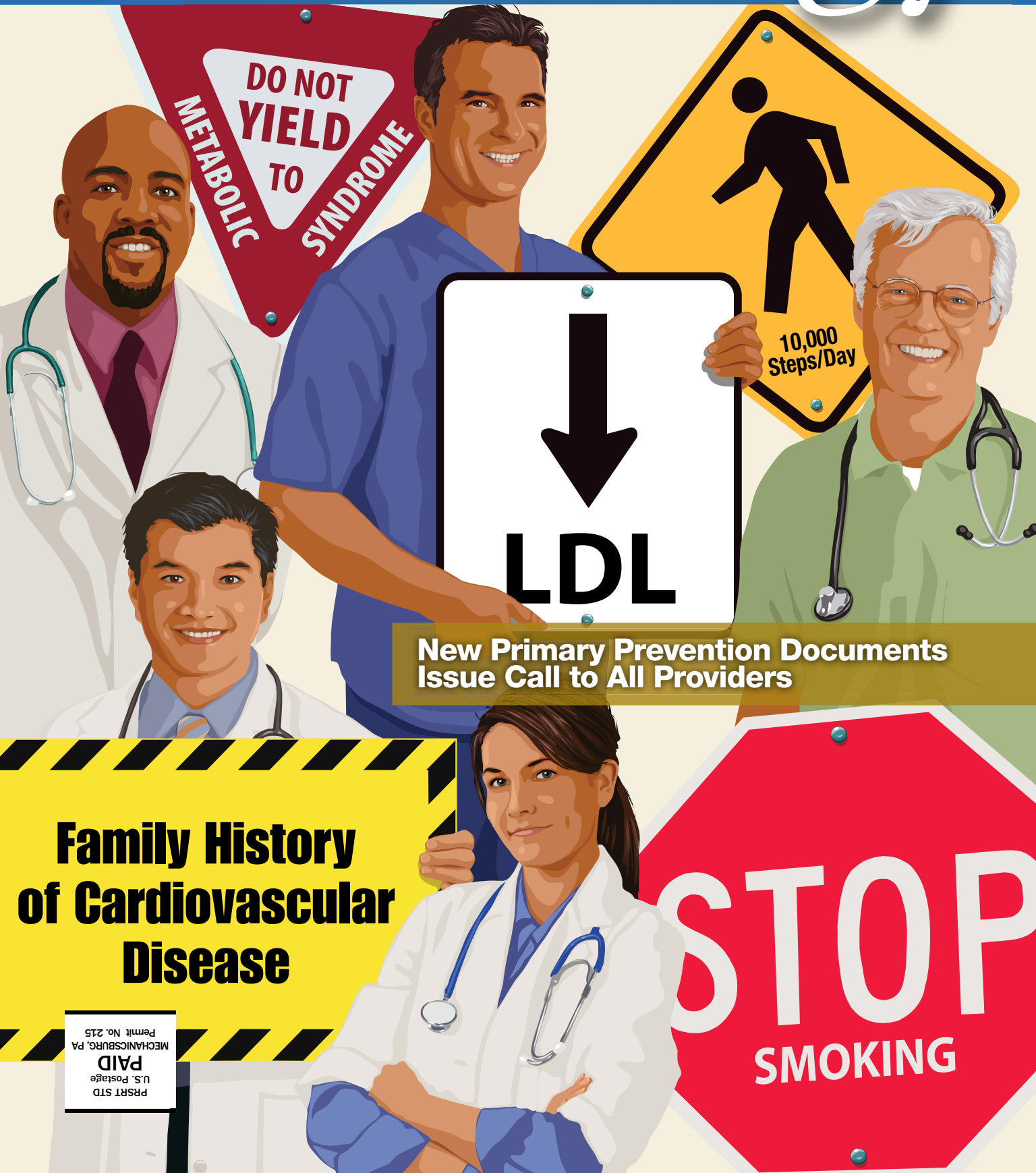




# Cardiology

A MEMBER PUBLICATION OF THE AMERICAN COLLEGE OF CARDIOLOGY



**New Primary Prevention Documents Issue Call to All Providers**

**Family History of Cardiovascular Disease**

**STOP SMOKING**

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Permit No. 215

*New*  **MULTAQ**<sup>®</sup>  
(dronedarone) **400**mg  
Tablets

*Now Approved!*  
*Now Available!*

Please see brief summary of Prescribing Information,  
including **boxed WARNING**, on adjacent page.

Visit [www.MULTAQ.com](http://www.MULTAQ.com)

**sanofi aventis**

Because health matters

**MULTAQ**  
(dronedaron) Tablets

Rx Only

Brief Summary of Prescribing Information

**WARNING: HEART FAILURE**  
**MULTAQ is contraindicated in patients with NYHA Class IV heart failure, or NYHA Class II – III heart failure with a recent decompensation requiring hospitalization or referral to a specialized heart failure clinic [see Contraindications (4)].**  
**In a placebo-controlled study in patients with severe heart failure requiring recent hospitalization or referral to a specialized heart failure clinic for worsening symptoms (the ANDROMEDA Study), patients given dronedarone had a greater than two-fold increase in mortality. Such patients should not be given dronedarone [see Clinical Studies (14.3) in the full prescribing information].**

**1 INDICATIONS AND USAGE**

MULTAQ® is indicated to reduce the risk of cardiovascular hospitalization in patients with paroxysmal or persistent atrial fibrillation (AF) or atrial flutter (AFL), with a recent episode of AF/AFL and associated cardiovascular risk factors (i.e., age >70, hypertension, diabetes, prior cerebrovascular accident, left atrial diameter ≥50 mm or left ventricular ejection fraction [LVEF] <40%), who are in sinus rhythm or who will be cardioverted [see Clinical Studies (14) in the full prescribing information].

**2 DOSAGE AND ADMINISTRATION**

The only recommended dosage of MULTAQ is 400 mg twice daily in adults. MULTAQ should be taken as one tablet with the morning meal and one tablet with the evening meal.

Treatment with Class I or III antiarrhythmics (e.g., amiodarone, flecainide, propafenone, quinidine, disopyramide, dofetilide, sotalol) or drugs that are strong inhibitors of CYP3A (e.g., ketoconazole) must be stopped before starting MULTAQ [see Contraindications (4)].

**4 CONTRAINDICATIONS**

MULTAQ is contraindicated in patients with:

- NYHA Class IV heart failure or NYHA Class II – III heart failure with a recent decompensation requiring hospitalization or referral to a specialized heart failure clinic [see Boxed Warning and Clinical Studies (14.3) in the full prescribing information]
- Second- or third-degree atrioventricular (AV) block or sick sinus syndrome (except when used in conjunction with a functioning pacemaker)
- Bradycardia <50 bpm
- Concomitant use of strong CYP 3A inhibitors, such as ketoconazole, itraconazole, voriconazole, cyclosporine, telithromycin, clarithromycin, nefazodone, and ritonavir [see Drug Interactions (7.2)]
- Concomitant use of drugs or herbal products that prolong the QT interval and might increase the risk of Torsade de Pointes, such as phenothiazine antipsychotics, tricyclic antidepressants, certain oral macrolide antibiotics, and Class I and III antiarrhythmics
- QTc Bazett interval ≥500 ms or PR interval >280 ms
- Severe hepatic impairment
- Pregnancy (Category X): MULTAQ may cause fetal harm when administered to a pregnant woman. MULTAQ is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to a fetus [see Use in Specific Populations (8.1)].
- Nursing mothers [see Use in Specific Populations (8.3)]

**5 WARNINGS AND PRECAUTIONS**

**5.1 Patients with New or Worsening Heart Failure during Treatment**

Advise patients to consult a physician if they develop signs or symptoms of heart failure, such as weight gain, dependent edema, or increasing shortness of breath. There are limited data available for AF/AFL patients who develop worsening heart failure during treatment with MULTAQ. If heart failure develops or worsens, consider the suspension or discontinuation of MULTAQ.

**5.2 Hypokalemia and Hypomagnesemia with Potassium-Depleting Diuretics**

Hypokalemia or hypomagnesemia may occur with concomitant administration of potassium-depleting diuretics. Potassium levels should be within the normal range prior to administration of MULTAQ and maintained in the normal range during administration of MULTAQ.

**5.3 QT Interval Prolongation**

Dronedaron induces a moderate (average of about 10 ms but much greater effects have been observed) QTc (Bazett) prolongation [see Clinical Pharmacology (12.2) in the full prescribing information and Clinical Studies (14.1) in the full prescribing information]. If the QTc Bazett interval is ≥500 ms, MULTAQ should be stopped [see Contraindications (4)].

**5.4 Increase in Creatinine after Treatment Initiation**

Serum creatinine levels increase by about 0.1 mg/dL following dronedaron treatment initiation.

The elevation has a rapid onset, reaches a plateau after 7 days and is reversible after discontinuation. If an increase in serum creatinine occurs and plateaus, this increased value should be used as the patient's new baseline. The change in creatinine levels has been shown to be the result of an inhibition of creatinine's tubular secretion, with no effect upon the glomerular filtration rate.

**5.5 Women of Childbearing Potential**

Premenopausal women who have not undergone a hysterectomy or oophorectomy must use effective contraception while using MULTAQ. Dronedaron caused fetal harm in animal studies at doses equivalent to recommended human doses. Women of childbearing potential should be counseled regarding appropriate contraceptive

choices taking into consideration their underlying medical conditions and lifestyle preferences [see Use in Specific Populations (8.1)].

**6 ADVERSE REACTIONS**

The following safety concerns are described elsewhere in the label:

- New or worsening heart failure [see Warnings and Precautions (5.1)]
- Hypokalemia and hypomagnesemia with potassium-depleting diuretics [see Warnings and Precautions (5.2)]
- QT prolongation [see Warnings and Precautions (5.3)]

The safety evaluation of dronedaron 400 mg twice daily in patients with AF or AFL is based on 5 placebo controlled studies. ATHENA, EURIDIS, ADONIS, ERATO and DAFNE. In these studies, a total of 6285 patients were randomized and treated, 3282 patients with MULTAQ 400 mg twice daily, and 2875 with placebo. The mean exposure across studies was 12 months. In ATHENA, the maximum follow-up was 30 months.

In clinical trials, premature discontinuation because of adverse reactions occurred in 11.8% of the dronedaron-treated patients and in 7.7% of the placebo-treated group. The most common reasons for discontinuation of therapy with MULTAQ were gastrointestinal disorders (3.2 % versus 1.8% in the placebo group) and QT prolongation (1.5% versus 0.5% in the placebo group).

The most frequent adverse reactions observed with MULTAQ 400 mg twice daily in the 5 studies were diarrhea, nausea, abdominal pain, vomiting, and asthenia.

Table 1 displays adverse reactions more common with dronedaron 400 mg twice daily than with placebo in AF or AFL patients, presented by system organ class and by decreasing order of frequency. Adverse laboratory and ECG effects are presented separately in Table 2.

**Table 1: Adverse Drug Reactions that Occurred in at Least 1% of Patients and Were More Frequent than Placebo**

	Placebo (N=2875)	Dronedaron 400 mg twice daily (N=3282)
<b>Gastrointestinal</b>		
Diarrhea	6%	9%
Nausea	3%	5%
Abdominal pain	3%	4%
Vomiting	1%	2%
Dyspeptic signs and symptoms	1%	2%
<b>General</b>		
Asthenic conditions	5%	7%
<b>Cardiac</b>		
Bradycardia	1%	3%
<b>Skin and subcutaneous tissue</b>		
Including rashes (generalized, macular, maculo-papular, erythematous), pruritus, eczema, dermatitis, dermatitis allergic	3%	5%

Photosensitivity reaction and dysgeusia have also been reported at an incidence less than 1% in patients treated with MULTAQ.

The following laboratory data/ECG parameters were reported with MULTAQ 400 mg twice daily.

**Table 2: Laboratory data/ECG parameters not necessarily reported as adverse events**

	Placebo (N=2875)	MULTAQ 400 mg twice daily (N=3282)
Serum creatinine increased ≥10% five days after treatment initiation	21%	51%
	(N=2237)	(N=2701)
QTc Bazett prolonged (>450 ms in males >470 ms in females)	19%	28%

Assessment of demographic factors such as gender or age on the incidence of treatment- emergent adverse events did not suggest an excess of adverse events in any particular sub-group.

**7 DRUG INTERACTIONS**

Dronedaron is metabolized primarily by CYP 3A and is a moderate inhibitor of CYP 3A and CYP 2D6 [see Clinical Pharmacology (12.3) in the full prescribing information]. Dronedaron's blood levels can therefore be affected by inhibitors and inducers of CYP 3A, and dronedaron can interact with drugs that are substrates of CYP 3A and CYP 2D6.

Dronedaron has no significant potential to inhibit CYP 1A2, CYP 2C9, CYP 2C19, CYP 2C8 and CYP 2B6. It has the potential to inhibit P-glycoprotein (P-gP) transport.

Pharmacodynamic interactions can be expected with beta-blockers; calcium antagonists and digoxin [see *Drug Interactions (7.1)*].

In clinical trials, patients treated with dronedarone received concomitant medications including beta-blockers, digoxin, calcium antagonists (including those with heart rate-lowering effects), statins and oral anticoagulants.

### 7.1 Pharmacodynamic Interactions

Drugs prolonging the QT interval (inducing Torsade de Pointes)

Co-administration of drugs prolonging the QT interval (such as certain phenothiazines, tricyclic antidepressants, certain macrolide antibiotics, and Class I and III antiarrhythmics) is contraindicated because of the potential risk of Torsade de Pointes-type ventricular tachycardia [see *Contraindications (4)*].

Digoxin

Digoxin can potentiate the electrophysiologic effects of dronedarone (such as decreased AV-node conduction). In clinical trials, increased levels of digoxin were observed when dronedarone was co-administered with digoxin. Gastrointestinal disorders were also increased.

Because of the pharmacokinetic interaction [see *Drug Interaction (7.3)*] and possible pharmacodynamic interaction, reconsider the need for digoxin therapy. If digoxin treatment is continued, halve the dose of digoxin, monitor serum levels closely, and observe for toxicity.

Calcium channel blockers

Calcium channel blockers with depressant effects on the sinus and AV nodes could potentiate dronedarone's effects on conduction.

Give low doses of calcium channel blockers initially and increase only after ECG verification of good tolerability [see *Drug Interactions (7.3)*].

Beta-blockers

In clinical trials, bradycardia was more frequently observed when dronedarone was given in combination with beta-blockers.

Give low dose of beta-blockers initially, and increase only after ECG verification of good tolerability [see *Drug Interactions (7.3)*].

### 7.2 Effects of Other Drugs on Dronedarone

Ketoconazole and other potent CYP 3A inhibitors

Repeated doses of ketoconazole, a strong CYP 3A inhibitor, resulted in a 17-fold increase in dronedarone exposure and a 9-fold increase in  $C_{max}$ . Concomitant use of ketoconazole as well as other potent CYP 3A inhibitors such as itraconazole, voriconazole, ritonavir, clarithromycin, and nefazodone is contraindicated [see *Contraindications (4)*].

Grapefruit juice

Grapefruit juice, a moderate inhibitor of CYP 3A, resulted in a 3-fold increase in dronedarone exposure and a 2.5-fold increase in  $C_{max}$ . Therefore, patients should avoid grapefruit juice beverages while taking MULTAQ.

Rifampin and other CYP 3A inducers

Rifampin decreased dronedarone exposure by 80%. Avoid rifampin or other CYP 3A inducers such as phenobarbital, carbamazepine, phenytoin, and St John's wort with dronedarone because they decrease its exposure significantly.

Calcium channel blockers

Verapamil and diltiazem are moderate CYP 3A inhibitors and increase dronedarone exposure by approximately 1.4- to 1.7-fold [see *Drug Interactions (7.1, 7.3)*].

Pantoprazole

Pantoprazole, a drug that increases gastric pH, did not have a significant effect on dronedarone pharmacokinetics.

### 7.3 Effects of Dronedarone on Other Drugs

Statins

Dronedarone increased simvastatin/simvastatin acid exposure by 4- and 2-fold, respectively.

Because of multiple mechanisms of interaction with statins (CYPs and transporters), follow statin label recommendations for use with CYP 3A and P-gP inhibitors such as dronedarone.

Calcium channel blockers

Dronedarone increases calcium channel blocker (verapamil, diltiazem or nifedipine) exposure by 1.4- to 1.5-fold [see *Drug Interactions (7.1)*].

Sirolimus, tacrolimus, and other CYP3A substrates with narrow therapeutic range  
Dronedarone can increase plasma concentrations of tacrolimus, sirolimus, and other CYP 3A substrates with a narrow therapeutic range when given orally. Monitor plasma concentrations and adjust dosage appropriately.

Beta-blockers and other CYP 2D6 substrates

Dronedarone increased propranolol exposure by approximately 1.3-fold following single dose administration. Dronedarone increased metoprolol exposure by 1.6-fold following multiple dose administration [see *Drug Interaction (7.1)*]. Other CYP 2D6 substrates, including other beta-blockers, tricyclic antidepressants, and selective serotonin reuptake inhibitors (SSRIs) may have increased exposure upon co-administration with dronedarone.

Digoxin and P-glycoprotein substrates

Dronedarone increased digoxin exposure by 2.5-fold by inhibiting the P-gP transporter [see *Drug Interactions (7.1)*]. Other P-gP substrates are expected to have increased exposure when coadministered with dronedarone.

Warfarin and losartan (CYP 2C9 substrates)

In healthy subjects, dronedarone at a dose of 600 mg twice daily increased S-warfarin exposure by 1.2-fold with no change in R-warfarin and with no clinically significant increase in INR. In clinical trials in patients with AF/AFL, there was no observed excess risk of bleeding compared to placebo when dronedarone was co-administered with oral anticoagulants. Monitor INR per the warfarin label. No interaction was observed between dronedarone and losartan.

Theophylline (CYP 1A2 substrate)

Dronedarone does not increase steady state theophylline exposure.

Oral contraceptives

No decreases in ethinylestradiol and levonorgestrel concentrations were observed in healthy subjects receiving dronedarone concomitantly with oral contraceptives.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

Pregnancy Category X [see *Contraindications (4)*]

MULTAQ may cause fetal harm when administered to a pregnant woman. In animal studies, dronedarone was teratogenic in rats at the maximum recommended human dose (MRHD), and in rabbits at half the MRHD. If this drug is used during pregnancy or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

When pregnant rats received dronedarone at oral doses greater than or equal to the MRHD (on a  $mg/m^2$  basis), fetuses had increased rates of external, visceral and skeletal malformations (cranioschisis, cleft palate, incomplete evagination of pineal body, brachygnathia, partially fused carotid arteries, truncus arteriosus, abnormal lobation of the liver, partially duplicated inferior vena cava, brachydactyly, ectrodactyly, syndactyly, and anterior and/or posterior club feet). When pregnant rabbits received dronedarone, at a dose approximately half the MRHD (on a  $mg/m^2$  basis), fetuses had an increased rate of skeletal abnormalities (anomalous ribcage and vertebrae, pelvic asymmetry) at doses  $\geq 20$  mg/kg (the lowest dose tested and approximately half the MRHD on a  $mg/m^2$  basis).

Actual animal doses: rat ( $\geq 80$  mg/kg/day); rabbit ( $\geq 20$  mg/kg)

### 8.3 Nursing Mothers

It is not known whether MULTAQ is excreted in human milk. Dronedarone and its metabolites are excreted in rat milk. During a pre- and post-natal study in rats, maternal dronedarone administration was associated with minor reduced body-weight gain in the offspring. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from MULTAQ, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother [see *Contraindications (4)*].

### 8.4 Pediatric Use

Safety and efficacy in children below the age of 18 years have not been established.

### 8.5 Geriatric Use

More than 4500 patients with AF or AFL aged 65 years or above were included in the MULTAQ clinical program (of whom more than 2000 patients were 75 years or older). Efficacy and safety were similar in elderly and younger patients.

### 8.6 Renal Impairment

Patients with renal impairment were included in clinical studies. Because renal excretion of dronedarone is minimal [see *Clinical Pharmacology (12.3)* in the full prescribing information], no dosing alteration is needed.

### 8.7 Hepatic Impairment

Dronedarone is extensively metabolized by the liver. There is little clinical experience with moderate hepatic impairment and none with severe impairment. No dosage adjustment is recommended for moderate hepatic impairment [see *Contraindications (4)* and *Clinical Pharmacology (12.3)* in the full prescribing information].

## 10 OVERDOSAGE

In the event of overdosage, monitor the patient's cardiac rhythm and blood pressure. Treatment should be supportive and based on symptoms.

It is not known whether dronedarone or its metabolites can be removed by dialysis (hemodialysis, peritoneal dialysis or hemofiltration).

There is no specific antidote available.

Manufactured by Sanofi Winthrop Industrie

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33440 Ambares, France

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Bridgewater, NJ 08807

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## Patients, Prevention, Payment Top ACC Agenda

Perhaps one of the better things that could come out of health care reform is the recognition that primary and secondary prevention of cardiovascular disease (CVD) is extremely important, and as such, it should be supported by payers. Most cardiovascular professionals see their patients after the time for many primary prevention steps has passed, and they are dealing more with secondary prevention. For this reason, the ACC guidelines, performance measures and competence statements have focused on secondary prevention.

Now, for the first time, the ACC, partnering with others, has developed and published two documents for primary prevention of CVD – the *ACCF/AHA/ACP 2009 Competence and Training Statement: A Curriculum on Prevention of Cardiovascular Disease* and the *ACCF/AHA 2009 Clinical Performance Measures for Primary Prevention*. Both documents have been developed with all providers, not just CV professionals, in mind. As you read the articles by the chairs of the two writing committees – **C. Noel Bairey Merz, M.D., F.A.C.C.**, and **Rita Redberg, M.D., F.A.C.C.** – you will find that both documents are the result of a collaborative approach among cardiologists, primary care physicians, family practitioners and other specialties.

Also important in the new performance measures is the addition of outcomes, efficiency and structures of care to processes of care in determining performance measures. These additions obviously help to further the quality improvement goals of performance measures.

Health care reform and the proposed fee cuts from the Centers for Medicare and Medicaid Services (CMS) continue to be in the forefront for most of us, and the ACC continues to press lawmakers on these issues. More than 350 ACC members attended the recent 2009 ACC Legislative Conference, which included visits to Congressional offices on Capitol Hill. ACC leadership and staff continue to carry the message and gather opposition to the CMS rule's implementation. As I am writing this column, we know that more than one-fourth of the members of Congress have written letters or asked questions of the Department of Health and Human Services about the rule's implementation. The letters and questions are the results of members contacting lawmakers directly on this issue. Don't stop calling, e-mailing or writing, and if you haven't taken action yet, time is running out. Contact your lawmakers now.

In this issue of *Cardiology*, several members have written articles on various issues related to health care reform and the fee cuts. Just as I encourage you to read their articles, I also encourage you to write and share your thoughts with your colleagues. This is a stressful time for many of us. If the CMS cuts go through as presented, some ACC members may have to shut down or severely modify their practices. Your ideas and thoughts may be useful to a colleague, if only to let them know that they are not alone.

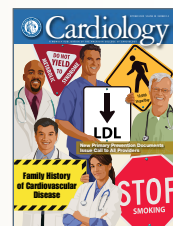
Finally, I return to our main purpose as physicians – the patients. By all estimates, we face a tough influenza season, compounded by the H1N1 virus. The ACC has always recommended that members make sure their patients get flu vaccines. The ACC Adult Congenital and Pediatric Cardiology Section – and Mended Hearts, Inc., as well – offers a reminder about the flu vaccine to all of us. Please make sure you follow up on the vaccines with your patients, your staff and yourselves.

Within the month we will know more about the immediate outcomes of our efforts on the CMS proposed cuts and health care reform and be able to discuss our next steps to ensure our ability to provide quality care to our patients.

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

October 2009

**4** **New Primary Prevention Documents Issue Call to All Providers**  
*Writing committee chairs for new Competence and Training Statement and Performance Measures take cardiovascular disease prevention to all members of the house of medicine*



**8** **Commentary**  
**Health Care Reform Perspectives Bending the Cost Curve Cardiology Workforce Crisis**

**12** **Advocacy**  
**ACC 2009 Legislative Conference Takes Hill by Storm Senate Finance Begins Health Reform Mark Up**

**14** **Fellows in Training**  
**We Need Everyone Involved if We Want to Win**

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## NEW PRIMARY PREVENTION DOCUMENT

## Training for Primary Prevention of CVD Fits Broader Spectrum

By C. Noel Bairey Merz, M.D., F.A.C.C.



**T**he introduction of the *ACCF/AHA/ACP\* 2009 Competence and Training Statement:*

*A Curriculum on Prevention of Cardiovascular Disease (CVD)* makes a clear statement about where the responsibility for primary prevention of cardiovascular disease (CVD) resides. CVD prevention falls under the purview of all health care providers — not just CV professionals — as is evidenced by the long list of other specialty societies that collaborated on this document.\*\*

The document addresses this broad spectrum of providers because, after all, most CV professionals see their patients as a referral from a primary care provider or family physician — or, more unfortunately, after a cardiac event has occurred. With this document, the writing committee hopes to generate a collaborative approach between cardiologists and primary care physicians, family practitioners and other specialties.

### Rapid Progress Calls for Action

We have made tremendous strides in CV research and medicine, and the results are making a difference as we see CVD rates plummeting among seniors.

Many seniors are living longer and have a better quality of life than they could have expected 10 or 20 years ago, thanks to dramatic increases in knowledge concerning specific risk factors in atherosclerosis, hypertension, thrombosis and other forms of vascular dysfunction. We even know that atherosclerosis can be stabilized or even modestly reversed.

### List of Areas Covered in Document

1. CV and Vascular Biology
2. Clinical Epidemiology, Biostatistics, Clinical Trials...
3. Individual and Family Genetic Assessment
4. Behavioral and psychosocial programs
5. Nutrition Management
6. Lipid Management
7. Thrombosis Management
8. Hypertension Management
9. Smoking Cessation
10. Obesity Management (Behavioral Programs)
11. Exercise Physiology and Physical Management and Cardiac Rehabilitation
12. Prediabetes, Metabolic Syndrome, Insulin Resistance, et al

Clinical trials have proven that the strategies aimed at the appropriate detection and modification of risk

factors will work to slow progression of atherosclerosis, diabetes mellitus and hypertension. They help to reduce clinical CV events in both primary and secondary settings. We also recognize that the growing knowledge base of molecular genetics, when applied to the CV system, could provide additional and productive information to the clinical practice of preventive CV medicine.

It could be said that the knowledge exists to prevent more than 80 percent of CVD, and all of us, no matter our specialty, share the responsibility of using that knowledge in caring for people at risk for CVD. With some patients, we may be able only to delay or modify the eventual outcome. However, our prevention efforts, if initiated early, will provide these patients with a better quality, longer life.

Yet the rapidly increasing bank of knowledge, including the area of preclinical disease detection, presents challenges for primary health care providers and others who work in primary and secondary CVD prevention. In addition, an increased number of patients with complex CVD are living longer and challenging professionals to know more about treating their conditions.

*continued on page 6*

\* American College of Cardiology Foundation, American Heart Association, American College of Physicians

\*\* Developed in collaboration with the American Academy of Neurology; American Association of Cardiovascular and Pulmonary Rehabilitation; American College of Preventive Medicine; American College of Sports Medicine; American Diabetes Association; American Society of Hypertension; Association of Black Cardiologists; Centers for Disease Control and Prevention; National Heart, Lung, and Blood Institute; National Lipid Association; and Preventive Cardiovascular Nurses Association

## Measures for Primary Prevention Include Quality Factors

By Rita Redberg, M.D., F.A.C.C.



The initial sets of performance measures first developed in 2005 by the ACC

Foundation (ACCF) and the American Heart Association (AHA) focused on processes of care or actions taken by health care providers, such as prescriptions for medications. These process measures were based on the strongest level of guideline recommendations —

in determining performance measures.

These primary prevention measures, which translate existing guidelines or principles important to heart disease prevention into practical steps for health care providers, are directed at primary care physicians, family practitioners and others who treat patients at risk for cardiovascular disease — not just cardiovascular professionals. They are the result of a collaborative, multidisciplinary

### Measuring Quality Improvement

Quality of care and quality improvement are driving elements in the health care landscape, giving greater import to the impact of these prevention measures. Although the performance measures are intended for quality improvement, we realize that the measures may be used by others for external review or as measures of provider performance. For that reason, the committee has indicated two types of measures in this document.

Performance measures are the metrics that the committee deems appropriate for quality improvement and external reporting. Test measures are considered appropriate for internal quality improvement only and should not be used for external review and accountability. Both types of measures are quality improvement measures.

### Reviewing Some Highlights

The writing committee recommends that these prevention measures be used by health care professionals treating adults 18 or older at risk for heart disease. Our goal is to help providers identify and reduce risk factors for heart disease early, as well as close the gap between optimal health care and the routine care that many patients receive.

*continued on page 6*

**With the positive results CV professionals have experienced in secondary prevention, there can be no doubt that with a commitment to primary prevention measures by primary care providers and other physicians, our integrated efforts would help to reduce deaths from heart disease even more.**

the processes of care that were labeled as Class I, which identifies processes or treatments that should be administered to patients, or Class III, which identifies processes or treatments that should not be administered.

However, processes of care are limited as the sole measures of quality. For that reason, as you will see in these *ACCF/AHA 2009 Clinical Performance Measures for Primary Prevention\**, we have now added outcomes, efficiency and structures of care to the processes of care

approach. As one could expect, working in a multidisciplinary structure meant that different points of view were expressed, and compromises attained. In the end, the measures fit the needs of the broad spectrum of providers represented by the committee. These measures also consider a caveat with which all providers must cope — patient ability to adhere to medical regimens — and recognize that providers may have to adjust accordingly.

\* Developed in Collaboration with the American Academy of Family Physicians, American Association of Cardiovascular and Pulmonary Rehabilitation, Preventive Cardiovascular Nurses Association and Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion Division for Heart Disease and Stroke Prevention. Endorsed by the American College of Preventive Medicine, American College of Sports Medicine and Society for Women's Health Research.

## Training Fits Broader Spectrum

continued from page 4

### Document Has Broad Purpose

This document is not aimed at CV professionals only. It is for those individuals who seek expertise at a leadership level in the field. It includes opportunities for formal training, as well as alternative routes to competence and maintenance of competence in prevention of CVD. It provides educational resources for the acquisition and maintenance of competence in the prevention of CVD. The field of CVD prevention requires an adequately trained force of providers, and this document is intended to help ensure that force is available.

It is aimed also at ensuring a pool of providers with the knowledge to run cardiac rehabilitation programs, to address issues of adherence, specialty patient care and consultation and to direct primary and secondary preventive CV programs.

It is a given that CV preventive specialists will vary in their areas of expertise and will not necessarily achieve all of the outlined areas of competencies. However, these clinical competency criteria in the area of specialty treatment and prevention of CVD are needed. Given the rapidly growing field of knowledge ranging from molecular and cellular mechanisms to clinical outcomes, they will be much needed to help translate the information.

**Bairey Merz is chair of the Writing Committee to Develop a Competence and Training Statement on Prevention of CVD.**

**A CVN interview of Bairey Merz by Anthony De Maria, M.D., M.A.C.C., may be seen at [www.cardiosource.com/cvn/index.asp?videoId=1262](http://www.cardiosource.com/cvn/index.asp?videoId=1262).**

**The full competence and training statement and the primary prevention performance measures document were published in the *Journal of the American College of Cardiology*, Sept. 29, 2009, Vol. 54, No. 14.; [content.onlinejacc.org/content/vol54/issue14](http://content.onlinejacc.org/content/vol54/issue14).**

## Measures Include Quality Factors

continued from page 5

The measures include:

- lifestyle/risk factor screening
- dietary intake and physical activity counseling
- smoking/tobacco use assessment; smoking cessation
- weight and body fat assessment; weight management
- blood pressure measurement; blood pressure control
- blood lipid measurement; blood lipid therapy and control
- estimation of a patient's global risk for developing heart disease
- aspirin use in at-risk patients

The committee also calls for a comprehensive risk assessment for all patients at least every five years and recommends more frequent assessments for patients with factors

that elevate risk, such as obesity, diabetes or tobacco use. All physicians can play a key role in reminding patients of the healthy lifestyle behaviors. Checking blood pressure and cholesterol levels in appropriately selected patients is an important part of preventing heart disease, and simple office-based risk scoring can help identify which patients are at higher risk for heart disease.

With the positive results CV professionals have experienced in secondary prevention, there can be no doubt that with a commitment to primary prevention measures by primary care providers and other physicians, our integrated efforts would help to reduce deaths from heart disease even more.

**Redberg is chair of the ACC/AHA Writing Committee to Develop Performance Measures for the Primary Prevention of Heart Disease.**

# Cardiology

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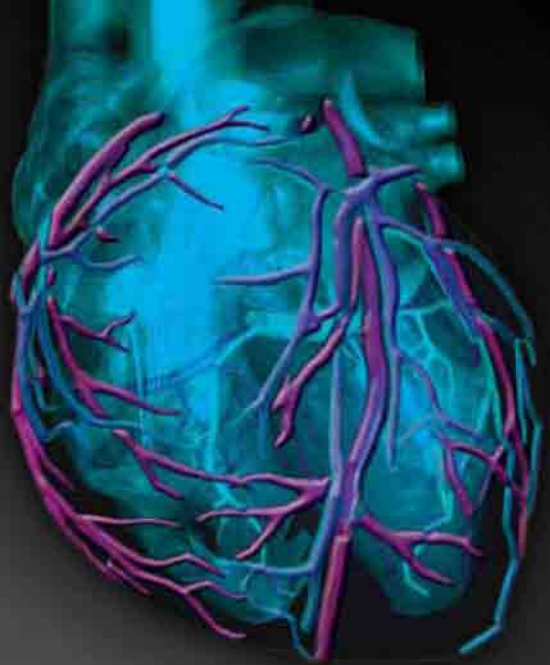
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## Health Care Reform: Perspectives from Two Cardiologists

By Eugene S. Chung, M.D., F.A.C.C., and Wojciech Mazur, M.D., F.A.C.C.

All physicians are aware that dramatic changes in all aspects of health care are being debated in Washington. As physicians and scientists, we find the current debates difficult to assess objectively and accurately. As most logical people would, we tend to focus on our own worlds, on what we know best. Amid the bluster and rancor from people we do not know or trust and who do not spend their careers immersed in health care, we have the ability to ignore the noise and read the proposals ourselves. That done, the two of us offer these thoughts.

The scope of the House of Representatives bill H.R. 3200 is impressively broad. It outlines plans to provide universal coverage, regulate the private insurance industry, introduce

**While we must overcome the notion that all things government are inherently inefficient and ineffective, it must also be noted that overzealous government intrusion can be deeply harmful, whether it arises from conservative or liberal agendas.**

a public health plan for Medicare ineligible patients, expand the existing quality measurement tools for hospitals and physicians and implement payment schemes based on these measures. However, it lacks mention of tort reform. In parallel with this process, we have the annual debate surrounding draconian cuts in physician reimbursement from the Centers for Medicare and Medicaid Services (CMS).

It seems a given that the current rate of growth in health care expenditures is not sustainable. Given the explosion of technology and services over the past few decades, unfavorable patient demographics (obesity, widening socioeconomic inequalities), a tort system that leads to defensive medicine and a payment system that is largely volume-based, it should

not come as a surprise that the system is in need of overhaul.

In 2007, of the total expenditures of \$2.24 trillion — both private and public — the four largest expenditures were:

- Hospital costs, **\$696.5 billion**
- Physician and clinical services, **\$478.8 billion**
- Prescription drugs, **\$227.5 billion**
- Government and private insurance administration, **\$155.7 billion**<sup>1</sup>

These four components account for nearly 70 percent of the overall expenditures, and any credible plan to reduce costs must touch all of them. As a percentage of the Gross National Product (GNP), health care expenditure has increased from 13.5 percent in 1997 to 16.2 percent in 2007 and is projected to rise to 20.1 percent by 2018.

### What is Relevant to Physicians

In the context of the health care proposals now present, we note these aspects of the national debate as relevant to all physicians — measurement of quality, conduct and interpretation of comparative research, reimbursement schemes and the medical-legal environment.

**Quality:** While many physicians remain skeptical that quality can be measured accurately, that movement is well on its way, both in the hospital and in the office. However, physician input will be extremely important in determining the methodology and conduct of this process.

**Comparative research:** As cardiologists specializing in heart failure and imaging, we see firsthand the fruits of government-sponsored and industry-funded innovation. As physicians practicing evidence-based medicine, we must

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<sup>1</sup> [www.cms.hhs.gov/NationalHealthExpendData](http://www.cms.hhs.gov/NationalHealthExpendData)

Commentary

# Bending the Cost Curve: A Fork in the Road

By Richard W. Snyder, M.D., F.A.C.C.



There's been a lot of discussion and debate recently over the best way to "bend the cost curve" in a reformed health care system. I think most would agree that the best way to do this would be to develop new incentives in payment that reward better outcomes with evidence-based medicine. I think most also would agree that physicians should play a pivotal role in developing these incentives and in the integrated health systems that emerge.

How best to develop these new incentives and what system — or systems — can or should be used as models

**You cannot have a discussion about health care reform and the most effective physician-hospital integration model and not mention a model that ranks first in the nation in two out of the four cardiac outcomes categories studied — all at lower costs.**

appears to be where we've hit a fork in the road. Some would argue that integrated systems like Cleveland Clinic or Mayo are the path to the future. These large systems use electronic medical records (EMRs) to coordinate care across sources and sites of care. Their physicians are salaried and — some argue — more motivated towards coordination of care and quality.

I would argue that physicians are best positioned to serve as advocates for patients in our pursuit of quality as partners and owners of the system, rather than as salaried employees. The Centers for Medicare and Medicaid Services (CMS) recently released the results from a risk-adjusted comparative survey of approximately 4,700 U.S. hospitals looking at the Medicare population from July 1, 2005, through June 30, 2008 ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)). Some

of the more popular "brand-name" physician-salaried hospital systems that are routinely promoted by *The New York Times* as ideal models for hospital-physician integration had congestive heart failure (CHF) re-admission rates that were "No Different" from the U.S. national rate. One finished in the "Worse" category (bottom 5 percent of the nation).

Of the four risk-adjusted cardiac clinical outcomes studied in this survey, physician-owned models were ranked No. 1 in the nation for lowest myocardial infarction (MI) mortality and for lowest

CHF re-admissions. In my home state of Texas, the top two hospitals in the state for lowest CHF re-admissions and MI mortality are physician-owned integrated models in both categories.

Furthermore, the median Medicare payment by diagnosis-related group (DRG) for these physician-salaried facilities was more than 15 percent to 25 percent higher than the physician-owned facilities that finished at the top. Physician-hospital ownership represents an alignment of interests between the hospital and physician in the pursuit of timely access to quality, cost-effective care.

In the future world of accountable care organizations (ACOs), where reimbursement will be bundled by DRG to an integrated system, a physician-owned hospital, in my opinion, is exactly the form of physician-hospital integration

that will be most effective from a quality, cost and timely accessibility perspective.

I am not advocating that the physician-owned model be the only model that is proposed for health care reform; however, it should not be left out of the discussion. You cannot have a discussion about health care reform and the most effective physician-hospital integration model and not mention a model that ranks first in the nation in two out of the four cardiac outcomes categories studied — all at lower costs.

In a July *USA Today* article about Baylor and its No.1 ranking, **ACC CEO Jack Lewin, M.D.**, was quoted as saying: "The best-quality health care in America is certainly not the most costly care . . . I would be very frustrated if our health reform agenda doesn't emphasize these kinds of opportunities."

Quality health care is inherently cost-effective. Judging by the recent CMS survey, I don't agree with the blanket statement that in general, salaried physicians at integrated institutions using EMRs have superior quality and are more affordable.

If salaried physicians in an integrated model using EMRs are the only keys to quality, cost-effective, and timely access to health care, then why is Congress even bothering to propose pilots? The government already operates a large, nationwide organization of salaried physicians under one roof in an exquisitely integrated system of health care delivery using EMRs. Why is this model not being proposed as the model in this grand debate of health care reform by Congress? I think we all know the answer.

**Snyder is with Heart Place, Dallas.**





## Commentary

# Cardiology Workforce Crisis: Team-Based Care as a Solution

By Mary Norine Walsh, M.D., F.A.C.C.

In September, the “ACC 2009 Survey Results and Recommendations: Addressing the Cardiology Workforce Crisis” was published in the *Journal of the American College of Cardiology (JACC)*. This document is the product of work done by the ACC Board of Trustees Workforce Task Force chaired by **George Rodgers, M.D., F.A.C.C.** Since 2001, under the leadership of **Bruce Fye, M.D., M.A.C.C.**, the ACC has drawn attention to the looming workforce crisis in our specialty. Some contributors to this crisis have been identified as:

- Increase in the incidence and prevalence of cardiovascular disease (CVD)
- Decrease in CV mortality and resulting increase in size of patient population
- Greater number of adults with congenital heart disease
- 20 percent decrease in number of CV specialists in training during the 1990s due to erroneous predictions of diminished demand
- Resultant decrease in the size of CV training programs and in the number of cardiologists trained

In 2006, the Workforce Task Force was formed to explore these workforce issues and to develop recommendations or solutions. The newly released paper in *JACC* is the result of some of their work. The ACC and ACCF then contracted with The Lewin Group and the Association of American Medical Colleges (AAMC) to conduct an analysis of factors affecting the cardiology workforce. One of the areas examined was the practice of team-based care in the form of employment of non-physician practitioners.

## Practice Efficiency

It is clear that the current and anticipated shortage of cardiologists calls for a careful analysis of methods to provide patient care more efficiently. In order to better define current practice efficiencies, the task force surveyed adult CV private practices, pediatric practices and academic practices. Several areas were explored; two of which were —

- Clinical staffing models (e.g., number of physicians, use of part-time physicians and/or non-physician practitioners)
- Practice operation and management (e.g., multi-specialty versus single specialty, number of offices, use of part-time or outreach offices, ownership type, practice setting)

Data from these surveys were then analyzed to determine the effects of the various practice characteristics on clinical productivity.

## Employment of Non-physician Practitioners

All practices were asked whether or not they employed non-physician practitioners (non-physician professional providers). Although state regulations differ regarding the scope of practice of non-physician practitioners — and this may have influenced practices’ employment of these individuals — data were not stratified according to state.

Overall, larger private practices were more likely to have nurse practitioners (NPs) or physician assistants (PAs) with 90 percent of practices of more than 10 cardiologists reporting employment of non-physician practitioners. However, among practices using NPs and PAs, the ratio of non-physician practitioners to physicians was much higher in the smaller practices.

In the larger groups, non-physician practitioners were often employed as part of a niche clinic (heart failure, device or anticoagulation) whereas smaller practices were more likely to use the skills of these providers in general practice, thus achieving substantial efficiencies.

All practices were asked to report either the number of relative value units as a standard metric of work per full-time equivalent (FTE) physician or gross revenues per FTE physician. Of the groups who employed non-physician providers, some groups found that non-physician providers generate one-third of the relative value units of an FTE cardiologist, and that NPs and PAs generate gross revenues three to four times greater than their incomes. Such favorable economics suggest that greater use of non-physician practitioners can enhance practice efficiency.

### Solutions/Recommendations

**Best practice sharing** — The results showed a lot of variability regarding employment of non-physician providers among the practices. Many practices reported no employment of non-physician practitioners, and on average, larger practices had lower ratios of non-physician practitioners per physician than smaller practices. This variability suggests an opportunity for sharing best practices. Successful models of partnership between cardiologists and NPs and PAs may be valuable to those practices that have not yet integrated non-physician practitioners into their practices.

**Advocacy** — On the advocacy front, the task force underscored the fact that along with the cardiology workforce crisis comes a need for more non-physician practitioners. As such, increased funding is needed to train more NPs and PAs to meet these demands.

**Education** — It is clear that education is the cornerstone of the development of effective models of team-based care. The ACC has initiated an educational program to assist NPs in gaining more proficiency specific to cardiology care and developed a core curriculum specific to this group. This program should serve to accelerate the availability of cardiology-trained non-physician practitioners.

Equally important is the development of education around team-based care. The practice surveys found that non-physician practitioners are underused in many practices. Our CCA colleagues will no doubt be able to lead us in the development of best practices in optimal multidisciplinary team-based care.

**Walsh, who is on the ACC Board of Trustees, is a member of the Workforce Task Force. She also sits on the CCA Committee.**



## Perspectives from Two Cardiologists

*continued from page 8*

support comparison of competing methods of diagnosis or treatment in determining meaningful outcomes.

**Reimbursement:** Sudden and dramatic reimbursement cuts (up to 40 percent) threaten to destroy specialty practice and, therefore, patient access. Pay-for-performance initiatives may be outlined in H.R. 3200, yet CMS sets actual reimbursement schedules in a separate process, and the two should not be confused.

**Medical-legal environment:** The absence of tort reform may be acceptable to some physicians — a bitter pill that must be swallowed to advance reform of an ailing system. For others, it will not be acceptable, no matter what else is contained in the bill. Where one falls on this continuum remains a personal decision, based on a balance between patient rights on one hand and protecting physicians' freedom from defensive medicine and frivolous lawsuits on the other.

While we must overcome the notion that all things government are inherently inefficient and ineffective, it must also be noted that overzealous government intrusion can be deeply harmful, whether it arises from conservative or liberal agendas. Health care may be too complex and medical decisions based too often on fear and emotion rather than logic to assume that a predominantly free market approach would be affordable.

The health care bill may be necessarily vague in terms of detail; however, it serves as a conceptual tree on which to hang the ornaments later. It appears that the majority party will likely pass some form of this legislation. Of major concern is the possibility that as various special interests, the minority party included, exert their influence, the resulting bill will be incomplete and unbalanced. After we have a final version of a health care bill, true advocacy from physicians will need to occur to optimize patient care within financial and regulatory constraints and to preserve the essential worth of a career in medicine.



Chung



Mazur

**Chung and Mazur are with The Heart and Vascular Center, The Christ Hospital, Cincinnati.**



Jack Lewin, M.D.



Mike Dunn



Ron Brownstein



Wendell Primus



Dana Lichtenberg



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James Paluskiewicz



Jim Fasules, M.D., James Dove, M.D., and Ralph Brindis, M.D.

## ACC's 2009 Legislative Conference Takes the Hill by Storm

The ACC held its 2009 Legislative Conference in Washington, D.C., Sept. 13 – 15. The conference brought together more than 350 ACC members from nearly every state to learn more about issues facing the cardiovascular community, including the proposed 2010 Medicare Physician Fee Schedule, health care reform, medical malpractice and state advocacy.

Participants heard from a host of speakers, including: **Ron Brownstein**, political director for Atlantic Media Co.; **Robert Kocher, M.D.**, of the White House National Economic Council; **Geoff Gerhardt** of the House Ways and Means Committee; **Wendell Primus** from the office of House Speaker Nancy Pelosi (Calif.); **Mike Dunn** of Dunn Associates; **James Paluskiewicz** from the Office of Rep. Michael Burgess (Texas) and **Dana Lichtenberg** from the office of Rep. Bart Gordon (Tenn.).

This year's conference was the largest ever, in part because of the proposed Medicare physician fee cuts that would have devastating impacts on the practice of cardiology. "We have to get involved," said **Zia Roshandel, M.D., F.A.C.C.**, a first-time Legislative Conference participant from Culpeper, Va. "If we don't, nobody else will do it for us." Roshandel, who was profiled in a previous issue of *Cardiology*, who would likely be forced to close his practice if the cuts go through.

On the final day of the conference, attendees made hundreds of visits to offices on Capitol Hill, reaching lawmakers and their staff to discuss the impact of the proposed cuts and the need for broad-based health system and payment reforms.

"We've been very successful in keeping people alive and healthy, and yet we are subject to the worst cuts we've seen in many years," said ACC President **Alfred Bove, M.D., Ph.D., F.A.C.C.**, in remarks during the conference. "We're here today because in the democratic process, if your voice isn't heard, nothing happens."

Visit ACC's blog, The Lewin Report ([lewinreport.acc.org](http://lewinreport.acc.org)), for overviews of key sessions and posts from attending members. Slides, briefing materials and a video summary of the conference are also available on the Legislative Conference Web site at: [www.acc.org/advocacy/leg\\_conf\\_09/about.htm](http://www.acc.org/advocacy/leg_conf_09/about.htm). In addition to the Hill meetings and educational sessions, print and online ads timed to coincide with the conference ran Sept. 14 – 25 in the *National Journal*, *Politico*, *CongressDaily* and *Roll Call*. To view the ad, go to: [qualityfirst.acc.org](http://qualityfirst.acc.org).

## Grants to Further ACC's IMPACT Registry; Study Comparative Effectiveness of PCI, CABG

The National Heart, Lung, and Blood Institute of the National Institutes of Health last month awarded a grant to the American College of Cardiology Foundation (ACCF) and the Society of Thoracic Surgeons (STS) to study the comparative effectiveness of the two forms of coronary

### IMPACT Registry™

revascularization, percutaneous coronary intervention (PCI) and coronary artery bypass graft (CABG) surgery. This award has been issued under the American Recovery and Reinvestment Act of 2009 and is in the amount of \$4,026,764 over the two-year period of the study.

This study will compare PCI and CABG procedures using existing databases from ACCF and STS, as well as the Centers for Medicare and Medicaid Services MEDPAR data. The goal is to

understand the procedures better, help physicians make better decisions and improve health care for patients with coronary artery disease. The techniques of analysis used in this proposed project should have broad application to the entire field of medicine.

Meanwhile, the Food and Drug Administration has awarded money to ACCF for further development of its new congenital heart disease registry. The NCDR® IMPACT Registry™ is piloting 15 sites and tracks 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 is expected to provide significant contributions to the knowledge base and outcomes associated with congenital heart disease.

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## Senate Finance Begins Health Reform Markup

The Senate Finance Committee has started its markup of its health care reform legislation. The ACC is pleased that the bill, drafted by Committee Chair Max Baucus (D-Mont.), attempts to expand coverage and strengthen Medicare. However, the College has concerns, including a mere one-year Band-aid to the Sustainable Growth Rate (SGR) formula.

The ACC is urging leaders in both the House and Senate to act this year on real health care reform that:

- Ensures access to affordable health care for all Americans;
- Includes delivery and payment system reforms that provide incentives for improvement of quality and outcomes;
- Repeals the sustainable growth rate (SGR) formula;
- Emphasizes professionalism and patient-centered care;
- Improves care coordination across sources and sites through interoperable health information technology;
- Implements medical liability reforms; and
- Promotes comparative effectiveness research to better inform guidelines, performance measures and appropriate use criteria.

Share your thoughts on health reform at [lewinreport.acc.org](http://lewinreport.acc.org).

## Advocacy Briefs

### CMS Eliminates Noncoverage of MRI for Blood Flow Determination

The Centers for Medicare and Medicaid Services (CMS) finalized its proposal to eliminate blanket noncoverage of MRI for blood flow determination and will allow local carriers to determine coverage policies for this service. The ACC worked with the Society for Cardiovascular Magnetic Resonance and the American College of Radiology to request that CMS consider current evidence on MRI blood flow determination and reverse its decision on noncoverage. Removal of the restriction on coverage will permit local carriers to cover blood flow determination performed with cardiac MR studies. In addition, a CPT coding change to be implemented in January 2009 will enable correct reporting of services. The CMS decision memo is available at [www.cms.hhs.org/mcd](http://www.cms.hhs.org/mcd).

### Weiner/Braley Imaging Amendment Withdrawn

The House Committee on Energy and Commerce last month considered several amendments to its health reform bill (H.R. 3200) that were left pending just before the August Congressional recess. In a big victory for imaging, the amendment by Reps. Anthony Weiner (D-N.Y.) and Bruce Braley (D-Iowa) to eliminate the ability of physicians to provide advanced diagnostic imaging services in their offices beginning in 2013 was withdrawn.

The ACC would like to thank its members who contacted their representatives on the House Energy and Commerce Committee asking them to oppose this amendment. Your letters and face-to-face visits were crucial to stopping this proposal from moving forward. ACC staff and leaders will 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.

### FDA Extends Tobacco Act Comment Period

The Food and Drug Administration (FDA) has extended the comment period for the implementation of the Family Smoking Prevention and Tobacco Control Act until Dec. 28. The deadline for comments originally was Sept. 29. The FDA said it received an extension request articulating concern that the 90-day comment period did not allow sufficient time to develop a meaningful or thoughtful response to the notice. Comments from the public will inform FDA's actions implementing the Tobacco Act. Comments can be submitted at: [www.regulations.gov](http://www.regulations.gov) or in hard copy to: Division of Dockets Management (HFA305), Food and Drug Administration, 5630 Fishers Lane, RM. 1061, Rockville, MD 20852. The FDA notice is available at [www.federalregister.gov](http://www.federalregister.gov).

## We Need Everyone Involved if We Want to Win

By Timothy Malins, M.D.

I arrived in Washington, D.C., for the 2009 ACC Legislative Conference as a Washington rookie. I had two goals as a constituent and ACC member. My first goal was to explain to our elected officials the problems at the core of the 2010 cuts proposed by the Centers for Medicare and Medicaid Services (CMS). Second, it was important to explain the astoundingly positive impact cardiologists have made in the treatment of their patients over the past several years.

**The fact that cardiologists are saving lives at rates unparalleled anywhere else in the world may have had only a little effect on my audience... What we need is more support – support from colleagues, all ACC members, our patients and other constituents – if we want to engender true support from our legislators.**

Since I knew I would be dealing with well-informed politicians and their aides, I arrived armed with the following facts to back up my concerns over the CMS cuts —

- The 2010 CMS cuts are based on only 55 practice expense surveys from the 3,500 that were sent out by the American Medical Association (AMA). Additionally, we do not know why only 55 were used as there has been little transparency regarding this.
- The data used from some respondents are not indicative of common cardiology practices today. For example, these respondents did not employ nurse practitioners and had little or no overhead.
- There was a contradictory calculation in determining cost of overhead that is based on physician work hours. In essence, the more hours a physician works, the less “relative” overhead he/she needs. On average, cardiologists work more than 60 hours a week, which unduly penalizes them in the overhead/work hour calculation.
- As a result of the flawed survey, CMS falsely concluded that cardiologists are practicing at a 40 percent reduction in overhead when compared to the last CMS proposal of 2007. This is the basis of their cuts.

My second point to our legislators was to highlight the improvements in cardiovascular mortality that we have gained.

In the past eight years, we have helped achieve an astonishing 27 percent reduction in cardiovascular mortality. This magnitude of reduction is unsurpassed anywhere else in the world.

Cardiovascular professionals in this country are on the front lines of research, innovation and treatment of cardiovascular disease. Our efforts have been vindicated by these results.

Since I am from New York, I arranged meetings with the offices of Sen. Charles Schumer, Sen. Kirsten Gillibrand and Rep. Louise Slaughter — all Democrats from New York. We met with an aide for Sen. Gillibrand; however, Rep. Slaughter personally met with us. Sen. Schumer was not able to keep his appointment, nor could he schedule an aide to stand in for him. Despite our positive meetings, I came away with the conclusion that this issue is bigger than we are. Clearly, we need more active participants and support.

The fact that cardiologists are saving lives at rates unparalleled anywhere else in the world may have had only a little effect on my audience. The fact that the proposed cuts are based on a faulty survey and a skewed analysis can be dismissed easily as unimpressive and irrelevant — if we do not act. What we need is more support — support from colleagues, all ACC members, our patients and other constituents — if we want to engender true support from our legislators.

I am convinced that our profession has reached a tipping point, and this is a pivotal time for the practice of cardiology. As I enter my last eight months of fellowship, I am concerned about how I will be able to care for my patients in the future.

I implore you to write to your legislators and to join the ACC PAC. I encourage you to speak freely with your patients about the potential problems facing our noble profession. We must all get involved, primarily for our patients’ wellbeing, but also for the preservation of the future of our profession.

**Malins is a fellow in training at the University of Rochester Strong Memorial Hospital, Rochester, N.Y.**





# Call for Late-Breaking Clinical Trials

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## Compensation Opportunities in Physician-Hospital Integration

By William T. Carlson Jr.

After talking to dozens of cardiology groups about their interest in hospital integration, I find one element common in every discussion — their interest is the result of falling payer reimbursements and their impact on physician compensation. As a result, while compensation is not the most important element of these integration discussions, it is the most visible. If you are considering integration, these principles should guide the discussion on compensation.

### Principle #1: Understand the economics of physician-hospital integration



Cardiologists frequently ask how hospitals can afford to purchase their practices and increase their compensation. The answer is provider-based reimbursement (PBR). PBR is the method by which hospitals are paid more for diagnostic tests than what physicians receive. The diagnostic tests must be provided in hospital space (which can be structured within physician offices), use hospital personnel (who usually are former group practice personnel) and must be within 35 miles of the hospital provider. However, if these requirements and others can be met, it can mean millions of dollars in additional revenue without any increase in use.

The existence of PBR does not mean that cardiologists can expect to receive every dollar of additional revenue produced. The limiting concept of Fair Market Value still exists for both practice valuation and physician compensation.

One additional consideration is that PBR raises the cost of health care to the patient because patient co-payments and deductibles are often higher. While providers typically do not walk away from PBR because of the revenue enhancement it represents, cardiologists should be prepared to explain the cost increase to their patients.

### Principle #2: Select your preferred compensation system



I regularly tell cardiologists they should choose a compensation system based on what behavior they want to reward. In considering this issue, the three primary systems are: productivity, equal split and the corridor system. The good news is that if you can explain your rationale, most hospitals permit cardiologists to select the system that best fits the group.

The productivity system rewards clinical activity. It is often referred to as the “Eat What You Kill” system because the more you do, the more you are paid. This system works best for those groups that have more work to do than there are physicians to do it, thereby avoiding intra-group competition. In this system, compensation is calculated by multiplying a productivity measure (usually Work Relative Value Units [WRVU] or Time Value Units) times a negotiated dollar figure (referred to as the Conversion Rate).

The equal split system rewards collegiality. Groups that have had an equal split system prior to integration tend to retain that system because they have found it promotes group harmony. A compensation pool is created based on a WRVU formula, and funds are then distributed equally among the cardiologists.

The corridor system is best suited for mature markets in which there is equilibrium between the supply of cardiologists and the demand for their services. In this system a specific W-2 compensation rate typically is negotiated, and the rate will not vary as long as the cardiologists maintain their productivity within a corridor of 5 percent up or down. For example, if a group is producing 100,000 WRVUs annually, their compensation would not vary as long as their productivity stayed within a range of 95,000 to 105,000 WRVUs. If their productivity did vary outside the range, the cardiologists would experience a compensation penalty below 95,000 and would receive incentive compensation for productivity above 105,000.



**Principle #3:**  
Understand productivity versus predictability

Cardiologists often want to know what kind of compensation they should expect their hospital will “guarantee.” Compensation guarantees are as rare as cost-based reimbursement. The reason is that hospitals learned a lesson 15 years ago when they employed primary care physicians without productivity requirements. When no incentive existed for physicians to maintain or increase their productivity, physician productivity declined.

Each of the compensation systems described here has some productivity element. The good news is that typically cardiologists will not have to increase their productivity in order to increase their compensation, but there will be additional compensation available if they do so.



**Principle #4:**  
Compensation should include non-clinical services

It is important to include non-clinical services in your negotiations. Said another way, if cardiologists are compensated only for clinical services, what happens to medical directorships, developing new outreach sites or participating in hospital-based teaching programs?

Compensation for non-clinical services typically follows one of two paths. First, you can develop separate contracts for these services and pay the participating cardiologists separately from the compensation for their clinical services. Second, you can supply RVU credit based on the time spent in providing these services, and the resulting amounts are included in the regular compensation system.

You have noticed by now there is no mention of how much compensation is typical in these integration deals. The reason is the figure varies based on numerous factors such as: physician productivity, diagnostic testing levels and the hospital administration’s understanding of the potential patient care benefits. Initial offers generally are in the \$500,000 – \$600,000 range, but those numbers often increase based on the cardiologists’ current compensation, the revenue generated by PBR and whether there are multiple hospitals interested in the group. Your negotiating ability will have a direct impact on the final number.



**Carlson is with Maynard Cooper & Gale, P.C., Birmingham, Ala. He was one of the authors of the original whitepaper on practice opportunities from ACC.09.**

## Cuts to Nuclear Cardiology Payments Likely

The cuts proposed to Medicare payment for cardiology services under the Medicare Physician Fee Schedule have caused enormous concern among practices. Unfortunately, even if the Centers for Medicare and Medicaid Services (CMS) does not finalize the cuts as proposed, substantial changes in payments to other services could occur. Most notably, myocardial perfusion imaging/SPECT testing has been subject to review by the CPT Editorial Panel to create a new code that combines the reporting of the SPECT test with the wall motion and ejection fraction services that are now reported as separate codes for the vast majority of SPECT studies.

ACC anticipates that the changes made to these codes could result in considerable reductions in payment for this service.

CMS does not release a final fee schedule until Nov. 1, so it is uncertain how much of a decrease in payment this service may receive. The examination of services that are performed together but coded separately has been of strong interest to policymakers. Other services that require the reporting of multiple codes for a single service may be subject to similar review and potential payment reductions in the future. More information from the CPT Editorial Panel will be available in coming months.



Dr. Douglas Weaver and Dr. Jay Alexander



Dr. Harry Odabashian



Dr. Marco Diaz, Maine Cardiology Associates



Dr. Robert Wesley



James Carville and ACCPAC supporters



## ACCPAC Names Outstanding Advocates

At the 2009 Legislative Conference, ACC's political action committee (ACCPAC) honored three ACC members and three cardiovascular practices for their commitment to ensuring the cardiovascular voice is heard on Capitol Hill both now and in the future.

The "Outstanding Advocate 2009" was awarded to three ACC members who made exceptional contributions to the ACCPAC through their gifts and fundraising efforts. The awards went to:

- W. Douglas Weaver, M.D., M.A.C.C., Mich.
- Harry Odabashian, M.D., F.A.C.C., N.Y.
- Robert Wesley, M.D., F.A.C.C., Nev.

The "Outstanding Practice 2009" was awarded to cardiology practices with nearly 100 percent participation in ACCPAC. The awards went to:

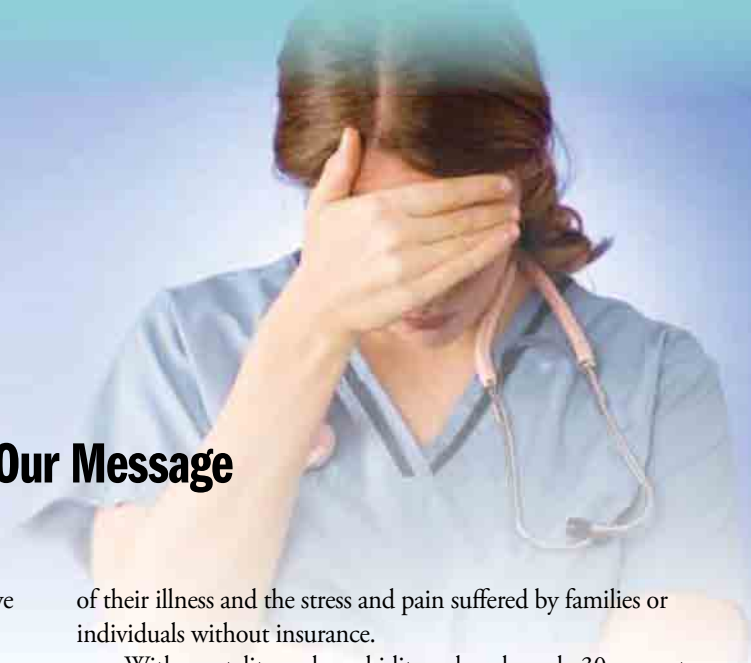
- Michigan Heart
- Tri City Cardiology Consultants
- Maine Cardiology Associates

In addition to presenting the Outstanding Advocate

and Outstanding Practice awards, the ACCPAC had a highly successful program at the conference. Politico and author James Carville spoke at a packed PAC-member only lunch, discussing the impact of forming relationships with lawmakers and the importance of being visible on Capitol Hill. The PAC also held its annual Texas Hold 'Em poker tournament and reception with more than 200 members in attendance.

Meanwhile, the ACCPAC's "1,000 from 1,000" state competition, which was promoted during the conference, continues to flourish. Florida and Nevada have raised the stakes for participation among the states, so far raising \$1,000 from 24 members and 22 members, respectively. California and Arizona follow at a distance with 16 and 18 members pledged, respectively.

Given the current legislative environment and so much at stake for cardiology, the ACCPAC amplifies cardiology's voice in a very competitive political environment. The ACCPAC serves a pivotal role in educating lawmakers on key issues and supporting candidates who understand the importance of cardiovascular care. For more information on the ACCPAC, go to [www.accpacweb.org](http://www.accpacweb.org).



## Proposed Cuts Bring Clarity to Our Message

By Eileen Pummer, R.N., M.S.N.

The American College of Cardiology 2009 Legislative Conference in Washington, D.C., Sept. 13 – 15 drew record attendance, but the catalyst wasn't the growing debate about health care reform in the nearby halls of Congress. The 350 cardiovascular (CV) professionals, 20 of whom were Cardiac Care Associate (CCA) members, found themselves addressing an even more pressing concern — the Centers for Medicare and Medicaid Services (CMS) proposed fee cuts.

Despite a clear desire to talk about various health care reforms with legislators, the group contended instead with a serious pocketbook issue. CMS' proposed 30 to 40 percent across-the-board reimbursement reductions for cardiovascular services stand to cause the closure of some practices and the elimination of CV nursing staff and other support services.

"Cuts of this magnitude will cripple cardiology practices and threaten access to services that prevent premature death and disability for millions of Americans," said ACC CEO Jack Lewin. "For advocacy leaders, the need for overarching health reform that focuses on both reducing costs and improving quality is where the dialogue should have been. ACC's history of well-crafted partnerships among legislators was seen as even more critical this year in expediting the progress needed."

Rather than lobbying for health care reform proposals that could benefit CV practices, the group was consigned to lobbying members of the Senate and House of Representatives to write letters on their behalf to CMS to halt the fee proposal.

### CCAs' Involvement and What It Means

Shortly before the conference started, 13 CCAs attended a first-ever breakout session to discuss what to expect during visits with members of Congress and their staffs. Part of the discussion centered on sharing real-life examples of patients to help these Washington insiders understand the human dimension of their decisions. They planned to share these sad realities — the needless deaths of patients who would have been spared if preventive care had been available; those who didn't get treatment soon enough after learning of the gravity

of their illness and the stress and pain suffered by families or individuals without insurance.

With mortality and morbidity reduced nearly 30 percent in recent years, CCAs know what is at stake and the potentially dangerous backsliding that the proposed CMS cuts will mean for the patients for whom they provide care.

**Despite a clear desire to talk about various health care reforms with legislators, the group contended instead with a serious pocketbook issue. CMS's proposed 30 to 40 percent across-the-board reimbursement reductions for cardiovascular services stands to cause the closure of some practices and the elimination of CV nursing staff and other support services.**

Lewin later offered encouragement to the entire conference: "The best way to predict the future is to create it."

From my perspective, CCAs have the opportunity to make a huge difference. As a cardiac quality specialist, I no longer provide direct care for patients in CCU, yet I know all too well that by keeping the emphasis on patient-centered, quality-focused and cost-effective care, we will be providing the most clinically effective advocacy possible. Meeting personally with Congressional leaders in Washington, D.C., and being in a position to help policymakers understand today's health care landscape has helped me to see the importance of that involvement.

**Pummer is Quality Manager, Quality Improvement and Patient Safety Department, Stanford Hospital and Clinics, Palo Alto, Calif.**



**2007** The world-renowned New York Cardiovascular Symposium marks its 40th anniversary. Program Director Valentin Fuster, M.D., Ph.D., F.A.C.C., is only the second director in the history of this remarkable program.



## Cardiologists for a Week: Chicago Students Trade Backpacks for Stethoscopes

By Martha Gulati, M.D., F.A.C.C.

Despite many efforts to achieve diversity in the fields of science, technology, engineering and mathematics, the U.S. still faces gender and racial disparities, including the under-representation of women and minorities. According to recent statistics from the National Science Foundation, women in the U.S. make up 44 percent of the workforce, yet they number only 26 percent of our scientists and engineers. In an effort to change these statistics one student at a time and

**Many times a career path is shaped when someone takes a specific interest in an individual. The goal of our program is to reach young women at an early age to inspire them and open their minds to the science and art of medicine and cardiology.**

turn high school girls on to careers in science and medicine, Northwestern University's Division of Cardiology partnered with the Institute for Women's Health Research at the school's Feinberg School of Medicine to create the Cardiology Summer Academy (CSA).

In June 2009, 16 students from the Young Women's Leadership Academy, a Chicago public school located on the city's south side, participated in a week-long in-depth program focused on cardiology and cardiovascular health.

The program was led by renowned physicians and researchers, who immersed the young women in a medical school-like environment to help them learn about heart disease treatment and prevention.

Megan Faurot, M.Ed., director of education programs for the Feinberg School of Medicine's Institute for Women's Health Research, helped me conduct the program, and, of course, we received assistance from every cardiologist and cardiac surgeon in our department. The CSA was funded in part by a grant from the Illinois Department of Public Health. The curriculum of the Young Women's Leadership Academy, where these girls go to high school, has a specific focus on math, science and technology.

We developed the CSA program to foster the academic and career pursuits of the girls interested in science and medicine. We wanted to show them real life examples of career paths they might consider and provide them with the opportunity to see women performing jobs in these fields.

Particularly in cardiology, which remains a male-dominated field, we are always trying to figure out how and when to attract women to the field. I believe there is no age too early to target when you want to interest women in medicine

and cardiology. These girls, as rising high school seniors, were the perfect age to introduce the possibilities in cardiology.

Many times a career path is shaped when someone takes a specific interest in an individual.

The goal of our program is to reach young women at an early age to inspire them and open their minds to the science and art of medicine and cardiology. Since heart disease is the number one killer of both men and women in this country, the program also serves as an important reminder of why it is important to maintain good heart health throughout life.

### Learning through Action

Throughout the program, the girls learned and applied science concepts and inquiry skills by doing hands-on laboratory and clinical activities, such as pig heart dissections. They observed cardiac surgery, participated in lectures on heart disease and heart disease prevention. They learned the basic anatomy and physiology of the cardiovascular system, participated in workshops and discussions about public health topics, heart failure and cardiac epidemiology. At the end, they all left with their CPR certification.

### Fostering Healthy Lifestyles

Our secondary goal with CSA was to educate the students about their own heart health. The school's student population is primarily African American and Hispanic, and according to the American Heart Association, women in those demographics have a greater risk for developing cardiovascular disease than white women. In addition, they are less likely to know that they have major risk factors including diabetes, smoking, high blood pressure, physical inactivity and a family history of heart disease.

Through conversations with the young women and their parents, we found many students with strong family histories of heart disease. At the end of the week, all of the students understood the importance of recognizing risk factors and

what prevention steps to take, such as maintaining a healthy diet and getting daily exercise.

To encourage students to take action and live a healthy life, the program integrated daily heart healthy practices, including exercise and diet, for the students to model. Students participated in daily, one-hour workout sessions that included both cardiovascular and strength-training exercises. Breakfast and lunch with a heart healthy focus were provided at the hospital. The students' families were invited to attend the graduation on the last day. As part of the day's program, the hospital chef prepared nutritious, heart healthy food in front of the audience and in keeping with their traditions, he used foods that were normally consumed by these families. After, he provided everyone with the recipes.

More than 35 staff members, the majority of them women, from the Northwestern University Feinberg School of Medicine participated in the CSA program and served as mentors to the students. For those of us who created this program and taught the girls, we got as much as the girls got out of the program, if not more. Their youthful enthusiasm to learn was contagious and inspired us. Their optimism for their future made us hopeful. It was an amazing week for everyone involved, and we hope that more talented and passionate young women take our career path to cardiology. Certainly, some of these 16 girls will.



**Gulati is a member of ACC's Women in Cardiology Section and Council. The WIC Section has sponsored**

**many activities, including its successful mentoring programs, to attract women to cardiology. Go to [www.acc.org/communities](http://www.acc.org/communities) for information.**

**For more information on the Cardiology Summer Academy, visit [whsp.northwestern.edu](http://whsp.northwestern.edu). For more information on the Bluhm Cardiovascular Institute, visit [www.nmh.org/heart](http://www.nmh.org/heart).**



## ACC.10/i2 Summit – Planned to Fit Your Needs, Your Schedules

By James B. McClurken, M.D., F.A.C.C.

**D**id you take advantage of the ACC.10/i2 Summit special member registration period that opened September 15, or are you still deciding whether or not you will go to ACC's 59th Annual Scientific Session, March 14 – 16, 2010, in Atlanta? As the chair of ACC.10, I can report that the vigor, enthusiasm and creativity exhibited by the 100 core volunteers and ACC staff planning ACC.10 will produce a unique educational and career-enhancing experience for you.

It's not just that ACC.10/i2 Summit will offer some of the most important cardiovascular (CV) research and scientific findings, nor is it that as the home of the broadest spectrum of CV professionals, ACC.10 offers some of the most integrated CV thinking and the best networking opportunities. In many ways, you will realize ways to push your thinking and practice about CV medicine and health care ahead of the curve. Some sessions will enhance your rate of learning with simulation exercises and interaction with experts. Also, we will have coverage on one of the hottest topics today — health care reform.

This meeting was planned to fit your varied information needs and professional schedules. For several years, we have been conducting intense analyses of the impressions of attendees at the Annual Scientific Session. The results helped us focus on enhancing the attendee experience. Educational programming has been planned to minimize competition between similar interest sessions at the two meetings and to allow dedicated time to visit the Exposition and Posters. ACC.10 and i2 Summit are

integrated in a way that allows all cardiovascular professionals — generalists, interventionalists, echocardiography specialists, electrophysiologists, cardiovascular surgeons, pediatric cardiologists, Cardiac Care Associates and others — to learn side-by-side.

### We Considered Your Time

Your time is important and for that reason, both meetings and exposition start this year on Sunday, March 14, and end Tuesday, March 16. Where else can you gather as much information in three days?

However, if you can spare the time, other exciting activities do take place on Saturday, March 13. In keeping with

**New this year**, one main education room — the CV Coliseum — will hold all late-breaking clinical trials, the opening Scientific Showcase session, the final Meeting Highlights Session and other special sessions planned by the ACC.10 and i2 planning committees.





the Year of the Patient, the Georgia ACC Chapter is hosting a cardiac health fair for patients and families. The Interventional Cardiology 2008/2009 American Board of Internal Medicine Update Maintenance of Certification study session and the i2 Cardiac Care Team Spotlight sessions also take place on Saturday, as do the “House of Cardiology” education sessions. ACC committee meetings are also scheduled for Friday and Saturday to avoid educational programming conflicts.

### Programming: Some Familiar, Some New — All Exciting

ACC’s attendees come from many CV specialties and countries. Their education needs and backgrounds are diverse, and their learning styles vary. Our job is to meet those individual needs and address the important hot topics in our profession.

ACC.10 and i2 Summit will feature numerous, dynamic learning experiences and options, including large and small state-of-the-art lecture venues, Meet-the-Experts sessions, roundtable sessions and several new and exciting formats. You asked for more real debates; look for at least one Great Debate in each of the major topics. The program includes live case scenarios, simulations and — per your requests — an increased number of sessions with audience response systems.

Once again, i2 is in partnership with the Cardiovascular Research Foundation (CRF), building on the success of last year’s meeting. Didactic and live case sessions will be integrated throughout the i2 meeting to facilitate transfer of the latest information and to allow both interventionalists and non-interventional cardiologists to learn about the newest intervention therapies available for their patients.

- Congenital Cardiology Solutions returns again this year with live cases involving both adult and pediatric congenital interventions.
- An increased number of sessions in general and interventional cardiology providing MOC credits toward recertification will be held throughout the meeting.
- Last year’s highly successful International Symposia return this year with topics from 15 countries being discussed by speakers from the U.S. and from the host country for each symposium. Other international activities include ACC joint sessions with the European Society of Cardiology and the British Cardiac Society, and the Interamerican seminar hosted by **Valentin Fuster, M.D., Ph.D., F.A.C.C.**

If you want intriguing sessions that address medicine’s future and challenge traditional thinking, **Anthony Atala, M.D.**, director of the Wake Forest Institute of Regenerative Medicine, will give the Simon Dack Lecture on Sunday, and

**Richard Satava, M.D.**, will discuss the rapidly advancing field of robotics and artificial intelligence applications in health care in the Bishop Lecture later in the meeting.

### Networking Opportunities Abound

Good networking opportunities are the core of a great meeting, and we have worked hard to make navigation at this meeting as easy as possible to help you have time to network with colleagues and still stay in tune with what is happening. You will find many displays throughout the convention center that provide information on the day’s activities and the late-breaking trial presentations. Join colleagues at one of the Heart Hubs and listen to key sessions. Fellows in Training (FITs), International Fellows and Cardiac Care Associates (CCAs), will once again have special areas.

### Atlanta Considers Your Schedule, Your Checkbook

Both the city of Atlanta and the Georgia World Congress Center (GWCC) provide all the key ingredients to ensuring a

**New this year**, the Vascular sessions have been planned jointly by ACC.10 and i2 Summit planning committees and will be presented jointly by ACC.10 and i2 faculty — and the learning pathway will be open to all ACC.10 and i2 attendees.



positive attendee experience. As a major city in the southern U.S., Atlanta is a national and international air hub, which makes travel easy and reasonably priced — an important factor in these tight economic times. The city offers a wide array of hotel accommodations close to the GWCC to match all tastes and price ranges, and it features many fabulous restaurants and unique area attractions. Finally, the GWCC is one of the most navigable sites for a meeting the size of ACC.10/i2 Summit.

We can assure you that ACC.10 and i2 Summit will provide a unique learning experience that you will not want to miss. Also, remember that the Full Access registration gives you access to both ACC.10 and i2 Summit. Plan now to come and enjoy meeting with colleagues, renewing old friendships and connecting with new acquaintances — and enjoy the Southern warmth and hospitality of Atlanta.

Be sure to register soon at [acc.10.acc.org](http://acc.10.acc.org) for what we are sure will be the best CV program in 2010. See you soon in Atlanta!

**McClurken is chair of ACC.10.**





## ACPC Section: ACC Members Should Talk with At-Risk Patients about Flu Shots

By Devyani Chowdhury, M.D., F.A.C.C.

With an unusual flu season quickly approaching, the ACC Adult Congenital and Pediatric Cardiology (ACPC) Section strongly advocates that ACC members follow the influenza immunization recommendations of the American Academy of Pediatrics. ACC members need to encourage patients to obtain annual influenza immunizations. This holds true particularly for patients with significant congenital heart disease (CHD) and their household contacts. Recommending influenza immunization in this high risk group will help protect this vulnerable population from the increased morbidity due to influenza. ACC members' recommendations will deliver a stronger message to CHD patients and other cardiac patients and will enhance care in this vulnerable population.

In addition to this year's efforts to advocate for increased influenza immunization, the ACPC Section's Quality Metrics Working Group (QMWG) is targeting the vaccination of CHD patients as a proposed quality improvement index for a national scorecard. The development of this metric will be part of their overall effort to develop quality indicators for the practice of pediatric cardiology and for adults with

### Coding for H1N1 Vaccines

The Centers for Medicare and Medicaid Services (CMS) has developed two new codes for H1N1 vaccination:

**G9141** – Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

**G9142** – Influenza A (H1N1) vaccine, any route of administration

Medicare will pay the same rate for H1N1 vaccination as it does for seasonal flu vaccination, about \$21; patients will not be charged co-pays or deductibles for the vaccine. The American Medical Association (AMA) has asked the Department of Health and Human Services to encourage private insurers to adopt the Medicare payment rate.

The AMA CPT editorial panel also has issued an H1N1 code and revised existing code 90663 for specificity to the H1N1 product:

**90470** – H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

**90663** – Influenza virus vaccine, pandemic formulation, H1N1

For more information, visit [www.ama-assn.org](http://www.ama-assn.org).

CHD as well. These indicators can then serve as a scorecard by a medical center to assess quality of care. Identification of such quality metrics will allow for overall improvement of health care. With the onset of the influenza season, the ambulatory cardiology team of the QMWG will be working also to develop a metric for assessing the immunization against influenza in children and adults with CHD.

We invite all cardiology colleagues involved in the care of pediatric cardiology or CHD patients, as well as other vulnerable populations, to visit the Childhood Influenza Immunization Coalition (CIIC) Web site at [www.preventchildhoodinfluenza.org](http://www.preventchildhoodinfluenza.org). An influenza risk calculator, articles for waiting rooms and posters for your exam rooms are available at this site. Additionally, links to other resources for education, regional and local immunization clinics and clinical updates are provided.

ACC has been a member of the CIIC since its founding in 2007. With your support, the College can help CIIC fulfill its objectives to speak with "one strong voice" to improve vaccination rates and ensure this vulnerable at-risk patient population receives optimal therapeutic and preventive care.



**Chowdhury is a member of the ACPC Section.**

### The Dark Truth of Flu and Heart Disease

In a study published in *The Lancet Infectious Diseases* (Vol. 9, No. 10, October 2009), British researchers, who analyzed 39 studies of heart patients, reported finding a consistent link between influenza and heart attacks. They found that up to 50 percent of the deaths were due to heart disease.

"The message of these study results is so strong and so logical that it's hard for us to ignore," commented **Ralph Brindis, M.D., M.P.H., F.A.C.C.**, ACC president-elect. If we can persuade cardiac patients to get a flu vaccine, that could ultimately save lives, he added.

To address the low flu vaccination rates among heart disease patients, Mended Hearts, Inc., launched "I Heart Flu Shots™," an educational campaign that helps educate people living with heart disease about the importance of getting a seasonal flu shot.

For more information about this campaign, go to [www.IHeartFluShots.com](http://www.IHeartFluShots.com).

## Risk Prediction with CAC vs. ATP III

While symptomatic patients with coronary artery disease (CAD) certainly face increased risk for cardiac events, asymptomatic individuals are at risk, too. About 50 percent of men and 64 percent of women experiencing sudden cardiac death had no prior symptoms of heart disease. Consequently, assessing individual patient risk continues to be a challenge.

Numerous models, such as the Framingham Risk Score (FRS) or the National Cholesterol Education Program (NCEP) Adult Treatment Panel (ATP) III, calculate “global risk” by weighing various established risk factors such as age, blood pressure, sex, lipid levels and blood glucose. More recently, other variables have been analyzed, such as homocysteine, C-reactive protein and lipoprotein (a). While their prognostic value is still unclear for standard office-based assessment, evidence points to their usefulness in refining risk in the population at large.

Another factor shown to be an independent predictor of cardiac events is coronary artery calcification (CAC) scoring. Based on the Multi-Ethnic Study of Atherosclerosis (MESA), CAC is a strong predictor of events in white, black, Hispanic, and Chinese men and women.

How does CAC measure up in predicting risk against other traditional factors? The Heinz Nixdorf Recall Study looked at whether CAC improves on cardiac event risk prediction versus ATP III. Investigators in Germany selected 4,487 participants without known CAD, assessed a variety of risk factors including CAC via electron beam computed tomography, and followed them for five years. Participants were classified into low-, intermediate- and high-risk categories by ATP III and CAC scoring.

The primary endpoint was coronary death or nonfatal myocardial infarction. In the final study cohort of 4,137 individuals, the total events numbered 93 (64 nonfatal, 29 fatal). According to lead investigator **Raimund Erbel, M.D., F.A.C.C.**, professor of medicine and director of cardiology at the University of Essen, “The event rate was clearly different in the different risk groups, and this difference was more striking with calcium scoring than with ATP III.” In the high-risk group in ATP III, the event rate was 4.2 percent compared to 8.2 percent in the high-score calcium group. So “clearly a difference,” he said, favoring CAC.

Moreover, CAC score seemed to determine risk better in many individuals classified as intermediate risk per ATP III. Specifically, by applying the CAC score tertile scores of low (<100) and high (>400) risk, 77 percent of ATP III intermediate risk subjects could be reclassified to either low or high risk.

Erbel added that for low-risk individuals coming in for a check-up, you don't need to go to calcium scoring because the risk is low even when you have a high calcium score. On the other side, if you have an intermediate-risk group, we can and should go to calcium scoring because we get better risk prediction.



Erbel



### ACC News

## Call for Committee Nominations and Applications

Volunteers are at the heart of the College's work. Our strength is the result of the time, effort and dedication provided by those who volunteer to serve their colleagues and help cardiology professionals learn, advance and heal. If you would like to participate in one of the College's committees and councils, now is the time to let us know. All College Fellows, Fellows in Training and Cardiac Care Associates are encouraged to nominate and/or apply. Applications are due Oct. 31. Applicants will be selected by the ACC President-Elect, **Ralph G. Brindis, M.D., M.P.H., F.A.C.C.**, this fall and notified of their selection in January 2010.

To view the list of committees with openings and to nominate and/or apply, please login at the Member Center, [members.acc.org](http://members.acc.org), on ACC's Web site.

Applicants will be asked to list professional experience and practices outside of ACC, honors and awards, most important publications and any experience and qualifications that may qualify them for a requested committee. All applicants are required to submit a letter of reference from an ACC member.

For questions about the process, please contact Marthea Wilson at (202) 375-6230 or [volunteers@acc.org](mailto:volunteers@acc.org).



**1986** Heart House Television transmits live procedures from Georgetown University Hospital to the Heart House Learning Center. Today, live cases are transmitted from around the world during ACC's Annual Scientific Session and i2 Summit.



ACC News

## ACCF Program One of Five Accredited by ANCC

The American Nurses Credentialing Center (ANCC) has accredited only five programs for its Nursing Skills Competency Program, and the ACC Foundation (ACCF) “2009 Foundations for Practice Excellence: A Core Curriculum for the Cardiovascular Practitioner” is one of the five.



The ANCC Nursing Skills Competency Program offers a national performance benchmark for selecting continuing education courses for nurses, and it provides employers and

nurses with a tool to identify educational programs that are appropriately designed to validate nursing skills and skill sets. Nurses benefit from this new method of substantiating their ability to perform a given skill. It also provides them with a competitive edge in obtaining and retaining positions. Employers and health care consumers also will be able to compare and judge the quality of skills validation programs that nurses attend, giving them confidence that the nurses meet competency requirements.

Through the ACCF Core Curriculum for the Cardiovascular Practitioner, nurses will be able to validate and claim continued proficiency in cardiovascular nursing. The ANCC accreditation, effective Sept. 8, 2009 – Sept. 8, 2011, further assures them of the value of the program.

**1953** The College holds “preceptor workshops,” in which the ACC enlisted leading teachers to open their offices and labs to small groups of physicians for two- to three-day workshops. By 1955, there were 37 such workshops, and by 1957, more than 70.



# 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

# 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

## Cardiology opening in Beautiful East Tennessee

Mercy Health Partners is seeking a BC/BE cardiologist to join a busy cardiology practice in Jefferson City, TN, 30 minutes from Knoxville TN. Practice currently has one invasive cardiologist and one nurse practitioner.

Physician will provide clinical outpatient services and inpatient consultations at St. Mary's Jefferson Memorial Hospital and provide invasive procedures at the St. Mary's Medical Center in Knoxville. A 64-Slice CT Scanner is available for CT angiography. Call is limited to 10 nights per month - for phone consultations only. Physician office management, marketing, credentialing and managed care contracting is provided by the group. Salaried position with incentive compensation, excellent benefits, malpractice, and CME allowance, and moving expenses provided.

Jefferson City sits in the foothills of the Great Smoky Mountains, where many people are retiring for its beauty and quality of life. With beautiful area lakes and parks, there are great recreational opportunities. Live on the lake, enjoy out door life and practice cardiology in a wonderful area of the country. You'll also be near the main campus of The University of Tennessee and have access to theatre, opera, and an excellent symphony orchestra.

**Contact: Karen McKinney, Physician Recruiter, Mercy Health Partners,  
Phone: (865) 549-4529 • Fax: (865) 549-4646  
Email: kmckinney@mercy.com**

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### CARDIOLOGY

Contact Ariel Medina to place  
your ad today!

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Fax: 212-633-3850  
E-mail: a.medina@elsevier.com

**IDAHO**



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

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

J-1 Visa applicants do not qualify.

[www.saintalphonus.org](http://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](mailto:jsemling@altru.org) Website: [www.altru.org](http://www.altru.org)

This Month in  
**JACC**

**October 6**

- The Role of Cardiovascular Magnetic Resonance Imaging in Heart Failure
- Statins in Acute Coronary Syndromes: Do the Guidelines Match the Evidence?
- Accuracy of Plasma B-type Natriuretic Peptide to Diagnose Significant Cardiovascular Disease in Children: The Better Not Pout Children! Study

**October 13**

- The Year in Non-ST-Segment Elevation Acute Coronary Syndrome
- Improving the Diagnosis of Acute Heart Failure Using a Validated Prediction Model
- Diagnosing Acute Heart Failure: the Mathematician and the Clinician

JACC  
cardiovascular  
**Interventions**

- Cracking the Mysteries of Diastolic Function in Atrial Fibrillation: New Technology for an Old Problem
- Influence of Abnormal Glucose Metabolism on Coronary Microvascular Function after a Recent Myocardial Infarction
- Relationship between Baseline Coronary Calcium Score and Demonstration of Coronary Artery Stenoses During Follow-up in the Multi-Ethnic Study of Atherosclerosis (MESA)

**October 20**

- Women and Ischemic Heart Disease: Evolving Knowledge
- Revascularization for Unprotected Left Main Disease: Evolution of the Evidence Basis to Redefine Treatment Standards
- The SLC01B1\*5 Genetic Variant is Associated with Statin-Induced Side Effects

**October 27**

- The Hospitalizations after Heart Failure Diagnosis: A Community Perspective
- Micronutrient Deficiencies: An Unmet Need in Heart Failure
- High Central Pulse Pressure is Independently Associated with Adverse Cardiovascular Outcome: The Strong Heart Study

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**Imaging**

- Systems of Care for ST-elevation Myocardial Infarction. Impact of Different Models on Clinical Outcomes
- The Ideal Reperfusion Strategy for the ST-Elevation Myocardial Infarction Patient with Expected Delay: Paradise Lost or Paradise Renamed?
- Proximal Embolic Protection and Thrombus Aspiration in STEMI

## Educational Programs Calendar

	October 22 - 25, 2009 <b>2009 Foundations for Practice Excellence: A Core Curriculum for the Cardiovascular Clinician</b> 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 <b>How to Become a Cardiovascular Investigator</b> Valentin Fuster, M.D., Ph.D., F.A.C.C.	Washington, D.C. CME
	December 11 - 13, 2009 <b>42nd Annual New York Cardiovascular Symposium</b> Valentin Fuster, M.D., Ph.D., F.A.C.C.	New York CME CE
	January 11 - 15, 2010 <b>41st Annual Cardiovascular Conference at Snowmass</b> Spencer B. King III, M.D., M.A.C.C.	Snowmass, Colo. CME
	January 22 - 24, 2010 <b>29th Annual Perspectives on New Diagnostic and Therapeutic Techniques in Clinical Cardiology</b> C. Richard Conti, M.D., F.A.C.C.	Lake Buena Vista, Fla.
	February 5 - 6, 2010 <b>Heart of Women's Health 2010</b> 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 <b>2nd Annual Clinical Practice of Peripheral Vascular Disease: Key Components for Cardiovascular Specialists</b> Michael R. Jaff, D.O., F.A.C.C. Christopher J. White, M.D., F.A.C.C.	Phoenix CME CE
	March 13, 2010 <b>"Boot Camp" for Cardiology Fellowship Program Directors and Coordinators: Educating the Educators</b> Jeffrey Kuvin, M.D., F.A.C.C.	Atlanta CME
	May 6 - 8, 2010 <b>32nd Annual Recent Advances in Clinical Nuclear Cardiology and Cardiac CT Featuring Case Review with the Experts</b> 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](http://www.acc.org/education/programs/programs.htm)



ACCF EDUCATIONAL PROGRAMS 2009

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# THE RIGHT CARE AT THE RIGHT TIME SAVES LIVES

Sounds simple enough. But the right care at the right time only saves patients with access to it. Unfortunately for patients with heart disease, Medicare is proposing drastic cuts for cardiovascular services that could make it harder for them to get the care they deserve. Cardiologists across the country may be forced to lay off staff, limit services and in some cases even close their doors.

**The American College of Cardiology** is working to stop these cuts, streamline costs and set a new standard for health care that delivers timely, appropriate care to ALL patients. Providing doctors and patients with the resources needed to ensure high-quality, evidence-based and cost-effective care not only stops doors from closing, it opens new ones for the 750,000 Americans who'll face a cardiac event this year.

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Setting standards. Saving lives.

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