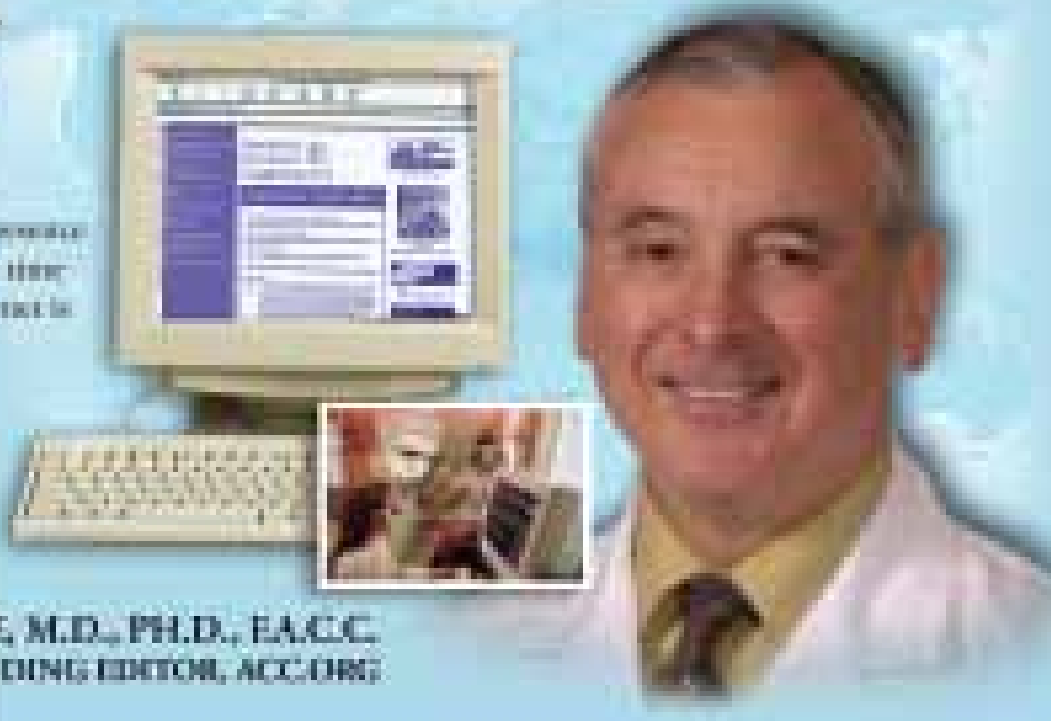
Freeman is chair of the ACC Fellows in Training Committee, which is now the FIT Council.

Figure 1. Estimated Costs and Time Commitment

	COSTS	TIME COMMITMENT
Cardiovascular Disease		
ABIM exam	$1,900	Two days
The ACCF Cardiovascular Board Review for Certification and Recertification	Registration: $700 Travel/lodging: $1,900 Note: Alternative courses can be even more expensive	Four days (includes travel time)
ACCSAP	$325	
EKG Review book	$90	
Other review books	$200 to $500	
Interventional Cardiology		
ABIM exam	Cost: ~$2,300	One day
ACCF/SCAI Premier Interventional Cardiology Overview and Board Preparatory Course	Registration: $425 Travel/lodging: $1,200	Seven days (includes travel time)
ACC CathSAP	$395	
Other review books	$200 to $500	
Clinical Cardiac Electrophysiology		
ABIM exam	Cost: $2,300	One day
HRS Board Review Course in Cardiac Electrophysiology	Registration: $1,200 Travel/lodging: $1,000	Five days (includes travel time)
ACC Arrhythmia-SAP	$115	
Other review books	$200 to $500	
Nuclear Cardiology		
CBNC Exam	$895	One day
ASNC Nuclear Cardiology Board Review Course	Registration: $600 Travel/Lodging: $1,000	Three days (includes travel time)
ASNC NKSAP	$180	
Nuclear Review Books/Physics Review	$100 to $250	
Echocardiography		
NBE Exam	$995	One day
ASCeXAM/ReASCE Review Course	Registration: $800 Travel/lodging: $1,200	Four days (includes travel time)
ACC Echo-SAP	$100	
Other review books	$200 to $400	
Cardiac CT		
CBCCT Exam	$895	One day
SCCT Review Course	Registration: $500 Travel/lodging: $950	Three days (includes travel time)
ACC CCT-SAP	$100	
Review Books/Physics Review	$100 to $250	
Vascular Medicine		
ABVM Exam	$1,100	One day
SVM Board Review Course	Registration: $525 Travel/lodging: $1,100	Four days (includes travel time)
Other review books	$100 to $300	

1996

The College establishes its presence on the World Wide Web at a time when education via the Internet is just beginning.



ALFRED BOVE, M.D., PH.D., F.A.C.C.
PRESIDENT, 2008; FOUNDING EDITOR, ACC.ORG

2009

With the addition of social media to the digital landscape, the ACC's presence on the Web is evolving to better meet the needs of members.

CHRIS CANNON, M.D., F.A.C.C.
EDITOR-IN-CHIEF OF CARDIOSOURCE, 2009

ACC Then and Now:
60 Years of Quality in Innovation

Certifications: Complex Problem That Needs Solving

By Richard A. Chazal, M.D., F.A.C.C.

The comments of Dr. Freeman and his colleagues on the Fellows in Training Committee bring a new perspective to issues surrounding certification in multiple cardiovascular disciplines. The figures alone are staggering — up to $17,000 in expenses incurred by a non-invasive cardiologist seeking certification in common areas of practice. Input from our colleagues in training is a breath of fresh air, welcomed as important and helpful. The ACC must hear this voice.

Many of the reasons for the expanding number of certification examinations are evident. The increase in subspecialty training and in new modalities prompts us as individuals to seek distinction and to benchmark ourselves against others.

All of us recognize that general cardiology training no longer ensures that the physician is adept at echocardiography, nuclear imaging, CT, MRI, electrophysiology and intervention.

Pressing Need for Clarification

Institutions — including hospitals, clinics and payers — need to clarify qualifications. Economic pressure often results in under-trained individuals engaging in complex imaging. Primary care physicians commonly read echo studies; radiologists without cardiovascular expertise often interpret nuclear images; and some cardiologists may also find themselves in similar situations. In other words, it's hard to recognize the players without a program.

Beyond this, one could ask whether our current certification processes are really working for the patient and the physician. I give as an example a recent situation. Last week, a neurologist sent "Mrs. Smith" to me for a transesophageal echocardiogram in the setting of vague neurologic symptoms and an abnormal trans-thoracic echo. The echo had noted a possible abnormal mass in the ascending aorta — it was a beam width artifact.

The study was interpreted by a primary care physician, who was related to the neurologist, using equipment and a technologist supplied by a radiology service company. Yet, Medicare reimbursement for that study is the same as for a study performed in an accredited lab, interpreted by a certified echocardiographer. Unfortunately, all of us have many such anecdotes.

Some institutions require a lot of certifications, while many do not. Patients are largely unaware of most of the boards and are confused by titles, abbreviations and training certificates, no matter their sources.

No Simple Answers

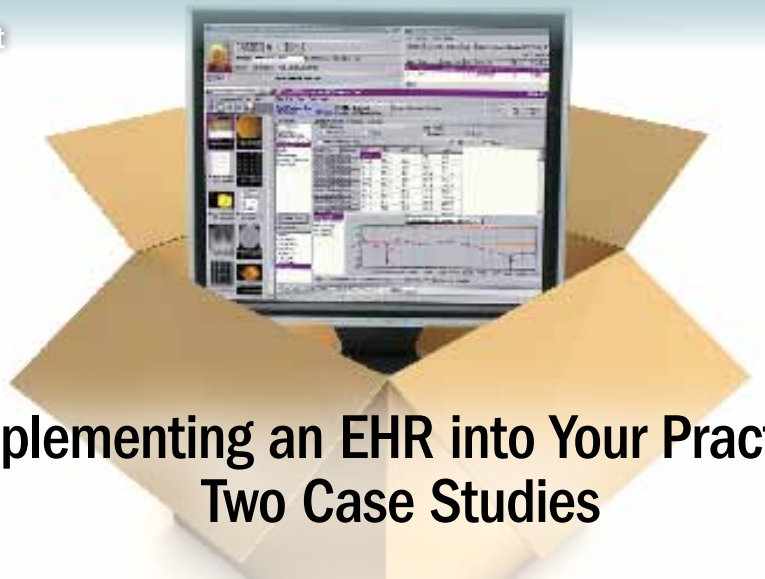
There is no simple solution. Eliminating certification exams altogether is unlikely. We need some form of delineation of qualifications, particularly in our current environment. Combining non-invasive imaging into one exam would aid some imaging specialists who are exiting training. However, that would not necessarily work for the physician specializing in high-level CT imaging, who has no interest in echocardiography, and we need these academically-focused super experts to expand the fields and knowledge base. It's also of no help for the mature nuclear cardiologist with no experience in MRI.

Our ultimate goal must be to help modify the system in such a way that we provide the highest quality of care to the most important shareholder – the patient.

Despite the complexities involved, the current trajectory of increasing exams, expense and time demands is, as pointed out by Dr. Freeman, unsustainable. ACC's Imaging Council is already hard at work on finding solutions. It is a difficult task, but we are confident in our collective ability to fix this.

There are a large number of shareholders involved — our members, teaching institutions, ABIM and other certifying entities, hospitals, group practices/clinics, subspecialty societies and payers. Our ultimate goal must be to help modify the system in such a way that we provide the highest quality of care to the most important shareholder — the patient.

Chazal is ACC Treasurer and a member of the Executive Committee.



Implementing an EHR into Your Practice: Two Case Studies

With the federal government authorized to give away $17.2 billion to assist providers who use health information technology (IT), the time has never been better to adopt an electronic health record (EHR) into your practice. The federal government will distribute the incentives through Medicare and Medicaid to assist providers who demonstrate "meaningful use" of an EHR from 2011to 2015.

Many ACC members currently use an EHR in their practice, but there are many resources available for those who do not. Below are the stories of two cardiologists who have implemented EHRs into their practice and hospital. **John Windle, M.D., F.A.C.C.,** is a cardiologist at the University of Nebraska Medical Center, which uses a comprehensive inpatient and outpatient medical record. **Jeff Westcott, M.D., F.A.C.C.,** practices at Seattle Cardiology, which uses one EHR in the ambulatory setting and a different EHR at its local hospital. Their full stories can be found at *www.acc.org/healthIT* in the EHR adoption toolkit.

Windle

Westcott

What made your practice decide to implement an EHR?

Windle: The paper record has a lot of limitations, such as completeness and availability. We liked the benefits of having an EHR. When I see a patient, I have all of his or her records. It's comprehensive and includes visits to other specialists and primary care physicians.

Westcott: Seattle Cardiology was a new group formed by the melding of three practices. As such, we needed to copy our old charts and bring them into a new practice. Implementing an EHR as part of that process made sense.

What does the EHR allow you to do now that you couldn't do before?

Windle: Our EHR gives us access to nursing charting, vital signs data and the ability to bring in outpatient records. We now have the ability to have both inpatient and outpatient records sitting side-by-side.

Westcott: Because the patient data are available in the office and remotely for quick and easy review, we are able to make better patient decisions based on that data review. As an example, if I get a call about Mrs. Jones, I can quickly call up her record and render an opinion based on the data there rather than relying on memory or a paper chart pull.

What challenges did you face with the EHR? Have you successfully overcome them?

Windle: Just the scope of the project was a challenge. Plus, the system is not very intuitive for users. We try to overcome this through a mixture of training and on-site practice. Putting the IT team right at the point of implementation is crucial because the system really goes across all boundaries.

Westcott: The main challenge to choosing an EHR, which we also faced, was thinking, "Gee, I don't want to choose the wrong one." Choosing the wrong EHR is really expensive. You also need a consensus among staff because implementation is extremely disruptive to workflow. It takes good leadership and a passionate group of people.

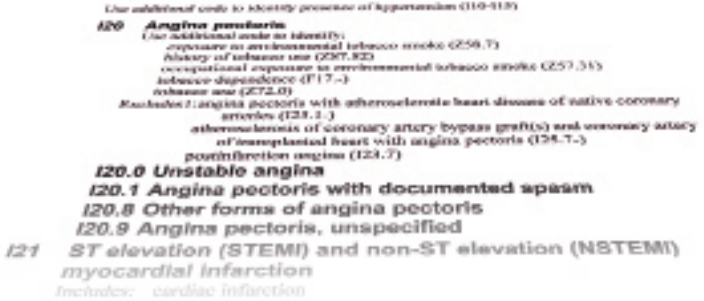
What advice do you have to offer to a practice looking for an EHR?

Windle: First, look at forward compatibility. The certification process is a good starting point. Have good analysis of what you're trying to accomplish and benefits you want to see. You need to understand the workflow changes that are going to happen, as well as the positives and negatives of having an EHR.

Westcott: Be realistic. It is a process that takes time, organization, consensus, determination and money. You'll need a strong implementation team, and as a practice, the physicians need to agree ahead of time that the EHR is a priority and that implementation will be universal. Agree to do it, and then just do it.

Visit *www.acc.org/healthIT* for more health IT resources from the ACC.

Prepping for the ICD-10 Transition



Oct. 1, 2013, will be a milestone in the world of health care administration. That is the day that the International Classification of Disease (ICD)-9, which has been used to code health diagnoses for more than 20 years, will be retired and replaced by a new version, ICD-10. The ICD coding system, the first version of which was introduced in 1893, is used to report and diagnose inpatient hospital procedures on health care transactions.

The Department of Health and Human Services (HHS) expects ICD-10 to have a host of positive effects, including providing more specific diagnosis and treatment information and supporting the comprehensive reporting of quality data and value-based purchasing. The agency also expects the system will ensure more accurate payments for new procedures and fewer rejected claims. As one of the few developed nations not already using ICD-10, the transition will allow the U.S. to track the incidence and spread of disease and treatment outcomes with that of other nations.

The new ICD-10 system includes 68,000 codes — up from 13,000 in ICD-9. Each code includes a letter followed by two digits, a decimal point, and then as many as three numbers. For example, angina pectoris, unspecified, is represented by I20.9 in the ICD-10 system. ICD-9 codes are formatted differently; they consist of at least 3 digits followed by a decimal point and two numbers in some cases.

ICD-10 Transition

The transition to ICD-10 will not be without difficulty. Practices are expected to face some level of administrative difficulty given the large number of new codes, the different code structure and the fact that these codes are used on a daily basis. The practice management and electronic health record systems used today will have to be upgraded or potentially replaced. In some cases, an upgrade to ICD-10 may be provided as part of a normal software upgrade, while in other cases, there may be considerable expense to upgrade or replace older software that cannot be made ICD-10 compliant.

Another aspect of the ICD-10 transition that practices must consider is how many documents in a physician practice include ICD-9 codes. For example, the superbills or charge slips used in practices generally include a list of common ICD-9 codes, as do orders for imaging or laboratory services. All of these will need to change in order for physicians to realize the benefits of transitioning to ICD-10.

Getting Started

While implementation is still four years away, practices should begin to take steps now to prepare for the transition. Practices should inquire with their vendors about ICD-10 compliance so that they can make budget accordingly for the coming years. Physicians should also begin familiarizing themselves with the codes. A preliminary version of the U.S. version of the codes is available at *www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm*. Although this version is likely to change substantially before it is implemented in 2013, it provides a window into the degrees of precision that are available under this new system.

While it seems clear that the implementation of ICD-10 is going to be a significant challenge for physician practices, preparing early and becoming familiar with the codes before they are required will help to ease that transition. For more information, visit the ICD-10 section of the Centers for Medicare and Medicaid Services Web site: *www.cms.hhs.gov/ICD10.*

CLARIFICATION: Correct Billing for Echo "Add-On" Codes

To clarify previous reports, although the National Correct Coding Initiative (NCCI) removed its restriction on billing the echocardiography "add-on" codes (CPT 93320 and 93325) together, it should be noted that 93307 should not be reported with 93320 and 93325. Instead, 93306 should be used, since it includes both add-on codes (93320 and 93325). The add-on codes should not be billed separately. This correction became effective Jan. 1.

93307 Transthoracic (2D) echocardiography without spectral or color Doppler

93306 Transthoracic (2D) echocardiography with spectral Doppler and color flow Doppler

+ 93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to code for echocardiographic imaging); complete

+ 93325 Doppler echocardiography color flow velocity mapping (List separately in addition to code for echocardiographic imaging)

The ACC advises its members and office practices to resubmit any claims on or after Jan. 1 denied for using CPT 93320 and 93325 together. For more information about coding changes for 2009, see the ACC 2009 Guide to Cardiology Coding and Payment Changes at *www.acc.org* under "Advocacy." In addition, the "Cardiovascular Coding 2009: Practical Reporting of Cardiovascular Services and Procedures" guide is now available for purchase. Go to *www.acc.org* for more information.

State Legislatures Wind Down for Year

With the majority of state legislatures winding down for the year, the following is a brief outline of key issues tackled across the country. Updates on states still in session will be included in future issues of *Cardiology*.

Imaging/Self-Referral

Despite several attempts by various radiology groups to pass state legislation restricting physician access to medical imaging, **Maryland** remains the only state in which radiology-exclusive groups and individual solo practitioner radiologists may perform in-office CT and MR. During the 2009 legislative session, the Maryland Chapter was once again able to introduce legislation in both the House and Senate to overturn the law. The bills garnered more cosponsors and supporters than similar legislation in 2008. The chapter also held its second Heart Healthy Day in February to provide free health screenings to legislators and staff. While the legislature unfortunately adjourned on April 13 without passing the bills, the major strides made during the course of the year have helped pave the way for 2010.

Bills modeled on the Maryland law were introduced in several states — the most onerous of which was in **Arkansas**. The bill (H.B. 1108), which added positron emission tomography (PET) to the list of services reserved to radiologists, never passed, thanks to the efforts of the Arkansas Chapter and the Arkansas Medical Society.

In **Arizona** legislation (H.B. 2376) requiring "medical services" to be delivered by the "appropriate medical specialty" through "accredited facilities" using "evidence-based medical standards and guidelines," was tabled as a result of the Arizona Chapter's efforts. While the bill reasonably required accountability and set standards, it raised questions about who would determine the appropriate specialty and who would establish guidelines.

The **Montana** state Senate passed a bill (S.B. 51) that would modify a law concerning physician ownership disclosure. While the chapter firmly supported the concept of the bill, it opposed the legislation in the House, noting it was far too sweeping in its applicability and in its definition of financial interest. Thanks to the efforts of the Montana Chapter, the bill died in the House.

Medical Liability/Insurance Reform

Oklahoma passed landmark medical liability reform legislation capping noneconomic damages at $400,000 outside of exceptional circumstances. In rare cases, any amount greater than $400,000 could be paid with a re-insurance policy the state would purchase. The bill creates a task force that will study the details of the policy and payment options prior to implementation. In order to have access to the re-insurance policy, doctors are required by the legislation to carry at least $1 million in medical liability insurance.

Meanwhile, in **Montana**, a bill (H.B. 362) was signed into law limiting the liability of health care professionals during a disaster. The **New Mexico** House of Representatives introduced similar legislation that did not pass. In **Nevada**, the chapter helped kill a bill that would have overturned parts of the state's malpractice law, which currently has a hard cap of $350,000. The bill would have allowed for greater damages in cases of "gross negligence," which under the bill's broad definition could have been anything.

On the insurance front, the **Florida** Chapter staunchly advocated for the passage of a bill (S. 1122) requiring managed care companies to honor an insured's assignment of benefits. The bill passed the Senate and awaits signature by the governor.

Public Health/Tobacco

Many Chapters were involved in important public health efforts across the country. In **Alabama**, the Chapter launched an "Assault on Alabama Cardiovascular Mortality" program designed to raise awareness of the high cardiovascular mortality rate in that state. Following a Lobby Day in

March, the Alabama House passed a resolution in support of the chapter's efforts. In **Kentucky**, the Chapter helped lead cardiovascular awareness efforts by participating in the Lieutenant Governor's Committee on Cardiovascular Health Summit in February. The meeting resulted in a series of recommendations aimed at improving heart health across the state.

The **Nevada** Chapter played a pivotal role in modifying a bill (A.B. 52) that would have required a hospital located in a county with a population of more than 400,000 to provide emergency care to a patient if that hospital had on its staff a specialist in the necessary type of care, or to enter into an agreement with another hospital to provide the service not offered by the hospital. The Chapter, through a lobby day and other efforts, helped to modify the bill so that it now essentially commissions a study on the effects of patient "dumping" in Clark County.

Tobacco also was a hot topic. While in most cases legislation did not pass in 2009, chapters in **Michigan**, **Alabama**, **Ohio** and **Indiana** made positive gains that should help with future passage of smoke-free legislation. In **Mississippi**, Gov. Haley Barbour approved an 18-cent-a-pack increase in the state's cigarette tax — the first increase in nearly a quarter century. In **Wisconsin**, Gov. Jim Doyle is expected to sign a bill banning smoking in restaurants, bars and other businesses starting in July 2010. The ban does not apply to Indian-run casinos.

Mission: Lifeline

Several states, including **Ohio** and **Indiana**, made inroads towards promoting Mission: Lifeline and STEMI systems of care. In **Florida**, a bill (H. 1033), which would have created a STEMI system of care in the state, was withdrawn from consideration thanks to efforts by the Florida Chapter. The chapter will continue to work with the American Heart Association on an appropriate STEMI program in the state.

Health Reform Legislation Expected in June

With Congress expected to unveil its overarching proposals in early June, the ACC is working to ensure any final proposal protects the ability of cardiovascular specialists to provide patients with quality care. To that end, the ACC in May submitted comments on several Senate Finance Committee health reform proposals, held a Legislative Fly-in that brought in 15 ACC leaders for face-to-face meetings with key lawmakers, and launched a comprehensive ad campaign aimed at D.C.-based health policy leaders.

The ACC on May 15 submitted comments in response to the Senate Finance Committee's paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs." The document contains policy options related to short- and long-term payment reform; infrastructure investments, the Physician Quality Reporting Initiative, imaging, workforce, comparative effectiveness and more. The ACC commended the committee for "setting out many positive delivery system reform policy options that would take needed steps toward improving the coordination and quality of care," adding, "The ACC believes reform of our current health care delivery system is essential and stands ready to help you as you undertake system transformation." The comments also address the necessity of medical liability reform.

Armed with these comments, May Fly-In participants met with roughly 40 congressional leaders and/or their staff about specific ways the medical profession can play a role in testing payment reform models, improving patient access to evidence-based, continuous care, while also reducing costs. ACC members are strongly encouraged to build on these efforts by calling, e-mailing or visiting members of Congress. More details, including specific talking points, can be found by calling ACC's toll-free grassroots hotline (800) 210-7193) or at *www.acc.org/can*.

Meanwhile, the ACC also recently launched an online and print advertising campaign around its Quality First health care reform campaign. The ads will run in key Capitol Hill publications over the next several months while Congress considers health care reform options. To view the ad and get the latest on ACC's health reform efforts, visit the Quality First Web site at *qualityfirst.acc.org*.

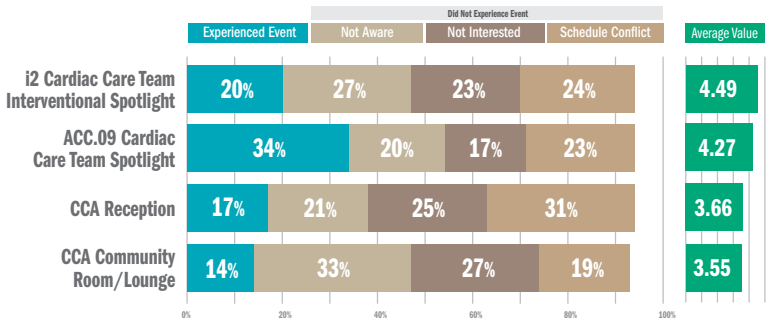
Quick Glance at Cardiovascular Care Team Members at ACC.09

More than 400 ACC members who fall into the category of non-physician cardiovascular team members attended ACC.09 and/or i2.09. Another 400 non-ACC non-physician team members also attended. The majority of the attendees signed up for the full-access registration, which allowed them to attend both meetings. These attendees included nurse practitioners, nurses, physician assistants, clinical nurse specialists, pharmacists, practice administrators and a few "other" members of cardiac care teams, such as nutritionists, exercise physiologists and technologists.

Since the inception of the ACC Cardiac Care Associate category, in addition to the regular scientific sessions attended by physicians and non-physicians, specialized programming, such as the Cardiac Care Spotlight Session, has also been developed for non-physician attendees. Yet, the statistics in the chart on this page indicate that many cardiac care team members were not aware of or did not take advantage of many of the special sessions or events.

CCA members have been part of the Annual Scientific Session Program Committee for several years now, and CCA members have also been more involved as presenters in many sessions. It would be valuable to understand more about the choices made by these attendees. If you have suggestions for ACC.10/i2.10 involving programming targeted for non-physician attendees or standard programming, please share them with members of the new ACC Cardiovascular Team Council* by contacting *kbohanno@acc.org* or send your comments to *Cardiology* (*adees@acc.org*).

CCA Events at ACC.09



Based on 281 respondents.
Average value based on scale of 1 to 5, with 5 representing significant value.

***Remember that the CCA membership is now part of the new ACC Cardiovascular Team Section and Council. See *Cardiology*, May 2009, page 14 for details.**

New Opportunities Opening for CV and Primary Care PAs


Eagle

Physician assistants (PAs) who work closely with CV patients may find a new program at the University of Illinois College of Medicine to be of great interest. The university plans to start the first PA postgraduate fellowship in the United States. It will be designed to provide additional clinical cardiovascular training for primary care PAs. **Ken Korber** is the PA consulting on the curriculum, which is scheduled to launch in 2010.

Kim Eagle, M.D., M.A.C.C., editor in chief of the *Cardiosource Review Journal*, has been a champion of this effort as well.

"As our population ages, the pressure to provide greater levels of outstanding cardiovascular care in our nation will reach unprecedented levels," says Eagle. "This care will have to be provided by outstanding care teams with physicians, nurses, physician assistants and other professionals working side-by-side. It will be best provided by individuals who have had dedicated training in management of complicated cardiovascular problems.

"The development of specific training avenues for physician assistants and advanced nurses in cardiovascular diseases is a critical part of meeting the burgeoning demand for care," he continued. "The new program at the University of Illinois is an exciting example of how this should proceed, and the ACC is delighted to be partnering with our Cardiovascular Team members in this evolving cardiovascular care landscape."

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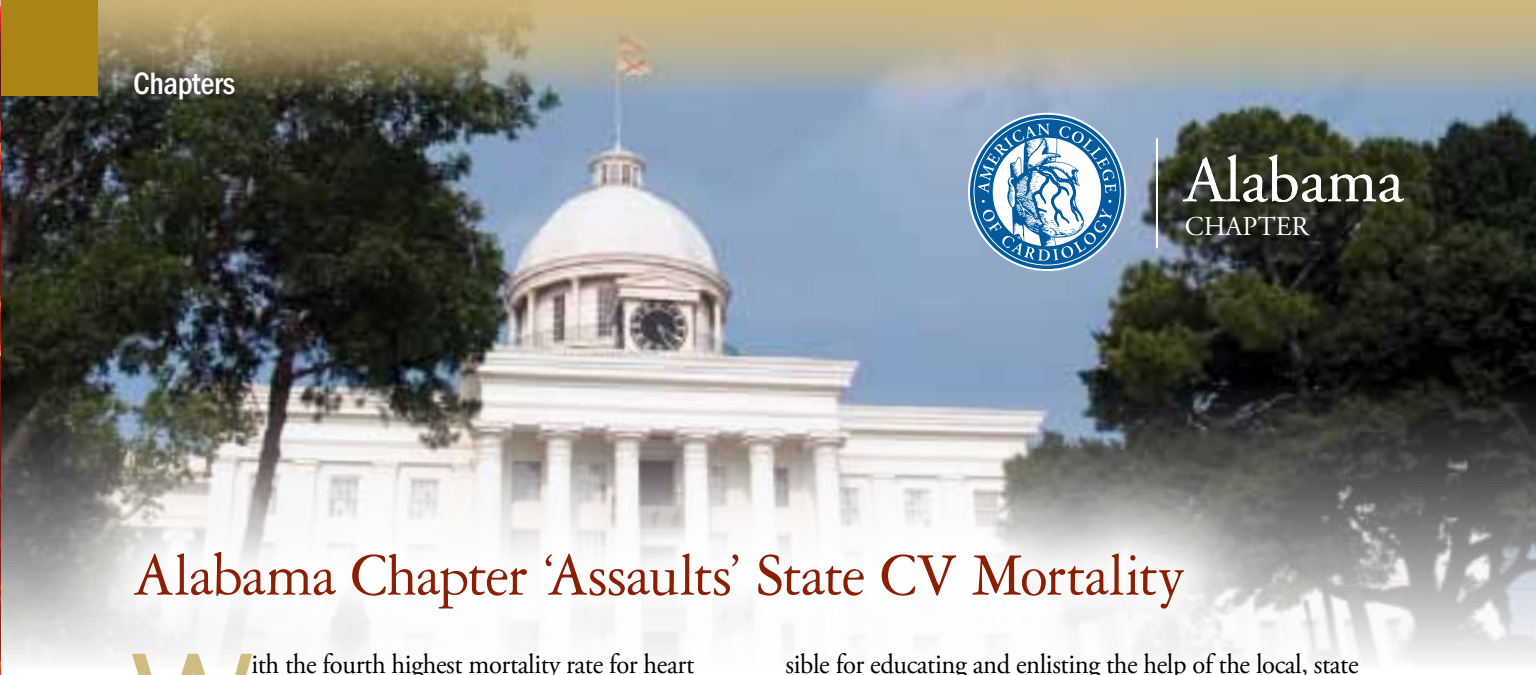

Alabama
CHAPTER

Alabama Chapter 'Assaults' State CV Mortality

With the fourth highest mortality rate for heart disease in the United States and the seventh highest for stroke, ACC's Alabama Chapter has an uphill battle to reduce the incidence of cardiovascular disease in the state. Rather than viewing the state's poor health as an insurmountable obstacle, the Chapter has responded by launching an aggressive campaign called, "Assault on Alabama Cardiovascular Mortality."

This campaign, a statewide program completed in partnership with the Alabama Department of Public Health, has earned the Chapter ACC's top distinction for 2008, the HERO ("Heroic Efforts creating Results and Opportunities") award. The award is given to the three chapters that show the most promise in upholding the mission of the ACC: education, advocacy and quality.

Extremely troubled by the cardiovascular crisis in the state, Chapter leaders in summer 2008 came together to create the campaign initiative. The initiative serves two functions —

- to raise awareness and promote changes that decrease the high levels of cardiovascular morbidity and mortality rate in the state
- to foster relationships with national and local legislators that will enable the Chapter to serve ACC's mission and meet the needs of patients better

Top: Chapter members with Alabama Lt. Govenor. Middle and Bottom: Chapter reception.

Initiative's Structure

The initiative features seven physician champions, one in each congressional district. The physician champion is responsible for educating and enlisting the help of the local, state and national elected representatives in his or her district, and promoting and advertising the campaign. Physician champions also pledge to hold a "Cardiologist for a Day" program with an elected official.

For patients, the campaign features "town hall talks," delivered by ACC members in each district, to raise awareness of cardiovascular mortality and risk factors. The Chapter created a clinical guideline-based slide set to assist members in giving the talks, helping to ensure the delivery of a consistent, high-quality message to all areas of the state.

By forming relationships with local and national lawmakers, the Chapter feels it will be more able to participate in discussions about legislation, such as a public smoking ban, which is gaining increasing support among lawmakers and the public. A version of the bill was introduced during the 2008 state legislative session and passed by the Alabama Senate. In the state House, the bill was approved in committee but did not receive a vote by the full chamber before the close of the session. The Chapter will continue its work in 2009 to see the bill passed into law.

In 2009 the Chapter plans to focus on increasing participation in their annual meeting, incorporating and providing value to their newest membership category of practice administrators and continuing to monitor attempts to limit access to imaging.

For more information on the Alabama Chapter, visit: *acc.org/chapters*.

ACC's Legislative Conference 2009

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New ACC International Council and Section Expand International Impact

By Huon H. Gray, M.D., F.R.C.P., F.E.S.C., F.A.C.C.

At ACC.09 in Orlando, the ACC Board of Trustees (BOT) established the International Council of the ACC. The Council, which reports to the BOT, will have as its Core Membership those who are overseas FACCs and hold leadership positions worldwide. The Council replaces the International Committee and raises the profile of ACC's international activities within the College's leadership structure. Establishing this new Council is part of the College's strategy to improve communication between the ACC and its members outside the U.S. This communication will be both ways; the ACC is keen to ensure that the views of its International Members are heard, and their needs met.

In addition to the International Council, the College has created an International Member Section, which will serve as a home for ACC's international members and U.S. members who are interested in being a part of the College's international activities. The Section provides a forum for engagement, enabling international members to have a voice in the governance of the ACC. As cardiologists, we all spend most of our professional lives helping those with cardiovascular disease and those who may be at risk of developing these conditions. The problems that our patients face, and with which governments have to grapple, are universal, and our specialty is truly international. Different conditions may be more prevalent in some parts of the world than in others, but the challenges cardiologists face are remarkably similar, irrespective of geography. This "common purpose" gives us great opportunities — for learning, building relationships, furthering our understanding of different cultures and speaking with one voice in our advocacy for patients. I believe that the College's new International Strategy will go a long way in helping us achieve our common purpose and in building professional friendships along the way.

Gray, who is chair of International Council of the American College of Cardiology, is Consultant Cardiologist, Southampton University Hospital, Southampton, UK.

International ACC Chapters Now a Reality

In April, the ACC launched its first international chapter during the annual meeting of the National Heart Association of Malaysia. The ACC's new international chapter program was established to help the ACC be more effective at providing grassroots-level support to Fellows who live outside of the United States. Of course, the formation of an ACC chapter must be approved by that country's national cardiovascular society. Once formed, the country-level chapters will send representatives to an International Assembly that will meet twice yearly and report to the new International Council. The new ACC Malaysia Chapter will work closely with the National Heart Association of Malaysia to fight heart disease in that part of the world.

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1997 The ACC first publishes a pocket version of an ACC/AHA practice guideline.

Treating Arrhythmias in the Real World

By Peter N. Smith, M.D., F.A.C.C.

Already in 2009 we've experienced some truly outstanding education in the field of arrhythmias.

I just returned from the Heart Rhythm Society's 30th Annual Scientific Sessions in Boston, where I enjoyed Atrial Fibrillation 360 sessions, Sudden Cardiac Death 360 sessions, as well as cutting-edge late-breaking clinical trials.

Of course, earlier this spring, I attended ACC.09, which included a wealth of electrophysiology science and education. What I find striking every time I attend one of these seminal events is the rapid advancement of our understanding of arrhythmias and our ability to treat them. For example, we now know that frequent premature ventricular complexes (PVCs) can reduce left-ventricular function, and suppression or ablation might lead to improved LV function. We also have a number of new therapeutic options available to us to treat atrial fibrillation. The options are very cutting-edge, even if we can't get a patient to an arrhythmia center.

Real World Options

There's more outstanding arrhythmia education on the horizon this summer that will address just what non-electrophysiologists (non-EPs) can do for patients outside an arrhythmia center. Arrhythmias in the Real World 2009, taking place Sept. 10 – 12 at Heart House in Washington, D.C., is an ACC Foundation educational program I direct along with co-directors **Kelley Anderson, M.D., F.A.C.C.,** and **Arthur Moss, M.D., F.A.C.C.** It's the premier arrhythmia conference for non-EPs. Our goal is to help physicians, nurses and other cardiovascular professionals understand what they can do for patients on a local level and what's coming down the pike in terms of new therapeutic options. We also help non-EP cardiologists understand when they need to call in an EP expert.

It's an intensely interactive event, and this year even more so. We're promoting camaraderie and intense discussion among attendees. Attendees from earlier years of the program will recognize that the format is different. We've instituted lots of audience participation, and it's a case-based symposium. We also have instituted a "Meet the Experts" session to allow small group or one-on-one discussion between conferees and the speakers. On Friday and Saturday morning, there will be an early-bird session on interpreting complex ECG tracings. Audience members will review the tracings and participate via an audience response system. Together we'll review the ECG findings.

We have an outstanding list of speakers as well. We've put together a dream team from the arrhythmia world — not just great researchers, but great communicators who can really teach. You'll find popular speakers from years past, including **Fred Morady, M.D., F.A.C.C.,** and **Jon Steinberg, M.D., F.A.C.C.** We also have **Jim Reiffel, M.D., F.A.C.C.,** an absolute expert in anti-arrhythmic drugs; **Hugh Calkins,** director of electrophysiology at Johns Hopkins; and **David Benditt,** who is a world-recognized expert on syncope.

I'm very proud of this event, and I hope it will enhance arrhythmia management for our conferees and their patients. I encourage you to learn more about Arrhythmias in the Real World, and to register for the program. Go to *www.acc.org* and click on Programs.

Smith is a cardiac electrophysiologist at the Marshfield Clinic in Marshfield, Wis.

Abstract Notes from HRS

Eight-year Follow-up Affirms ICD Value

Ilan Goldenberg, M.D., reported the beneficial results of an eight-year follow-up study of the MADIT-II (Multicenter Automatic Defibrillator Trial II) trial at a late-breaking clinical trials session at HRS. The results affirmed that, except for patients who developed worsening heart failure, the ICD reduced the cumulative probability of all–cause mortality.

The initial results of the MADIT-II trial in 2002 showed a 31 percent improvement in survival with an ICD implantation after myocardial infarction (MI) versus optimal medical therapy.

Interestingly, Goldenberg's report indicated a continuous improvement over the years. As he explained it, at the mid-point of the follow-up (four years), the ICD arm of the study showed a 41 percent relative risk reduction. At eight years the relative risk reduction was down to 37 percent in that arm.

Goldenberg is with the University of Rochester Medical Center, Rochester, N.Y.

New Consensus Document Addresses VA Catheter Ablation

The European Heart Rhythm Association (EHRA) in partnership with the Heart Rhythm Society (HRS) has published an expert consensus statement on the use of catheter ablation for ventricular arrhythmias. The statement was developed in collaboration with the American College of Cardiology (ACC) and the American Heart Association (AHA).

The statement provides a state-of-the-art review of the field of catheter ablation of ventricular tachycardia (VT). It also reports the findings of an EHRA/HRS task force that was charged with defining the indications, techniques and outcomes of the procedure.

A consensus statement does not carry the same weight as an evidence-based guideline. It is essentially a summary of the consensus opinion of the task force members based on their experience and a review of the literature.

The task force members defined consensus as 70 percent or greater agreement by the members of the group. They also make it clear that the statement is directed to all health care professionals who treat patients who are considered for catheter ablation of VT, and it is not intended to recommend or promote catheter ablation of VT.

As part of their work, the group chose to standardize VT definitions, mechanisms and rationale for ablation. Other sections review technical aspects, VT in structural heart disease, ablation outcomes and considerations in specific diseases and idiopathic VT.

Although they included training and institutional requirements and competencies, the task force statement did not offer specific numbers when it came to how many procedures should be required to establish or maintain competency.

The full document was published in *Heart Rhythm*, June 2009, 6(6): 886-933 and is also on *cardiosource.com*.

Educational Programs Calendar

2009* **ACCF/SCCT Coronary CTA Practicum** **Program Dates available online*	*Washington, D.C.*	CME
June 19 - 21, 2009 **2nd Annual West Coast Cardiovascular Forum** Valentin Fuster, M.D., Ph.D., F.A.C.C.	*San Francisco*	CME CE
August 20, 2009 **ACCF Study Session for Maintenance of Certification – Interventional Cardiology Updates 2007 and 2008** Joseph D. Babb, M.D., F.S.C.A.I., F.A.C.C. James E. Tcheng, M.D., F.A.C.C., F.S.C.A.I., F.E.S.C	*Dallas*	CME
August 21 - 23, 2009 **ACCF/SCAI Premier Interventional Cardiology Overview and Board Preparatory Course** Joseph D. Babb, M.D., F.S.C.A.I., F.A.C.C. James E. Tcheng, M.D., F.A.C.C., F.S.C.A.I., F.E.S.C	*Dallas*	CME
September 8 - 13, 2009 **ACCF Cardiovascular Board Review for Certification and Recertification** Kim A. Eagle, M.D., M.A.C.C. Patrick T. O'Gara, M.D., F.A.C.C.	*Lake Las Vegas, Nev.*	CME
September 10 - 12, 2009 **Arrhythmias in the Real World 2009** Peter N. Smith, M.D., F.A.C.C.	*Washington, D.C.*	CME CE
September 10 - 12, 2009 **2009 Heart Valve Summit** David H. Adams, M.D., F.A.C.C. Steven F. Bolling, M.D., F.A.C.C. Robert O. Bonow, M.D., M.A.C.C. Howard C. Herrmann, M.D., F.A.C.C.	*Washington, D.C.*	CME CE
September 12, 2009 **ACCF Study Session for Maintenance of Certification (MOC): Cardiovascular Disease Updates 2008 and 2009** Rick A. Nishimura, M.D., F.A.C.C. Patrick T. O'Gara, M.D., F.A.C.C.	*Lake Las Vegas, Nev.*	CME
September 22, 2009 **Hot Topics in Clinical Cardiology ACC.09 Highlights for the Interventional, Invasive and General Cardiologist** Aaron Kugelmass, M.D., F.A.C.C. Marc E. Shelton, M.D., F.A.C.C.	*San Francisco*	CME
October 22 - 25, 2009 **2009 Foundations for Practice Excellence: A Core Curriculum for the Cardiovascular Clinician** Eileen M. Handberg, Ph.D., A.R.N.P., F.A.H.A., F.A.C.C. Joseph S. Alpert, M.D., F.A.C.C.	*Washington, D.C.*	CE PA
December 4 - 5, 2009 **How to Become a Cardiovascular Investigator** Valentin Fuster, M.D., Ph.D., F.A.C.C.	*Washington, D.C.*	CME

For a complete listing of upcoming events and to register online, go to *www.acc.org/education/programs/programs.htm*

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Typical of most training directors, **Michael Benitez, M.D., F.A.C.C.,** director of the cardiovascular fellowship training program at the University of Maryland Medical Center, is always on the hunt for the best tools to educate and assess his cardiology fellows. Three years ago, the University of Maryland began using Cardiosource Plus for Institutions, making his life much easier, he says.

Cardiosource Plus is the institutional model for Cardiosource, the College's premier online clinical portal. For one price, institutions, practices and training programs get access to all the resources available on Cardiosource, including clinical trials, an extensive library of still and full-motion images, practice guidelines and more for an unlimited number of individual users. In addition, Cardiosource Plus offers access to all the ACCF self-assessment programs and Meetings on Demand.

Useful for Self-Education and Board Review Conferences

Benitez and the University of Maryland fellows use Cardiosource Plus on a daily basis. "The fellows use it for their own self-education; the amount of educational material that's there to help them is incredible," he says. "In addition, we use it frequently as part of our conference series. At our board review conference, which is a weekly event, we use a lot of the self-assessment programs like ACCSAP 7. We've used it in our subspecialty conferences on echocardiography and interventional cardiology, and it fits into almost every major subgroup area for fellows."

Benitez particularly appreciates the clinical vignettes available on Cardiosource Plus, such as the Case Studies, which describe a patient's presentation and present a diagnostic dilemma for the fellows to engage in and discuss. "Those have been a lot of fun," he says.

Cardiosource Plus is both fun and practical, offering a convenient way to fulfill Accreditation Council for Graduate Medical Education (ACGME) and other regulatory and (re)certification requirements.

Cardiosource Plus includes ACCIS, or American College of Cardiology In Service, which includes ABIM-style learning materials and assessment tools for ECGs and care of older adults. "It's a wonderful means for program directors and fellows to assess fellows' skills in an ABIM method," Benitez says. "It's particularly useful to evaluate how they're doing with care of the elderly, an ACGME requirement that's difficult to fill through any cardiology rotations." ACCIS currently is available to all cardiology fellows, regardless of whether their institution subscribes to Cardiosource Plus, through a grant from the Hartford Foundation, but when the grant runs out will be available only to subscribers.

"Cardiosource Plus gives us all this material and all these different modules, anytime, any place at no additional price," Benitez says. Most important for his institution and for any practice or institution that needs widespread access to clinical and educational materials, "it does so in a way that's easy for us to use and access as a group."

To learn more about Cardiosource Plus, call (800) 253-4636, ext. 6253, or visit *www.cardiosource.com/institutional.asp.*

Benitez is associate professor of medicine and director, Cardiovascular Fellowship Training Program, at the University of Maryland Medical Center.

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1998 ACC publishes the "Professional Life Survey," designed to identify areas of professional and personal life of concern to women in cardiovascular medicine. That same year, the College elevated its Women in Cardiology Task Force to the Women in Cardiology Committee.

ACC.09/i2.09 Satisfaction Surpasses Previous Years, Survey Finds

"A great deal of thought was put into this meeting. The organization and the integration of technology was outstanding."

ACC FIT from Louisville, Ky.

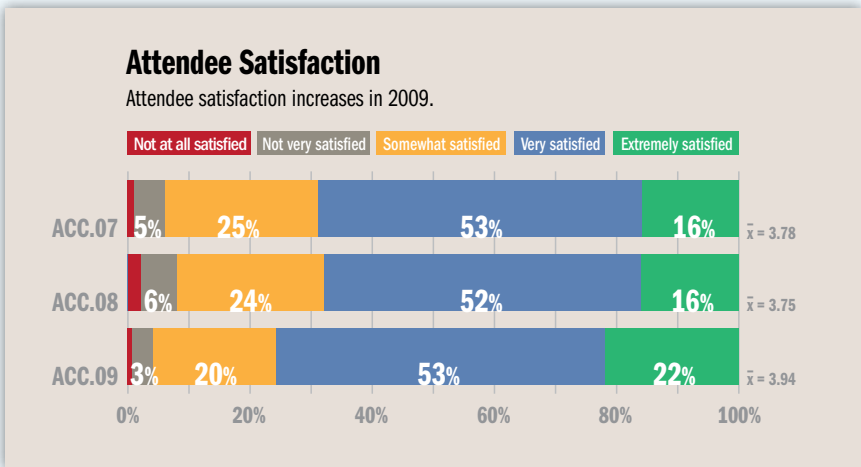
The 58th Annual Scientific Session in Orlando, ushered in a new year, a new president and new findings that the ACC's annual meetings are top notch. Every year, the ACC Market Intelligence team surveys attendees about their experience at ACC's most recent Annual Scientific Session. This year, 75 percent of the respondents rated ACC.09/i2.09 as being better than other comparable annual meetings, a post-meeting survey shows. The survey also highlights increased attendee satisfaction with both ACC.09 and i2 Summit 2009, when they are compared to ACC.07/i2.07 and ACC.08/i2.08. Three-quarters of the respondents reported being extremely or very satisfied with ACC.09.

The i2 Summit 2009, which focuses on advancing the science and practice of interventional cardiology, showed a 4 percent increase in the number of attendees who were extremely satisfied with the experience. Almost all of the respondents (89 percent) referencing i2.09 reported that the meeting met or surpassed their expectations. They responded favorably about all i2.09 events but were particularly positive regarding the synchronization with and access to ACC.09, live cases and exhibits.

Attendees found value in new educational offerings at ACC.09, according to the findings. Popular education activities included some features new to ACC.09, such as the synchronized time slots between meetings, Maintenance of Certification (MOC) and Core Curriculum sessions, the International Lunchtime Symposia and dedicated Expo/Poster hours.

Spending an average of one to two hours on the floor, 90 percent of meeting attendees said that they visited the Expo hall, and 92 percent visited companies that they wanted to see. Eighty-four percent of the meeting attendees reported that visiting the Expo floor is an important part of their overall ACC educational experience.

Survey respondents brought positive attention to the international nature of the ACC's annual meetings. An M.D. from Sao Paulo, Brazil, noted as a positive attribute of the meeting, "the global approach of ACC — one unforgettable experience for me." A non-member Registered Nurse attendee from Sarasota, Fla., pointed to the "camaraderie across countries" at the meeting.

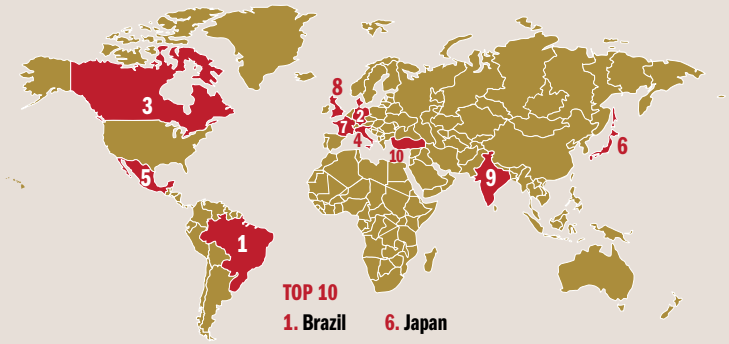


"The latest breaking science discoveries and presentations. Also, the very open honest discussions on health care reform and policy issues ongoing in the federal government and ACC's approach."

FACC from San Francisco

ACC.09 International Attendance

113 countries, excluding U.S., represented



TOP 10

1. Brazil
2. Germany
3. Canada
4. Italy
5. Mexico
6. Japan
7. France
8. United Kingdom
9. India
10. Turkey

"The experience reinforces the notion that the ACC convention is still the Mecca of cardiology. No other convention comes close."

M.D. from the Philippines

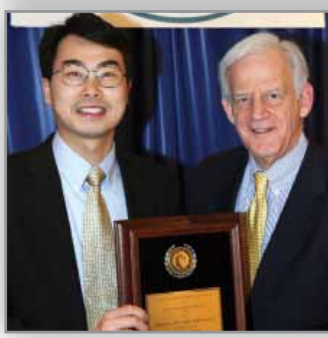
The online survey was sent to 12,750 registered attendees who provided e-mail addresses. The survey was available from April 10 through April 27, 2009, and reminder e-mails were sent on April 16 and April 22. The survey was completed by 2,052 attendees at a 16 percent response rate, and of that number, 945 attended i2.09 either as a stand-alone meeting or in combination with ACC.09. In the analysis, responses were weighted to reflect actual attendee distribution with 47 percent attending ACC.09 only, 1 percent attending i2.09 only and 52 percent attending both ACC.09 and i2.09.

"We were very pleased to get such great feedback. We do not however take time to rest on our laurels! We will continue to look for ways to enhance the meeting experience for our attendees and learners by providing the best cutting-edge education and science in multiple formats, quality and showsite experience at future meetings."

Sue Sears Hamilton, Associate Vice President, Annual Scientific Session and i2 Summit

Parmley Prize Recognizes Young *JACC* Authors, Investigators

Every year at ACC's Annual Scientific Session, the Editorial Board of the *Journal of the American College of Cardiology* (*JACC*) awards the Parmley Prize to two young investigators whose outstanding papers were published in *JACC* during the previous year. The award honors the young investigators as well as the programs in which they are working. This year's winners were **Emmanouil S. Brilakis, M.D., Ph.D.,** and **Joseph C. Wu, M.D., Ph.D.,** both pictured with **Anthony N. DeMaria, M.D., M.A.C.C.,** *JACC* Editor-in-Chief.



Dr. Anthony DeMaria (right) presents the Parmley Prize to Dr. Emmanouil Brilakis (top) and Dr. Joseph Wu (bottom)

Young investigators apply for the award when they submit their manuscripts to *JACC* (and of course, their papers must be accepted for publication.) The standard criteria for the award include originality, methodology, presentation and importance. For the purpose of this award, a young investigator is designated as one who is within five years of having completed the training requirements for specialty Board Certification or Ph.D. degree. However, it is important for program directors and colleagues to nominate and identify individuals who are eligible for the award.

For papers submitted in 2009 to be awarded in March 2010, a similar prize is being established for the two new journals — a Young Author Award for *JACC: CV Imaging* and for *JACC: CV Interventions*. For additional information, go to *www.acc.org* or contact the *JACC* editorial office.

Career Opportunities

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The College does not investigate the offers made in these advertisements and assumes no liability concerning them. Acceptance of advertising is limited to employment, professional and educational opportunities.

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For Career Opportunities rates and information, please contact:
Ariel Medina, Elsevier,
360 Park Ave. South, New York, NY 10010-1710;
Direct: (212) 633-3689; Fax: (212) 633-3850;
a.medina@elsevier.com

Look for these upcoming topics in

Cardiology

Imaging: Choosing the Right Modality

PA Practice Duties with HF Patients

Practice Integration Strategies

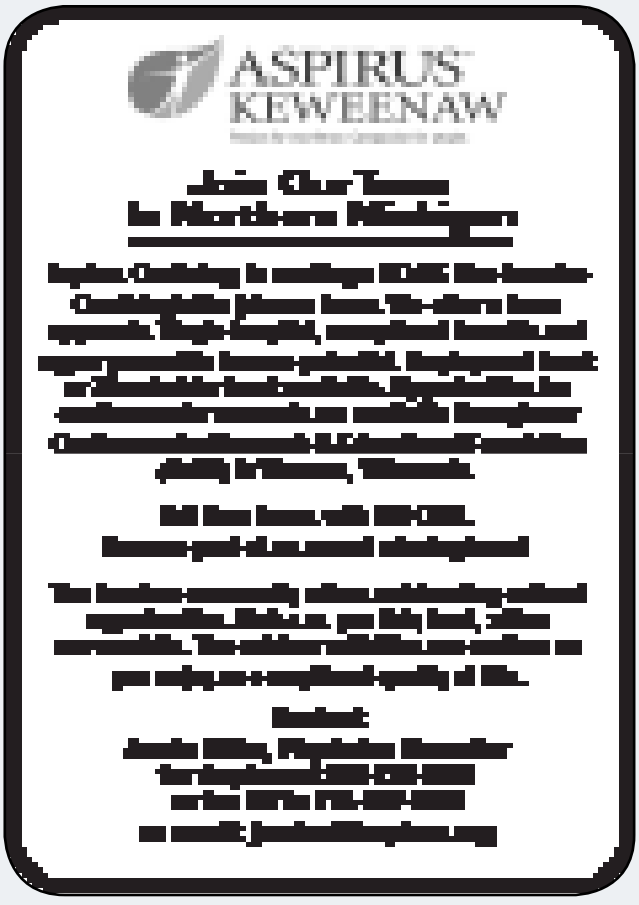
Selling or Leasing Cardiology Practices to Hospitals and Health Systems

International Perspectives: Rapid Reperfusion Strategies

About

Writing for Cardiology

Cardiology magazine, which is written by, for and about ACC members, attempts to put research, science and clinical guidelines in the context of daily clinical practice and to keep you informed about ACC and professional news. We are always looking for new authors, ideas and contributions. Short articles or letters to the editor run 350 to 500 words. Longer articles run 500 to 800 words. Feel free to submit ideas or articles to either *adees@acc.org* or *cardiologyeditor@acc.org*.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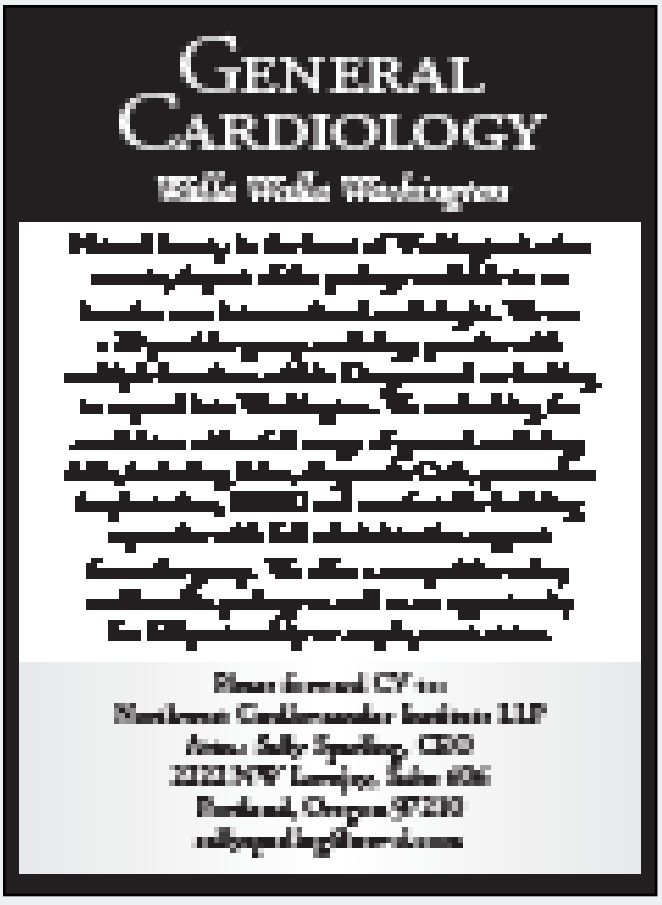
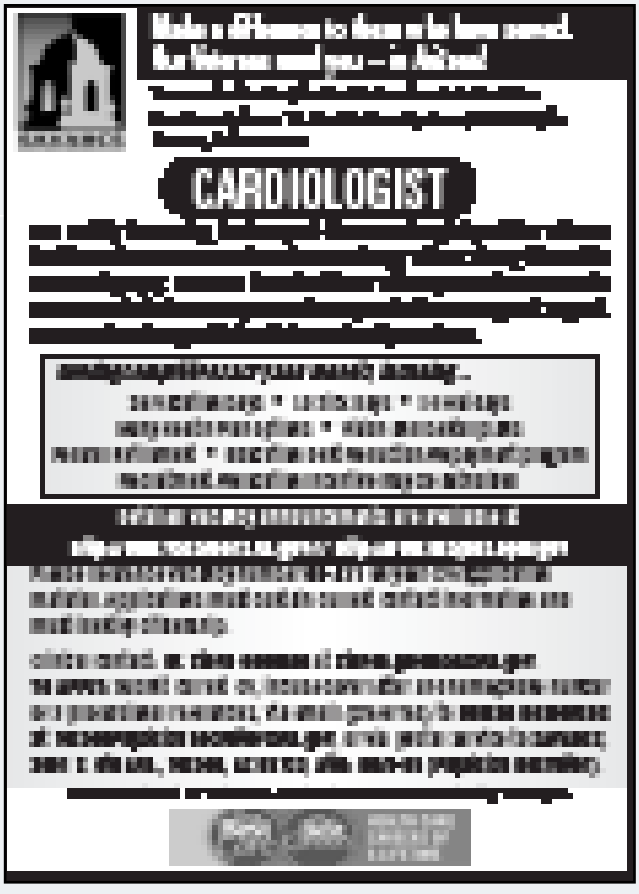

GENERAL
CARDIOLOGY


CARDIOLOGIST

This Month in

JACC

June 9

- The Use of Intracardiac Echocardiography and Other Intracardiac Imaging Tools to Guide Noncoronary Cardiac Interventions
- Local Cytokine Concentrations and Oxygen Pressure Are Related to Maturation of the Collateral Circulation in Man
- Beta-blockade with Nebivolol in Elderly Heart Failure Patients with Impaired and Preserved Left Ventricular Ejection Fraction: Data from SENIORS

June 16

- BALANCE-Study: Clinical Benefit and Long-Term Outcome after Intracoronary Autologous Bone Marrow Cell Transplantation in Patients with AMI
- Long-Term Outcome of Stem Cell Therapy for Acute Myocardial Infarction: Right Results, Wrong Reasons
- The Acute Effect of Various Glycemic Index Dietary Carbohydrates on Endothelial Function in Non-Diabetic Overweight and Obese Subjects

June 23

- Promoting Mechanisms of Vascular Health: Circulating Progenitor cells, Angiogenesis, and Reverse Cholesterol Transport
- Maximising Patient Benefit from Cardiac Resynchronisation Therapy with the Addition of Structured Exercise Training — A Randomised Controlled Study
- Are BNP Changes During Hospitalization for Heart Failure a Reliable Surrogate for Predicting the Effects of Therapies on Post-discharge Mortality?

June 30

- Cardiac Rehabilitation and Survival in Older Coronary Patients
- Computed Tomography Characteristics of Atherosclerotic Plaques Subsequently Resulting in Acute Coronary Syndrome
- Non-Invasive Detection of Vulnerable Coronary Plaques: Locking the Barn Door Before the Horse is Stolen
- Percutaneous Coronary Interventions in Facilities Without Cardiac Surgery On-Site: A Report from the National Cardiovascular Data Registry (NCDR®)

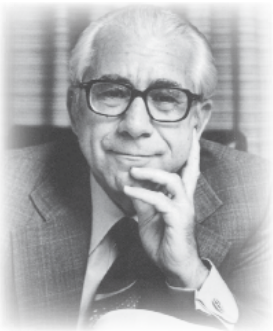
JACC cardiovascular Interventions

- Chronic Total Occlusion Angioplasty in the United States: State of the Art and Future Direction
- PaclitAxel or Sirolimus-Eluting Stent vs Bare Metal Stent in primary angioplasty (PASEO) randomized trial
- In-Stent Neointimal Suppression by Pioglitazone
- Pioglitazone to Reduce Restenosis Following Bare Metal Stent Placement?

JACC cardiovascular Imaging

- Prognostic and Diagnostic Value of Absence of Coronary Artery Calcification: The Significance of Zero
- Left Ventricular Untwisting is an Important Determinant of Early Diastolic Function in Humans
- Non-invasive Evaluation of Cardiac Allograft Rejection by Cellular and Functional MRI

JACC Simon Dack Award Recognizes Critical Excellence



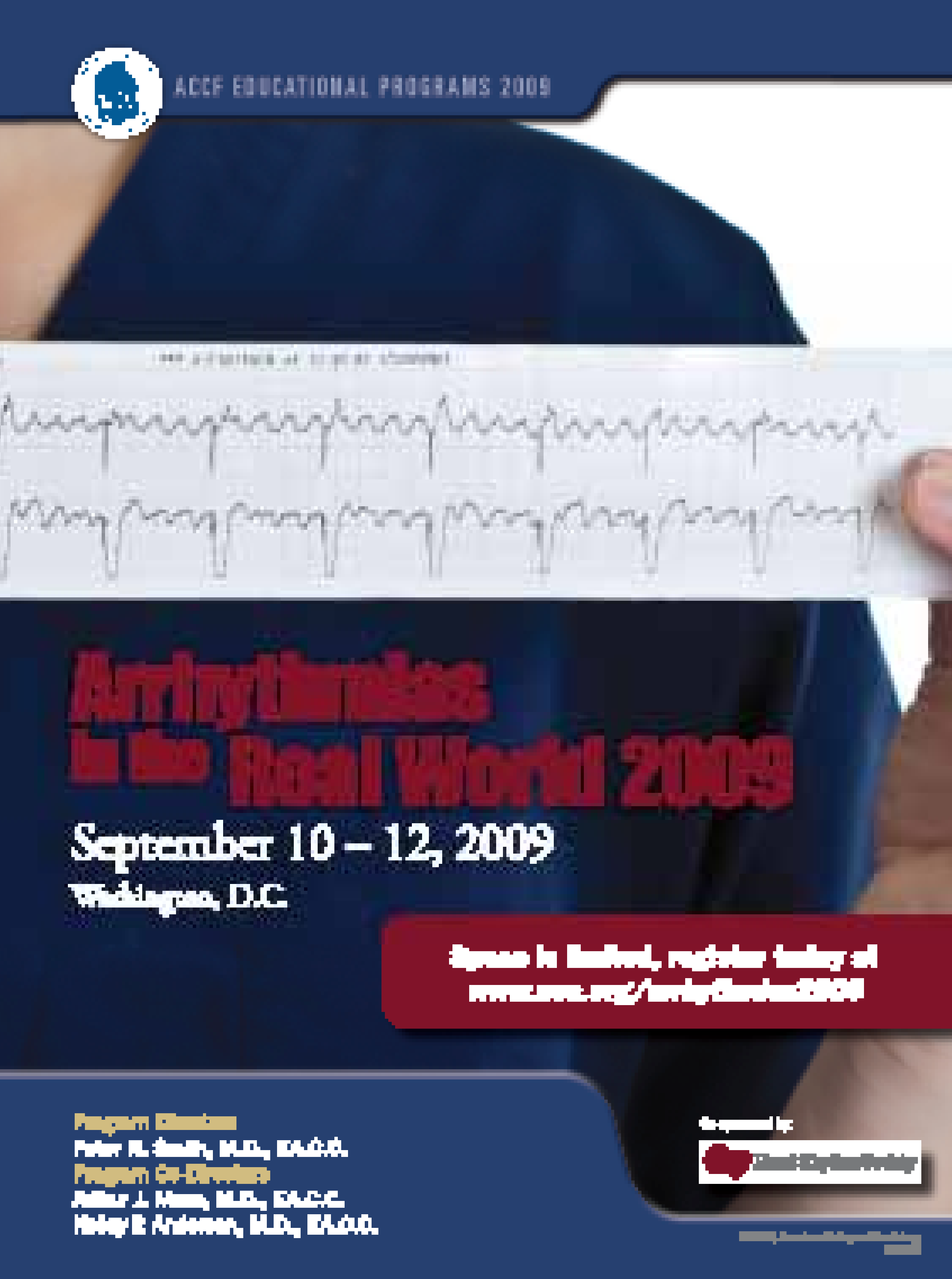
This year, 33 reviewers received the new Simon Dack Award for Outstanding Scholarship in recognition of their "excellence in critical reviews of original research for the *JACC* Journals." These 33 people had written at least 100 excellent reviews of manuscripts for the *Journal of the American College of Cardiology* (*JACC*).

In speaking about the award, *JACC* Editor in Chief **Anthony N. DeMaria, M.D., M.A.C.C.,** commented, "It has been appreciated for many years that the peer review of an original research manuscript is one of the most important but least recognized functions in academic medicine. In addition to evaluating the science of a paper, an excellent critique can place it in the context of the existing knowledge, potential clinical relevance and interest to readers. Since we currently have the ability to publish only 10 percent of submissions, the task of prioritizing new information for publication is of even greater importance. The Simon Dack Award was instituted in honor of Simon Dack, founding editor of *JACC*, to recognize this most important contribution."

The award recipients were selected based on the excellence of their critical evaluations and the number and timeliness of their reviews. Their names were published in *JACC* and they were recognized at the *JACC* Editorial Board meeting during ACC.09. They also received plaques.

Stephan Achenbach, M.D., F.A.C.C.
Fernando Alfonso, M.D., Ph.D.
Martin A. Alpert, M.D., F.A.C.C.
H. Vernon Anderson, M.D., F.A.C.C.
Robert J. Applegate, M.D., F.A.C.C.
Pol Aukrust, M.D., Ph.D.
Eric R. Bates, M.D., F.A.C.C.
Deepak L. Bhatt, M.D., F.A.C.C.
John A. Bittl, M.D., F.A.C.C.
Sorin J. Brener, M.D., F.A.C.C.
Javed Butler, M.D., M.P.H., F.A.C.C.
Robert M. Califf, M.D., M.A.C.C.
David Celermajer, M.B.B.S., D.Sc.
Antonio Colombo, M.D., F.A.C.C.
Harold L. Dauerman, M.D., F.A.C.C.
Kenneth A. Ellenbogen, M.D., F.A.C.C.
Pim J. de Feyter, M.D., Ph.D., F.A.C.C.
Morton J. Kern, M.D., F.A.C.C.
Neal S. Kleiman, M.D., F.A.C.C.
Thomas H. Marwick, M.B.B.S., Ph.D., F.A.C.C.
Peter A. McCullough, M.D., M.P.H., F.A.C.C.
Roger M. Mills, M.D., F.A.C.C.
Fred Morady, M.D., F.A.C.C.
Sherif F. Nagueh, M.D., F.A.C.C.
William F. Penny, M.D., F.A.C.C.
Don Poldermans, M.D., Ph.D.
Leslee J. Shaw, Ph.D.
Goran Stankovic, M.D., Ph.D., F.A.C.C.
Carl L. Tommaso, M.D., F.A.C.C.
Zoltan G. Turi, M.D., F.A.C.C.
Hector O. Ventura, M.D., F.A.C.C.
Robert A. Vogel, M.D., F.A.C.C.
William S. Weintraub, M.D., F.A.C.C.

Also recognized at ACC.09 were the *JACC* Elite Reviewers. This longstanding award recognizes those who have consistently submitted excellent reviews in a timely manner during that year. The names of the approximately 40 Elite Reviewers are also published in *JACC*.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Washington, D.C.