



AUGUST 2009 VOLUME 38 NUMBER 8

Cardiology

A MEMBER PUBLICATION OF THE AMERICAN COLLEGE OF CARDIOLOGY

**MAKE YOUR
VOICE HEARD!**

**STOP
MEDICARE PAYMENT
CUTS FOR
CARDIOLOGISTS!**

PRSR1 STD
U.S. Postage
PAID
MECHANICSBURG, PA
Permit No. 215

Now Available!

Heart Songs 2



Learn Heart Songs at Home, in the Office, or On the Go.

College students have traditionally been taught as if the entire cardiovascular system were a single entity. However, by a brief discussion of heart anatomy, this approach has yielded disappointing results, with many students still unable to identify the major vessels and structures of the heart. Heart Songs 2 is the first book to present a comprehensive, step-by-step approach to learning the anatomy of the heart. This degree of repetition is necessary for the retention of its complex, multi-step information. The book's illustrations and diagrams are designed to be easy to understand, and its step-by-step approach is designed to be easy to follow. Heart Songs 2 is a significant improvement in the way students learn anatomy. This book is the first to present a comprehensive, step-by-step approach to learning the anatomy of the heart.

How is Heart Songs 2 Different from the Original Heart Songs?

Heart Songs 2 covers everything that the original Heart Songs did, plus the following material:

- New illustrations and diagrams that are easier to understand.
- A discussion of the importance of the heart in the body and its role in the body.
- A number of new exercises that are easier to understand, especially for students who are unable to understand the original Heart Songs.
- New topics on the heart, including the heart's role in the body, the heart's role in the body, and the heart's role in the body.
- Diagrams, illustrations, and diagrams that are easier to understand, especially for students who are unable to understand the original Heart Songs.

Order Today!



MEMBERSHIP TYPE	PRICE
ACC Member	\$100
Nonmember	\$130
FT/CCM/Enthusiast	\$70

Visit www.acc.org/heart songs2 or call (800) 222-4444, ext. 8000



AMERICAN
COLLEGE OF
CARDIOLOGY
PUBLISHED BY



CMS Cuts: You Have the Power to Change the Outcome

We all realize that the payment cuts proposed by the Centers for Medicare and Medicaid Services (CMS) for 2010 could cripple cardiology practices across the nation and threaten our ability to serve the millions of Americans with heart disease.

Your ACC leaders and advocacy staff are making an all-out effort to bring cardiology's message to Capitol Hill, but legislators need to hear from you, your support staff and your patients. The "collective you" that is ACC membership carries the greatest power to shape the outcome with CMS.

You might ask why CMS is proposing these cuts in cardiovascular medicine. Their proposal incorporates data from the American Medical Association's Physician Practice Information Survey (PPI) into the formula used to determine the practice expense portion of the Medicare payment. CMS is projecting that this change alone would cut overall cardiology payments by at least 10 percent. In reality, some key cardiovascular services would be cut by more than 40 percent.

The new PPI survey data would replace data from AMA surveys conducted in the late 1990s, as well as supplemental surveys submitted to CMS by several specialties, including cardiology. The ACC supported the AMA's survey effort, provided financial contributions and encouraged members to participate if selected for the survey.

However, we have serious concerns about the survey process, CMS's review of the data, the level of information made available for public comment and the precision of the data itself. CMS believes it isn't necessary to hold the new data to the same standards applied to earlier surveys. The ACC disagrees. We believe CMS has an obligation to allow meaningful public comment on the data and to demonstrate that the survey meets accepted standards for data quality. Simply put, that hasn't happened, and we need to insist on it.

No one in cardiology will be unscathed if the new survey data is implemented as proposed. I've already heard from many practices that will be forced to lay off key staff and/or limit the number of new Medicare patients. Some practices may have to shut down. See the Commentary on page 7 in which **Zia Roshandel, M.D., F.A.C.C.**, tells of the potential impact on his practice and the rural community in which he practices.

I can't emphasize enough the importance of preventing CMS from implementing the proposal to use these questionable data in next year's fee schedule. We are challenging CMS directly, but comment letters alone will not accomplish the change that's necessary. Political pressure from Congress is needed now, and the pressure to make Congress act must come from you and your patients.

Every member must phone, e-mail or visit his or her legislators to point out the serious consequences of these rules. The proposed cuts must be rescinded, and real payment reform that replaces the flawed Sustainable Growth Rate (SGR) formula must be included in any overarching health care reform legislation. Primary care needs to be funded, but not by damaging cardiology and other specialties. Talking points, patient materials and sample letters are available at www.acc.org/can. Advocacy staff is on hand to help schedule appointments with lawmakers. E-mail Molly Nicholson (mnichels@acc.org) or Justin Beland (jbeland@acc.org).

We can prevail with numbers; we can lose by inaction. Thank you for your commitment to your patients and to the ACC. Together we can make a difference.

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

August 2009



2 Practice Viability Threatened by Proposed Large-Scale Medicare Payment Cuts

This overview prepares you to speak with your legislators on this urgent issue.

7 Commentary One Story (Among Many) That Needs Telling

What will happen to a small, rural practice if cuts happen?

8 Feature Missouri's Emergency Medical System Expands to Treat Trauma, Stroke and STEMI Better

First state STEMI law enacted after years of work

11 Quality HHS Health IT Committee Approves 'Meaningful Use' Definition Matrix NCDR Signs Reporting Agreement with HCA, BMC2

12 Practice Management Considering a Sale? What You Should Know

Valuation methods, physician employment and preserving physician control of patient care decisions

14 Letter Recognizing the Whole WG

15 Cardiac Care Small Study Captures PA Role in HF Management

17 Advocacy FTC Reprieve on Red Flags Rules ACC Fighting Proposals to Eliminate In-Office Imaging Services

19 Communities ACC Well-Posed for Partnership, Collaboration in International Arena FIT: Our Future Is Now

21 Clinical Perspectives ACCEL: OMEGA trial revelations

22 Education ACCF Efforts on Disparities Take Shape

24 ACC News Helping You Stay in Touch, ACC Launches Online Campaign PAD Performance Measures Open for Comment

Practice Viability Threatened by Proposed Large-Scale Medicare Payment Cuts

By Vincent Bufalino, M.D., F.A.C.C.

By now everyone should be aware that the Centers for Medicare and Medicaid Services (CMS) has released a proposed rule for the 2010 Medicare Physician Fee Schedule that includes policies representing a grave threat to the ongoing viability of many cardiology practices. The good news is that the policies are subject to revision. However, achieving the positive changes will require not only the careful technical analysis and arguments we routinely apply to regulatory proposals, but also political pressure from each and every ACC member.

The following is an overview of the major provisions in the rule that affect the practice of cardiology.

Serious Impact on Patients

Practice Expense vs Payment

CMS has proposed incorporating the results of the American Medical Association's (AMA) Physician Practice Information Survey into its formula for calculating practice expense relative value units (RVUs). This proposed change would result in a 10 percent decrease in Medicare payments for the average cardiology practice and a 10 percent to 42 percent decrease in payments for many common cardiology services. While absolutely no one is untouched by the cuts, the devastating cuts proposed for echocardiography and nuclear cardiology procedures are by far the most problematic. A few key examples:

- Transthoracic echo with spectral and color flow Doppler (93306): **42 percent cut**
- Left heart catheterization (93510-26): **24 percent cut**
- EKG: **21 percent cut**

The ACC is fighting back regarding the validity of the AMA data, which showed a substantial drop in practice expense per hour for cardiology and a substantial increase in practice expense per hour for most other specialties. While the ACC contributed financially to the AMA survey and made great efforts to encourage members to participate, the practice expense per hour data that CMS proposes to use is based on the responses of only 55 physicians. CMS did not review the new AMA data to determine if it passed the same precision tests required of past surveys.

To date, ACC leaders and staff have met extensively with CMS staff, the Obama Administration and members of

Cuts as massive as the ones proposed by CMS will have an enormous effect on the practice of cardiology — and not just on the practices. Patients will feel the effects also. While CMS may not have intended to reduce access to much-needed cardiovascular services, reduced access will happen if these cuts go through. Here's what the cuts could mean for patients —

1. REDUCED ACCESS. Practices won't be able to afford to provide certain services to patients, and patients will have to go to the hospital to receive necessary care. This will require more time off work for additional office visits and higher co-pays. In addition, the nearest hospital could be hours away for patients in more rural or low-access areas.

2. STAFF LAY-OFFS. With drastically reduced incomes, cardiology practices are going to have difficulty maintaining current staffing levels. This will have negative effects on the customer service offered to patients, as offices try to do more with less. In my practice alone, we would have to stop hiring new physicians and begin shrinking our staff base in order to remain fiscally sound. This would clearly affect our service and stop us from doing the free community work that we have become known for in the area.

3. REDUCED QUALITY. Rates for heart disease deaths have dropped 29 percent over the last eight years. This is because cardiologists are committed to quality. We're a leader in the creation of clinical guidelines and appropriate use criteria. Not to mention, our incredibly well-developed registries have proven to help improve patient care. Large numbers of us participate in quality improvement initiatives, and we use electronic health records at higher rates than other specialties. While we are a specialty committed to quality improvement, these activities often require a heavy administrative burden and up-front investments with minimal financial return in the short-term. Our ability to continue these efforts is threatened by our inability to afford the overhead.

Congress and will continue to do so. We also are working closely with our partner cardiovascular specialty societies and oncology in both our response to CMS and our efforts to bring political pressure to bear on the agency. On the regulatory side, ACC staff is preparing a substantive analysis and response to the CMS proposal.

Confusion with Consultations

CMS proposes to eliminate payments for consultations in order to end a long-standing debate over the definition of a consultation versus a clinically similar office or hospital visit. Under the proposed rule, services now reported with consultation codes would be reported using visit codes, and the RVUs associated with consultations would be redistributed across these visit codes. This change would result in at least a small decrease in payments, but because of the increase in payment for visits, it is unclear how much of an overall reduction would occur. The ACC is opposed to the reallocation given that it will create considerable coding confusion, while further reducing physician reimbursement. The AMA is also likely to challenge this issue, given that the CPT panel recently clarified the definition of a consultation.

Accreditation Standards for Advanced Imaging

The proposed rule would move forward with a requirement that providers of the technical component of advanced imaging (CT/MR/nuclear) be certified by certain designated organizations. Under the rule, organizations would

continued on next page

Wanted: Strength in Numbers

The ACC has launched a massive campaign to stop the CMS cuts. Every single ACC member is encouraged to make use of the tools outlined below:

1. Call, e-mail or visit with your lawmakers to point out the serious consequences of the proposed rule. The ACC has talking points, patient materials and a sample letter available on www.acc.org/can. Advocacy staff can help you schedule appointments with your lawmakers, which will be especially effective if you visit during the August recess when they are back in their districts. For more information contact jbeland@acc.org or mnichels@acc.org.

2. Attend this year's Legislative Conference, Sept. 13 – 15, in Washington, D.C. Don't miss this opportunity to help educate Congress about the effects of these cuts and the need for overarching health reform. Go to www.acc.org for more information.

3. Take part in the ACC's "Cut the Cuts Roadshow." The ACC has developed a PowerPoint presentation about the cuts and ways to get involved that can be shared with your practice and/or hospital. In addition, a video presentation featuring ACC's presidential team is also available. The video focuses on the cuts and the need for overarching health reform done the right way. E-mail qualityfirst@acc.org for more information.

4. Give to the ACC Political Action Committee if you have not already done so. For more information on the PAC, visit www.accpacweb.org.

Payment Cuts

continued from page 3

be requested to nominate themselves in 2009, with accreditation to begin in 2012. The ACC continues to work with CMS on defining these regulations, which are based on legislation that the College strongly supported last year. (See also page 25 for information about the Intersocietal Accreditation Commission.)

Changes to Equipment Use Formula

CMS proposes adopting the Medicare Payment Advisory Commission's (MedPAC) recommendation to change the agency's formula for calculating the per-procedure cost of medical equipment worth more than \$1 million. The proposal would assume that all equipment with an acquisition cost greater than \$1 million is used 90 percent of the time that an office is open, thus driving down the practice expense RVUs for services using that equipment. Within cardiology, cardiac MR, cardiac CT and non-hospital cardiac catheterization services would see payment cuts as a result of this change.

Malpractice RVUs

CMS proposes to update the malpractice RVUs with data from a new survey of specialty-level malpractice premiums. In addition, CMS has proposed a new method for determining malpractice RVUs for technical component services. The proposed new malpractice RVUs would reduce cardiology payments by 1 percent.

Good-bye to SGR?

As required by law, CMS proposes to implement a 21.5 percent reduction in the conversion factor as a result of the flawed Sustainable Growth Rate (SGR) formula. The ACC continues to work with Congress to stop these cuts and find a long-term solution for the SGR. On a more positive note, CMS does propose eliminating retroactively the inclusion of physician-administered drugs in the SGR calculation. While this does not impact payments this year, it significantly reduces the accumulated debt and reduces the cost of Congressional reform of this issue. The ACC has long supported the removal of drugs from the calculation.

Some Positive News for e-Prescribers

In a bit of positive news, CMS has proposed simplifying the electronic prescribing (e-prescribing) incentive program to encourage greater participation. The agency has proposed giving successful e-prescribers bonuses equal to 2 percent of total estimated allowed charges for all covered Medicare services provided in 2010. Physicians would report only one code (G8443) at least 25



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

Ralph G. Brindis, M.D., M.P.H., F.A.C.C.
President-Elect

David R. Holmes Jr., M.D., F.A.C.C.
Vice President

John G. Harold, M.D., F.A.C.C.
Secretary

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

Aaron Kugelmass, M.D., F.A.C.C.
Marc Shelton, M.D., F.A.C.C.
Mary Norine Walsh, M.D., F.A.C.C.
W. Douglas Weaver, M.D., M.A.C.C.
Medical Advisers

Publisher
John C. (Jack) Lewin, M.D., CEO

Executive Editor
Alicia Sokol

Editor
Anne Dees

Associate Editors
Shalen Fairbanks
Autumn Strass
Peggy Tresky
Emily Zeigenfuse

Design
Tony Ciccolella

Director, Creative and Branding
Morgan Bramlet

Advertising Manager
Keith Dillon

Cardiology
is published monthly by the
American College of Cardiology,
2400 N Street NW
Washington, DC 20037-1153.

Telephone: (800) 992-7224
or (202) 375-6000

Fax: (202) 375-7000

E-mail: cardiologyeditor@acc.org

Web site: www.acc.org

To subscribe or report a change of address,
call (800) 253-4636, ext. 5603,
or e-mail resource@acc.org

All contents ©2009,
American College of Cardiology.

Send correspondence and letters to the
editor to cardiologyeditor@acc.org.

Opinions expressed in *Cardiology* are those
of the identified authors and do not necessarily
reflect the opinions or policies of the
American College of Cardiology.

Also, paid advertisements do not reflect an
endorsement of a product or program by the
ACC. All advertisements are subject to review
and approval by the ACC. The ACC reserves
the right to decline, withdraw or modify
advertisements at its discretion.

For questions regarding advertising in
Cardiology please contact:

For Display Advertising
Pharmaceutical Media, Inc., 30 East 33rd St.,
New York, N.Y. 10016-5337; Tim Wolfinger,
(212) 904-0379, twolfinger@pminy.com and
Gina Bencicasa, (212) 904-0362,
gbencicasa@pminy.com.

For Classified Advertising
Ariel Medina, Elsevier, 360 Park Ave. South,
New York, NY 10010-1710;
Direct: (212) 633-3689;
Fax: (212) 633-3850;
a.medina@elsevier.com

times during the year, indicating at least one prescription was generated for that office visit. In addition, data could be submitted through claims, a qualified registry or qualified electronic health record (EHR) system. CMS proposes to report publicly the names of successful e-prescribers in 2011 after the 2010 payments are made.

Additionally, CMS is offering group practices the option to participate in a combined incentive program that includes both the e-prescribing and the Physician Quality Reporting Initiative (PQRI). Interested group practices would be required to

However, in an effort to move physicians away from claims-based reporting and towards registry and EHR-based reporting, many of the new measures, some of the old measures and both new cardiology measures groups could only be reported through a registry. While the cardiology measures groups were recommended by ACC, it was not anticipated that so many measures would be registry-only. As the PQRI program moves towards a registry or EHR model, the ACC is working to determine where its IC3 Program® and other tools best fit in the PQRI reporting world for

...the time has come for every ACC member to become an activist on these issues. It is critical that Congress and the administration hear first-hand from ACC members, their support staff and patients about the impact of these cuts.

submit a self-nomination letter to CMS that includes how the practice will report data (whether through claims, registry or EHRs). Under this proposal, the group practice would need to report at least one electronic prescription for at least 2,500 patient visits. However, individual physicians could not report data separately to earn bonus payments.

PQRI Update

The proposed rule includes a number of new cardiology measures for Physicians Quality Reporting Initiative (PQRI). In addition, the agency has proposed creating two new measures groups for cardiology — one for heart failure and one for coronary artery disease. These measures would allow physicians to report on 30 patients rather than 80 percent of cases throughout the year and the 30 patients would no longer need to be consecutive.

practicing cardiologists.

The ACC leadership and staff are working hard to resolve many of issues with the CMS proposed rule. However, the time has come for every ACC member to become an activist on these issues. It is critical that Congress and the administration hear first-hand from ACC members, their support staff and patients about the impact of these cuts. Every member is being encouraged to phone, e-mail or personally visit his or her legislators to point out the serious consequences of the proposed rule. Patient materials and sample letters are available at www.acc.org/can.

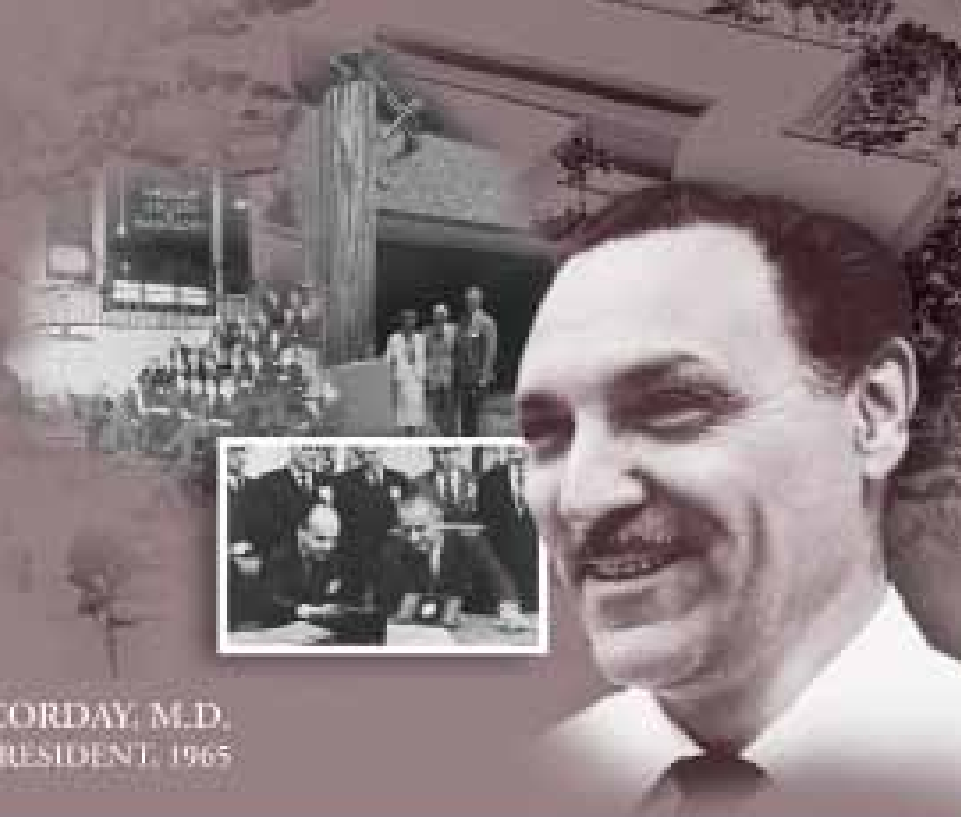
You can help shape your future in health care, but only if you participate in the dialogue.

Bufalino is co-chair of the ACC Advocacy Committee



1965

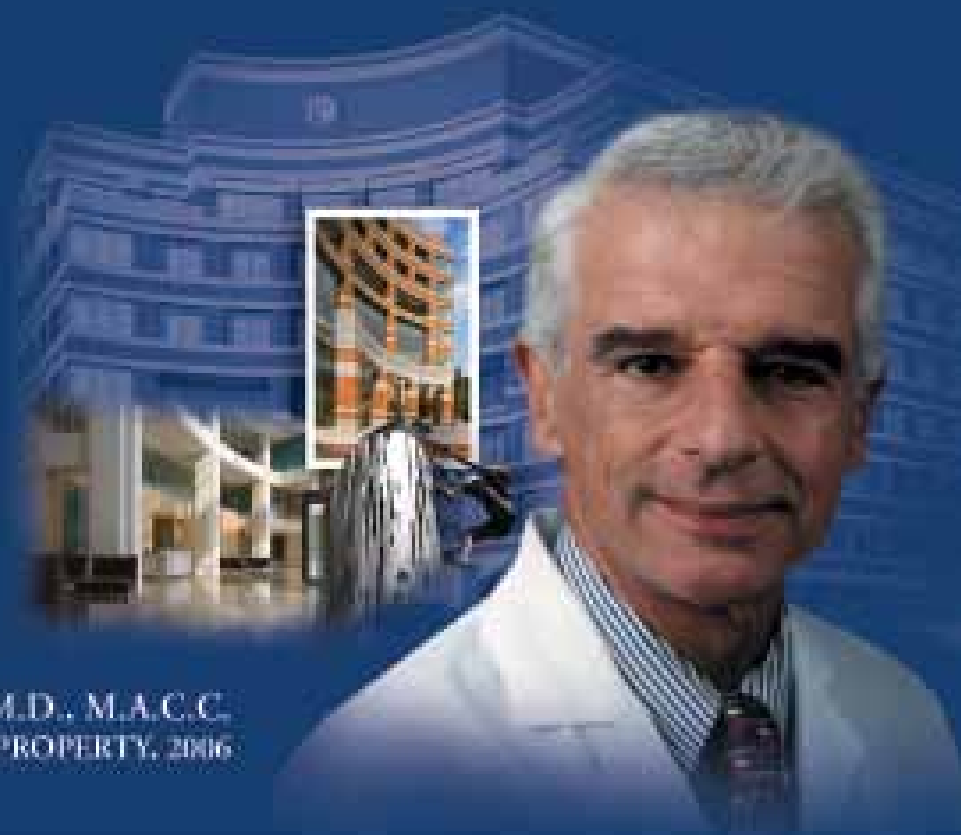
President Johnson signs Medicare into law, followed by the ACC move from New York to Bethesda, Md., in 1977, to be closer to the National Institutes of Health.



ELIOT CORDAY, M.D.,
PRESIDENT, 1965

2009

A new, state-of-the-art Heart House in our nation's capital allows easy access to legislators. The ACC is leading the way to health system reform that is patient-centered and value-based.



CARL PEPINE, M.D., M.A.C.C.,
CHAIR OF THE TASK FORCE ON PROPERTY, 2006



ACC THEN AND NOW: 60 YEARS OF QUALITY IN ADVOCACY

One Story (Among Many) That Needs Telling

By Zia Roshandel, M.D., F.A.C.C.

I practice non-invasive cardiology in a rural town in Virginia. My partner established the practice about five years ago. I have been here about three years. Prior to that, I was in Michigan. We are the only cardiology practice in the area. Our practice hires one additional cardiologist part-time, and we have 12 other staff members.

In addition to our office practice, we also see an unlimited number of patients from the free clinic and are on call 24/7 for the local community hospital and emergency room. We care for insured and, particularly in this community, a large number of uninsured patients. We perform stress tests, echocardiograms, holter monitor, INR

Medicare patients. I would have to lay 12 employees off; four of whom are the sole wage earners for their families because their spouses have already been laid off from their jobs.

Yes, my partner and I could accept jobs elsewhere, but what about our community? Patients with heart disease would have significantly longer drives to receive cardiac care. The hospital/ER would have to transfer every chest pain, congestive heart failure, arrhythmia or any potential cardiac disease presentation to the larger hospital, which is 45 to 50 minutes away. This would represent a significant financial loss and a survival challenge for our small community hospital and a personal hardship for many patients. The community

“ In this last year, we have taken additional savings measures, such as reducing the number of employees, cutting employee salaries by 10 percent, renegotiating our health insurance to save \$70,000, reducing employee hours while we physicians work longer days. Despite these measures, our survival is tenuous, and we could close at any time. ”

measurements, carotid ultrasound tests and pacemaker checks. We purchased the equipment to do echocardiograms and a nuclear camera in the last two years.

My annual income is in the 50th percentile scale of the salary chart from the Medical Group Management Association. As the economy has struggled, the number of uninsured patients has grown, and we struggle to cover our costs. Both my partner and I have foregone salaries for many months in order to invest in our practice and build the quality of care we could provide. In this last year, we have taken additional savings measures, such as reducing the number of employees, cutting employee salaries by 10 percent, renegotiating our health insurance to save \$70,000, reducing employee hours while we physicians work longer days. Despite these measures, our survival is tenuous, and we could close at any time.

I am very concerned about the CMS proposal that could result in 10 percent to 40 percent cuts for cardiology practices. My practice clearly cannot survive such drastic cuts. About 65 percent of my practice is Medicare, and I cannot refuse to see

might have to struggle for a long time with this outcome, too, because, historically, small towns have a difficult time recruiting specialists. Our patients are very concerned about the outcome of these cuts and health care reform.

I truly appreciate ACC efforts to help us in this difficult time, and I have never felt as proud as I do now to be an ACC member.

However, I realize that we as individuals must take action; we cannot be passive at this crucial time. I have called my legislators in Virginia, and when I was unable to talk with anyone in their offices, I sent them e-mails as recommended by ACC. I will be attending the Legislative Conference, Sept. 13 – 15, in Washington, D.C. and will join other ACC members as we take our story to Capitol Hill.

My dear colleagues, I urge every one of you to step up, speak out and take action in determining your professional future before it is too late.

Roshandel is with Blue Ridge Cardiovascular Associates, Culpeper, Va.



Missouri's Emergency Medical System Expands to Treat Trauma, Stroke and STEMI Better

By Samar Muzaffar, M.D., M.P.H., and George M. Kichura, M.D., F.A.C.C.

Missouri cardiovascular specialists will have an important role in a new emergency medical system being introduced statewide in 2010. The Time Critical Diagnosis (TCD) system uses the trauma system model for emergency treatment of stroke and ST-elevation myocardial infarction (STEMI).

More than 250 medical professionals, health care leaders and emergency medical care providers from across the state, including many ACC members, have been meeting regularly since September 2008 to formulate regulations and guidelines for the TCD system. The regulations are in draft form and will go through professional and legal reviews before they are filed with the Secretary of State's Office in 2010.

Timely Treatment for STEMI Patients

Heart disease, including STEMI, is the leading cause of death in Missouri. Delayed treatment increases a patient's risk for death and disability. The national standard for hospitals is to have a door-to-balloon time of 90 minute or less, including transport time.

According to a study published in the *New England Journal of Medicine*, patients suffering heart

attacks who receive care within 90 minutes fare better than those who do not. However, based on a survey published in *NEJM* (Oct. 18, 2007), only about 35 percent of hospitals nationwide had adopted time-saving procedures to achieve this standard of care. This is why

Missouri created the TCD team. The team is charged with developing a statewide system to improve emergency response and treatment for STEMI and stroke, another diagnosis whose outcomes are



The 360°/365 Emergency Medical Care System diagram developed by the Missouri Time Critical Diagnosis Task Force. The circle of care diagram demonstrates a complete, integrated circle of care from incident recognition to rehabilitation and improvement.

highly dependent on timeliness of treatment. It is hoped that implementation of this system will lead to a greater proportion of regional systems and hospitals improving timeliness of transport and treatment for STEMI patients.

Missouri hospitals already have a trauma designation that differentiates which hospitals can treat patients with more severe injuries. The TCD system will provide a similar structure for STEMI and stroke patients. The focus is on timely assessment and transport to a designated facility that can provide definitive care.

A Voluntary System

While the TCD system will be adopted statewide, participation by hospitals is completely voluntary. The regulations will outline standards for centers providing four distinct levels of care for stroke and STEMI patients. Hospitals must meet these standards — including staffing, equipment, specialized services and hours of availability — to become designated as stroke and STEMI centers.

Once these regulations are adopted, hospitals may apply to the Missouri Department of Health and Senior Services (DHSS) through a process that is similar to the one currently in place for trauma center designation. It is expected that the regulations will be in place by Fall 2010.

Time Critical Diagnosis Goal:

To improve health outcomes for Missourians who suffer trauma, stroke or ST-elevation myocardial infarction (STEMI) by establishing a Time Critical Diagnosis (TCD) system.

STEMI Systems, Laws and ACC

Missouri is the only state that has enacted a STEMI law. It was the product of many years of work on the part of the state department of health, the hospitals and physicians. Now begins the complex rulemaking process to implement the law.

At present, no states have legislation that mandates transfer of all STEMI patients to a PCI center. Some states, such as Iowa, do have legislation referencing trauma patients. Iowa's legislation mandates that patients within 30 minutes of a level I trauma center must be taken directly to the trauma center. Much debate exists about implementing this type of legislation for STEMI patients.

The ACC favors cooperative agreements creating STEMI systems among stakeholders over legislative mandates because legislation can be cumbersome to change as treatment options and quality issues are updated. However, in some states, regulatory adjustments may be necessary to enable cooperative agreements to move forward.

North Carolina, Minnesota, Maine and parts of Los Angeles County, Calif., are some of the jurisdictions that have implemented STEMI systems as a result of cooperative agreements among stakeholders. In the seven-county area around Birmingham, Ala., half of the hospitals are PCI-capable and are being credentialed as STEMI centers by the STEMI Plan Implementation Committee of the Birmingham Regional Emergency Medical Services System. The STEMI plan is modeled on Alabama's Trauma and Stroke systems.

First, D2B; Now, ACTION Registry-GWTG

A process that first began with the implementation of ACC's D2B: An Alliance for Quality has morphed into much more. The complex process of system development in the modern setting requires the cooperative effort of a multifaceted collection of stakeholders. Process measurement, intervention and outcome evaluation are pivotal requirements to improving the effectiveness of a system.

The ACTION Registry-GWTG program, a partnership between the ACC and the American Heart Association, has embarked on a national measurement program focused on myocardial infarction patients in the acute care setting.

ACTION Registry-GWTG The program provides participants with rapid compar-

ative feedback on their facility's performance per ACC/AHA STEMI and UA/NSTEMI clinical practice guidelines. ACC and AHA, under the Mission Lifeline banner, also are developing specific quality improvement reports and tools to support STEMI systems of care. The ACC encourages all U.S. hospitals to enroll in the ACTION Registry-GWTG program. For more information, contact the NCDR Service Center at (800) 257-4737 or ncdr@acc.org.

How It Started

In 2003, the Missouri Foundation for Health (MFH) identified the need for EMS/Trauma reform in the state. MFH organized statewide meetings that included emergency department physicians, trauma nurses, state health officials and other health care professionals. Soon, legislators and other public policy leaders joined the planning process. DHSS began its collaboration with the MFH in 2005 to create the TCD System.

The late Bill Jermyn, M.D., who was chair of the State Advisory Council on Emergency Medical Services, was instrumental in forging this collaboration. He later became the State EMS Medical Director. The strategic plan, drafted in 2006 under his leadership, is still being implemented today.

In 2008, a new law was enacted in Missouri to put the TCD system into effect. Many partner agencies continue to be involved in the project. Cardiovascular specialists in facilities throughout the state have been active in helping to craft the regulations and guidelines that will one day save lives across Missouri.

For more information about the Time Critical Diagnosis system, please visit www.dhss.mo.gov/TCD_System/Implementation.html.

Muzaffar is EMS Medical Director for the Missouri DHSS. Kichura is the Task Force's STEMI technical advisor. Other ACC members on the TCD team include Belinda Huff, R.N., Steve Marso, M.D., F.A.C.C.; Lisa Riggs, R.N., M.S.N.; and Michael Lim, M.D., F.A.C.C.

Public Input Meetings to be Held Statewide in Fall 2009

Health professionals are invited to attend one of six public meetings being held throughout the state in late September and early October 2009. These meetings will provide an overview regarding the TCD system and review the key standards being proposed for stroke and STEMI centers.

Those attending are encouraged to provide feedback on the draft regulations and to share their thoughts.

For information on meeting locations, dates and times, please visit www.dhss.mo.gov/TCD_System/Implementation.html. The draft regulations will be available for review online after September 15, 2009.



ACCF EDUCATIONAL PROGRAMS 2009

The ACCF Cardiovascular Board Review

for Certification and Recertification

September 8 – 13, 2009

The Ritz-Carlton, Lake Las Vegas, Nev.

SAVE THE DATE
and secure your place!
Register now for reduced rates at
www.accf.org/education

HHS Health IT Committee Approves 'Meaningful Use' Definition Matrix

The Department of Health and Human Services' Health Information Technology Policy Committee on July 16 approved a revised definition matrix for "meaningful use" of electronic health records (EHR). The new definition will be used by the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS) to develop proposed rules by December 2009 for physicians and hospitals to receive incentive payments beginning in 2011 for adopting and using EHRs. The revisions include a recommendation that CMS use an "adoption year" timeframe for providers. Under this plan, physicians who implement a system after 2011 could report measures included in the 2011 criteria or "Adoption Year 1" without having to meet the 2013 measures requirements. Physicians would still be reimbursed on the original schedule. Those adopting in 2011 or 2012 are eligible for the full bonus. Later adopters will receive smaller bonuses, but they would not need to meet the more stringent requirements anticipated for 2013 immediately.

The ACC continues to weigh in on these issues with ONC and others. We will be crafting a long-range strategic plan to engage with ONC, CMS and others to ensure that process and quality measures, certification requirements and other factors are adequately included in the final regulations. More information is available at www.acc.org/healthit.



NCDR Signs Reporting Agreement with HCA, BMC2

The ACC's National Cardiovascular Data Registry (NCDR®) has signed an agreement with Hospital Corporation of America (HCA) Management Services for NCDR Analytic and Reporting Services. The agreement will include data for both the CathPCI® and ICD Registry™ and is the first analytic and reporting agreement for the ICD Registry. Under the agreement, HCA will receive information about their hospitals' performances on a variety of measures and comparisons between different HCA hospital tiers and the national average.

NCDR also has signed an agreement with the University of Michigan to receive NCDR Analytic and Reporting Services reports for the CathPCI Registry to support the Blue Cross Blue Shield of Michigan Cardiovascular



Consortium (BMC2), a regional collaborative consortium of health care providers focused on quality improvement in percutaneous coronary interventions (PCI) outcomes. The NCDR agreement, which is limited to PCI hospitals, is expected by 2010 to bring all hospitals in the state into the CathPCI Registry when combined with the state's CathPCI Registry participation requirement for hospitals with catheterization labs. The effort was led by BMC2 physician leaders **Mauro Moscucci, M.D., F.A.C.C.**, and **Hitinder Gurm, M.B.B.S., F.A.C.C.**

CMS Releases 30-Day Re-admission Data for AMI, HF

CMS recently updated its Hospital Compare Web site with Medicare's 30-day hospital re-admission rates for acute myocardial infarction (AMI), heart failure (HF) and pneumonia. In addition to re-admission rates, the Hospital Compare Web site also provides information on 30-day mortality measures for AMI, HF and pneumonia. The ACC supports public reporting of these measures because they are intended to drive quality improvement efforts to enhance care in these important and high-volume clinical areas. The ACC is gearing up to help hospitals respond to the measures through its new "Hospital to Home" (H2H)

initiative, which will provide evidence-based strategies for reducing cardiovascular re-admissions by 20 percent by 2012. Learn more or enroll at www.acc.org/h2h/enrollment. For media coverage, visit The Lewin Report at lewinreport.acc.org



NQF Panel Recommends 30-Day PCI Mortality Measures

The National Quality Forum (NQF) Consensus Standards Approval Committee met July 15 – 16 and recommended for the full board's endorsement two 30-day PCI mortality measures submitted by the Centers for Medicare and Medicaid Services (CMS) late last year. The measures, which are intended to be reported as a pair, include: 30-day all-cause risk-standardized PCI mortality rate for patients without STEMI and without cardiogenic shock and 30-day all-cause risk-standardized PCI mortality rate for patients with STEMI or cardiogenic shock. Both measures were developed by the Yale New Haven Hospital-Center for Outcomes Research and Evaluation (YNHH-CORE), using data from the CathPCI Registry®, and are endorsed by the ACC Board of Trustees.

CathPCI Registry

The NQF will issue its endorsement decision, which would deem the measures scientifically acceptable and suitable for public reporting. CMS has indicated that these measures are intended for public reporting purposes. In May, CMS invited comment on including these proposed measures for payment determination beginning in FY 2012 as part of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.



Considering a Sale? What You Should Know

By Elias N. Matsakis, J.D.

As was expressed in “Assessing Current Practice Management Issues in a Challenging Environment” in the July issue, cardiologists, other specialists and hospitals are showing a keen interest in creating new types of working relationships.

Although a number of hospital and physician group practice integration approaches are being explored ranging from least-integrated (gain-sharing, service line management or practice management agreements) to most-integrated (sale of the practice with employment), this article addresses the principal areas of concern with respect to a sale of the group practice assets to a health system. Issues under consideration fall into three basic categories: valuation, compensation and governance.

Valuation: How Will Practice Assets Be Valued?

Both for-profit and not-for-profit health systems require that a practice's fair market value be independently appraised. For-profit third-party buyers not affiliated with a hospital do not have this constraint as there is no risk that the sales price was intended to compensate the group for referrals. Good appraisers will meet collectively and separately with all parties in a transaction to make sure they fully understand all parties' short-term, mid-term and long-term goals prior to beginning the valuation process.

Appraisers use three methods of valuation:

Income Approach — Determines a value indication for a group practice using methods that convert anticipated future economic benefits of ownership into a single present value. Generally, appraisers applying the income approach to cardiology practices use the Discounted Cash Flow (DCF)

Method, where future cash flows of the practice as a standalone entity are projected and together with a terminal value as of the end of that period are discounted to their present value using a discount rate commensurate with the risk of realizing the projected cash flows.

Market Approach — Determines a value indication of the practice by comparing sale prices of cardiology practices with similar attributes. Typically, the appraisers have a database of private — and occasionally public — transactions. They look to multiples of income or per physician pricing and attempt to correlate higher or lower risk factors with the appraised practice to the practices that were actually sold to estimate value.

Asset Approach — Determines a value indication of the practice based on the value of the assets net of liabilities as a viable business, not as a liquidation. The resulting equity value is considered to be the practice's fair market value on a controlling, marketable basis. In using the asset approach, appraisers will often look to the replacement cost method as a method for determining value — in other words, the cost of replacing the assets, recruiting physicians, work force, etc.

Appraisers most often use multiple methods to test the value determined by the predominant method they choose to use. Also, higher values typically can be obtained where the group practice revenue from ancillary services is profitable and can be separately valued using market or discounted cash flow methodologies as if sold as a separate asset, rather than just the supply and equipment values of such ancillaries.

Health systems are showing increased reluctance to pay for physician goodwill; however, they are paying for medical records, the business value of ancillaries and trained workforce in place when the payments can be supported by independent

valuations. Similarly, appraisers may select the market approach either directly or as a test for their other valuation methodology.

The key to reaching a fair value is to insist on an appraiser who will explore all methods and provide an independent valuation that represents a true “viable business” value rather than default to a book value on the unsubstantiated — and often wrong — assumption that all practice income is converted into compensation.

Physician Employment Structures

Cardiac group practices have focused increased attention on future compensation methodologies in evaluating the merits of any practice sale proposal. The trend in physician employment is strongly focused on compensation based on individual and group productivity rather than salary guarantees. Many systems are prepared to guarantee salaries for a few years based on productivity assumptions but subject to fair market value appraisals.

In assessing sale of their practice, physicians need to ensure that the transaction is structured such that these “integration benefits” are designed, implemented and evaluated in a manner that includes and values physician input. In other words, purchase price and employment income are not the sole determinants of the “right deal.”

Governance, What You Live with Every Day

To cite the original Whitepaper, “[Governance] is the most important aspect of a potential integration negotiation. Frankly, if a transaction is consummated, cardiologists will remember how much money they make once every two weeks, but how the practice runs will affect them every day.”

Three basic models are used in connection with the operation of a group practice after any sale —

- direct employment
- employment through a hospital- or buyer-controlled

“ [Governance] is the most important aspect of a potential integration negotiation. Frankly, if a transaction is consummated, cardiologists will remember how much money they make once every two weeks, but how the practice runs will affect them every day. ”



Some valuation firms structure the employment as a formula (net receipts minus net expenses) with physicians benefiting from the retention of their existing receivables with compensation paid on an accrual basis as to their future services. Other employment models use relative value units so as to make the physician compensation neutral regardless of the payer. Often, the system support for new physician recruiting, electronic medical records, improved top-line reimbursement or realization and certain economies of scale in the cost side of the practice are captured in Management Service Organization (MSO) arrangements that offer physicians a lower overhead.

What Drives Value?

The key drivers of value are excellent clinical reputation, strong physician leadership, leading market position, group loyalty, clinical innovation and positive partnering between the institutions. Other value drivers include strong administrative leadership, practice infrastructure, broad geographic coverage, efficient and clinically appropriate ancillary services and favorable managed care contracts. Strategic objectives include preserving operating margins or securing greater reimbursement from governmental and third-party payers. The objective of this alignment is more cost-effective and higher-quality care through more rapid implementation of best practices, demonstrable quality and outcomes, economies of scale and efficiencies and IT compatibility.

physician group practice

- employment through a system-controlled physician division entity with separate administration and governance that reports directly to a system board with oversight over both hospital and physician operations

Often these structures are complemented with an MSO with independent or physician ownership to provide strong physician control over the practice site. Ancillary activities are maintained in the group practice or incorporated into the hospital's service offering.

When physician group practices are left administratively intact, have strong autonomy at the office level and physician leadership at all levels with administrators accountable to a system board rather than to other hospital administrators, cardiologists will be able to exercise appropriate control in delivering care in the inpatient and outpatient settings.

In more integrated systems, physicians are involved in numerous physician-led committees with the authority to create the initiatives necessary to ensure that the practice is adequately supported with capital investment, clinical personnel, tools and protocols to coordinate patient care among all providers.

Other key terms in employment agreements include the initial term, the standard for termination, specific governance rights, overhead charge limits, other bonus pools, ability

continued on next page

to maintain group practice ancillaries, treatment of legacy investments in competing providers, benefits and professional liability responsibility, continuing education, compliance with quality and peer review requirements and other practice support. In states where they are enforceable, virtually all employment agreements have non-compete agreements with significant penalties.

What Issues Provide The Greatest Challenges?

Integrating cultures represents the greatest challenge to any merger or sale. Integrating into larger organizations inevitably results in some loss of autonomy and includes increased

Pending changes in health policy will probably mandate or compel all providers who care for patients with chronic and acute cardiac conditions to collaborate and communicate more effectively. The possibility exists that providers could be receiving a single global payment that will rise or fall on their collective effectiveness.

CV Professionals in Unique Position

Cardiovascular professionals are in a unique position to lead that effort. Some may choose to integrate their practices into a larger health system. Any sale of a cardiology practice should provide fair value for what is being transferred but should also



“Some may choose to integrate their practice into a larger health system. Any sale of a cardiology practice should provide fair value for what is being transferred but should also contain employment agreements and governance structures that enhance — not diminish — physician control over care delivery.”

oversight, stricter compliance expectations, more bureaucracy and decreased flexibility in staffing of support personnel.

Unwinding existing arrangements, establishing a governance grid that ensures physicians the requisite control of their practice, integrating IT systems and human resource policies — all are challenging to resolve. The acquired practice is expected to work with system- or hospital-employed physicians without disturbing their existing referral relationships with independent medical staff. Cardiologists with medical staff memberships at multiple, competing hospitals face additional challenges.

contain employment agreements and governance structures that enhance — not diminish — physician control over care delivery. Cardiologists also might consider other partnering arrangements with a hospital or other physicians that preserve autonomy but achieve some alignment, such as service line joint ventures, MSO arrangements and other hospital management arrangements as an alternative to or as a first step towards fuller integration.

Matsakis, who is with Holland & Knight LLP, is one of the authors of “Assessing Current Practice Management Issues in a Challenging Environment.”



Letter to the Editor

Recognizing the Whole Working Group

The article “Are Doctors Shackled by Malpractice Insurance? Where It’s Going, What We Can Do” in the July 2009 issue of *Cardiology* presents a brief, accurate summary of the issues being addressed by the ACC Working Group (WG) on Malpractice Insurance.

However, it did not credit the additional members of the WG who, besides Dr. Rodgers and us, are working hard to ameliorate the problem of medical malpractice. These members are **Joseph G. Cacchione, M.D., F.A.C.C.**; **Paul N. Casale, M.D., F.A.C.C.**; **James T. Dove, M.D., M.A.C.C.**, and **Suzette E.G. Jaske**. Excellent staff support and

direction are provided by Brenda Hindle (bhindle@acc.org).

We encourage you to send your suggestions and ideas to assist us in achieving our goals.

John G. Harold, M.D., F.A.C.C.
Los Angeles
john.harold@cshs.org

William J. Oetgen, M.D., M.B.A., F.A.C.C.
Alexandria, Va.
oetgenw@georgetown.edu

Small Study Captures PA Use in Heart Failure Management

By Michael G. Clark, Ph.D., P.A.-C.,
and James Leddy, M.P.A.S.-III

According to the American Heart Association 2009 Heart Disease and Stroke Update, cardiovascular mortality has declined over the past 10 years. However, despite significant advances in therapeutic options, in our aging population, the incidence of heart failure remains high with approximately 500,000 new diagnoses each year.

Equally concerning is that key risk factors for heart failure such as diabetes, obesity, atherosclerotic disease and hypertension — even with new screening, education and treatment efforts — are on the rise in the U.S. population. Further compounding this is the expectation that the over-65 population will double in the next 20 years.

Certainly, the need for heart failure care will continue to challenge cardiology practices in an environment in which manpower is already stretched for services. To help meet these demands, many cardiology practices have employed mid-level providers such as Physician Assistants (PAs) and Advanced Practice Nurses (APNs) to help manage these patients.

The American Academy of Physician Assistants (AAPA) estimates there are nearly 70,000 PAs in clinical practice across the spectrum of more than 60 practice specialties in 2009. About 37 percent of PAs practice in general practice settings such as family medicine, general internal medicine, pediatrics and obstetrics/gynecology. About 10 percent practice in internal medicine subspecialties, such as cardiology.



According to the AAPA, more than 2,000 PA members now identify cardiology as their primary practice setting, which is essentially twice the number represented in the 2007 AAPA member roll.

As the PA and APN roles in cardiology have evolved, they have become integral to the provision of care, particularly for heart failure management. The AAPA and the Association of Physician Assistants in Cardiology (APAC) have conducted surveys of clinical duties that PAs perform in a cardiology practice, but no specific data exist on how PAs are used for heart failure management in a cardiology practice setting.

In 2008, the Physician Assistant Studies Program of the University of North Texas Health Science Center in Fort Worth, Texas, conducted a study of 70 cardiology PAs who manage heart failure patients to better understand their use in this practice setting. Most of the respondents (77 percent) managed heart failure patients in both the inpatient and outpatient setting. All of the respondents also participated in other aspects of cardiovascular care. Interestingly, though, most devoted 50 percent or more time to the management of heart failure patients.

The most common duties performed by the PAs included:

- managing acute congestive HF patients (97 percent)
- monitoring patient response to medication management (96 percent)
- titrating/adjusting HF-specific medications (94 percent)
- patient education, such as counseling HF patients concerning disease management, advanced directives, diet and exercise (93 percent).

Legislative Conference Travel Awards

Congratulations to these CCA members, who are recipients of the CCA Travel Awards to ACC's 2009 Legislative Conference —

Melanie T. Gura, R.N., M.S.N., C.S.N.
Janet Wyman, M.S.N., A.P.R.N.
Frances Saldivar, N.P.
Bridget Case, R.N.
Eileen Pummer, R.N., M.S.N., C.P.H.Q.
Jackie Roberts, R.N.
Linda Tavares, N.P.
Susan Wojcik, F.N.P.
Tracey Shannon, R.N.
Michael Schroyer, R.N.

Clark is vice-chair of clinical education in PA studies, University of North Texas Health Science Center, Fort Worth. Leddy is a student at the Science Center.

As a female cardiologist you can have it all. Let us be your stepping stone.

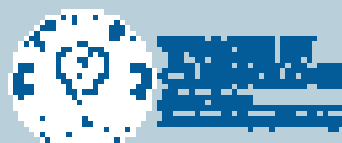
The Women in Cardiology Section of the American College of Cardiology offers women the support they need to advance their careers and help them thrive in the field of cardiology by addressing their professional needs.

- Network
- Take advantage of leadership opportunities
- Participate in mentoring programs
- Take part in professional development programs
- ...and much more

The Women in Cardiology Section of the ACC.

YOUR COMMUNITY. GREAT OPPORTUNITY. GREAT IMPACT.

Visit wic.acc.org to learn more.



ACC Fighting Proposals to Eliminate In-Office Imaging Services

The ACC is working hard to fight the American College of Radiology's efforts to attach self-referral provisions to health care reform. In fact, the College signed a joint letter with 23 other medical professional societies late last month to Rep. Henry Waxman (D-CA), chair of the House Energy and Commerce Committee. The letter opposed an amendment by Reps. Anthony Weiner (D-NY) and Bruce Braley (D-IA) to eliminate the ability of physicians to provide advanced diagnostic imaging services in their offices beginning in 2013. ACC staff and leaders continue to meet regularly with members of Congress about the benefits of appropriate use criteria and clinical guidelines to ensure that the right tests are delivered at the right time to the right patients. The ACC also supports mandatory imaging laboratory accreditation to improve the quality of imaging.

Bill Introduced for U.S. Production of Mo-99

House Energy and Commerce Subcommittee on Energy and the Environment Chair Edward Markey (D-Mass.) on July 21 introduced the American Medical Isotopes Production Act. This bill would authorize \$163 million over five years to start domestic production of molybdenum-99 (Mo-99) as soon as possible. Under the bill, the funds would be used to support private sector or research sector projects to establish domestic Mo-99 production.

In May, the Canadian reactor that usually supplies 60 percent of the U.S. supply broke down and the major reactor in The Netherlands will shut down for necessary maintenance later this month. This will leave the total global production capacity at approximately 10 percent of normal levels for one month. The ACC and other cardiovascular specialty societies endorse the legislation. More information about the shortages is available on the American Society of Nuclear Cardiology's Web site (www.asnc.org).

ACC Comments on Proposed Inpatient Payment Rule

The ACC recently offered comments on the proposed Hospital Inpatient Prospective Payment System, published in the *Federal Register* on May 22. The comments focus on the quality measures that hospitals report on as part of the Reporting of Hospital Quality Data for Annual Payment Update program and other issues related to the quality of care provided to hospitalized patients. The full letter is available at www.acc.org.

FTC Reprieve on Red Flags Rules

The Federal Trade Commission (FTC) has further delayed implementation of new rules aimed at preventing identity theft until Nov. 1, after delaying until August 1. The ACC, the American Medical Association (AMA), Medical Group Management Association (MGMA) and other medical associations have challenged the rules' inclusion of physicians as creditors because they regularly defer payment for goods and services. The FTC released rules in November 2007 requiring all financial institutions and "creditors" to develop and implement a written program to protect consumers by identifying potentially suspicious "red flags" that may signal identity theft. The ACC is taking advantage of this newest reprieve to continue efforts to have physicians removed from the "creditor" definition.

In the meantime, the ACC recommends that practices begin preparing a written identity theft detection and prevention program that complies with the new rules as a contingency plan. The AMA and MGMA have developed Red Flags Rule guidance documents and sample policies that can be modified. The FTC also has developed and made available on its Web site a template that groups at low risk can use to develop their programs. Contact Gretchen Wyatt at gwyatt@acc.org with questions.

Register for ACC's 2009 Legislative Conference

The ACC will hold its 2009 Legislative Conference Sept. 13 – 15 at the Fairmont Hotel in Washington, D.C. Given the drastic payment cuts proposed by CMS, as well as efforts to pass overarching health reform legislation, don't miss this opportunity to help educate Congress about the important work the ACC is doing in the areas of quality improvement and medical imaging. Even more important, you can help advocate for fair reimbursement and sound, unobtrusive policies that will ensure that cardiovascular professionals can continue to practice medicine in a manner that provides the greatest benefit for their patients. To register, go to www.acc.org.

ACC Well-Poised for Partnership, Collaboration in International Arena

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

Cardiologists around the world and across the pond face similar challenges in their practice and look to the ACC to support them, according to a survey with practitioners from 10 countries.

Conducted online in native languages by the College's Market Intelligence team, the 2008 ACC International

findings were presented at the International Committee meeting in November 2008.

Not surprisingly, cardiologists around the globe identified "time" as the single biggest challenge faced by their practices; "financial limitations" was the second biggest challenge cited by 50 percent of the respondents. Other

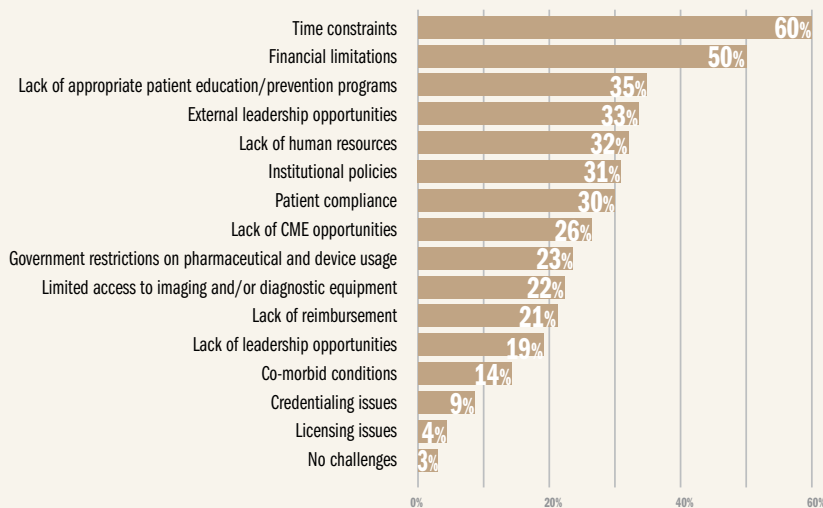
tions, guidelines and articles were the most popular learning sources for international cardiologists. Acute coronary syndromes, heart failure, arrhythmias and ischemic heart disease rate were at the top of clinical areas of interest within these delivery methods, as is also true among domestic cardiologists.

The research also suggests that ACC is the right partner to support cardiologists on addressing their practice needs. The ACC is known internationally and rated highest for its vision, innovation, ability to get things done and deliver on promises. The ACC's strength in these leadership qualities means that international cardiologists find the College trustworthy and well-poised to provide the right balance of science and quality.

Collaboration, a Key Component

While global needs and opportunities are clear, a consistent message throughout the responses to the survey was a desire among international cardiologists to have coordinated efforts between the ACC and their national cardiovascular society. This desired partnership blends the strengths of both organizations and reflects favorably on the College. The more aware a cardiologist is of the relationship between ACC and their national society, the higher their overall satisfaction with ACC. Additionally, 80 percent of the respondents indicated that they would be more involved with ACC if the College's information resources were offered by their local societies, or if the ACC partnered more closely with national societies.

Biggest Challenges Faced at Practice Level

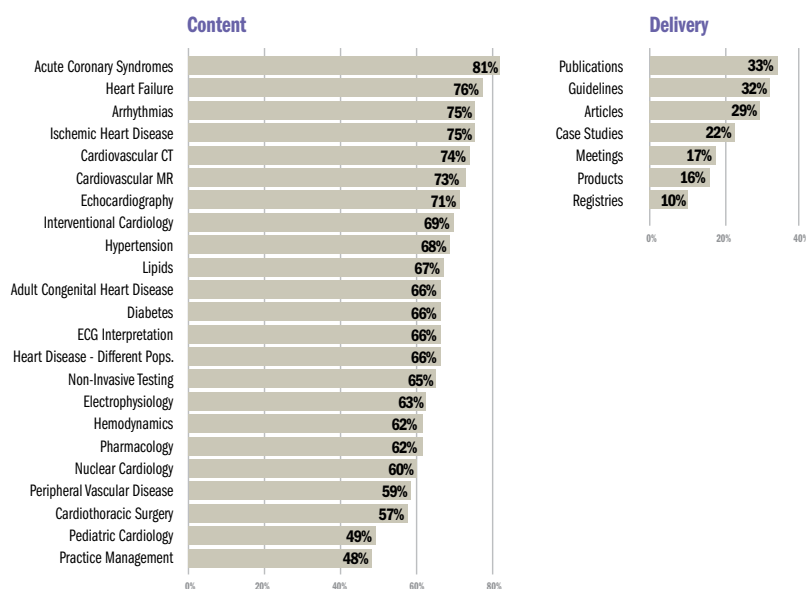


Strategy survey was sent to all member and non-member international cardiologists recorded in the ACC database from Argentina, Australia, Brazil, Canada, China, Germany, India, Japan, Mexico and the United Kingdom. Between Sept. 12 and Oct. 14, 2008, 1,107 cardiologists completed the survey and the

challenges included prevention, patient compliance, staff shortages, government restriction, access to equipment and co-morbid conditions. Access to certification maintenance education (CME) was identified as problematic by 25 percent of the respondents.

For education purposes, publica-

Top Clinical Areas of Interest



ACC Presence Strong

The research found high satisfaction with the College among international members. Of equal importance was the value assigned to being an ACC Fellow. Cardiovascular professionals from the 10 countries were more likely to value the F.A.C.C. designation over other society designations.

Clearly, there is support for ACC having an international presence. The survey showed strong support for both ACC international chapters and the International Section. Additionally, research revealed that many international cardiologists who are not members of the College do actually qualify for ACC membership. Given that, our immediate focus is to generate awareness and simplify the application process to increase interest in ACC membership.

Since this survey was conducted, the opportunities for partnership, networking and education from around the world have continued to grow. ACC harbors great international possibilities in its science, quality and education initiatives and plans to use these results to continue to support cardiovascular professionals around the world and help

them optimize patient care.

While the College has much to do and must continue its strategy of increased engagement with cardiologists and their national societies, it can also take credit for many developments over recent years. These developments, prospectively and thoughtfully undertaken — and with resources allocated to them — have resulted in an organization that is increasingly seen as having an international presence, while still retaining a focus on its core membership. The ACC remains a prestigious organization with which to be associated, and the feedback we get is that many more overseas cardiologists, would like to be members. This must be a healthy state of affairs and one that I believe gives cause for optimism despite our living in economically and professionally challenging times.

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



Our Future Is Now



“The 2009 ACC Legislative Conference may be the most important conference of my career. There is little doubt that the U.S. health care system needs fine-tuning, but as I prepare to start practice, I have serious concerns about our future and some of the proposed plans. The Legislative Conference is our chance to be heard, and I hope our elected officials will be listening.”

Timothy J. Malins, M.D.

Congratulations to these winners of the FIT Travel Awards for ACC's 2009 Legislative Conference —

I-Hui (Ann) Chiang, M.D.

Baylor College of Medicine

Sandra McCearley, M.D.

University of Mississippi Medical Center

Tyler Taigen, M.D.

Cleveland Clinic

Faisal Khan, M.D.

University of Cincinnati College of Medicine

Josh Leitner, M.D.

Warren Alpert Medical School of Brown University

Walter Coats, D.O.

University of Missouri-Columbia

Timothy Malins, M.D.

University of Rochester Medical Center

Sendhil Krishnan, M.D.

University of South Florida.

Daniel Mudrick, M.D.

Duke University

Rahul Sakhujia, M.D., M.P.P., M.Sc.

Massachusetts General Hospital



1982 ACC member William C. DeVries, M.D., F.A.C.C., performs the first successful permanent artificial heart implantation.

Career Development Awards

Outstanding Career
Development Opportunities

for **Research & Travel**

in 2009-2010

Application Deadlines: Fall 2009

The American College of Cardiology Foundation will provide almost half a million to support the training and development of young cardiovascular investigators. Will you be one of them?

Visit www.acc.org/researchawards to apply today!



AMERICAN
COLLEGE
OF CARDIOLOGY
FOUNDATION



ACCEL

OMEGA Trial: Omega-3 Fatty Acids, No Additional Benefit at One Year in AMI Patients

Researchers hypothesized that omega-3 (n-3) fatty acids, such as those in fish oil, might have beneficial effects in preventing adverse cardiac events. Several studies have evaluated n-3 fatty acids as supplements to medical therapy to determine whether they reduce the risk of cardiac death, infarction and stroke.

For example, the GISSI-HF trial looked at whether the addition of n-3 polyunsaturated fatty acids (PUFAs) would lower morbidity and mortality in patients with symptomatic heart failure. While there were small reductions in mortality and hospital admissions among patients with systolic heart failure, neither reached statistical significance. In the Study on Omega 3 Fatty Acid and Ventricular Arrhythmia (SOFA), in which n-3 PUFAs were studied in patients with implantable cardioverter-defibrillators, the additional treatment did not significantly affect life-threatening arrhythmias or death at 12 months, the primary endpoint.

A different patient population — those recovering from an acute myocardial infarction (AMI) — was the subject of the Fish and Omega-3 Fatty Acid Intake and Incident Atrial Fibrillation: The Women's Health Initiative (OMEGA) Trial. The rationale for the study came from an observation that Inuits of Greenland, who consume large amounts of fish oil, have low cardiac morbidity and mortality. Researchers wanted to assess the effect of adding n-3 fatty acids to current guideline-recommended therapy in terms of secondary prevention in the year following an AMI.

Senges and colleagues randomized 3,851 patients from

104 centers throughout Germany to guideline recommended medical therapy plus either n-3 fatty acids 1 g qd (n = 1,940) or placebo (n = 1,911). Patients were enrolled three to 14 days post-AMI. The primary endpoint was sudden cardiac death, with secondary endpoints including total deaths, reinfarction, stroke, major arrhythmic events and revascularization within one year following the index event. Adherence to guidelines was strict, with more than 90 percent of patients receiving statins plus beta-blockers, aspirin, clopidogrel and ACE inhibitors.

At one year, the primary endpoint was 1.5 percent in both arms (p = 0.84). According to principal investigator **Jochen Seneges, M.D., F.A.C.C.**, professor of medicine and cardiology at Heidelberg University in Germany, "The Kaplan-Meier curves were absolutely superimposable. So, this was a neutral effect on these patients on optimized current guideline therapy." Moreover, there were no significant differences in secondary endpoints.

Despite recruiting nearly 4,000 patients, Seneges noted that the sample size should have been larger to power the trial adequately. "We had assumed the power of 80 percent but we realized only 50 percent power to exclude or prove the hypothesis because of the low event rate." The results, he said, suggest that with strict guidelines-based therapy, there are very low complication rates in patients during the first year following an acute MI. Investigators are considering whether longer follow-up may provide additional information regarding the effectiveness of n-3 fatty acids in these patients.

ACCF Efforts on Disparities Take Shape

Disparities in cardiovascular disease (CVD) outcomes and care among people from different racial and ethnic groups, as well as between men and women, have been well-documented. The disparities reflect multiple factors, including socioeconomic status, reduced access, health literacy challenges, as well as provider factors. Educational efforts that assist health care providers in meeting the needs of their increasingly diverse patient populations will undoubtedly help to reduce these disparities.

To that end, the ACC Foundation (ACCF) launched the Coalition to Reduce Racial and Ethnic Disparities in Cardiovascular Outcomes (*credo*). The coalition comprises national leading CV health care organizations and experts. Members of *credo* hope their combined efforts, particularly in education, will result in measurable reductions in the disparities that exist in the management of CVD and related conditions.

As part of their initial planning, *credo* has outlined these goals —

- Identify evidence-based principles of provider education that lead to equitable CVD care and outcomes
- Recognize and facilitate dissemination of existing educational activities that meet *credo* principles
- Demonstrate the effectiveness of education in reducing disparate care
- Design and implement Performance Improvement educational activities that target specific CVD clinical areas based on quality measures from ACC's NCDR®, IC3 Program® and other sources, provide CME/CE, and meet the requirements for Maintenance of Certification (MOC) Part IV credit

The ultimate goal of *credo* is to show that evidence-based education can reduce disparities in CVD care. The primary focus is CV risk factors and chronic heart failure, both areas of documented disparities in care and outcomes for which education is clearly a part of the solution.

The *credo* Advisory Group recently met at Heart House to begin mapping its strategy to tackle disparate CV care.



Photos clockwise from top: the *credo* Advisory Group meeting at Heart House, Dr. Ventura, Drs. Wang and Yancy.

Co-chairs of the Advisory Group are —

- **Tracy Y. Wang, M.D., M.H.S.**, assistant professor of medicine, Duke Clinical Research Institute, Durham, N.C.
- **Clyde W. Yancy, M.D., F.A.C.C., F.A.H.A.**, medical director, Baylor Heart and Vascular Institute, Dallas, and president of the American Heart Association (AHA)
- **Hector O. Ventura, M.D., F.A.C.C.**, Tulane School of Medicine and member, National Hispanic Cardiologists Leadership Network

Other members of the advisory group include —

- **Paul N. Casale, M.D., F.A.C.C.**, president, Pennsylvania Chapter, ACC
- **Marshall Chin, M.D., M.P.H.**, Finding Answers: Disparities Research for Change, University of Chicago
- **Elizabeth DeLima**, vice president, cultural initiatives, AHA
- **Keith C. Ferdinand, M.D., F.A.C.C.**, Morehouse School of Medicine, Emory University, Association of Black Cardiologists, Inc.
- **Gordon L. Fung, M.D., Ph.D., F.A.C.C.**, clinical professor of medicine, director, UCSF Asian Heart & Vascular Center, immediate past governor, Northern California Chapter, ACC
- **Marcia Jackson, Ph.D.**, president, CME by Design
- **Robert C. Like, M.D., M.S.**, professor and director, Center for Healthy Families and Cultural Diversity, UMDNJ-Robert Wood Johnson Medical School
- **Douglas L. Mann, M.D., F.A.C.C.**, president, Heart Failure Society of America, Baylor College
- **Ileana L. Piña, M.D., F.A.C.C.**, professor of medicine, Case Western Reserve University, and member, National Hispanic Cardiologists Leadership Network
- **John S. Rumsfeld, M.D., Ph.D., F.A.C.C.**, Denver VAMC, chief science officer, NCDR®
- **Sarah H. Scholle, Dr.P.H., M.P.H.**, assistant vice president, National Committee for Quality Assurance
- **Joanna D. Sikkema, M.S.N., A.R.N.P.**, University of Miami, Whole Health Management, and past president, Preventive Cardiology Nurses Association
- **Kris Vijay, M.D., F.A.C.C.**, president/governor-Arizona Chapter, ACC, Scottsdale Clinical Research Institute
- **Karol E. Watson, M.D., Ph.D., F.A.C.C.**, associate professor of medicine, Geffen School of Medicine

Look for more information about credo in the weeks ahead, and a special session at ACC's 59th Annual Scientific Session/i2 Summit, March 14-16, 2010.

Chapter Briefs

Right Way, Wrong Way to Reform Health System, Tenn. Gov. Writes

ACC Chapter Gov. **George Crossley, M.D., F.A.C.C.**, was featured in an opinion piece on health care reform in *The Tennessean* on July 28. Crossley wrote, "There is a right way and a wrong way to reform our health care system. And while opinions clearly differ on right and wrong in the halls of government and at our nation's kitchen tables, one aspect of reform cannot be overlooked: doctors."



Crossley

Crossley also addressed the payment cuts that would result from the proposed 2010 Physician Fee Schedule, noting that the "large-scale arbitrary cuts" will inhibit cardiovascular professionals' ability "to make great strides in how patients with heart disease and other illnesses are treated." A link to the op-ed is posted at qualityfirst.acc.org.

ACC Talks with 70 State Lawmakers on CV Issues

The National Conference of State Legislatures (NCSL) held its annual meeting last week in Philadelphia. ACC President **Alfred Bove, M.D., F.A.C.C.**, attended the event, along with the chapter executive of the Florida, Virginia and Maryland Chapters, **Jennifer Ray Beckman**, and several ACC staff. During the event, the ACC spoke with 70 state legislators on the topics of health care reform and Quality First, the "Year of the Patient" and some state-specific legislation. The ACC discussed the Proposed 2010 Physician Fee Schedule and attempts to limit self-referral, and the effects of these policies on access to cardiovascular services. The ACC attendees also met with other medical organizations to discuss continuing or new areas of collaboration. In addition, the ACC was a part of a panel called "Legislators in the Lab Showcase," which provided an overview of the state of cardiovascular health in the U.S. and was presented in part by **James Galloway, M.D., F.A.C.C.** For more information on advocacy issues, visit: www.acc.org/advocacy/advocacy.htm.



Galloway



1965 Five ACC members and their wives are detained in Czechoslovakia en route to Poland, where they are to teach an International Circuit Course. After spending a night on the floor of a jail cell, former ACC President Forrest Adams, M.D.,

M.A.C.C., and the other members of the ACC delegation are finally permitted to continue to Warsaw, where they teach a standing-room only course.

Helping You Stay in Touch, ACC Launches Social Media Campaign

Stay tuned in to ACC activities and important clinical and advocacy news with “ACC in Touch,” the College’s new social media campaign. If you’re active on the popular networking sites of Facebook, Twitter and LinkedIn, look for the logo pictured here to check out the new online options for ACC members and others interested in learning more about the ACC.

Twitter

Twitter, the fastest growing networking site, is a real-time messaging service that asks the question “What are you doing?” in 140 characters or less. The ACC has four profiles tailored to your interests:

- **@ACCinTouch:** ACC’s main Twitter account. This feed provides general information about the College and updates of use to cardiovascular professionals (twitter.com/ACCinTouch)
- **@Cardiosource:** This account is dedicated to the latest science from Cardiosource (twitter.com/Cardiosource)
- **@Cardiology:** ACC’s advocacy account, which provides legislative updates, interesting articles about health reform and updates from ACC’s blog (twitter.com/Cardiology)
- **@CardioSmart:** This account features patient-centered news and updates from CardioSmart (twitter.com/CardioSmart)

Twitter is a great way to get information from the College, connect with others with similar interests and provide feedback on ACC activities. Follow the

ACC on Twitter by visiting: twitter.com/ACCinTouch.

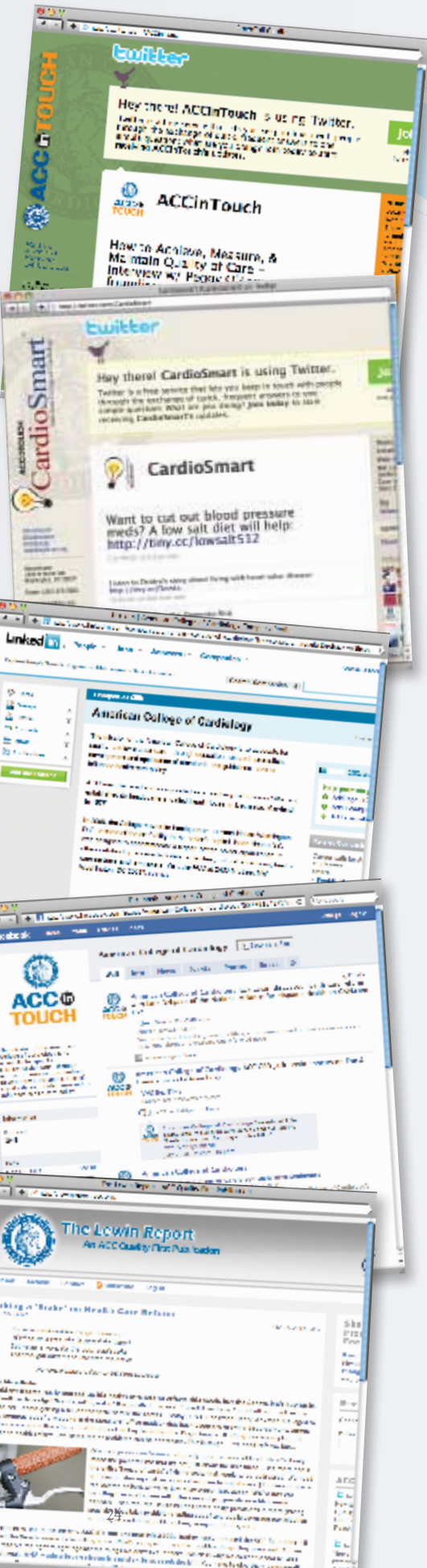
Facebook, LinkedIn

Facebook and LinkedIn are two other popular Web sites. Facebook, which is the largest social networking site, allows people to connect with friends or colleagues by creating a profile, joining groups and becoming “fans” of pages on certain topics. LinkedIn is a professional networking site on which you create a profile of your work experiences, are able to “recommend” others for employment and may join groups based on your interests.

If you’re a Facebook member, we encourage you to become a “fan” of the American College of Cardiology. If you’re on LinkedIn, please join the American College of Cardiology group. Both sites will feature the latest news from the College, including more information about ACC’s many initiatives in education, science and quality, advocacy and member services.

Blogging

The ACC also has a blog, The Lewin Report, which discusses issues related to quality and health care reform, such as access to care, care coordination and





transparency. The Lewin Report, active for two years, continues to grow in popularity and interactivity, and it now includes more interactive features, such as videos and polls. The Lewin Report is intended as a forum for members to voice their concerns and thoughts about health care reform and interact with other members who have similar interests. Check out the blog at: lewinreport.acc.org.

Get in Touch Today

Here's what you can do to get involved online:

- Visit and comment on the blog: lewinreport.acc.org. You can subscribe by adding its feed to your RSS reader or by entering your e-mail address in the box on the right. To leave a comment, click on the "Comment" link at the bottom of each post and then start typing. The blog is PDA-friendly, so you don't need a computer to visit.
- Follow us on Twitter: Twitter is available at twitter.com, and links to the individual profiles are listed above. Follow one or all four accounts based on your interests.
- Facebook, LinkedIn: If you're a member of Facebook or LinkedIn, make sure to connect with us through our fan page or group. Just look for the ACC in Touch logo.

The College is looking for more ways to use emerging social media — if you have ideas, suggestions or want to get involved, contact Emily Zeigenfuse at ezeigenf@acc.org.

More Imaging Labs Seeking Accreditation

ACC has always encouraged members to participate in laboratory accreditation, particularly since the College adopted the official Statement on Accreditation/Certification in 2005. The ACC is one of the sponsoring societies for the Intersocietal Accreditation Commission (IAC), which is a national, nonprofit organization that evaluates and accredits diagnostic imaging facilities.

The IAC reports a steady increase in the number of applications for accreditation, most likely due to more stringent payment policies and increased concern for quality in diagnostic imaging.

To date, approximately 8,200 physicians' offices, freestanding diagnostic imaging centers and hospital imaging departments are accredited by the IAC. Given its intersocietal philosophy, the IAC unites all medical specialties when it uses a diagnostic imaging modality for writing standards and administering the accreditation programs. Multiple specialists — including cardiologists, nuclear medicine physicians, neurologists, orthopedic surgeons, otolaryngologists, radiologists, vascular surgeons, physicists and specialty-specific technologists — are represented on these five individual IAC accrediting divisions —

- **Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)**, providing accreditation for facilities performing noninvasive vascular testing, www.icavl.org
- **Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEI)**, providing accreditation for facilities performing echocardiography, www.icael.org
- **Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL)**, providing accreditation for facilities performing nuclear cardiology, general nuclear medicine, and/or PET imaging, www.icanl.org
- **Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories (ICAMRL)**, providing accreditation for facilities performing magnetic resonance imaging, www.icamrl.org
- **Intersocietal Commission for the Accreditation of Computed Tomography Laboratories (ICACTL)**, providing accreditation for facilities performing computed tomography, www.icactl.org

To find out more about these accrediting divisions and the new Online Accreditation application format, contact IAC at (800) 838-2110 or visit www.intersocietal.org.

PAD Performance Measures Open for Comment

The ACCF/AHA Task Force on Performance Measures invites you to review the draft ACCF/AHA/ACR/SCAI/SIR/SVM/SVN/SVS Clinical Performance Measures for Peripheral Artery Disease in Adults, which is available for public comment through Aug. 18, 2009. The draft document and comment form may be found at: www.acc.org/qualityandscience/clinical/PPCDA.htm. For questions, contact Kay Conley at kconley@acc.org or (202) 375-6275.

GENERAL CARDIOLOGY

Washoe Valley, Washington

Washoe Valley Medical Center is seeking a full-time, permanent, board-certified cardiologist to join our team. The successful candidate will be responsible for providing comprehensive cardiovascular care to our patients. The position is located in our new, state-of-the-art facility in Washoe Valley, Washington. The position offers a competitive salary and a comprehensive benefits package. For consideration, please send your CV to:

**Human Resources Director
Washoe Valley Medical Center
1234 NW Lenoir, Suite 400
Portland, Oregon 97203
wvmc@washoevalley.com**

CARDIOLOGY FACULTY POSITION

Northern
CALIFORNIA

The City of Hope National Medical Center, and NCI-designated comprehensive cancer center is seeking a **MD/BC** Cardiologist to join the Department of Cardiology. **Non-Invasive Cardiology** experience including TEE and STRESS ECHO. **3-5 years of experience** required.

**MD/BC BC
E. Modesto, CA
Department of Cardiology
City of Hope National Medical Center
1500 N. Lake Street
Orange, CA 92668**

Career Opportunities

Ad Policy

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.

The College reserves the right to decline, withdraw or modify advertisements at its discretion; the College also exerts every precaution against mistakes but assumes no responsibility for clerical or printer's errors. All advertisements are subject to review, edit and approval by the American College of Cardiology.

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



Interventional Cardiologist

Identified in 2007 as one of the top 100 hospitals in the nation for Cardiovascular Care, Altru Health System has an opportunity for **BC/BS** interventional cardiologist to join our practice in Grand Forks, ND. Practice in a 200-bed, Level II Trauma Center with three state-of-the-art cath labs including Philips first-percut technology with the most advanced diagnostic imaging and complemented by highly trained medical, nursing and technical staff, a 18-bed medical critical care unit and a 18-bed surgical critical care unit.

Altru also offers an extensive and comprehensive benefit package. To forward your CV for consideration contact: Jenny Goring, Altru Health System, PO Box 6000, Grand Forks, ND 58201-0001
Phone: 1-800-437-5878 Fax: 701-790-0641
Email: jgoring@altru.org Website: www.altru.org



IDAHO

Seeking Interventional and Non-Interventional Cardiologists to join a call group of eight experienced Cardiologists.
We offer competitive salary and benefits.

Beth Vance-Wehrli at 800-509-5388
Email: bethvance@saintalphonsus.org
Fax: 208-367-7964



[-] Visa applicants do not qualify.
www.saintalphonsus.org

Cardiology Associates, Inc. Honolulu, Hawaii

Is seeking a BE/BC Cardiologist, invasive or non-invasive, to join a well-established group of three cardiologists. One is retiring. Our growing practice includes three clinics with the main office located in downtown Honolulu.

Hawaii, the Aloha State, is a multi-cultural chain of islands in the Pacific Ocean. The diverse ethnic population has growing demands bringing new health challenges for the future.

Please send Curriculum Vitae to:
William M. Dang, Jr., MD or
Atsushi Jim Tenakubo, MD
1329 Lusitana Street, Suite #409
Honolulu, HI 96813
Email: cj@cardiohawaii.com
Tel: 808-533-0010 • Fax: 808-523-5873



ASPIRUS
KEWEENAW

Part of the Aspirus Health System

Join Our Team

In Northern Michigan

Aspirus Healthcare is seeking a BC/BE Non-Invasive Cardiologist to join our team. We offer a team approach, single-hospital, comprehensive and open practice lower potential. Employment track or locum tenens track available. Opportunities for continuing education and available through our Cardiovascular Research & Educational Foundation (CREF) in Wilson, Wisconsin.

Will share team with MD/CHL.

Be a part of our award winning team!

The Lansing community offers outstanding cultural opportunities. Enjoy all you love, live, and do as you wish. The entire region is within an hour of a beautiful quality of life.

Contact Janelle Sileo, Physician Recruiter for Aspirus at 800-752-8728
or fax CV to 716-447-2742 or email janelle@aspirus.org

August 4

- Professional Accountability in Health System Reform
- Heart Failure in Women: A Need for Prospective Data
- Long Term Follow-Up of Idiopathic Ventricular Fibrillation Ablation: A Multicenter Study

August 11

- Omega-3 Polyunsaturated Fatty Acids and Cardiovascular Diseases - A Fish Tale with Growing Credibility
- Transpulmonary BNP Uptake and cGMP Release in Heart Failure and Pulmonary Hypertension: The Effects of Sildenafil
- Efficacy of Antiarrhythmic Drugs in Arrhythmogenic Right Ventricular Cardiomyopathy: A Report from the North American ARVC Registry
- Global Two-Dimensional Strain as a New Prognosticator in Patients with Heart Failure

August 18

- CD40/CD40 Ligand System: Linking Inflammation with Atherothrombosis
- The Efficacy and Safety of Prasugrel with and without a Glycoprotein IIb/IIIa Inhibitor in Patients with Acute Coronary Syndromes Undergoing Percutaneous Intervention: A TRITON-TIMI 38 Analysis
- Increased Wave Reflection Rather Than Central Arterial Stiffness is the Main Determinant of Raised Pulse Pressure in Women and Relates to Mismatch in Arterial Dimensions: A Twin Study
- Impact of Heart Rate on Central Aortic Pressures and Hemodynamics - Analysis from the Conduit Artery Function Evaluation (CAFE) Study: CAFE-Heart Rate

August 25

- Indications for Implantable Cardioverter-Defibrillators Based on Evidence and Judgment
- The Effects of Right Ventricular Apical Pacing on Ventricular Function and Dyssynchrony - Implications for Therapy
- Clinical Predictors of Termination and Clinical Outcome of Catheter Ablation for Persistent Atrial Fibrillation













JACC cardiovascular Interventions

- Drug-Eluting Stent Thrombosis: The Kounis Syndrome Revisited
- Percutaneous Left Atrial Appendage Occlusion for Patients in Atrial Fibrillation Suboptimal for Warfarin Therapy: 5 Year Results of the PLAATO Study
- Drug-Eluting Stents and the Use of PCI among Patients with Class I Indications for CABG Undergoing Index Revascularization: Analysis from the NCDR®

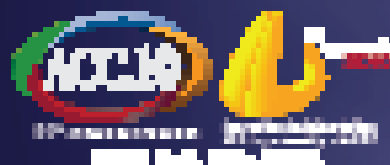
JACC cardiovascular Imaging

- Association of Myocardial Deformation with Mortality Independent of Myocardial Ischemia and Left Ventricular Hypertrophy
- Real-Time 3-D Echocardiographic Assessment of Left Ventricular Dyssynchrony: Pitfalls in Patients with Dilated Cardiomyopathy
- Diagnostic Accuracy of CT Angiography in Patients after Bypass Grafting: Comparison to Invasive Coronary Angiography

Educational Programs Calendar

	2009* ACCF/SCCT Coronary CTA Practicum <i>*Program Dates available online</i>	Washington, D.C. 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.	Chicago 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., B.C., 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
	December 11 - 13, 2009 42nd Annual New York Cardiovascular Symposium Valentin Fuster, M.D., Ph.D., F.A.C.C.	New York CME CE
	January 11 - 15, 2010 41st Annual Cardiovascular Conference at Snowmass Spencer B. King III, M.D., M.A.C.C.	Snowmass, Colo. CME
	February 5 - 6, 2010 Heart of Women's Health 2010 Joanne M. Foody, M.D., F.A.C.C. Suzanne Hughes, M.S.N., R.N.	Washington, D.C. CME CE
	February 12 - 14, 2010 2nd Annual Clinical Practice of Peripheral Vascular Disease: Key Components for Cardiovascular Specialists Michael R. Jaff, D.O., F.A.C.C. Christopher J. White, M.D., F.A.C.C.	Phoenix CME CE

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



Call for Abstracts

Submit your research to be considered for —

- Posters and presentations featuring expert summary comments and panel discussions
- Classic live poster presentations with dedicated viewing hours and poster discussions
- “Best Poster” Awards Competition
- A feature on ACC Online and CardioSource.com. Plus, approximately 50 abstracts will be recommended for ACC Rapid Review to be featured in special issues of ACC and ACC Interventions.

Abstract Submissions: Aug. 31 – Oct. 6, 8 a.m. ET

Call for Young Investigators — Don't miss this opportunity to present at ACC 10. Apply online for the Young Investigators Awards by Oct. 6. For more information go to www.acc.org/about/awards/younginvestigators

acc10.acc.org

For more information on submitting your science

Don't forget —

- Registration opens for members on Sept. 15 and nonmembers on Sept. 29. Register early for discounted early bird rates!
- Late-Breaking Clinical Trial submissions are accepted from Oct. 15 – Nov. 8!

The Future of Cardiology Awaits **You** in Atlanta.

