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the Purchase
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ACC Chapters and Members Step Up

This month we hope to see some positive movement on health care reform and the fee cuts proposed by the Centers for Medicare and Medicaid Services (CMS). Despite the August recess, lawmakers have been busy, attempting to have conversations with their constituents. Yet we are all aware of the difficulties they have experienced in conducting those discussions because the issues have been so confounded by misleading or inaccurate information.

As for the CMS proposed cuts, ACC leadership and staff have continued reaching out to lawmakers and others. However, it is the members of the ACC who have had the greatest impact as you will read in the Chapters section in this issue. You answered the call to contact your congressmen and senators. ACC Chapters have organized their members using creative solutions to open dialogues with their lawmakers. We need to continue with these efforts and maintain the opened communication lines.

Some health care reform proposals may be set aside, but we know that both sides of the aisle understand and support the adoption of electronic health records (EHR). ACC's Health IT Committee continues to develop materials that will assist members in making this change. The article in this issue, "Demystifying the Purchase of EHR," compiles a list of features that are important to consider when you purchase an EHR system. If you have incorporated EHR already in your practice and have suggestions for purchasing and implementing EHR, please consider sending your ideas to *Cardiology* magazine (adees@acc.org) so they may be shared with your colleagues.

Finally, the extended dialogue based on the Practice Integration Opportunities Whitepaper continues with a more detailed explanation of valuation by Michael Carlson. Much as we might hope that none of us has to take this step, our reality is that some of us will. In actuality, some practices have already done so. It is incumbent upon us to make sure that we enter a negotiation well-informed and prepared to negotiate the most effective deal that ensures our ability to continue providing the best quality of care for our patients.

I hope to see many of you at ACC's Legislative Conference, Sept. 13 - 15. The conference provides you with the opportunity to learn about issues and to interact with your lawmakers. Almost as important is the time spent with your professional colleagues and ACC leadership. You are a valuable resource for those of us who were elected to lead the ACC. We need to hear about your opinions and your experiences. If you are not able to attend, consider sharing what is happening in your practice and community by writing for *Cardiology* as **Zia Roshandel, M.D., F.A.C.C.**, did in August. Also, don't forget that you may contact me directly via e-mail: president@acc.org.

Change is never easy, and no matter the precise details of pending health care reform legislation, we are going through changing times in medicine. Together we can make a difference and help each other, particularly if we focus on the most important aspect of our profession, which is ensuring quality care for every patient.

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

September 2009

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Demystifying the Purchase of an **EHR**

By Michael J. Mirro, M.D., F.A.C.C.
and James E. Tcheng, M.D., F.A.C.C.



Mirro



Tcheng

Confused about what you should be looking for in an electronic health record (EHR) for your cardiology practice? Do you want to take advantage of the incentive payments offered by the federal government, but are unsure where to begin?

The ACC Health Information Technology (IT) Committee, formerly known as the Informatics Committee, has compiled a list of features to look for when purchasing an EHR to help you begin your search. The list is not exhaustive, in part because the health IT field is changing so rapidly and some of the functionality listed below will change right along with it. In addition, some functionality will not actually be available until 2010. Make sure that you establish a timeline and commitment in your EHR purchase contract that the vendor will provide the missing functionality once it is established.

Also, we recommend you “test drive” any EHR you’re considering. Only you will know if you like how it works and

displays information. These factors, called usability and user interface, usually heavily influence a buyer’s selection, so you’ll want to test them.

The ACC does not recommend specific EHR programs. Choosing the right EHR depends on what a practice needs, and the practice should determine its needs based on an in-depth assessment.

Although the Health IT Committee cannot help with individual practices’ EHR selection, we do make a variety of other resources available at www.acc.org/healthIT, and we can provide you with this checklist of important recommendations.



CCHIT Certification

The Certification Commission for Health Information Technology (CCHIT), an independent certifying body, has developed a set of testing criteria for ambulatory EHRs that focus on the functionalities needed for the office setting. The ACC recommends that members purchase EHRs that have received Ambulatory EHR Certification. Members should also look for EHRs that have CCHIT’s Cardiovascular Medicine certification. Be sure that any EHR you are considering is certified for the most recent year. EHRs certified for previous years may not include many features that are necessary or helpful to run your practice efficiently and in compliance with regulations. Current certification is good for two years.

Why should you purchase a CCHIT-certified EHR? The benefit is that you know the application will meet an exhaustive list of criteria for the most important capabilities. The CCHIT ambulatory certification process focuses on EHR functionality that is both required to meet federal program objectives and desired in the office setting.

Its testing requires 100 percent compliance in the areas of functionality, interoperability, security and privacy. CCHIT certification does not include usability testing at present; however, CCHIT plans to add the feature soon.

One other perk of purchasing CCHIT-certified exists. It is anticipated that physicians will be required to use

CCHIT-certified EHRs to qualify for the federal EHR incentive program, created under the American Recovery and Reinvestment Act (ARRA). For this reason, you must insist that your vendor commits to maintaining up-to-date CCHIT-certification for your EHR.



Use an Application Service Provider (ASP) solution

Unless you have very specific needs, you should select a vendor that provides the EHR through an application service provider (ASP). Web-based e-mail solutions provided by Yahoo!, Gmail, and Hotmail follow the ASP model — all you need is a Web browser and a connection to the Internet. An EHR hosted through an ASP takes care of all IT issues related to the operation of the EHR, including hosting the servers and maintaining the software. With an ASP, there is typically a nominal start-up charge as well as monthly maintenance fees, which are determined by usage.

The alternative — the traditional “client-server” solution — should be considered only if you are in a large practice with more than 12 – 15 cardiologists. The client-server approach requires substantial financial outlay as you host your own hardware, must purchase the software and will need IT staff to maintain, update and troubleshoot the system.



continued on next page



3 Integrated e-Prescribing

E-Prescribing is a foundational component of any EHR solution. Any EHR that is CCHIT-certified will contain an e-prescribing feature, including bidirectional electronic transmission of prescription data through SureScripts/RxHub. Also, it will be compliant with the Medicare Modernization Act of 2003 Part D prescription drug program, which includes information on plan formularies, beneficiary enrollment and uniform standards for information sharing.



4 Compliance with IHE profiles specific to your practice

The importance of data exchange and interoperability among systems cannot be overstated, which is why members looking for an EHR should find a vendor that actively participates in the Integrating the Healthcare Enterprise (IHE) survey and certification process. IHE is a non-profit organization that works to define and demonstrate information exchange between devices and health IT systems. There are a number of profiles applicable to typical cardiology workflows, and vendors that offer these profiles have a proven commitment to interoperability. IHE profiles can be found at www.ihe.net.



5 Compliance with HIPAA

As of January 2009, protected health information is no longer included in the Health Information Portability and Accountability Act (HIPAA) exemptions for Treatment, Payment or Operations. HIPAA is central to U.S. legal requirements regarding patient privacy, system security and transaction processing. Your EHR should allow you to create an audit trail for your use of protected health information to comply with HIPAA.



6 Eligibility for ARRA stimulus funds

Full use of the EHR should allow the practice to be eligible to receive the financial incentives created by ARRA for EHR adoption. This incentive program enables physicians to receive up to \$44,000 per physician if their EHR is implemented by 2011. To be eligible for incentive payments under ARRA, physicians will need to use a certified EHR and demonstrate that they use their EHR to reach quality and technical goals that will become progressively more stringent. Physicians must be able to show that their EHR meets specific certification requirements to validate that they are using certain health IT functions and exchanging information in approved formats. Therefore, you should require that your EHR purchase contract include a guarantee that the vendor will make the changes necessary to qualify for financial incentives under the ARRA program through 2015.

What Else Is on Your Wish List?

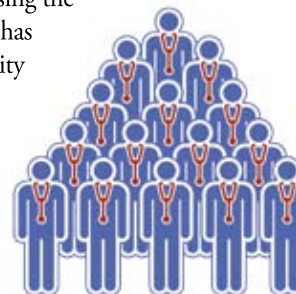
Beyond the checklist, what else would you like your EHR to do?

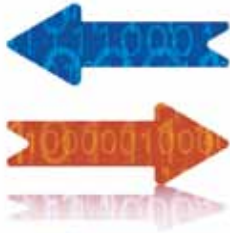
- Interface with dictation vendors and/or speech recognition software?
- Create ad hoc reports at both the physician and practice levels for practice management, quality improvement and compliance?
- Allow for remote secure access 24 hours a day?
- Have cardiology-specific templates for physical examinations, data review and consultations?
- Generate high-quality professional consultation letters from within the EHR?
- Have the ability to scan documents and reports?
- Be capable of autofaxing documents?

7 Minimum of 100 other practices actively using the EHR

The EHR should have an established presence in the marketplace, with a minimum of 100 active physician offices using the

product. This helps ensure that the vendor has demonstrated corporate and product viability and is large enough to provide customer support and business continuity at a level adequate for ACC members. Also, ask the vendor for the sizes and specialties of the physician practices cited as references. Are they large groups, small groups, exclusively cardiology or mixed specialty groups?





8 Integration with the practice management system

The ability to exchange data with your office practice management system is essential for successful EHR implementation. The simplest approach is to use a single vendor for both the practice management and EHR systems. An alternative is to have systems from separate vendors that share the requisite data seamlessly.

9 Owning the EHR data

Be sure that the EHR gives your practice sole legal ownership over your data. Ownership allows you to export data from one EHR into another EHR, should you decide to change vendors. The export program should be in a generalized format such as CDA (clinical data architecture) that can be imported into another vendor's product. The EHR also must be able to export individual patient data reports into both paper and electronic formats for patient requests or departures.



10 Ancillary system connectivity

Look for an EHR that interfaces with all the different ancillary systems, such as laboratory vendors (e.g., LabCorp, Quest), ECG systems, PACs systems and office practice management systems. You'll want an EHR that can automatically import information from these different systems into the EHR. Make sure the ancillary systems with which your practice wants to connect are supported and included in the software contract. Also, look for EHRs that provide interoperability plug-ins for laboratories and clinical messaging, etc.



Additional questions to ask an EHR vendor:

- Does your current or future EHR support “automatic” reporting for the Physician Quality Reporting Initiative (PQRI) without requiring a specific action by the provider? Recently proposed rules for 2010 PQRI reporting offer physicians the opportunity to report through their EHRs, and federal officials expect to propose additional opportunities for EHR-reporting in the future.
- When you access the EHR from a remote site or public computer, how does the vendor ensure security?
- If you have a local or regional health information organization or exchange with which you want to share patient information, is the EHR interoperable?

11 EHR upgrades

Know whether the vendor provides free upgrades needed because of changes in registry reporting and government programs, or if you will have to purchase these required upgrades. You may want to consider the cost and give greater consideration to vendors that include the upgrades.



12 Support

Make sure the EHR vendor's support hours match your practice's hours of operation. However, consider that after-hours technical support may be more beneficial than standard business hours.



13 Quality Reporting

An EHR should be able to export quality metrics from the EHR to a registry or data repository, such as clinical quality performance measures like beta-blocker use in congestive heart failure.



Mirro and Tchong are Chair and Vice Chair, respectively, of the Health IT committee.

The ACC would like to acknowledge the efforts of the entire Health IT Committee in the drafting this article, which is based on the document, “ACC Electronic Health Record Optimal Functional Requirements for Cardiologists,” written by the Committee. All of the Committee's documents can be found at www.acc.org/healthit.

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Active Recruitment of CV Practice Administrators Benefits All

By Phillip Laney, M.D., F.A.C.C.

Recently, ACC Chapter leaders were asked to take a more active role in recruiting practice administrators into the College. The request came from ACC Board of Governors Chair, **John G. Harold, M.D., F.A.C.C.**, and **George Rodgers, M.D., F.A.C.C.**, chair of ACC Workforce Taskforce.

We have already started a practice administrator branch in the Alabama ACC Chapter, and **Larry Johnston, F.A.C.H.E.**, who is president of the practice administrators' branch, sits on our Chapter Council, too. He has done an incredible job starting this program, and we already see many benefits in terms of networking and problem solving.

The College created the Practice Administrator membership category because it recognized that practice administrators wanted to be more fully informed about key issues affecting cardiovascular care, their practices and patients. Practice administrators also needed the opportunity to influence policy issues that would have a direct impact on the delivery of care and the efficiency of the practice. The ACC realized that the administrators' perspectives were vital in our efforts to guide the outcome of health care reform discussions and ensure that quality of patient care remains a priority and guiding light.

By joining the ACC, practice administrators have access to —

- **Leadership opportunities** through networking with other pace-setting practice administrator members, an advanced leadership workshop and a voice in the Practice Administrator Advisory Work Group.
- **National platform** and opportunity to

address reimbursement issues collectively in government and payer forums.

- **CardioAdvocacy Network (ACC | CAN)**, a grassroots network designed to keep them up to date on key health care issues before Congress.
- **ACC Legislative Conference**, where ACC leaders meet with Congressional lawmakers to reinforce quality outcomes for both patients and our practices.
- **ACC Cardiology Careers** online career center to post job opportunities and find job seekers.
- **Annual Scientific Session**, featuring exclusive programs for practice administrators at a substantially discounted rate.
- **Cardiosource**, the premier online source of cardiovascular clinical information, news and the *Journal of the American College of Cardiology*.
- Free subscription to *Cardiology*, the ACC's monthly print news magazine.

Whether large or small, CV practices will find it is to their advantage to have their practice administrators join the College. ACC Chapters also will benefit from their presence. For chapters that are interested in starting an active program for practice administrators, visit our Web site, www.alaacc.org, and click the link for practice administrators. I encourage all ACC chapters and individual members to realize the value of adding your practice administrators to our official cardiovascular team.

Laney is the Alabama Chapter Governor.



Chapters Take Lead in Fighting Proposed Physician Fee Schedule

ACC chapters across the country have made remarkable efforts to mobilize around the drastic cuts to cardiovascular services proposed by the Centers for Medicare and Medicaid Services (CMS) under the proposed 2010 Physician Fee Schedule. As of late-August, more than 4,000 e-mails, faxes, letters and phone calls had been placed to congressional offices across the country. In addition, ACC leadership and staff have made more than 80 visits to congressional offices and CMS. To date, seven opinion pieces have been placed regarding the payment cuts and their impacts on quality and patient access.

Chapters worked hard to mobilize their members and patients. Chapters have sent letters to their entire state congressional delegations and scheduled face-to-face meetings with members of Congress during August recess. The Michigan and Pennsylvania Chapters have hosted “Cardiologist for a Day” events. The Kentucky, Louisiana, Indiana, Maryland and South Carolina Chapters all have events scheduled for the near future. In mobilizing patients, the Delaware Chapter had noteworthy success; in just one week some 400 patients wrote to their lawmakers to protest the proposed rule.

Florida Rallies Around Cuts

The Florida Chapter sponsored a rally of about 2,500 individuals — including hundreds of cardiovascular professionals — in downtown Orlando on August 21 to protest the proposed rule. Event speakers discussed the devastating effects that the implementation of the rule will have on patients’ access to diagnostic testing and quality of care. On the panel of speakers was U.S. Rep. Alan Grayson (D), who promised he would work to stop the cuts from going into effect.

“The event was a great opportunity to raise the profile in Florida about the effects of the proposed rule. We have to let the public know that this rule is going to majorly affect cardiovascular quality and patients. We needed to take action,” says ACC’s Florida Chapter Gov. **Alberto Montalvo, M.D., F.A.C.C.**

Creative Thinking in Ohio

The Ohio Chapter of the ACC educated its members about the payment cuts and the overarching need for real health care reform by hosting a food and wine tasting on August 26 in Cincinnati. As a background to their food and wine pairings, attendees viewed “The Case for Reform,” ACC’s video that features the presidential team urging members to voice their opposition to the proposed cuts. The video includes segments on professionalism and patient value, delivery system improvement and payment reform.

Cincinnati-area ACC trustees **Florence Rothenberg, M.D., F.A.C.C.**, and **Sai Hanumanthu, M.D., F.A.C.C.**, sought to bring members together to learn more about the Chapter and hear how the College is advocating on behalf of members. Attendees learned about the current health care reform climate in Washington, D.C., and shared thoughts with ACC staff on the messages to take to Capitol Hill during ACC’s 2009 Legislative Conference, which will be held Sept. 13-15.

In addition to this event, the Chapter has been very active in reaching out to its federal lawmakers and has sent well over 300 e-mails and letters to Congress in opposition to the proposed cuts.



ACC Trustees Florence Rothenberg and Sai Hanumanthu at the Ohio Chapter health care reform event



1986 The ACC develops its Key Contact program to familiarize College members with federal policies. These early efforts to be involved in federal legislative actions have resulted in a robust Advocacy program today that includes state, federal and payer advocacy and hundreds of member volunteers.

IMPACT Pilot Launch an Important Step for CHD Patients

By Gerard R. Martin, M.D., F.A.C.C.

In September a six-month pilot of great importance to individuals with congenital heart disease will be launched by the ACC. The pilot represents the beginning stages of the actual IMPACT Registry™ (Improving Pediatric and Adult Congenital Treatment). However, it also represents several years of effort that began as an initiative launched by ACC's Section of Adult Congenital and Pediatric Cardiology (ACPC) and pursued by the IMPACT Steering Committee. With the September launch, this initiative is becoming a reality.

The Importance of IMPACT

In June 2009, **Jack Rome, M.D.**, a member of the IMPACT Steering Committee, presented an overview of the IMPACT Registry at PCCS 2009, the 5th World Congress of Pediatric Cardiology and Cardiac Surgery in Cairns, Australia. Rome, who is with Children's Hospital of Philadelphia, presented the overview on behalf of the IMPACT Steering Committee. In August, the *Wall Street Journal* wrote of the need for the kind of information that will be provided by this new registry and mentioned the launch of the IMPACT Registry.

What makes this registry so important? It will be the first national registry to provide data relating to demographics, acute management and in-hospital outcomes for a comprehensive selection of patients undergoing diagnostic catheterization or catheter-based interventions for congenital heart disease. Additionally, it will serve as the benchmark for comparing catheter-based interventions to the more traditional surgically-based interventions currently in practice.

Need for Data

Cardiac catheterization has taken on a critical role in the management of congenital heart disease. With the advent of new interventional techniques, what was once mainly a diagnostic modality, catheterization, has become the primary method of treatment for many defects. Important clinical work has been done to obtain approval for devices necessary to treat children and adults with congenital heart disease; however, little is known about the application of

these techniques to the whole population of patients with congenital heart disease. The IMPACT Registry will allow us to create national guidelines based on real data rather than solely on expert consensus.

Studies performed in congenital heart disease are generally small in number and prior registries of congenital heart disease have been limited in scope. NCDR projects have shown the value of collecting data on large numbers of people undergoing treatment at many centers. Congenital cardiologists and their patients will benefit greatly from the information gathered in this registry. We will generate evidence-based data relating to the use of diagnostic catheterization and catheter-based interventions, and learn the morbidity and mortality associated with these procedures. This data will allow us to strengthen current national guidelines derived from expert opinion and develop future guidelines.

The IMPACT Registry pilot will run for six months and test the usefulness of data elements collected and the feasibility for all centers to collect the information. The full launch of the IMPACT Registry will be in 2010, and those who provide care for the congenital heart disease population will be able to align data with their experience and knowledge, thus furthering the quality of care for their patients.

Many thanks to the original ACPC work group and these IMPACT Steering Committee members —

- Frank F. Ing, M.D., M.D., F.A.C.C.
- Kathy J. Jenkins, M.D., F.A.C.C.
- John W.M. Moore, M.D., F.A.C.C.
- Richard E. Ringel, M.D., F.A.C.C.
- Jonathan J. Rome, M.D.
- Carlos E. Ruiz, M.D., F.A.C.C.
- Robert N. Vincent, M.D., F.A.C.C.

Martin is chair of the IMPACT Steering Committee.



D2B: Sustain the Gain Holds EMS Activation Webinar



“D2B: Sustain the Gain” on August 4 hosted a Webinar on “EMS Activation of the Cath Lab in LA County,” presented by **Ivan Rokos, M.D., F.A.C.C.**, an emergency medicine physician at UCLA Hospital. Rokos discussed the key elements to pre-hospital cardiac triage, including the “30-30-30 goal” of less than 30 minutes for: emergency medical services, the emergency department and the cardiac catheterization lab activation. Visit d2balliance.org for a link to the Webinar archive and for more information on the D2B program.

IMPACT Registry™ to Fill in Gaps in Pediatric CHD Evidence, WSJ Writes

The *Wall Street Journal* recently profiled the problem in treating pediatric heart defects: “Hardly any of the myriad drugs and devices developed for the multibillion-dollar market for cardiovascular disease are designed with kids in mind.” The result is that in treating children with heart defects “physicians often must rely on instinct, back-of-the-envelope calculations and anecdotal case reports swapped at medical meetings, instead of the more rigorous clinical evidence.”

Filling in some of the gaps in research will be NCDR’s IMPACT Registry™ (For Improving Pediatric and Adult Congenital Treatment). The IMPACT Registry will assess the prevalence, demographics, management and outcomes of pediatric and adult patients with congenital heart disease who are undergoing diagnostic catheterizations and catheter-based interventions. The IMPACT Registry will provide significant contributions to the knowledge base and outcomes associated with congenital heart disease. For more information, visit: www.impact.ncdr.com.

Results of Value-Based Purchasing Demos Released

The Centers for Medicare and Medicaid Services (CMS) on August 17 announced the results of three demonstrations testing the effects of offering financial incentives for improving or delivering high quality care. The demonstrations, which were part of a CMS value-based purchasing initiative, took place in three care settings: large physician practices, small physician practices and hospitals. CMS says that the results of the demonstration “continue to provide strong evidence that offering financial incentives for improving or delivering high quality care increases quality and can reduce the growth in Medicare expenditures.”

ACC Past Presidents, CEO Featured in JACC Article

ACC Past Presidents **James Dove, M.D., M.A.C.C.**, and **W. Douglas Weaver, M.D., M.A.C.C.**, and ACC CEO **Jack Lewin, M.D.**, are featured in the Sept. 8 issue of the *Journal of the American College of Cardiology* (JACC) discussing the feasibility of implementing accountable care organizations (ACO) as part of delivery system reform. Dove, Weaver and Lewin discuss the legal challenges of implementing the ACO concept in the ambulatory setting in practices not part of an established integrated system. However, they note that because delivery system reform is necessary, experimentation with different concepts, including the ACO concept, should be part of this process. To read more, pick up the Sept. 8 issue of JACC.

Class I Recall of Abbott Catheter

Abbott and the Food and Drug Administration (FDA) have issued a national Class 1 recall of four lots of POWERSAIL Coronary Dilatation Catheters after complaints that the distal shaft of the catheter exhibited damage. This damage could lead to catheter functional failures and clinical consequences, including air embolism and myocardial infarction. Customers with questions or concerns should call the company at 1 (800) 227-9902. Any adverse reactions experienced with the use of this product and/or quality problems should also be reported to the FDA’s MedWatch Adverse Event Reporting program by phone at 1 (800) 332-1088 or online at www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm.



ACC Submits Comments on Proposed Physician Fee Schedule

The ACC in late August submitted comments to the Centers for Medicare and Medicaid Services (CMS) on its proposed 2010 Physician Fee Schedule, articulating ACC's strong opposition to many of its provisions. Under the proposed rule, total Medicare payments to cardiology are projected to decrease by 11 percent, but some services could be cut by as much as 42 percent. Highlights of the ACC comments are below.

Practice Expense

In its comments, the ACC decries the use of the American Medical Association's (AMA) Physician Practice Information Survey to calculate practice expense relative value units (RVUs). This proposed change would result in payment cuts ranging from 10 percent to 42 percent for many common cardiology services. The AMA data has not been reviewed for precision or accuracy, and the ACC is strongly urging CMS (and Congress) not to finalize this proposal without further examination. See sidebar for more on ACC's efforts.

Equipment Utilization

The comments also articulate ACC's opposition to a proposal to adopt a 90 percent utilization rate for equipment with an acquisition cost greater than \$1 million. This proposal would reduce the practice expense RVUs for services using that equipment. The proposal is based on findings from limited studies that only examine the use of computed tomography and magnetic resonance imaging machines. No studies exist to

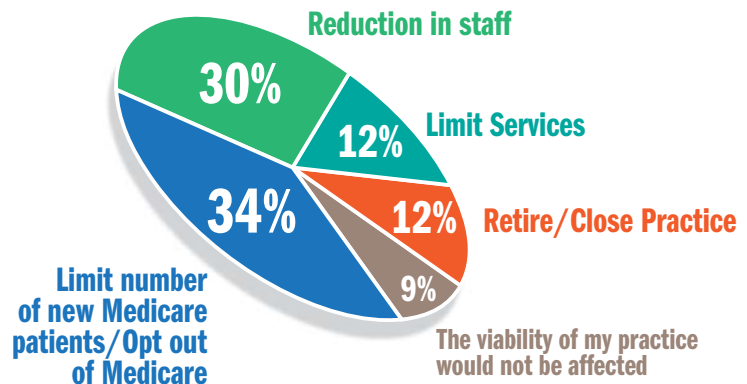
“ We are already struggling. My income is down about a third of what it was 3 years ago. Much more pressure and I will have to pay to practice cardiology! ”

F.A.C.C. from Tennessee

Practice Viability Poll

91% of respondents indicated that the viability of their practice would be affected.

CMS has proposed 2010 payments cuts that could range from 20-40 percent for cardiovascular practices. If these cuts go through, what is the primary way your practice viability will be affected?



Posted on www.cardiosource.com with 392 responses

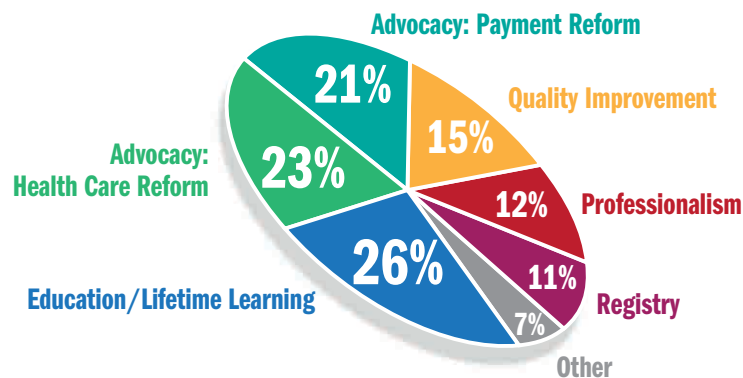
test the use of other equipment covered by the proposed change. In addition, the study used was not nationally representative.

Malpractice

CMS proposes to update the malpractice RVUs with data from a new survey of specialty-level malpractice premiums, along with a new method for determining malpractice RVUs for technical component services. While

the ACC comments support some provisions of the malpractice proposed changes, they also raise concerns about the implementation of the new malpractice RVUs methodology and recommend they be phased in over two or more years. More importantly, the ACC recommends changes to the proposed RVUs to reflect the risk associated with interventional cardiology and electrophysiology procedures more accurately.

Allocation of ACC Time and Resources: Quality of Care



The ACC conducted an online survey with members from June 11 – 22, 2009. 5,418 e-mail invitations sent to members on June 11 and a reminder was sent on June 16. 554 members participated in the survey, resulting in a 10 percent response rate.

“ I already provide service in a rural setting with lower pay than my colleagues due to the Medicare payment formula. This decrease would have a profound impact on our ability to keep satellite offices open, and will likely cause me to retire earlier than previously planned. It will also make hiring new cardiologists to the area more problematic, since Maryland’s reimbursement is already on the low end of the states. We will not be able to hire competitively. All this while the population continues to age. ”

F.A.C.C. from Maryland

Consultations

The ACC expressed its vehement disagreement with CMS’ proposal to eliminate payments for consultations provided in office and hospital settings, stating that consultations often are more complex than the typical visit and worthy of higher valuation.

SGR

The ACC reiterated its opposition to the sustainable growth rate (SGR) to calculate Medicare physician reimbursement. As required by current law, the proposed rule includes a 21.5 percent reduction in physician payment beginning Jan. 1, 2010. However, the ACC did thank CMS for removing the cost of physician-administered drugs from the SGR.

PQRI

The proposed rule includes a number of new cardiology measures for the Physician Quality Reporting Initiative (PQRI), along with two new measures groups: heart failure and coronary artery disease, which the ACC recommended. In its comments, the ACC expresses support for these new measures groups, as well as for the proposed transition away from claims-based submission and toward registry-based submissions. However, the College cautions that registry-based submissions “must be balanced by a practical consideration of the current state of registries.”

Taking to the Streets

ACC chapters and cardiovascular specialists across the country are drawing attention to the impacts of the cuts on practices and patients. To date, ACC Chapters have generated more than 4,000 of letters from patients and cardiovascular care providers asking Congress to protect their access to quality cardiovascular care. ACC members have also been rallying each other to get involved, resulting in face-to-face visits with key House and Senate leaders and detailed letters to members of Congress about the affects of the cuts on practices, staff and local communities.

This month’s Legislative Conference is also looking to be the largest ever with more than 250 ACC members slated to descend on Capitol Hill, September 13-15. The ACC is also supporting the Cardiovascular Advocacy Alliance on their PR campaign designed to draw attention to the cuts and the need for real health reform.

With Congress back from recess and approximately two months before CMS releases its final rule, it’s critical that these efforts continue. The ACC has developed patient materials, talking points and sample letters, all of which are available at www.acc.org/can.





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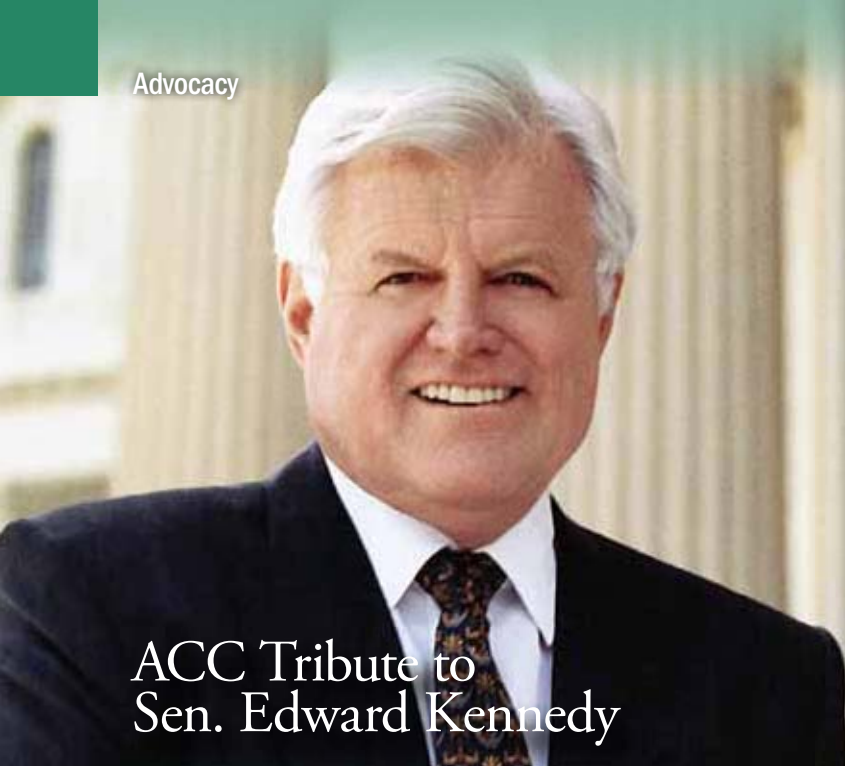


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ACC Tribute to Sen. Edward Kennedy

Sen. Edward M. Kennedy (D-Mass.) served in the U.S. Senate for nearly 47 years before succumbing to glioblastoma at the age of 77. Even through this challenge he waged a gallant effort. The “lion” of the Senate, Sen. Kennedy championed many progressive issues through his storied career, but none more consistently than his passion for health care. His clear vision was that all Americans should have access to affordable, high-quality care.

Known as the most organized and capable member of the Chamber of Colleagues, he was more able than any member in recent history to reach across the aisle to form bipartisan agreement on the toughest issues and with his toughest adversaries. He exhibited extraordinary and youthful leadership in helping President Lyndon B. Johnson with the passage of Medicare and Medicaid in 1965, just five years after assuming his brother’s Senate seat at age 30, and just two years after President John F. Kennedy’s assassination. It was then that he earned, and has maintained, a reputation as a man who was consistently true to his word and his promises, an increasing rarity in the politics of today.

Sen. Kennedy’s death comes during a time when the financial world has become especially jittery about increased federal spending and big initiatives, with the announcement that projections of the national debt greatly exceed previous forecasts. What timing: the sentiments and loyalties to the Lion will certainly tilt Congress’ agenda toward passage of some kind of historic health reform bill. Whatever it contains, it will be more than it might have been in his honor and memory. Regardless of partisan views and his often liberal leanings, all members of Congress, citizens of the nation, and members of the College should pause in respectful recognition that a great man has left the world stage, but that his legacy will surely live on in the health of our nation.

Jack Lewin
August 26, 2009

Advocacy Briefs

New on The Lewin Report: CCA Leader Encourages Action; Members React

ACC’s blog, *The Lewin Report*, in August featured commentary from **Margo Minissian, A.C.N.P.-B.C., M.S.N.**, chair of the CCA Chapter Liaison Working Group and co-chair of the Cardiovascular Team Council. Minissian discusses the importance of the entire care team meeting with their lawmakers on issues important to the cardiovascular community. She writes, “WE are the experts on health care, and our lawmakers need us to get up-to-date on the different issues.” Read the post in full and comment at lewinreport.acc.org.

Also on *The Lewin Report*, following July’s commentary from **Vince Bufalino, M.D., F.A.C.C.**, on the Proposed 2010 Physician Fee Schedule, several members wrote in to describe their reaction to the proposed rule. Their responses are varied, but the message is the same: These cuts cannot go through. Leave your thoughts on the proposed cuts at: lewinreport.acc.org. Also, make sure to check out the ACC on other social media sites like Facebook, LinkedIn and Twitter (twitter.com/ACCinTouch).

Members Blitz Media with Opinion Pieces

Several members in July and August were featured in opinion pieces in their local papers. Most recently, **Craig Clark, M.D., F.A.C.C.**, president of ACC’s Iowa Chapter, was a guest columnist in the *Des Moines Register*. He discusses the importance of focusing on the patient in designing health care reform because if the “focus [is] on patients, we will simultaneously increase quality and reduce expenses, making our system viable in the long term, so we can provide access to quality care for all Americans.”

On August 9, president of ACC’s Oregon Chapter **Michael Widmer, M.D., F.A.C.C.**, was featured in an opinion piece in the *Oregonian*. He describes the payment cuts under the proposed physician fee schedule and writes that they will “lead to reduced access and quality care for patients with cardiovascular disease,” as well as reduce the free care provided to the uninsured and indigent. ACC CEO Jack Lewin also was featured in *Roll Call* discussing health care reform. Links to the opinion pieces are posted at: qualityfirst.acc.org.

Use Tobacco Policies to Reduce Obesity, Former ACC President Says

Lawmakers should use policies that have lowered tobacco use as examples to address the U.S. obesity epidemic, according to a new report from the Urban Institute, co-authored by ACC Past President **Tim Garson, M.D., M.P.H., M.A.C.C.** The report, “Reducing Obesity: Policy Strategies from the Tobacco Wars,” notes that raising taxes on tobacco, improving labeling on tobacco products and restricting advertising helped to reduce use of tobacco and suggests that these tactics also could help reduce unhealthy eating habits among kids. The report is available at www.urban.org.

Valuation: The First Move Toward Physician-Hospital Integration

By William T. Carlson Jr.

When a group of cardiologists and a hospital agree to discuss the possibility of integration, the discussion typically follows a well-established path much like a three-act play: valuation, compensation and governance. This first of three articles will focus on valuation and some basic principles to guide cardiologists who are considering this move. October and November *Cardiology* will carry articles on compensation and governance, respectively.

Hospitals try to temper expectations by saying they cannot pay more than Fair Market Value (FMV) for a practice. While the concept captured in the Internal Revenue Code for non-profit hospitals and in the federal anti-kickback statutes for all Medicare providers is true, it is not the whole truth. What hospitals don't tell cardiologists is FMV is more art than science, and it is not a single dollar figure but varies based on both the practice and the valuation consultant. By way of example, I have seen valuations of less than \$100,000 per cardiologist to more than \$1,000,000 per cardiologist.

To determine FMV, most hospitals hire an outside accounting firm to provide an independent FMV opinion. To provide this FMV opinion, the group must provide at least 12 months of detailed financial data about its revenue, expenses and productivity.

Principle #1:
Do not provide any financial data without a signed Confidentiality Agreement.

The rationale for this principle is that you will have provided significant proprietary information about your practice if the transaction does not close. This data could enable the hospital to make offers to a few of the group's most productive cardiologists. Data could provide information concerning the group's commercial contracts thereby giving hospitals a potential negotiating advantage. While most hospitals act more honorably than that, a Confidentiality Agreement provides the group with legal rights in case they do not.

Principle #2:
Make the valuation firm a party to the Confidentiality Agreement.

Invariably valuation firms ask for more information than necessary to perform an initial valuation. However, because some of the information they request could yield a more accurate valuation report, you may want to provide it with some additional protection. If the valuation firm is a party to the confidentiality agreement, they can receive the raw data for purposes of their analysis, but would agree not to provide anything

but the analysis to the hospital without the cardiologists' permission. In addition, if the valuation firm violates the Agreement, it is easier to proceed against them if necessary.



Principle #3:
The income valuation approach may be the most popular, but is the least useful for physician practices.

Accounting firms typically use one of three methodologies to value a practice: income, market and asset. The income — or discounted cash flow — methodology is the one accounting firms gravitate to first because it is the one most often used in the sale of other businesses. This methodology looks at the EBITDA (earnings before interest, taxes, depreciation and amortization) trend for a business and assigns a “multiple” in order to calculate the business’s value. The multiple is higher if EBITDA is growing; if EBITDA

is stagnant or declining, the multiple is lower.



Of course, the problem is that most cardiology practices do not have earnings. As a matter of good tax planning, practices distribute their cash at year-end. While some accounting firms attempt a work-around for this “no earnings” problem, the simple truth is that the income method does not work well in the sale of cardiology practices.

Principle #4:
The market approach is the most accurate, but lack of data means it is not helpful.

A basic definition for FMV is the value a willing buyer will pay a willing seller when neither party is compelled to enter into the transaction. Therefore, in determining FMV, it would be helpful to know the price other cardiologists have received when they willingly sell their practice to a hospital buyer, especially when the price is a result of more than one hospital competing for that practice.

Multiple problems make this approach unrealistic. First, there is no national database that contains this information. After all, even national firms do less than a handful of cardiology practice sales a year. Second, it is impossible to control for all the variables that might affect a practice’s FMV. For example, a group of cardiologists who work at a single hospital will be valued differently from a group of the same size that works at six different hospitals. The value of groups also will be affected by such things as productivity, age stratification, number of diagnostic modalities and the usage of those ancillary services. As a result, the price one cardiology practice receives is unlikely to be indicative of the FMV of another practice, given the likely variance in these factors.

Principle #5:
The asset methodology is usually the fairest approach.

Because the asset approach is divided into tangible and intangible assets, it is usually the fairest approach. The tangible side of the equation is straightforward. It is the value of your computers, desks, nuclear cameras, echo machines and so on. Many accounting firms will use a book value approach for the initial valuation, but will hire an outside firm to inventory and value every tangible asset of the practice before the transaction is actually closed.

The intangible side of the equation is anything but straightforward. Most hospitals think intangible value is synonymous with “goodwill,” but such thinking is wrong. Said another way, most cardiology practices have an intangible value that should be recognized. For example, many groups have practice names, logos and even telephone numbers that are recognized throughout their communities.

However, because it can be difficult to value these intangible elements, the most common approach accounting firms use is called “workforce-in-place.” They will attempt to estimate what it would cost to re-create the practice by hiring replacements for the physicians, clinical and non-clinical staff. Accounting firms also often assign intangible value for a practice’s medical records. The amount will vary based on whether the cardiologists use paper charts or have transitioned to an electronic health record.

Because of the broad view that the asset method encompasses, it is most often thought to be the fairest valuation methodology.

Carlson is with Maynard Cooper & Gale, P.C., Birmingham, Ala.



DMAA Comments on Health Care Reform and Chronic Disease Management

By Jeanette C. May, Ph.D., M.P.H.



Policymakers crafting health care reform initiatives do seem to understand that chronic disease is the primary driver of health care costs in the U.S. As such, several themes have emerged in the debate on how to respond and mitigate the increasing prevalence and cost of caring for chronically ill individuals.

The themes include increased and continued emphasis on wellness and prevention, improved coordination of care, effective transitions of care, the role of health teams, an increased role for accountability and expanded adoption of health information technology.

These themes were apparent in the 2009 stimulus legislation, the American Recovery and Reinvestment Act of 2009 (Pub.L.111-5), as well as in various health system reform proposals now before House and Senate committees.

These themes align closely with the direction of population health management in recent years and expansion beyond single-state disease management to whole person, total population management that we have seen. This expansion has included a dramatic increase in health care team building, collaboration and support for the primary care physician as the health team leader.

“ Various reform models under consideration — such as accountable care organizations (ACOs), patient-centered medical homes and health care cooperatives — share strategies and components that have roots in population health management. The population health management industry supports these various care delivery models and the ultimate goals of improved care coordination, reduced health care costs and better patient outcomes. ”



Various reform models under consideration — such as accountable care organizations (ACOs), patient-centered medical homes and health care cooperatives — share strategies and components that have roots in population health management. The population health management industry supports these various care delivery models and the ultimate goals of improved care coordination, reduced health care costs and better patient outcomes.

These various health care delivery models share strategies and components, including —

- population identification strategies and processes
- comprehensive needs assessments — physical, psychological, economic and environmental
- proactive health promotion programs that increase awareness of the health risks associated with certain behaviors and lifestyles



- patient-centric health management goals and education, including prevention and behavior modification
- self-management interventions
- routine reporting and feedback among patients, caregivers, providers and health plans
- evaluation of clinical, humanistic and economic outcomes on an ongoing basis.

Health information technology (IT) plays a critical role in the success of these programs, and the population health management industry has a long history of using advanced health IT for effective coordination and service delivery. Their experience and expertise contribute significantly to the health reform discussion as health IT continues to be seen as an essential element for health care change.

Health care reform debates have also placed greater emphasis on understanding both clinical and financial program outcomes. These outcome evaluations will play an increasingly important role in coming years as more emphasis is placed on comparative effectiveness. Comprehensive consensus guidelines for program evaluation developed by the population health management industry offer important opportunities for understanding the value of population health management and will help to inform comparative effectiveness research.

May is vice president, research & quality, DMAA: The Care Continuum Alliance, Washington, D.C.

Strengthen Your Team with the CCA Member-Get-a-Member Program

The American College of Cardiology values Cardiac Care Associate (CCA) members as important players on the health care team, particularly in their highly interactive roles with the patients. The College also knows that ACC members are the best communicators when it comes to telling their cardiac care team colleagues about the value of ACC membership and the College's commitment to quality health care for patients. Now you have the opportunity to play an active role in connecting all qualified cardiac care team professionals with the College by participating in the new CCA Member-Get-a-Member Program.

When you refer a colleague for ACC Cardiac Care Associate membership, you are offering to share with them the clinical education, networking and leadership opportunities that you experience now. With the College's publications, Web site resources and programs, your new colleagues will receive the latest cardiovascular care guidelines and patient education resources. Most important, sharing the value of ACC membership strengthens the power of all of us who are committed to educating ourselves on the best care and advocating for better health care policies.

Beginning Sept. 1, 2009, the ACC will reward every member who recruits a new CCA member – that includes nurse practitioners, registered nurses, clinical nurse specialists, physician assistants and pharmacists. With each new CCA member referred, the referring member will earn \$20 in discounts to put toward ACC educational products and programs. Top recruiters will be recognized in *Cardiology* magazine and the Cardiovascular Care Team Newsletter.

Star recruiters referring more than five new CCA members by Dec. 31, 2009 will also be eligible for several prizes including:

- Grand Prize: **Apple iPod Touch 16G**
- Second Prize: **Free Domestic Roundtrip Ticket on United or American Airlines**
- Third Prize: **\$100 gift card**

Send referrals to Kelli Bohannon at kbohanno@acc.org or visit ACC.org/CCArecruitment for more information and to download a recruitment toolkit and membership application. Please write your name at the top of the form, or be certain to remind your colleagues to include your name when submitting their application to the College so that you receive credit.





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ACPC Working Group Developing Quality Metrics



In March 2008, the ACC Performance Measures Working Group invited members of ACC's Adult Congenital and Pediatric Cardiology (ACPC) Section to an open discussion to identify performance measures relevant to the practice of general pediatric cardiology. This initial step led to the formation of the ACPC Quality Metrics Working Group, which set to work on filling the void that existed in pediatric cardiology.

More than 80 members divided into teams to define quality measures in eight areas: heart failure/transplantation, imaging, adult Congenital Heart Disease, general pediatric cardiology, electrophysiology, cardiac intervention, critical care and nursing. They worked to determine not only what constitutes a valid indicator of quality, but also how to measure it accurately.

"The challenge is getting the measures honed down so they really make sense in the end," said **Kathy Jenkins, M.D., M.P.H., F.A.C.C.**, senior vice president, chief safety and quality officer and a senior associate in cardiology at Children's Hospital Boston. "What is the population? What's in the numerator? What's in the denominator? How will you display that measure? Does it need to be risk-adjusted? If so, what methodology should be used? That's the hard part."

Ultimately, the Quality Metrics Working Group wanted to create a scorecard that medical centers could use to judge their own quality of care. Examples of quality metrics under

development include sedation-related practices and complications, use of CT and MRI after surgery for coarctation of the aorta and catheter-associated bloodstream infections.

These and other measures are in the vetting process now. Participants have been able to post preliminary measures on a Web portal to obtain feedback from other members of the working group and receive updates on quality improvement. The next step was reviews by the ACPC Section and Council and the ACC Task Force on

Performance Measures. The expectation is that several of the quality metrics will be approved soon.

"I'm very excited about this," Jenkins says. "The best quality measures are coming from within the pediatric subspecialty areas, and I think we're really going to jump ahead of the game. We're creating a process that is very forward looking."

Other ACPC News

Charles E. Mullins, M.D., F.A.C.C., will deliver the first McNamara Lecture in conjunction with Congenital Cardiology Solutions (CCS.10) at ACC.10 in Atlanta, March 14 – 16, 2010. The McNamara Lecture was established to honor **Dan Goodrich McNamara, M.D., M.A.C.C.** McNamara is internationally recognized as a pioneer in the congenital heart disease field. Information about the McNamara Lecture and corresponding endowment is available at www.acc.org/membership/community/pediatric.



ADULT CONGENITAL & PEDIATRIC CARDIOLOGY
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FELLOWS IN TRAINING
American College of Cardiology

Fellows in Training News

FIT 2009 – 2010 Research, Travel Awards

Applications are being accepted for the 2009 – 2010 research and travel awards for fellows in training. The application deadline for FIT Travel Awards for ACC.10 is Oct. 30, 2009. The deadline for research and career development awards is Oct. 6. Information is available at: www.acc.org/about/award/awardoppo.htm.



Chapter Involvement

More and more FITs are getting involved in their local ACC chapters. To find out what is happening with your local chapter, go to: www.acc.org/about/chapters/chapters_list.htm



What FITs Are Talking About

Several fellows in training have raised important issues in the FIT TalkBack forum on *Cardiosource.com*. Topics include cardiology training programs issues, contract pitfalls with new jobs and CME scores and quality of care. Take a few moments to join these discussions with your FIT colleagues or start a new discussion. Go to: www.cardiosource.com/forum.



Puerto Rico Considers FIT Needs

The ACC Puerto Rico Chapter is developing a series of activities that will address the needs of its fellows in training. The first conference, "How to Establish Your Cardiology Practice" will be held Oct. 27, 2009. For more information, call (787) 649-7681 or (939) 644-3771.



1949 The 14 founders of the American College of Cardiology contribute \$15 each to fund the incorporation of their new organization.



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ACCEL

Revascularization in the Very Elderly: Harmful or Helpful?

Is 85 the new 70? For many years, clinical trials would often “top out” by excluding patients older than 70 years. That predisposition or — and perhaps a Catch-22 — often filtered down to clinical practice, where older patients were less likely to receive various treatments because they were untested in this growing population.

Of course, aging does present particular concerns, but researchers are trying to determine if these challenges preclude certain treatments. For example, the Hypertension in the Very Elderly (HYVET) study, which involved 3,845 patients ages

The ACC/American Heart Association guidelines note that age alone should not be the single criterion when considering revascularization. However, does revascularization benefit the very elderly?

80 or older, demonstrated that use of indapamide plus perindopril not only reduced hypertension in this population but also reduced total mortality, fatal stroke and heart failure.

When considering revascularization in the very elderly, registry data show that apprehension about elevated risk is well-founded. In-hospital mortality associated with percutaneous coronary intervention (PCI) is less than 1 percent in those under 60 years but greater than 5 percent in those over 80. Nonfatal complications increase in older patients as does the duration of post-procedural disability and rehabilitation.

According to **Cindy Grines, M.D., F.A.C.C.**, vice chief of academic affairs at William Beaumont Hospital, Royal Oak, Mich., physiology in the elderly definitely presents obstacles to revascularization. “Vessels become stiff, calcified, making it more likely there will be difficulty with access as well as difficulty with performing percutaneous interventions,” she said. Plus, there are physiologic changes (e.g., endothelial dysfunction), fewer collaterals and left ventricle thickening, creating more diastolic and systolic dysfunction.

The ACC/American Heart Association guidelines note that age alone should not be the single criterion when considering revascularization. However, does revascularization benefit the very elderly? In the TIME study, investigators compared PCI or bypass to optimized medical therapy in coronary artery disease patients 75 years or older with angina refractory to standard therapy. The revascularization advantage seen at six months disappeared at one year, and each therapy presented risks such that neither could claim a clear advantage overall.

Mortality and complication rates in the elderly rise exponentially with age, Grines added, “so, we tend to be more selective in terms of weighing the risk/benefit ratio in the elderly.” Part of that equation involves greater intolerance — or at least a narrower range of tolerance — for various medical therapies. For example, lower heart rates in the very elderly require judicious use of beta blockade and optimal anti-anginal therapies often cannot be titrated appropriately for these patients.

However, newer agents such as bivalirudin may be more efficacious than heparin in reducing intervention-related bleeding; plus, technological advances, such as smaller sheaths, may ameliorate some vascular access concerns. These are critical issues, said Dr. Grines: “You have to assume the elderly patient has coronary disease. In my opinion, once you ascertain that the patient has coronary disease, you should be evaluating them for any potential need for revascularization.”



1986 The U.S. Postal Service honors Paul Dudley White, M.D., with a commemorative stamp.



1961

The first ACC International Circuit Course brings continuing education to cardiologists in the Philippines and Taiwan.



LOUIS F. BISHOP, M.D.
PRESIDENT, 1961

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ALFRED BOVE, M.D., F.A.C.C.
PRESIDENT, 2009



ACC THEN AND NOW: 60 YEARS OF QUALITY IN EDUCATION



Practice Integration Guidance and More at November Symposium

Health care reform and economic downturns are leading many cardiovascular practices to take a look at new models for many aspects of their practices. To that end, the American College of Cardiology Foundation's (ACCF) has scheduled a new symposium, "Evolving Models of Cardiovascular Practice," to address health care reform proposals that will have significant implications for cardiology — from reimbursement and practice workflow to employment models for providers of cardiology services.

Experts at the symposium will discuss ways in which cardiovascular professionals may optimize their practices and thrive in this rapidly changing health care reform and economic environment. Many of the presenters are the authors of ACC's "Practice Opportunities: Practice Integration, Management Contracts, Practice Opportunities" Whitepaper. These experts in practice integration will provide information about various models and accountable care organizations.

The symposium will be held Nov. 5 – 6, 2009, at Heart House, Washington, D.C. Topics include —

- State of Health Care and the Cardiology Practice
- Environmental Scan, Drivers Behind Various Alignment Models
- Models of Practice Alignment
- The Hospital CEO Vantage Point
- Case Studies on Physician Alignment Models and Legal Issues

The list of speakers includes James T. Dove, M.D., M.A.C.C.; Jack C. Lewin, M.D., ACC CEO; Fred Bove, M.D., F.A.C.C., Ph.D.; Mike Carlson (see pages 14 and 15); and Michele M. Molden, president and chairman of the Board, Piedmont Heart Institute.

For more information and to register, please visit www.acc.org/practiceopportunities.

It's Time to Think about ACC.10 and i2.10

It may be 2009 still, but it's time to start making your plans for ACC.10 and i2.10, March 14 – 16, 2010, in Atlanta. Member registration opens September 15. Be sure to mark down these important dates:

Sept. 15:	Member Registration Opens (Remember that members get the first choice on hotels if they register now!)
Sept. 29:	Non-member Registration Opens
Oct. 6:	Deadline for Call for Abstracts
Oct. 19:	Deadline for Early Bird Registration



While you're thinking about registration, make sure to set your Twitter account to follow ACC.10 and i2.10 (@ACC_10) on Twitter. Visit twitter.com/ACC_10 for updates on registration dates and deals, as well as the latest news and highlights. When you tweet about the ACC.10 or i2.10, use the #ACC10 hash tag so that others can follow the discussion. For more information on what Twitter is and how to use it, visit help.twitter.com.

CardioQuestions Self-Assessment Program Now Available

ACCF presents the new online self-assessment program designed to help you with the Maintenance of Certification (MOC) process. Consisting of 100 self-assessment questions reflecting all areas

CardioQuestions

of general cardiology, the product is designed to help you obtain points toward the MOC program, prepare for the Board exams, and/or identify clinical knowledge gaps. For more

information or to order CardioQuestions online www.acc.org/education/products/cardioquestions.htm

Please note that all purchasers of ACCSAP 7 have complimentary access to this product, so if you've already bought ACCSAP 7, you simply need to login to Cardiosource and click this program's "Start Program" button to get access.

AMA Urges: Get Involved with Reform

The American Medical Association (AMA) is urging health care practitioners to get involved in health care reform. In a letter from President **Jim Rohack, M.D., F.A.C.C.**, the AMA explains its support of HR 3200, the House health reform bill. The bill will achieve many of AMA's



high-priority goals, Rohack writes, including increasing access, investing in the physician workforce, making positive changes to the payment formula, increasing attention to preventive care and wellness, and simplifying administrative burdens for patients and physicians. Rohack notes that "there will be ample opportunity to work with legislators on refinements to the bill" and the AMA will "continue to work collaboratively with legislators of both political parties" to "share our views with the White House."

The AMA has developed a dedicated health care reform web page on which it posts important facts and breaking news, so that physicians have access to the best, most up-to-date information about reform. Visit www.ama-assn.org/go/reform now to sign up for e-updates, get the latest news, download patient information and take action.

ACC CEO in Top 100 Most Powerful in Health Care

ACC CEO **Jack Lewin, M.D.**, has been named as one of the "100 Most Powerful People in Healthcare," according to *Modern Healthcare* magazine. The heads of several major medical associations were on the list, with Lewin ranked No. 80; president of the American Academy of Family Physicians, Ted Epperly, ranked No. 84; Executive Vice President and CEO of the American College of Physicians ranked No. 86; and J. James Rohack, president of the American Medical Association ranked No. 95. President Obama was ranked as the most powerful, followed by Department of Health and Human Services Secretary Kathleen Sebelius and White House Office of Health Reform Director Nancy Ann-DeParle ranking second and third, respectively. The full list is available at www.modernhealthcare.com.



ACC.08 Exposition Honored in Top 100 Trade Shows

The ACC.08 Exposition, which was held in conjunction with the Annual Scientific Session in Chicago, is one of only four medical meetings selected to be honored at Trade Show Executive magazine's 2nd Annual Gold 100 Awards and Summit, which honors the 100 best and brightest in the trade show industry. The other three societies were HIMSS, the Radiological Society of North America and the Academy of Orthopaedic Surgeons. Among the non-medical honorees are the who's who of trade show giants: International CES, CONEXPO-CON/AGG, CTIA (wireless communications), NAB (broadcasters), MINExpo, PITTCO, and MAGIC.

**CARDIOLOGY DIVISION DIRECTOR
DEPARTMENT OF INTERNAL MEDICINE
FACULTY RECRUITMENT ADVERTISEMENT**

Saint Louis University, a Catholic Jesuit institution dedicated to student learning, research, health care and service, is seeking applications for a director of the Division of Cardiology, Department of Internal Medicine. Candidates are expected to have established leadership skills that exemplify academic excellence and the potential to develop a strong clinical and translational research program. The successful candidate will expand existing faculty, capitalizing on areas of excellence; integrate strong clinical cardiology programs at St. Louis VAMC with Saint Louis University Hospital programs; and help develop collaborative research programs with the basic science Center for Cardiovascular Research. The position has an endowed professorship and funding to recruit faculty that will further enhance Saint Louis University School of Medicine as a regional and national leader in the provision of outstanding cardiac health care and the training and education of physicians. Eligibility for licensure in Missouri and certification by the ABIM in internal medicine and cardiovascular diseases are required. Salary and academic rank will be commensurate with experience and qualifications.

Interested candidates should submit a cover letter, application and curriculum vitae to <http://jobs.slu.edu>. Additionally, candidates should send a cover letter and current curriculum vitae to:

*Search Committee,
c/o Bernard R. Chaitman, M.D., Chairman
Cardiology Search Committee
Saint Louis University School of Medicine
1034 S. Brentwood Blvd., Suite 1550
St. Louis, MO, 63117
chaitman@slu.edu.*

Review of applications begins immediately and continues until the position is filled.

Saint Louis University is an Affirmative Action, Equal Opportunity Employer, and encourages nominations and applications of women and minorities.

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

**GENERAL
CARDIOLOGY**
Walla Walla Washington

Natural beauty in the heart of Washington's wine country is part of the package available to an invasive non interventional cardiologist. We are a 20 provider group cardiology practice with multiple locations within Oregon and are looking to expand into Washington. We are looking for candidates with a full range of general cardiology skills, including Echo, diagnostic Cath, pacemaker implantation, BE/BC and comfortable building a practice with full administrative support from the group. We offer a competitive salary and benefits package as well as an opportunity for full partnership or employment status.

Please forward CV to:
Northwest Cardiovascular Institute LLP
Attn.: Sally Sparling, CEO
2222 NW Lovejoy, Suite 606
Portland, Oregon 97210
sallysparling@nw-ci.com

Central Alabama Veterans Health Administration (CAVHCS),

is recruiting for one physician for a position in the Acute Care Service and Specialties Service Line. Noninvasive Non-interventional Cardiologist needed. Applicants should be Board Certified or Board Eligible in Cardiology. Must have the ability to perform and interpret trans-esophageal echo studies. Other clinical work includes cardiology outpatient clinic, inpatient consultation, ECG and Holter interpretation, trans-thoracic echo interpretation, exercise and pharmacologic stress and temporary pacing. The appointee will be an active participant in VA performance improvement activities, which include serving as Chairperson of the Critical Care Committee.

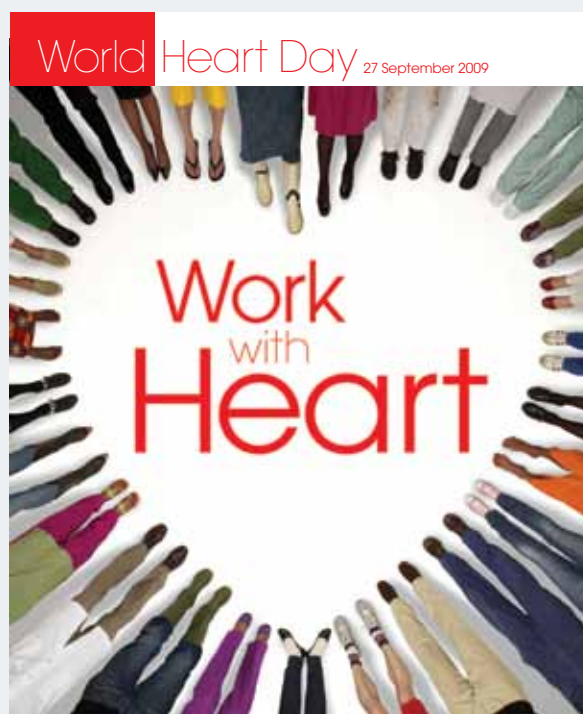
Applicants should have good computer skills. CAVHCS has two locations served by cardiology that are 36 miles apart. Some travel may be needed. On-call coverage is on an alternating basis at the acute care site in Montgomery.

Send CV's to : **Dan T. Stewart, HR Specialist**
Central Alabama Veterans Health Care System (CAVHCS)
2400 Hospital Road
Tuskegee, AL 36083
Phone Number: (334) 725-2756

About

Writing for Cardiology

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





Join Our Team

In Northern Michigan

ASPIRUS CARDIOLOGY is seeking a BC/BE Non-Invasive Cardiologist to join our team. We offer a team approach. Single hospital, exceptional benefits and upper percentile income potential. Employment track or Shareholder track available. Opportunities for cardiovascular research are available through our Cardiovascular Research & Educational Foundation (CaRE) in Wausau, Wisconsin.

Full time hours with NO CALL.

Become part of an award winning team!

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Contact Jamie Sitko, Physician Recruiter for Aspirus at 800-792-8728 or fax CV to 715-847-2742 or email: jamiesi@aspirus.org

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Beth Vance-Wehrli at 800-309-5388
Email: bethvanc@sarmc.org
Fax: 208-367-7964

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www.saintalphonus.org



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/BE interventional cardiologist to join our practice in Grand Forks, ND. Practice in a 262-bed, Level II Trauma Center with three state-of-the-art cath labs including Philips flat-panel technology with the most advanced diagnostic imaging and complemented by highly trained medical, nursing and technical staff, a 16-bed medical critical care unit and a 10-bed surgical critical care unit.

Altru also offers an extensive and comprehensive benefit package. To forward your CV for consideration contact: Jenny Semling, Altru Health System, PO Box 6003, Grand Forks, ND 58201-6003
Phone: 1-800-437-5373 Fax: 701-780-6641
Email: jsemling@altru.org Website: www.altru.org

CARDIOLOGY FACULTY POSITION

SOUTHERN
CALIFORNIA

The City of Hope National Medical Center, and NCI-designated comprehensive cancer center, is seeking a BE/BC Cardiologist to join the Department of Cardiology. Non-Invasive Cardiology experience including TEE and STRESS ECHO. 2-5 years of experience required.

Send CV to:

K. Venkataraman, MD
Department of Cardiology
City of Hope Medical Center
1500 E. Duarte Road
Duarte, CA 91010

September 2009 Cardiology

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This Month in

JACC

September 1

- Effect of Long-acting Testosterone Treatment on Functional Exercise Capacity, Skeletal Muscle Performance, Insulin Resistance and Baroreflex Sensitivity in Elderly Patients with Chronic Heart Failure: a Double-blind, Placebo-controlled Randomized Study
- Mutations in RNA Binding Protein Gene Cause Familial Dilated Cardiomyopathy
- Splicing and Dilated Cardiomyopathy: One Gene to Rule Them All?

September 8

- Bleeding Risk during Oral Anticoagulation in Atrial Fibrillation Patients Older than 80 Years
- Systematic Strategy of Prophylactic Coronary Angiography Improves Perioperative and Long-term Outcome after Major Vascular Surgery in Medium-High Risk Patients: A Prospective, Randomized Study

September 15

- Pharmacogenetics in Cardiovascular Antithrombotic Therapy
- Adenosine-induced Stress Myocardial Perfusion Imaging using Dual Source Cardiac Computed Tomography
- Effect of Intracoronary Streptokinase Administered Immediately after Primary Percutaneous Coronary Intervention on Long-term Left Ventricular Infarct Size, Volumes and Function

September 22

- Comparison of Omeprazole and Pantoprazole Influence on Clopidogrel Effect of a High 150 mg Maintenance Dose: the Proton Pump Inhibitors and Clopidogrel Association (PACA) Prospective, Randomized Study

- Baseline Heart Rate, Antihypertensive Treatment and Prevention of Cardiovascular Outcomes in the Anglo-Scandinavian Cardiac Outcomes Trial
- Association of Chronic Kidney Disease with the Spectrum of Ankle Brachial Index: The Cardiovascular Health Study

September 29

- Cardiovascular Effect of Bans on Smoking in Public Places: A Systematic Review and Meta-analysis
- Effects of Cardiac Resynchronization Therapy on Left Ventricular Twist
- Delayed Untwisting: The Mechanistic Link between Dynamic Obstruction and Exercise Tolerance in Patients with Hypertrophic Obstructive Cardiomyopathy









JACC cardiovascular Interventions

- Intravascular Ultrasound Comparison of the Retrograde vs Antegrade Approach to Percutaneous Intervention for Chronic Total Coronary Occlusions
- Transcatheter Aortic Valve Implantation: Review of the Nature, Management and Avoidance of Procedural Complications

JACC cardiovascular Imaging

- Safety of Contrast Agent Use during Stress Echocardiography: A Cohort Study from a Single-Center, 4-Year Experience With 26,774 Patients
- Identification of High Risk Patients with Ischemic Cardiomyopathy: Increasing Benefit from Revascularization is Associated with Increasing Amounts of Myocardial Hibernation. A substudy of the PARR2 trial

Educational Programs Calendar

	2009* ACCF/SCCT Coronary CTA Practicum <i>*Program Dates available online</i>	Washington, D.C. 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., FA.H.A., F.A.C.C. Joseph S. Alpert, M.D., F.A.C.C.	Washington, D.C. CE PA CME
	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
	May 6 - 8, 2010 32nd Annual Recent Advances in Clinical Nuclear Cardiology and Cardiac CT Featuring Case Review with the Experts Daniel S. Berman, M.D., F.A.C.C. Guido Germano, Ph.D., M.B.A., F.A.C.C. Jamshid Maddahi, M.D., F.A.C.C.	Washington, D.C. CME CE TECH

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



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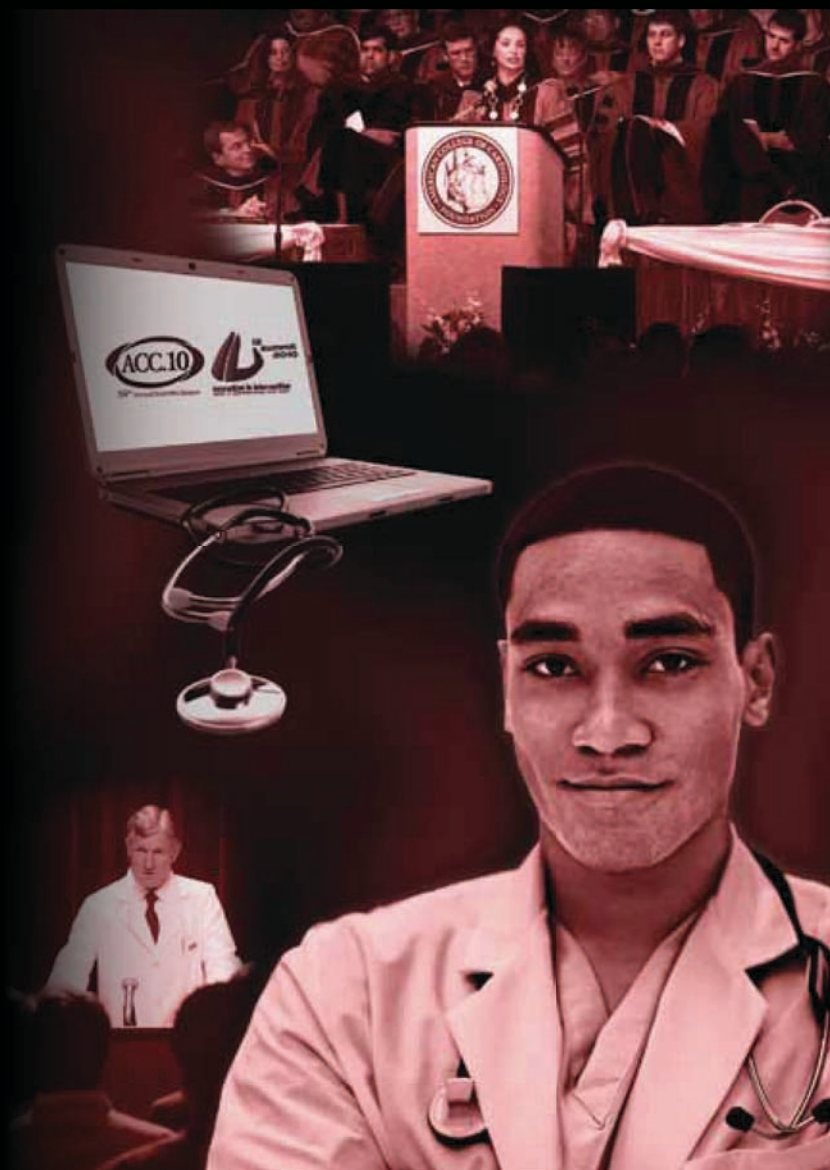
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