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# Cardiology

A MEMBER PUBLICATION OF THE AMERICAN COLLEGE OF CARDIOLOGY

What's Next?  
The Latest News  
and a Look Ahead  
at Medicare Payment

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# Welcome to 2010!

As most of you know, the College in late December brought a lawsuit against the Secretary of Health and Human Services (HHS), alleging that she unlawfully adopted the payment rates for cardiology services in the 2010 Medicare Physician Fee Schedule in a manner that threatens access to patient care and precipitously increases Medicare costs. According to the complaint, the Physician Practice Information Survey, which was used to justify the cuts to Medicare reimbursements rates for cardiology, was critically flawed.

The ACC, along with the Florida ACC Chapter, American Society of Nuclear Cardiology, the Association of Black Cardiologists and the Cardiology Advocacy Alliance, sought a preliminary injunction against the implementation of the 2010 Fee Schedule and asked the court to rule it invalid and order HHS to commission a new practice expense survey. Unfortunately, the judge ruled that the court had no jurisdiction over the subject matter of the case and refused to hear it. For more on what's next, read our cover story, What's Next: The Latest News and a Look Ahead at Medicare Payment.

Despite the challenges cardiology faces in 2010, the ACC is approaching the new year with undaunted determination and unabashed enthusiasm about the great work our members do every day.

In this issue, we reflect on 2009 and its lessons. **Jack Lewin, M.D., F.A.C.C.**, recounts the many ways in which the College excelled in its mission – despite the prevailing economic woes and Medicare payment nightmare. The California Chapter reports on its patient-centric focus in 2009 and the outstanding results.

We also look ahead to what 2010 has in store. ACC.10 and i2 Summit are right around the corner, and in this issue **Michelle Gurvitz, M.D., F.A.C.C.**, and **Jacqueline Kreutzer, M.D., F.A.C.C.**, preview Congenital Cardiology Solutions 2010. Paul Mather discusses the value of ACC.10 for the practicing cardiologist, and **Andrew Freeman, M.D.**, and **Michael Barrett, M.D., F.A.C.C.**, share their excitement about the opportunities available to Fellows in Training. **John G. Harold, M.D., F.A.C.C.**, offers a vision for the Board of Governors in the year ahead, and **Paul Douglass, M.D., F.A.C.C.**, tells us about a new endeavor: a large-scale community health event planned to coincide with our Annual Scientific Session in Atlanta.

Of course our enthusiasm for the possibilities unfolding before us is tempered with uncertainty – about Medicare payment, health care reform and more. Certainly 2010 could be a year of dramatic change for many ACC members. This issue also includes a wealth of information designed to help you make the important decisions facing you in this coming year. Attorneys George Sanders and Henry Allen provide advice for antitrust concerns in practice integration, and we demystify the Physician Quality Reporting Initiative and “meaningful use.”

No matter what 2010 may bring, your College will remain steadfast in its commitment to you and your patients. I wish you all a very happy, healthy and prosperous New Year!

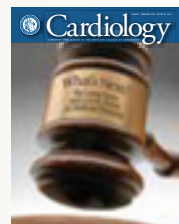
**Alfred A. Bove, M.D., Ph.D., F.A.C.C.**  
ACC President

January – February 2010

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ACC Senior Vice President of Advocacy **James Fasules, M.D., F.A.C.C.**, shares the outcome of ACC's legal proceedings against CMS and tells you what's next in our battle against cuts included in the 2010 Physician Payment Rule.



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# What's Next:

## The Latest News and a Look Ahead at Medicare Payment

By James Fasules, M.D., F.A.C.C.



Despite the unprecedented advocacy efforts of the entire house of cardiology, the mammoth payment cuts to cardiology services included in the final 2010 Medicare physician fee schedule took effect on Jan. 1.

These cuts are bad policy. They will hurt access to care, particularly for disadvantaged populations, and will dramatically increase Medicare costs by shifting services to the hospital setting. The American College of Cardiology (ACC) is committed to continuing efforts to mitigate these cuts in the legislative and regulatory settings, though our chances for significant reversals are low. At the same time we are moving forward with efforts to develop and test new payment

**“ These cuts are bad policy. They will hurt access to care, particularly for disadvantaged populations, and will dramatically increase Medicare costs by shifting services to the hospital setting. ”**

methodologies that would put an end to these yearly fights for good.

Unfortunately, the College's legal efforts to fight the cuts ended on Jan. 12 when the U.S. District Court in Florida refused to hear our case on jurisdictional grounds. The judge opined that statutory language governing the Medicare program precludes judicial review of the relative value units and the methods for determining the RVUs in the Medicare fee schedule. This is a worrisome precedent, given our argument centered on the Centers for Medicare and Medicaid Services' (CMS) congressionally-mandated responsibility to use valid data.

The College, along with the Florida ACC Chapter, the American Society of Nuclear Cardiology, the Association of Black Cardiologists and the Cardiology Advocacy Alliance, on Dec. 28 filed a complaint, as well as motions for a preliminary injunction and expedited discovery, against Health and Human

**“ The ACC recognizes that community-based cardiology is engaged in a fight for survival. Every cardiologist in the United States must commit to our efforts to protect patient access. ”**

Services (HHS) Secretary Kathleen Sebelius. According to the complaint, clear and critical defects existed within the Physician Practice Information Survey (PPIS), which was used to justify cuts to Medicare reimbursement rates for cardiology and which directly undermined the viability of community practices. The complaint requested a preliminary injunction against the implementation of the 2010 fee schedule and asked the court to rule it invalid and order HHS to commission a new practice expense survey.

While the ACC is very frustrated by the court's decision, it was not unexpected given the traditional hesitancy of any court to oppose the federal government. That said, the College discovered through the legal process just how little CMS knew about the PPIS data. This information will be extremely useful as the College moves forward with CMS, Congress and, to the extent possible, the public on next steps to prevent a disruption of cardiac care.

#### Next Steps

The New Year brings with it new and continued opportunities. Rep. Charlie Gonzalez (D-Texas) introduced legislation in December to hold cardiology at 2009 practice expense values. This bill still is active with 70 cosponsors, and we continue to urge its support. Also, before recessing for the holidays, Congress approved a temporary freeze on the scheduled 2010 Sustainable Growth Rate cuts. The House and Senate will need to act soon to stop these cuts for another year — or, even better, for good. Also encouraging was a letter from House leaders to CMS calling for a phase-in of the nuclear cuts. Of course, health care reform still is in play, and the ACC will continue its ongoing efforts to ensure any final legislation protects practices and patients. The drastic cuts only serve to underscore why real reform is so needed.

On the regulatory front, we are calling for a refinement panel to re-evaluate the physician work relative value unit assigned to two of the new nuclear codes (78451 and 78452),

as CMS decided not to use the Relative Value Scale Update Committee (RUC) recommendation. We'll also continue to advocate for changes to future rules. It's hard to believe, but there is only a narrow window to influence the proposed 2011 rule. We already are arranging meetings with CMS staff in order to discuss issues ranging from coverage decisions to coding changes. Stay tuned to *Cardiology* and the ACC Advocate for ways you can get involved in these efforts.

The personal stories from patients and their cardiac care providers about the impacts of the 2010 cuts have made, and continue to make, headlines in newspapers across the country. The ACC recognizes that community-based cardiology is engaged in a fight for survival. Every cardiologist in the United States must commit to our efforts to protect patient access. With the viability of outpatient cardiology — and hence patient access to quality cardiovascular care — at extreme risk, standing silent is not an option.

There are several opportunities for the cardiovascular community to lessen the impacts of the cuts. Participation in the **Physician Quality Reporting Initiative (PQRI)** and e-prescribing offers the opportunity for bonuses. The College has tools and resources available to help guide your participation at [www.acc.org/healthbit](http://www.acc.org/healthbit). The College also has

**“ With the viability of outpatient cardiology — and hence patient access to quality cardiovascular care — at extreme risk, standing silent is not an option. ”**

prepared a **Practice Survival Toolkit** to help navigate the new coding changes, assess your practice options and determine the impacts of the rule on your practice. In addition, the **Campaign for Patient Access** Web site makes it easy to donate to the campaign and/or the ACC's Political Action Committee to help subsidize the costs associated with these multifaceted advocacy efforts. The campaign Web site also makes it easy to contact members of Congress and share your stories. For more information, go to [www.campaignforpatient-access.org](http://www.campaignforpatient-access.org).

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Fasules is senior vice president for Advocacy at the ACC.

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## The Party's Over By Jack Lewin, M.D., F.A.C.C.

Since the release of the 2010 Medicare Physician Fee Schedule, the College's focus has, by necessity, been on fighting implementation of the massive payment cuts to cardiovascular services. At the same time, however, the College is working with a variety of stakeholders to develop a new and better payment system so we don't have to go through this Medicare payment nightmare again. We believe we must build a system that rewards — not penalizes — physicians and other medical professionals for their commitment to quality and evidence-based care.

In order to realize true payment reform, we will have to put aside the partisan rhetoric, cynicism and understandable frustration that have characterized many discussions about health care reform. We need to shift our focus to developing, testing and implementing systems that will promote our best future, protect our practices and ensure patient access to care.

**“ Some kind of health reform bill is almost certain to pass. We can either work to make it better, or we can stand by and watch it happen. ”**

The challenge of making positive change requires a more discerning, bipartisan course. Americans want prudent reform to protect their access to good and affordable health care. We can help get there, provided we focus on the merits of each issue, rather than

partisan debate. If we can do that, we'll be staying close to our patients and the public in the mainstream — where we need to be to survive. While we might not like a lot of what's in the current 2,000 pages of the health care reform bill, there are sorely needed provisions included in the bill as well.

Cardiovascular professionals are leaders in bridging the gaps between science and practice. Our lawmakers recognize this. We have the opportunity and ability to influence legislators on both side of the aisle. Although the ACC has not endorsed the bill as a whole, we're staying at the table with lawmakers by praising the worthy provisions and offering guidance about what needs to change. We're working to ensure that final legislation promotes appropriate use of diagnostic equipment; adherence to clinical guidelines and appropriate use criteria; improved care coordination through the use of clinical registries; and reduced hospital readmissions and geographic variations in care.

The status quo in health care is unsustainable and a certain fiscal nightmare. Doing nothing is not a responsible course; nor is taking a purely partisan stance. The ACC has tried to find a critical path through the reform quagmire that truly meets the needs and goals of the cardiology community, while also protecting the patient-physician relationship.

Finding a balance is what we need to do together. Now is the time for all of us to ask our patients, our staff and our colleagues what they need and then work to meet those needs. Some kind of health reform bill is almost certain to pass. We can either work to make it better, or we can stand by and watch it happen. As an eternal optimist, I would like to see us enact some real change and help influence what that change will be.

Lewin is CEO of the ACC.

# Heart Rhythm



## 2010

The focus of this year's Annual Scientific Sessions, **Leaders in Quality**, addresses the current challenges facing the field and the impact on quality and outcomes.

The Opening Plenary Session will address some of the tough questions surrounding the impact of health care reform on quality and outcomes, and interpret its meaning for the field.

### Opening Plenary Session panelists:



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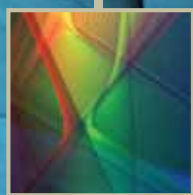
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## Lessons Learned: A Firsthand Look at How Appropriate Use Criteria Can Improve Patient Care



**Cardiology recently interviewed Patrick Hughes, M.D., F.A.C.C., assistant professor of medicine at the University of Wisconsin School of Medicine and Public Health, about his experiences using AUC to ensure patients are receiving the most appropriate, evidence-based care.**

The American College of Cardiology (ACC) in January launched a new initiative called FOCUS designed to help practices best use appropriate use criteria (AUC) at the point of care and ultimately reduce inappropriate imaging. The goal of FOCUS is to create an online community where participants can share ways to maximize use of AUC, as well as benefit from online AUC-specific educational tools and resources. As the College embarks on this new endeavor, *Cardiology* recently interviewed **Patrick Hughes, M.D., F.A.C.C.**, assistant professor of medicine at the University of Wisconsin School of Medicine and Public Health, about his experiences using AUC to ensure patients are receiving the most appropriate, evidence-based care.

***Your practice undertook a study of how your use of SPECT Myocardial Perfusion Imaging (MPI) adhered to the ACC's AUC for SPECT MPI. Could you briefly explain your reasons for doing so?***

I came to the University of Wisconsin Medical Foundation (UWMF) from a smaller private practice. One of the things I observed in this much larger UWMF group was that it seemed as if we were often performing outpatient stress nuclear exams for individuals at low risk, such as a preoperative evaluation for cataract surgery. When I pointed this out to our chief of cardiology, he suggested

that we conduct a survey to see how often this happens and if we should do something about it.

***What methods did you use to conduct your survey?***

Data were collected for 387 patients ranging from 26 to 90 years of age who underwent a SPECT-MPI exam from September 2008 through November 2008. We used the ACC's SPECT MPI Appropriate Use Criteria decision support application for PDAs designed by Skyscape during patient exams. An "appropriate use score" was obtained from the ACC Algorithm by our nuclear technologists and recorded in a registry as "appropriate," "uncertain" or "inappropriate." As a cardiologist, I served as a resource when questions arose as to how to evaluate and score an individual patient's data. Referring physicians, for the most part, did not know this survey was occurring.

***What were some of the challenges you faced in implementing the AUC?***

We had to work through a few challenges in developing the survey. Even though the Skyscape algorithm was very well designed, it still took us a while to learn how to use it and score patients appropriately. The intended meaning of some terms used in the algorithm is different from the meaning those terms have in my day-to-day practice. For instance the term "atypical angina," as used in the

algorithm is intended to characterize symptoms that the ordering physician thinks most likely are a consequence of serious obstructive coronary artery disease (CAD). I think most of us use the adjective "atypical" to imply that we don't think a patient's symptoms are consistent with myocardial ischemia. We also found it important to conduct periodic reviews of the AUC scores. This required individual chart reviews. Even with a fully integrated electronic medical record, this was a time-consuming process. Roughly one third of scores initially assigned by our nuclear technologists needed to be revised, and most of the reassigned scores were lower. We did learn that it was good to have someone in the review process who was one step removed from actually conducting the tests.

***What were some of your specific findings?***

We found that 31 percent of the tests ordered were considered inappropriate based on the AUC. The frequency with which a test was scored as inappropriate depended on who ordered the exam. Thirty-four percent of exams ordered by primary care physicians and 22 percent of those ordered by cardiologists scored as inappropriate in our outpatient nuclear lab. There were just a few clinical scenarios that explained almost all of the "inappropriate" tests. They were exactly the same as those identified in the ACC's AUC pilot study with United



Healthcare, the results of which were presented at ACC.09. They include:

- Evaluation of chest pain, low probability pt; Interpretable ECG and able to exercise
- Detection of CAD; Asymptomatic, low CHD risk
- Pre-operative assessment; Low-risk surgery
- Asymptomatic or stable symptoms, known CAD; < 1 year after cath or abnormal prior SPECT
- Asymptomatic, post-revascularization; < 2 years after PCI, symptoms before PCI

The common denominator is that patients in these clinical circumstances all have a low pretest probability of serious obstructive coronary artery disease.

***On a broader level, why do you believe gaps exist between the recommended use of this technology and actual practice?***

In short, it's because our day-to-day working concept of the pathophysiology of coronary artery disease is different from what science tells us, and appropriate use criteria are based on science. In my opinion there are a few important misconceptions that many of us may hold without being aware:

- In low-risk patients who are able to exercise, stress testing with imaging is a more valuable technique than the exercise EKG alone.
- Major adverse coronary events are a result of slowly progressive stenoses that culminate in thrombotic obstruction.
- By detecting severe stenoses (with stress testing) and performing elective coronary artery revascularization we can prevent myocardial

infarction and improve survival.

- Coronary revascularization prior to elective non-cardiac surgery will make that surgery safer.

***What are you doing today as a result of the survey findings?***

We're working very hard to educate everyone at UWMF about these findings and, most importantly, about the misconceptions that led to them. By following AUC and reducing the number of inappropriate tests ordered, we are not only saving money, we are also protecting our patients from unnecessary radiation and tests. We are continuing to track our practice's adherence to the 2005 AUC. When a computer-based algorithm for the updated AUC from 2009 becomes available, we will switch to that. We also have sent the ACC's AUC pocket card for SPECT MPI, which outlines the most common clinical scenarios that fail to meet AUC for stress testing with imaging to our referring physicians and are meeting with them on an ongoing basis.

***Why should other practices use AUC?***

As a specialty, I think the development of AUC is something that we in cardiology can really be very proud of. This is one way that we as a profession distinguish ourselves as responsible stewards of the lives of the patients we care for and the resources needed to provide that care. I believe the College should continue to promote implementation of the AUC and develop tools that make it feasible to do so (like the PDA decision support tools and pocket cards). However, at least as important is finding a way to realign financial incentives so that they are in synch with the AUC.

## Leveraging Health: 15 Ideas to Improve U.S. Health Outcomes



Value in health care — balancing costs and quality — is frequently overlooked in health care reform discussions. To help policymakers better understand the importance of value, three authors at the Center for Health Value Innovation (CHVI) — **Cyndy Nayer, Jack Mahoney, M.D., and Jan Berger, M.D.** — have published a new book that examines 15 structures and incentives used by corporations, municipalities, health insurers and others to improve the health of their communities and increase value.

In the book, *Leveraging Health*, the authors discuss the importance of value-based design in the health system. A successful value-based design begins by focusing on prevention and wellness, according to Nayer, president and CEO of CHVI.

In a value-based design, the focus is on outcomes rather than cost. "It's a recipe for the health-value chain that promotes better outcomes for the communities," says Mahoney, chief medical officer at CHVI.

Currently, the health system puts costs before outcomes, Nayer says. "Patients rely on their doctor for trusted advice. We need to foster that relationship, and we need to consider the specialist a key component of the total health management team. We need all the resources we can leverage efficiently to keep people healthy," she says.

If the strategies in the book were implemented nationwide, the result would be completely aligned incentives focused on producing healthy employees, rather than on payment models, according to Nayer. "We're now seeing communities begin to grasp that traditional payment models do not produce healthier people, and that the health of their community affects their total health care costs."

Value-based design "will improve the cost trend, quality and outcomes across the board," says Berger, a CHVI strategic advisor. She adds that CHVI expects the book to show policymakers that health system stakeholders can create aligned incentives for better health and sustainable outcomes.



Nayer



Mahoney



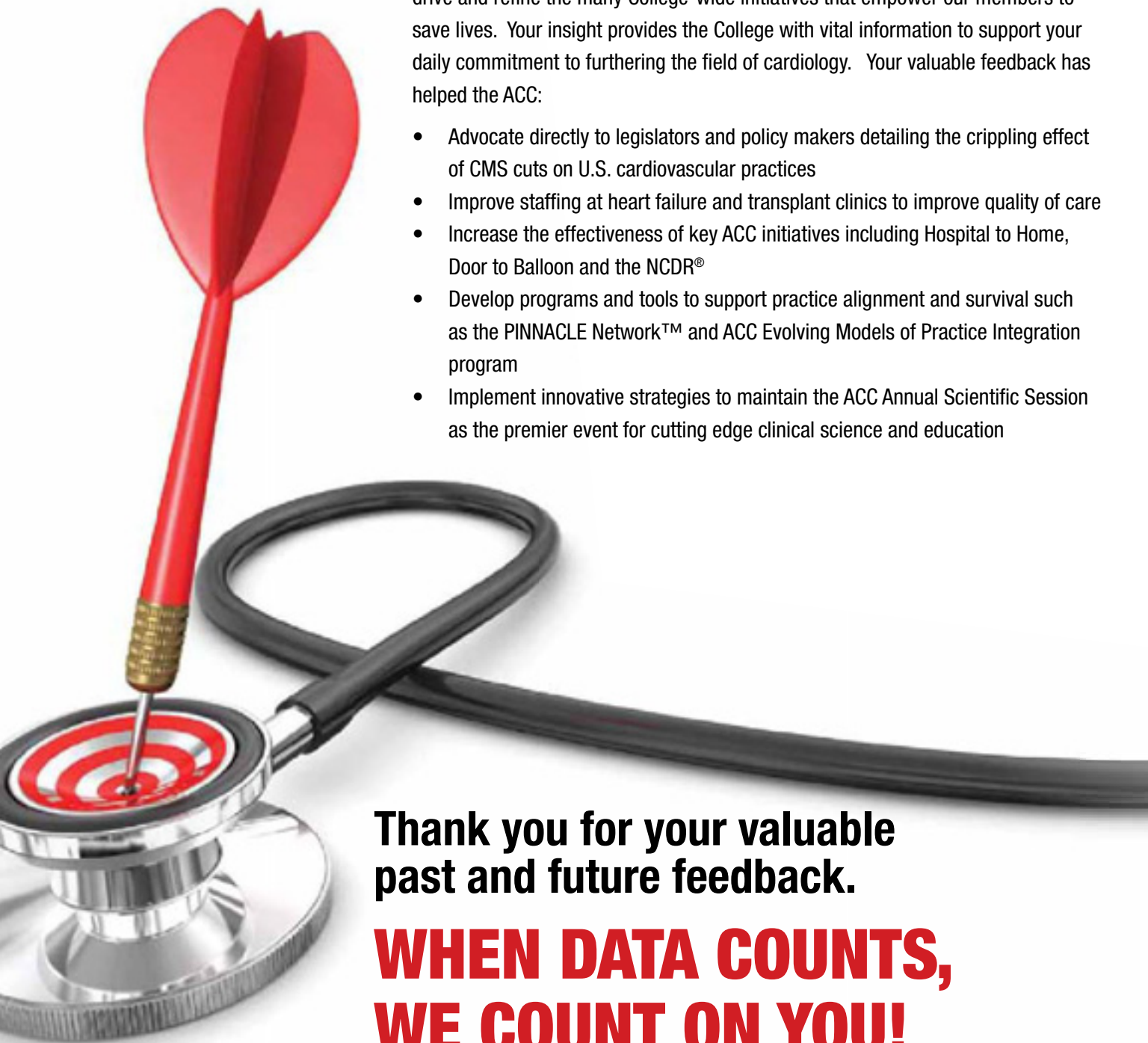
Berger

For more information about *Leveraging Health*, visit: [vbhealth.org](http://vbhealth.org).

# YOUR FEEDBACK DRIVES ACTION

Each year participation in ACC surveys helps our dedicated research staff to support, drive and refine the many College-wide initiatives that empower our members to save lives. Your insight provides the College with vital information to support your daily commitment to furthering the field of cardiology. Your valuable feedback has helped the ACC:

- Advocate directly to legislators and policy makers detailing the crippling effect of CMS cuts on U.S. cardiovascular practices
- Improve staffing at heart failure and transplant clinics to improve quality of care
- Increase the effectiveness of key ACC initiatives including Hospital to Home, Door to Balloon and the NCDR®
- Develop programs and tools to support practice alignment and survival such as the PINNACLE Network™ and ACC Evolving Models of Practice Integration program
- Implement innovative strategies to maintain the ACC Annual Scientific Session as the premier event for cutting edge clinical science and education



**Thank you for your valuable  
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## 2010 Coding Changes Now in Effect

**As of Jan. 1, substantial changes occurred in the coding for three commonly used services – myocardial perfusion/SPECT imaging, coronary CT angiography (CTA) and cardiac MRI.**

### SPECT Imaging

CMS' continued pressure to bundle imaging services reported with multiple codes has now hit myocardial perfusion imaging. In 2010, myocardial perfusion imaging/SPECT studies, including wall motion and ejection fraction, will be reported with a single code (**78452**). Multiple study SPECT imaging typically has been reported using three codes: **78465** to report the heart imaging, and two add-on codes, **78478** for wall motion study and **78480** for ejection fraction. Similarly, codes for a single SPECT study and planar studies have been created that bundle wall motion and ejection fraction codes. Even if a SPECT or planar study is performed without these additional studies, it still should be reported with these new codes as the old codes have been deleted.

CMS decided to substantially reduce the payment for myocardial perfusion imaging as part of its final rule by reducing both the physician work value and the practice expense value. As a result, the Medicare payment rates for myocardial perfusion imaging have decreased by 30 – 40 percent from the payments for the combined codes in 2009.

### Coronary CTA

The codes for coronary CTA also have changed for 2010. Although coronary

CTA in the past was reported using eight different Category III codes, in 2010, these codes have been replaced with four Category I codes. Because of this, it is important to review the service provided to determine which code is most appropriate.

The changes for coronary CTA codes are as follows:

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**75571** now is used to report evaluation of coronary calcium, which was previously reported as 0144T

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**75572** replaces 0145T for CT, heart, without contrast/with contrast and further sections

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**75573** replaces 0150T for a CTA performed in a patient with known or suspected congenital heart disease

---

**75574** now is used for a CTA performed in a non-congenital case, replacing codes 0146T-0149T

---

While use of coronary CTA has grown substantially in the past five years, it was carrier-priced by region prior to 2010. This means that the impact of these changes on payment will be different depending on where the service is provided.

### Cardiac MRI

The reporting structure for cardiac MRI codes changed slightly in 2010. As a result of the reporting change, four codes were deleted and a new add-on code created. Services previously reported with **75558**, **75560**, **75556** and **75564**, which all included velocity flow mapping, now should be reported with the appropriate code from **75557-75563** with an add-on code, **75565**, to report the velocity flow mapping.

### Next Steps for Practices

With these changes in effect, practices need to work with their health plans to accurately implement and crosswalk the 2009 codes to the new 2010 codes so processing goes smoothly. Practices also should negotiate with health plans to avoid tying future private payer rates to Medicare rates, as Medicare rates for certain services will decrease over coming years.

Given the complicated nature of these coding changes, the ACC has created resources for practices to help them with the transition, along with the other changes to the cardiovascular practice environment. Visit [www.acc.org/practicemanagement](http://www.acc.org/practicemanagement) for more. For issues with implementation of new coverage policies, please contact Henry McCants at [hmccants@acc.org](mailto:hmccants@acc.org).



## CMS Releases Proposed Rule Defining Meaningful Use of Health IT

**The “American Recovery and Reinvestment Act of 2009” (ARRA) authorized \$17.2 billion in incentives through Medicare and Medicaid to assist providers in adopting health information technology (IT). Under the law, physicians who demonstrate “meaningful use” of electronic health record (EHR) technology and performance starting in 2011 and ending in 2015 will be eligible for annual payment incentives.**

Over the last year, the American College of Cardiology (ACC) has been working with the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) — which is responsible for coordinating the health IT programs created by ARRA and endorsing certification and standards — to provide feedback on what constitutes “meaningful use.” Specifically, the College has cautioned against defining meaningful use in a way that creates additional barriers to EHR adoption. Both CMS and ONC are responsible for determining how the program will function.

Most recently, CMS released a long-awaited proposed rule outlining the agency’s vision for the new EHR incentive program and providing the structure for both the Medicare and Medicaid programs. Specifically, the proposed rule outlines the initial criteria eligible parties must meet to qualify for an incentive payment, when the payments will begin and how the payments will be calculated.

Under ARRA, physicians are able to receive incentives equal to 75 percent of their allowable Medicare Part B charges, subject to an annual limit that varies based on when the individual begins participating in the program (see

chart). CMS has proposed that payments be made annually on a rolling basis after the individual has qualified and has reached the threshold for maximum payment. The payments would be based on allowed charges submitted during the calendar year.

It is important to note that only non-hospital-based physicians, dentists, podiatrists, optometrists and chiropractors are eligible for the EHR incentives under the Medicare program. Non-physicians are only eligible for EHR incentives under the Medicaid program. Hospital-based physicians are defined in the proposed rule as those who furnish 90 percent or more of their services in the hospital-based setting. This determination would be made based on the place of service codes included on claims

Calendar Year	First CY in Which the Eligible Professional Receives Incentive Payment				
	2011	2012	2013	2014	2015 & beyond
2011	\$18,000	—	—	—	—
2012	\$12,000	\$18,000	—	—	—
2013	\$8,000	\$12,000	\$15,000	—	—
2014	\$4,000	\$8,000	\$12,000	\$12,000	—
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	—	\$2,000	\$4,000	\$4,000	\$0
<b>TOTAL</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>	<b>\$0</b>

submitted to CMS. The one exception would be for physicians who practice predominantly in a federally qualified health center or a rural health clinic.

Recognizing that EHRs still are relatively new and that requirements are likely to change as technology evolves, CMS also has proposed a three-staged definition of “meaningful use.”

Stage 1 would begin in 2011 and would require basic use of an EHR. Specifically, physicians would need to report on 25 proposed measures requiring computerized physician order entry (CPOE) for 80 percent of all physician orders and 10 percent of all hospital orders. While most of these measures related to the functionality of EHRs, physicians would be required to report on five clinical quality measures, including a mix of core and specialty-specific measures. CMS, for now, proposes to define CPOE merely as capturing data, not electronically sharing it. This definition, however, will likely change in future stages. Most of the clinical quality measures are National Quality Forum-endorsed and track with the Physician Quality Reporting Initiative and the Reporting Hospital Quality Data for Annual Payment Update programs. Stages two and three include increased requirements, and CMS has said it will release proposed rules for each stage.

CMS has provided a 60-day public comment period for this rule, as well as a closely related interim final rule issued at the same time by the ONC. The interim final rule defines the initial standards, implementation specifications and certification criteria for EHRs. It also sets forth the capability requirements for EHRs, another key component of the program. ONC also will be issuing a notice of proposed rulemaking on the process for organizations to conduct the certification of EHR technology in the near future.

The ACC is in the process of developing formal comments on both rules and will continue to work with CMS and the ONC to help shape the final program and ensure that ACC members are in a position to take advantage of these incentives, particularly in a time of declining reimbursement.

In general, the ACC recommends that members who currently do not use an EHR begin the process of adoption in order to receive the maximum bonuses available under the program. Practices interested in implementing EHR systems should be sure that EHR vendors provide a guaranteed upgrade path that ensures their products will meet certification criteria as established by the Department of Health and Human Services. The ACC also recommends purchasing a Certification Commission for Health Information Technology-certified EHR.

For more information on the proposed and interim final rules, as well as more information on choosing an EHR, visit [www.acc.org/healthit](http://www.acc.org/healthit).

## CHF Act Included in Senate Reform Bill

Portions of the Congenital Heart Futures (CHF) Act were included in the Senate health care reform bill. The ACC Adult Congenital and Pediatric Cardiology (ACPC) Section has been very active in promoting the CHF Act, which aims to promote education, awareness and research in congenital heart disease. The legislation passed in the Senate would –

- Develop a National Congenital Heart Disease Surveillance System at the Centers for Disease Control and Prevention to track the epidemiology of congenital heart disease in individuals of all ages; and
- Promote the coordination and expansion of the National Heart, Lung, and Blood Institute's congenital heart disease research, including a focus on causation; long-term outcomes; diagnosis, treatment and prevention; longitudinal studies; and barriers to care.

The passage of this bill is a great beginning, along with the NCDR® IMPACT Registry™, in bringing awareness to the growing population of adults with congenital heart problems.

## Get to the Heart of Women's Health

The Fourth Annual Heart of Women's Health takes place Feb. 5 – 6 at Heart House in Washington, D.C. This educational event is dedicated to helping health care professionals provide better treatment for female patients battling heart disease, the No. 1 cause of death and disability among American women.

Through stimulating, interactive learning sessions taught by expert faculty, the event raises awareness and increases knowledge for all providers who treat female patients with cardiovascular disease (CVD) or those at risk for its development. Led by **JoAnne Foody, M.D., F.A.C.C.**, and **Suzanne Hughes, M.S.N., R.N.**, this one-and-a-half day conference covers such important topics as valve disease; hypertension; dietary and lifestyle intervention; gender, racial and ethnic differences in acute presentation; and response to therapies. Course offerings examine contemporary methods of advising women at risk of heart disease, encouraging lifestyle strategies for the prevention of CVD, and providing optimal care for those who develop CVD.

Register online at [acc.org](http://acc.org) by Jan. 22 or register in person on site.

## CMS Revises Carotid Stenting Coverage Decision

The Centers for Medicare and Medicaid Services (CMS) recently revised its National Coverage Decision (NCD) regarding percutaneous transluminal angioplasty (PTA) of the carotid artery concurrent with stenting. This was CMS' seventh reconsideration of its NCD, and little change was made. CMS once again declined to expand coverage for PTA of the carotid artery concurrent with stenting, despite recommendations made by the ACC and the Society for Cardiovascular Angiography and Interventions. Instead, the change to the NCD focused on the clearance of new embolic protection devices by the Food and Drug Administration.



## 2010 Changes to the E-Prescribing, PQRI Programs Make Participation Easier

In this uncertain practice environment, two programs from the Centers for Medicare and Medicaid Services (CMS) offer practitioners the opportunity to increase their earnings by up to 4 percent of applicable Medicare charges. Recent changes as part of the 2010 Physician Fee Schedule have made participation in the 2010 Physician Quality Reporting Initiative (PQRI) and the E-Prescribing Incentive Program less cumbersome.

### 2010 PQRI

In the 2010 PQRI program, new measures groups for coronary artery disease (CAD) and heart failure (HF) are available for reporting and require physicians to report on only 30 patients instead of 80 percent of eligible patients to qualify for a 2 percent bonus. The patients also no longer need to be consecutive. In addition to the measures groups, there are five new individual measures for 2010 that can be reported through a registry:

- **CAD:** Symptom and Activity Assessment
- **CAD:** Drug Therapy for Lowering LDL Cholesterol
- **HF:** Left Ventricular Function (LVF) Assessment
- **HF:** Patient Education
- **HF:** Warfarin Therapy for Patients with Atrial Fibrillation

### Submit 2009 PQRI Data before Feb. 21

Feb. 21 is the last day to submit data for the 2009 Physician Quality Reporting Initiative (PQRI) using measures groups. Successful participation in the 2009 PQRI program enables participants to earn a 2 percent incentive payment on all Medicare Part B professional services for 2009. The ACC has partnered with CECity to offer PQRIwizard<sup>SM</sup>, an online subscription-based program that has been qualified for PQRI submission by the Centers for Medicare and Medicaid Services. PQRIwizard can be used to report on the following measures groups:

- Diabetes Mellitus
- Preventative Care
- Rheumatoid Arthritis
- Back Pain
- Chronic Kidney Disease
- Coronary Artery Bypass Graft
- Perioperative Care

Data submissions must be for patient visits within the 2009 calendar year. For more information or to register for the PQRIwizard, visit: [acc.pqriwizard.com](http://acc.pqriwizard.com).

For more detailed information about the 2010 measures and measures groups, visit: [www.acc.org/advocacy/advoc\\_issues/pqri\\_FAQ.cfm](http://www.acc.org/advocacy/advoc_issues/pqri_FAQ.cfm).

Most cardiologists who participated in PQRI over the past two years have participated using the claims-based process, but that option has been eliminated for most of the measures that have been developed by

**PINNACLE Registry™**

ACC. Physicians who wish to participate using ACC-developed measures now must report through a registry. ACC's PINNACLE Registry™, formerly known as the IC<sup>3</sup> Program, has submitted a self-nomination letter to CMS to retain its status as a qualified PQRI registry. In addition, the ACC has partnered with CECity to offer ACC members an easy online tool, PQRIwizard<sup>SM</sup>, to participate in the 2010 PQRI measures groups. CECity also has submitted a self-nomination letter to CMS to continue as an online, subscription-based, qualified PQRI registry.

Cardiologists who wish to continue participation in PQRI via claims-based submission should carefully review the list of eligible measures to determine which measures they will report. Although there is only one ACC-supported option (Measure 6: Antiplatelet therapy prescribed for CAD

patients), there are measures that were not developed by ACC that cardiologists are eligible to report.

#### 2010 E-Prescribing Incentive Program

Several changes have been made to the CMS E-Prescribing Incentive Program, which provides a 2 percent bonus of applicable Medicare allowed charges to successful e-prescribers.

Of note, reporting requirements have been simplified. Rather than reporting on 50 percent of applicable cases using one of three G-codes, participants are required to report use of a qualified e-prescribing system during 25 separate patient encounters. To qualify as a patient encounter, the visit must involve at least one prescription generated and transmitted using an e-prescribing system. Patient encounters that involve no prescriptions, patients who insist on paper prescriptions or prescriptions for controlled substances are no longer considered reportable events.

Reporting may be done through the claims-based process, a qualified registry or a qualified electronic health record (EHR). Registries and EHRs must first be approved by CMS for participation in this program.

Additional changes to the program include an expansion of services with which the e-prescribing charges must be associated to include skilled nursing facilities and home visits in addition to office visits. Another change includes new e-prescribing system requirements under Medicare Part D. Meeting Part D standards is required to successfully participate in the e-prescribing program, and practices should consult with their vendor to determine if their system meets these new standards.

For more information on these two programs, visit: [www.cms.hhs.gov/pqri/](http://www.cms.hhs.gov/pqri/). For ACC resources on health information technology, visit: [www.acc.org/healthit](http://www.acc.org/healthit).

## Reaching Out to Earthquake Victims

In the wake of the devastating earthquake in Haiti, Ophelia Dahl, director of Partners in Health (PIH), sent an appeal to her colleagues to assist in the relief efforts PIH is providing through its Zanmi Lasante (“Partners in Health” in Haitian Kreyol) sites.

PIH staff in Boston and Haiti are coordinating the efforts that will include more than 120 physicians and nearly 500 nurses and nursing assistants who work at Zanmi Lasante locations in Haiti.

PIH is setting up field hospital sites in Port-au-Prince to triage patients, provide emergency



**Partners  
In Health**

care, and send those who need surgery or more complex treatment to its functioning hospitals and surgical facilities. The organization also is working to ensure that its facilities in the Central Plateau are ready to serve the flow of patients from Port-au-Prince. Operating and procedure rooms are staffed, supplied and equipped for surgeries, and the group has converted a church in Cange into a large triage area. The sites in Cange and Hinche were reporting a steady flow of patients from the capital city as this publication went to press.

PIH reports that its greatest need is for financial support. Haiti is facing a crisis worse than it has seen in years, and it is a country that has faced years of crisis, both natural and otherwise. The country is in need of millions of dollars to meet the needs of the communities hit by the earthquake. PIH also needs cash to quickly procure emergency medical supplies, basic living necessities, as well as transportation and logistics support for the tens of thousands of people who will seek care at mobile field hospitals in the capital city.

To learn more or to make a donation to support Haitian relief efforts, go to [www.pih.org](http://www.pih.org).



## Creating a Pro-Competitive Physician Network

By George M. Sanders, P.C., and Henry S. Allen Jr.

Changes in health care markets over the last 20 years have raised many challenges for physicians. For example, the wave of mergers between health insurers has significantly concentrated the markets for health insurance throughout the country. The increased concentration of health care markets has given many large health insurers the ability to dictate reimbursement levels. Changes in Medicare and Medicaid reimbursement policies have also added pressure on physicians. In this new environment, many physicians are striving to develop new business models that will give them the ability to address, constructively, the significant changes that have transformed health care markets. The development of new business arrangements by physicians who formerly competed against one another can raise antitrust issues. Physicians, however, have many options when it comes to developing business models that address changes within the health care industry. Some of these options were addressed in the ACC Foundation white paper “Practice Opportunities: Practice Integration, Management Contracts, Hospital Integration.” This article provides a brief overview of some antitrust issues. A more complete discussion of the antitrust issues that physician integration can raise is contained in the Practice Opportunities white paper.

The federal antitrust laws are designed to encourage and protect competition. As a result, the antitrust laws discourage certain types of business arrangements that reduce or limit rivalry between competitors. Oftentimes, however, collab-

orative arrangements between competitors enhance consumer welfare. The antitrust laws refer to these types of arrangements as being procompetitive. As a general rule of thumb, business arrangements do not run afoul of the antitrust laws when the consumer benefits created by the collaboration outweigh the reduction in competition caused by the collaborative effort.

A business collaboration is pro-competitive, within the meaning of the antitrust laws, when it creates efficiencies. A business arrangement is efficient when it provides higher quality services at a constant or lower cost. Under basic economic theory, such efficiencies increase competitive pressures in the market, because the other firms in the market now have to improve their services if they want to maintain their market share.

Mergers represent the most complete form of integration and have played, and will continue to play, a critical role in the improvement and modernization of markets. It is well recognized today that mergers can create substantial efficiencies that enhance consumer welfare. Consistent with this understanding, the courts and federal enforcement agencies do not look upon mergers as simply a device by two former competitors to engage in price-fixing. Instead, they apply realistic analytical tools that are designed to separate mergers that create efficiencies from mergers that will improperly consolidate economic power.

The level of integration demanded by a merger is not suitable for many physicians or for the goals they are trying



to achieve. For example, many physicians want to create networks that will create the infrastructure needed to improve care, acquire and maintain health information technology systems, create pay for performance programs, and negotiate contracts with payers. Oftentimes, these networks are structured as an independent physicians association (IPA). Given the number of physicians needed to make an IPA work and the different specialties and practice groups the IPA must recruit, a merger is rarely, if ever, a suitable method of creating an IPA. Instead, the IPA is less integrated than a merged company, and physicians retain a greater degree of control over their individual practices.

The level of integration that an IPA or other physician joint venture must possess is fundamentally a business decision. If the IPA or joint venture wants to negotiate fee-for-service contracts for its members, however, the antitrust laws will demand a level of integration that justifies the joint negotiation of prices. The Federal Trade Commission and the Department of Justice, which enforce the federal antitrust laws, have provided physicians with guidance as to the level of integration needed to pass antitrust scrutiny.

Agreements between direct competitors to set prices or jointly negotiate historically have been considered *per se* unlawful. This means that the pricing arrangement is condemned without conducting any analysis into whether the concerted conduct would have a positive effect on competition or consumers, or if it would even hurt consumers. As the antitrust laws have evolved, the courts and the antitrust enforcement agencies have recognized some exceptions to the rigid application of the *per se* rule against price fixing. The most commonly recognized exception exists when competitors form a joint venture (short of a merger) through which they create a business that creates efficiencies that benefit consumers and competition.

Under current antitrust enforcement policy, an IPA or physician network that wants to negotiate fee-for-

service contracts will need to have a high level of clinical integration in order to justify the joint negotiation. As a general matter, clinical integration is an active and ongoing program to evaluate and modify the practice patterns of physicians and create a high level of interdependence and cooperation between the participating physicians. Elements of a properly structured clinical integration program include (a) the collection of clinical data, (b) the development of best practices, (c) a feedback loop between the data and the development of best practices, (d) cost control measures and

benchmarks, (e) a significant financial stake in the venture by its physician members and (f) mechanisms that ensure compliance with the network's clinical and operational requirements. Health information technology systems will play an important role in any clinical integration effort.

While the federal antitrust enforcement agencies have accepted the concept of clinical integration, they have not clearly identified the level of clinical integration needed to justify the joint negotiation of fee-for-service contracts. Physicians creating such arrangements will have to show that the organization has a level of integration that will actually improve care and lower costs, and that the joint negotiation of fee-for-service contracts is needed in

order to create the expected efficiencies.

Overall, the antitrust laws leave the door open to many types of business arrangements. The key is identifying the potential risks. Sometimes, the parties can achieve their goals while making changes that eliminate the antitrust issue. When the risks persist, the parties can develop their efficiency story in advance so they can proactively address any possible antitrust scrutiny.

## Elements of a properly structured clinical integration program include:

- A. The collection of clinical data**
- B. The development of best practices**
- C. A feedback loop between the data and the development of best practices**
- D. Cost control measures and benchmarks**
- E. A significant financial stake in the venture by its physician members**
- F. Mechanisms that ensure compliance with the network's clinical and operational requirements**

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The Law Offices of George M. Sanders, P.C., represents physicians nationwide in antitrust health care law. Allen is Senior Attorney, Private Sector Advocacy for the American Medical Association, Adjunct Professor at the Northwestern University School of Law, and a lecturer at Cornell University Sloan Institute of Health Services Administration. Stay tuned for the next installment in this ongoing series about the ACC Foundation white paper. See the full version at [www.acc.org/practicemgt/practiceintegration081209.pdf](http://www.acc.org/practicemgt/practiceintegration081209.pdf).

## Interactivity Allows FITs to Help Shape ACC.10, i2 Summit

By Michael Barrett, M.D., F.A.C.C., and Andrew Freeman, M.D.



**“ At ACC.10, we plan to use the group’s answers via the audience response system to help shape the nature of the content as it is presented. ”**

This year’s Annual Scientific Session and i2 Summit are designed to allow Fellows in Training (FITs) an unprecedented amount of interaction with experts in cardiovascular medicine. In fact, we have made this year’s program so interactive that FITs can actually help shape what they’re learning while the faculty are teaching.

We hope the use of audience response systems in many sessions designed for FITs will offer them important feedback about how well they understand the concepts at hand. We also hope it will give the presenters feedback about how to define their presentations. Most continuing medical education is a linear process: You answer the question and get the feedback, you move on to the next question. At ACC.10, we plan to use the group’s answers via the audience response system to help shape the nature of the content as it is presented. If the answers show that nobody in the audience understands the content, the faculty can slow down or go into greater depth. If the answers show the

questions are too elementary, the faculty can move on to other content.

In addition to interaction through the audience response systems, FITs will find engaging content and interaction with the luminaries in

cardiovascular medicine. The content will not only bring FITs up to date, but also give them face time with the speakers — the experts who appear in the journals and actually developed the concepts, technologies and procedures FITs use every day.

While you may have exposure to a handful of faculty in your training program, ACC.10 and i2 Summit expose you to hundreds of experts, giving you a unique opportunity to see how cardiovascular medicine is practiced outside your program. This broad view of the practice of cardiology will allow you to grow as a clinician and a trainee.

Don’t underestimate the value of interacting with other FITs. It’s a tough economy, and ACC.10 and i2 Summit offer a wealth of opportunity to network with fellows and employers from around the world. Visit the FIT Lounge and attend career sessions that offer outstanding, practical advice for entering the job market (see sidebar).

### Program Highlights

Fellows in Training won’t want to miss these interactive sessions at ACC.10 and i2 Summit:



### Fellows Bootcamps

Three exciting ACC.10 Bootcamp sessions will cover detection of coronary artery disease (CAD), assessment of left ventricular function and assessment of myocardial viability. These 90-minute sessions will offer an overview of these topics, from soup to nuts. These sessions don't cover the latest research or the fine details, but in 90 minutes, attendees will get the salient information they need to be literate in these topics. Each participant will be able to use the audience response system to answer questions from the presenters throughout the session. The session on detection of CAD takes place Tuesday, March 16, at 8 a.m. The session on assessment of left ventricular function takes place Tuesday from 10:30 a.m. to noon. The session on assessment of myocardial viability takes place Tuesday at 12:15 p.m.

### Fellows Case Bowl

Capping off this year's FIT Bootcamp program will be a new session in a spirited, fun, contest-type learning format. This new session brings competitive flair to the Annual Scientific Session. Fellows from three training programs, Walter Reed, Emory and Cedars-Sinai, will answer board-type questions relevant to everyday practice (selected by fellows who recently sat for their board exams). There will be dialogue between competitors and audience, and the audience will be able to "tweet" its comments via Twitter for display on large screens in the session room, allowing interactivity between presenters and audience and among audience members. The Case Bowl takes place Tuesday, March 16, at 2:30 p.m.

### i2 Summit FIT Spotlight

The i2 FIT Spotlight covers the fundamentals of interventional cardiovascular medicine in a day-long spotlight session. FITs helped shape this session, too, by submitting challenging or difficult cases for review by the experts during the lunch presentation. The session takes place Monday, March 15, with programming from 8 a.m. to 6 p.m.

You won't want to miss the programming designed for — and by — FITs at this year's Annual Scientific Session. Go to [acc10.acc.org](http://acc10.acc.org) to peruse the wealth of education available at this year's meeting, and register today if you haven't already. We look forward to welcoming you to Atlanta!

Barrett is adjunct clinical associate professor of medicine and director of the Fellows Cardiac Clinic at Temple University School of Medicine in Philadelphia. He is co-chair of the ACC.10 Program Committee. Freeman is an assistant professor at National Jewish Health in Denver, a member of the FIT Spotlight Committee, and the Fellows in Training Council chair.



## Career Options at ACC.10, i2 Summit

### FITs: What You Need to Know in Starting a Cardiology Career

Sunday, March 14 12:15 – 1:45 p.m.

This is a must-attend session for every Fellow in Training. You will learn how to get involved at the ACC, what you need to know to pass your boards, how to document and get paid for services you perform, how to select the professional practice that is right for you after your training is over, and more.

### FIT Forum: Stimulating Options 2010

Monday, March 15 12:15 – 1:45 p.m.

Decisions about your career are looming large. You have options you probably don't know you have. Clinical investigator in an academic center? Clinician and educator in an academic medical center? We will explain a variety of options to help you make the best decisions for you and your family. Time for questions and answers has been built into the session.

### Pediatric and Congenital Cardiology Career Mentoring Session

Monday, March 15 Noon – 2 p.m.

FITs interested in pediatric or congenital cardiology should attend this mentoring session for valuable career advice.

### FIT Community Lounge

Go to the FIT Community Lounge to relax, check your e-mail and network with FIT peers. Located in the convention center, the FIT Community Lounge will be your base of operations while navigating ACC.10. The lounge will be open Sunday through Tuesday during the meeting and will offer light refreshments throughout the day.

Go to [acc10.acc.org/SpecialInterest/Pages/FITs.aspx](http://acc10.acc.org/SpecialInterest/Pages/FITs.aspx) for updates on these events and resources.

# A Look Back at 2009

By Jack Lewin, M.D., F.A.C.C.

The year 2009 proved a difficult one for the nation, for cardiovascular medicine and for its College. The ACC grappled with a flagging economy and massive proposed cuts to physician payment. The advocacy efforts with respect to reversing the injustices in the 2010 Physician Payment Rule will continue to be the dominant focus of the College until the mission is accomplished, along with ensuring that our principles and policies related to health care reform are to the extent possible incorporated in the emerging legislation. But let's not forget everything else the College stands for and is contributing to members, patients and society in improving cardiovascular health and care.

Despite the challenges of 2009, the College had a landmark year with remarkable success due to the commitment of its members. Read on to find out more about what we accomplished together. I hope you will find inspiration in our many successful endeavors in 2009 and excitement about the prospects of 2010. I look forward to working with each of you in the new year as we advance the interests of cardiovascular patients everywhere.

Lewin is CEO of the American College of Cardiology.

First Quarter

The **Door-to-Balloon Initiative (D2B)** continued to grow and produce results. By March 2008, over 75 percent of patients in participating hospitals had D2B times of less than 90 minutes, with average times continuing to decline.



**ACC President Fred Bove, M.D., Ph.D., F.A.C.C.**, reaffirmed our commitment to quality care and the best interest of our patients by kicking off the Year of the Patient at ACC.09.



The **Hospital to Home Initiative (H2H)** launched with a goal to reduce cardiovascular readmissions by 20 percent by December 2012. H2H has received its first funding grant.

Second Quarter



We launched new self-assessment programs, including **ACCSAP 7, CardioQuestions, Focus on Vascular Disease, Focus on Valvular Disease, EchoSAP 6** and **CCT-SAP 2**. In addition, the very first version of Heart Songs to include video will launch in 2010.

Third Quarter



ACC's **Legislative Conference 2009**

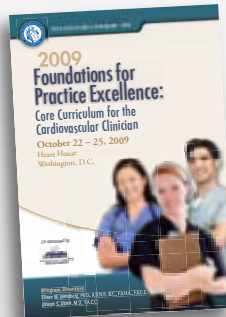
The **Annual Legislative Conference** brought a record 350-plus members to Congress to discuss health care reform, physician payment, quality care and more.

**IMPACT Registry™**

The NCDR® launched the **IMPACT Registry™** pilot. The pilot is underway at 16 sites, of which six have begun collecting data on catheter-based diagnostics and interventions in congenital heart disease patients.

Fourth Quarter

IC3 Program  
**PINNACLE Registry™**



**Foundations for Practice Excellence: A Core Curriculum for the Cardiovascular Clinician** (programming designed for cardiac care associates and cosponsored by the American Nurses Association) sold out for the second year in a row.

After a successful two-year pilot, the IC3 Program became the **PINNACLE Registry™**. NCDR's first national ambulatory quality improvement registry has more than 190 participating practices and more than 340,000 patient records.



The College launched the **PINNACLE Network™**, the nation's first registry-based practice network, offering practice and financial management tools, as well as integration with the PINNACLE Registry™ to build a foundation for rewards based on quality care.

By Year End

The College now counts **51 state chapters** — one in every state and Puerto Rico. The ACC launched an International Council and Section, around which four new international Chapters have emerged.



The **CardioSmart** Web site continues to grow and is an integral part of the Year of the Patient Initiative. CardioSmart now is poised to expand to encompass national communication efforts and local initiatives as part of a comprehensive campaign for heart health.



The **NCDR®** has presented **41 abstracts at major medical meetings in 2009** and published 18 papers in journals including the *Journal of the American Medical Association, JACC, Circulation* and others. The registries have submitted a record-breaking 27 abstracts from six registries for the 2010 ACC Annual Scientific Session.



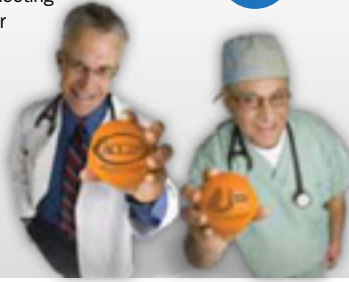
**CardioSource 3.0** is in development and slated to launch in the spring.



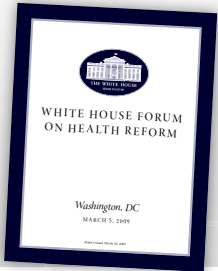
# Convergence of Diabetes & Cardiovascular Disease



Attendees at **ACC.09 and i2 Summit 2009** reported increased satisfaction over 2008 meeting attendees — satisfaction scores for ACC increased from 3.75 to 3.94 and for i2 from 3.79 to 3.89.



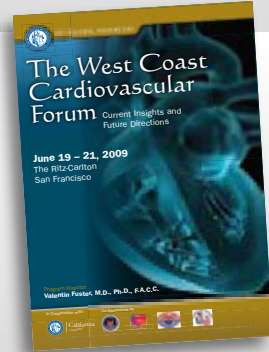
The College launched **The Convergence of Type 2 Diabetes and Cardiovascular Disease: Current Insights and Future Directions**, a landmark educational initiative designed to address gaps in the treatment of cardiovascular disease and Type 2 diabetes.



The ACC solidified its position as a leader in health care reform, participating in major events like the **White House Summit on Health Care**.



The **West Coast Cardiovascular Forum** attracted four international cosponsors: the Singapore Cardiac Society, Japanese Circulation Society, National Heart Association of Malaysia and the Chinese Society of Cardiology. All four have agreed to cosponsor the program in 2010, as well.



The College emerged as a **national leader in improving principles and practices for relationships with industry**. We developed impeccable systems of transparency and became a respected leader in avoiding conflicts of interest.

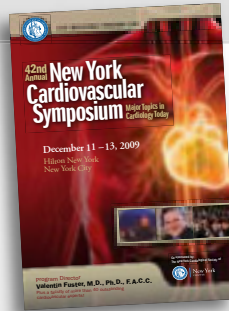
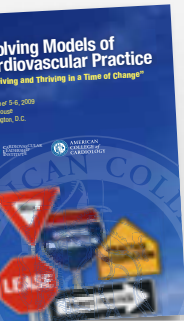
The College advocated strongly against proposed payment cuts to physicians. The advocacy efforts of members during the third quarter prompted the Centers for Medicare and Medicaid Services to phase in cuts over four years when it announced the 2010 Physician Fee Schedule in October.



We secured two federal **Grand Opportunities (GO) Grants in 2009** to support comparative effectiveness research on coronary revascularization and to build a clinical research training program. The ACC received an additional Food and Drug Administration funding commitment for the IMPACT Registry™.



The inaugural **Evolving Models of CV Practice Symposium** offered attendees advice and strategies for practice integration and other models of practice in today's changing environment. The event was sold out, and demand was so great that the meeting is now available as a Meeting on Demand.



The **New York Cardiovascular Symposium** was a phenomenal success in its 42nd year, with more than 2,000 attendees from around the world.

The ACC defended members and their patients with a massive advocacy effort designed to combat cuts included in the Centers for Medicare and Medicaid Services' 2010 Physician Payment Rule. The College's multi-pronged approach included legislation introduced by Rep. Charles Gonzalez (D-Texas), legal action against CMS, direct negotiations with the Department of Health and Human Services, and massive media outreach and member engagement.

The successful partnership between the ACC and the American Heart Association on the **ACTION®-GWTG™ Registry** continued. The registry will offer a Limited Version in 2010, allowing participants an option with less data collection.



The **Journal of the American College of Cardiology** counts more than 6,000 quality submissions per year, with an 8 percent acceptance rate. The impact factor (or average number of citations per article) is 11.5.



**Educational programs are thriving**, with registrations at 108 percent of targets for the year.



Overall ACC membership has increased to over **37,000**, with CCAs, PharmDs and practice administrators adding huge value to the ACC community.

The **ACC/AHA Practice Guidelines** number 19 topics with three in process. We have six sets of Appropriate Use Criteria with one in process.



The ACC has grown from \$86 million in revenues in 2008 to **over \$92 million in 2009**, when most other organizations were contracting.





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**INTERACTIVE. INFORMATIVE. INTIMATE.**

# Learning Portfolio Takes FITs from Training to Retirement

By Jeffrey Kuvin, M.D., F.A.C.C., and John G. Harold, M.D., F.A.C.C.



“ Lifelong learning is a professional responsibility throughout the entire career of a cardiologist. The FIT Portfolio will be the College’s system to launch this journey. ”

Education is a lifelong endeavor for cardiovascular professionals. The ACC is well into the process of developing a learning portfolio designed to support the learner from training to retirement. The aim of the portfolio project is to shift the paradigm from traditional activity-based learning to learner-centered, performance- and outcomes-based education driven by the learner’s assessment of individual practice patterns and understanding of how to address knowledge gaps.

The Fellows in Training (FIT) learning portfolio is designed to address the specific needs of FITs and become an educational “home” for FIT members. This Web-based tool allows users to connect in online communities focused on quality improvement and education; access the American Board of Internal Medicine’s (ABIM) Web site, *www.abim.org*, and physician login for more information about Maintenance of Certification enrollment and requirements, including ABIM’s Practice Improvement Modules; create a personalized curriculum vitae using customized templates to facilitate a job search post-board certification; and select education activities that match their personal learning needs.

The College is developing new learning tools, such as ACC In-Service (ACCIS), a series of learning modules with pre and post tests to assess gaps in knowledge, to support this individualized learning. ACCIS learning tools in electrocardiography, geriatric cardiology and diabetes already have been incorporated into many fellowship training programs. The FIT Portfolio will integrate existing learning activities, such as ACCIS, within CardioSource. One major goal of the learning portfolio is to document learning, academic achievements and participation in quality initiatives.

The FIT Portfolio content is closely aligned with the American Board of Internal Medicine (ABIM) to ensure that it meets the standards of this organization. Lifelong learning is a professional responsibility throughout the entire career of a cardiologist. The FIT Portfolio will be the College’s system to launch this journey. FITs will gain an understanding about the process of continuous professional development and lifelong learning, which will prepare them for recertification requirements in their future. We also hope the FIT Portfolio will engage FITs earlier in the cycle of ACC membership and

encourage the development of new emerging faculty and experts who will become tomorrow’s educational and quality leaders.

The FIT Portfolio is directly linked to the Lifelong Learning (LLL)

Portfolio that will support members throughout the remainder of their careers. The LLL Portfolio will seamlessly maintain learners’ ongoing achievements and individual assessments. Members will be able to draw upon valuable College resources, such as the National Cardiovascular Data Registry (NCDR®), other quality initiatives and the extensive educational opportunities offered by the ACC Foundation. The LLL Portfolio’s personalized support system will have increasing value to members as regulatory agencies and payers demand documentation of physician continuing competence.

## Partners in Learning

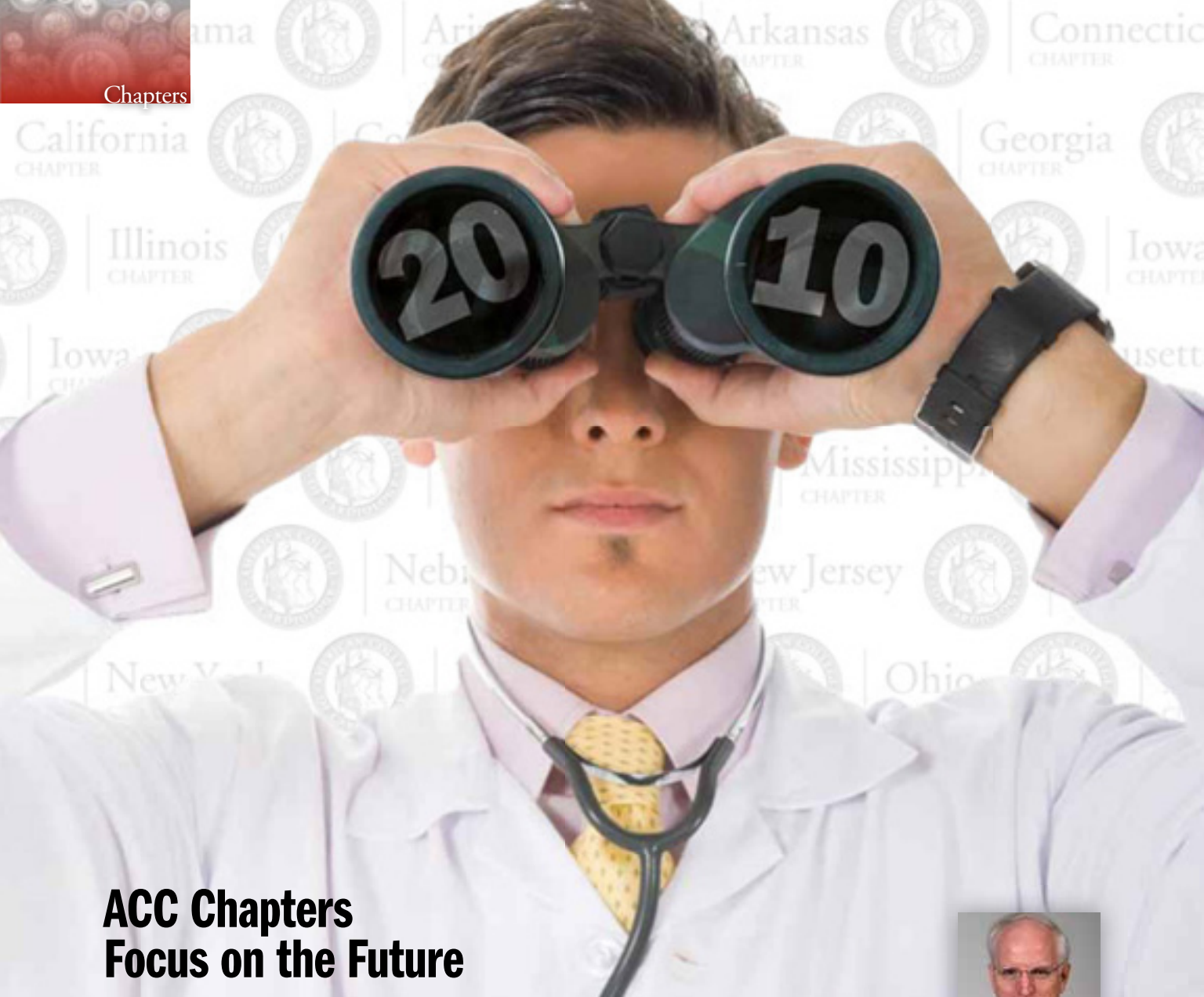
The ACC has teamed with staff from the ABIM’s Academic Affairs section to develop competencies for Fellows in Training and Training Program Directors. **William Iobst, M.D.**, director of the ABIM section of Academic Affairs, has worked closely with key stakeholders in the academic Internal Medicine community in designing a similar portfolio for Internal Medicine and will be assisting with this project. Working with such an outstanding partner ensures that the ACC will be able to provide true Lifelong Learning for our members, from fellowship to retirement.



The overarching goal of the Portfolio Workgroup is to provide a system for fellows and members at all levels to catalog achievements and to support the lifelong effort to remain abreast of the fast-moving changes in the practice of cardiovascular medicine. The tremendous resources of the ACC — members, experts, content, data, performance measures, quality improvement tools, educational offerings — make this a remarkable project bound to improve the quality of cardiovascular care and patient outcomes.

The ACC’s Learning Portfolio project already is underway with several pilot projects, initially focused on FIT education. Further roll-out of the project is expected in 2010.

Kuvin is director of the Cardiovascular Fellowship Training Program at Tufts Medical Center in Boston and chair of the FIT Learning Portfolio Workgroup. Harold is with Cedars-Sinai Medical Center in Los Angeles and is chair of the Board of Governors and a member of the ABIM Board of Directors.



## ACC Chapters Focus on the Future

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



**“ Our dilemma is that we hate change and love it at the same time; what we really want is for things to remain the same but get better. ”**

*Sydney J. Harris*

**T**he American College of Cardiology (ACC) faced unprecedented challenges in 2009. Devastating Medicare cuts already were forcing cardiovascular practices across the country to take hard looks at staffing and services, but always in the interest of putting patients first. Unfortunately, 2010 hasn't started out much better. As *Cardiology* went to press, practices still reeling from the Jan. 1 Medicare cuts were hearing from private insurers that have

decided to follow CMS' lead and drastically reduce payments for office-based cardiovascular services. Disruption of the current system for patient access will disproportionately hurt rural, minority and disadvantaged populations the most, further worsening health disparities and further increasing cost. Not only will quality cardiovascular care be threatened, but Medicare beneficiaries already are seeing increased costs, less access, higher fees and longer waits.

Now that the House and Senate have passed their own health care reform bills, we are close to having legislation signed into law by the president that will create the biggest changes in health care in a generation. This perfect storm of



economic stress and the paradigm shifts implicit in health care reform has generated significant uncertainty for the future among our members. Adding to our trepidation is a shortage of cardiologists to deal with the approaching tsunami of heart-related illness in the United States. The current 3,000-physician shortage could reach 16,000 by the year 2050 if changes are not made in expanding cardiovascular training programs. Forty-three percent of practicing cardiologists are 55 or older, and the convergence of health care reform and economic cutbacks may further exacerbate this shortage.

The College, as a result of these issues and the lackluster economy, had to scale back its traditional focus and commitments to education, scientific excellence and promotion of quality to instead focus on the agenda of practice viability and member self preservation. All of these developments are understandably frustrating, disturbing and risky not only for

potential impact on quality patient care.

The Door-to-Balloon (D2B) program also continues to see results in meeting guideline-recommended D2B times of 90 minutes or less. The ACC's newest initiative, called FOCUS, is designed to help practices best use appropriate use criteria and ultimately reduce inappropriate imaging. The outcomes of FOCUS could have real positive impacts on future imaging policies and decisions. We also are exploring opportunities to partner with other specialties including our cardiac surgical colleagues to better serve our patients.

On the practice management front, the new PINNACLE Network™ and corresponding registry are moving forward to help practices not only survive the challenging health care environment, but also enhance the quality of care provided to patients. The ACC is leading a revolution in cardiovascular education with the goal of



**“ ...there are numerous new opportunities for ACC Chapters to lead and be on the ground floor of new initiatives that have the ability to truly transform health care. ”**

our profession, but for the patients we all serve.

That being said, I am confident that we will overcome this “blip in our history” and will continue to lead the way to improving health care quality, outcomes, efficiency, patient satisfaction, and diagnostic and therapeutic innovation.

In addition, there are numerous new opportunities for ACC Chapters to lead and be on the ground floor of new initiatives that have the ability to truly transform health care. The College is leading the way in defining care for the cardiovascular community and patients. Its guidelines and clinical documents are designed to transform the very best in cardiovascular knowledge into practice, and its registries provide a means to benchmark quality and improve upon it. Specifically, participation in the College's Hospital to Home (H2H) initiative has real opportunities to influence national efforts to reduce costly hospital readmissions and through proposed reimbursement models could generate improved member compensation. The H2H quality initiative will address the complex challenge of creating a coordinated health care team in order to provide safe, reliable and health-enhancing transitions for cardiovascular patients. Literature and experience strongly suggest that a bundle of interventions for improving transitions out of the hospital has the highest leverage and

helping members take an individualized lifelong approach to learning. The ACC's Learning Portfolio project is already underway with several pilot projects, initially focused on Fellows in Training education with further roll-out of the project expected later this year.

All of these tools have the capability of building on the College's powerful legacy. ACC Chapters are in unique positions to move these innovative programs forward and actually help to encourage implementation at the grassroots level. We also are in a position to take advantage of new communication technologies and reach out to wider audiences about both national and state issues of importance. As we enter our seventh decade, we are redoubling our commitment to medical professionalism and to quality cardiovascular care through education, research promotion, development and application of standards and guidelines and to influence health care policy. Despite the difficult times, our future is bright and better than ever.

I look forward to working with all of you moving forward as we focus on the future.

---

Harold is chair of the Board of Governors.



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## California Gives Back, Celebrates Year of the Patient

**Among the Chapter's more than one dozen patient-centered activities in 2009, three events drew the largest crowds and set the highest bars for future ACC Chapter patient outreach.**

**A**CC's California Chapter spent 2009 using the College's "Year of the Patient" theme as a launch pad for a variety of initiatives designed to give back to the community. Among the Chapter's more than one dozen patient-centered activities, three events drew the largest crowds and set the highest bars for future ACC Chapter patient outreach.

The year began with a patient education seminar homing in on stress. **Sheila Kar, M.B.B.S.**, of the The Sheila Kar Health Foundation, led "Stress and Heart Disease; Stress and Your Body" — a Heart Protection Seminar Valentine's Day event at the Beverly Hills Hotel for patients in the region. Celebrity guests included television's Robert Culp from "I Spy" and William Petersen from "CSI."

Later in 2009, the Chapter turned its attention to California's youngest patients. Chapter Member **Ramin Manshadi, M.D., F.A.C.C.**, noticed that local schools in Stockton, Calif., were not equipped with portable automated external defibrillators (AED) due to budget restraints, a dangerous omission considering the heart risks involved in many high school sports. Through generous donations from industry, hospitals and the ACC California Chapter, Manshadi was able to raise funds to equip seven schools in the Stockton area with these lifesaving devices. The program also provided the schools with

training on how to operate the AEDs. The high schools were presented with the devices at a large assembly on Dec. 7, 2009, with students, parents, coaches, elected officials and media in attendance.

Stockton also was the home of "The Athletic Heart" — another Year of the Patient event spearheaded by Manshadi. More than 35 area coaches gathered for the presentation to learn more about the cardiovascular risk factors athletes face. Former professional athletes joined the group, including retired National Football League linebackers Michael Merriweather and Anthony Bell, and former National Basketball Association player Geoff Petrie.

Together, these events attracted more than 800 patients, community leaders, elected officials, medical professionals and media. ACC California Governors **Dipti Itchhaporia, M.D., F.A.C.C.**, and **George Smith, M.D., F.A.C.C.**, praise Manshadi and Kar for their efforts to strengthen the relationship between cardiovascular practitioners and patients.

The Chapter will continue its commitment to California patients in 2010. Another Valentine's Day event is in the works with a patient education session titled "But I Feel Great! Why Should I See the Doctor?" The session will be followed by two hours of entertainment from the musical *Jersey Boys* and Joe Piscopo from "Saturday Night Live." Nearly 500 cardiovascular patients are expected to attend in addition to donors and supporters with a grand total reaching over 700 attendees.



Top: Ramin Manshadi, M.D., F.A.C.C., with special guests at "The Athletic Heart" event.

Bottom: Sheila Kar, M.B.B.S., of the The Sheila Kar Health Foundation, joins Gordon Fung, M.D., F.A.C.C., and John Harold, M.D., F.A.C.C., at the Valentine's Day heart protection seminar in Beverly Hills.

## ACC.10 Education: Bench to Bedside

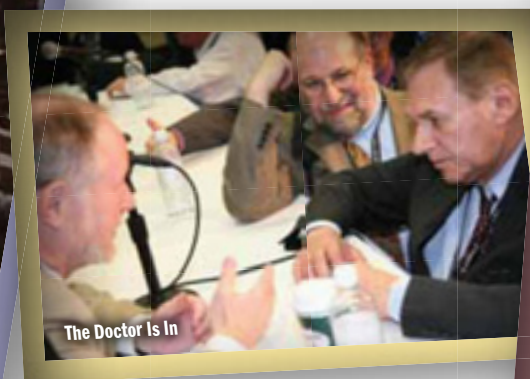
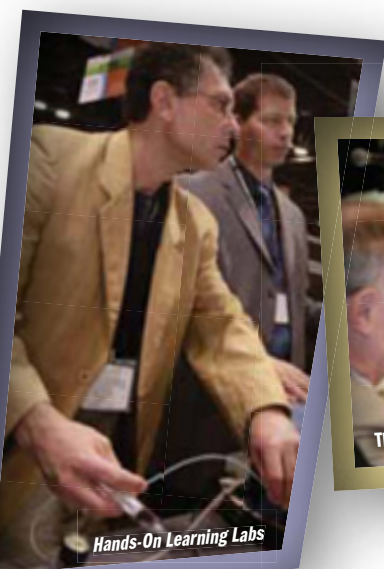
By Paul Mather, M.D., F.A.C.C.



**M**ost national medical specialty meetings make it their goal to bridge the gap in attendees' knowledge. The ACC Annual Scientific Session takes that goal one step further. The College prides itself on bridging not only the knowledge gap, but the gap between knowledge and practice. Your Program Committee has designed a meeting that links cutting-edge cardiovascular science to the clinical realm.

In a new era of shrinking resources and threatened reimbursement, I consider it fundamentally important that ACC.10 meet the changing needs of practitioners. ACC.10 education will expand on basic science knowledge and create

**Annual Simon Dack Lecture** — Anthony Atala, M.D., will present the annual Simon Dack Lecture during the Scientific Showcase Session on Sunday, March 14. Dr. Atala is the William H. Boyce Professor and chair of the Department of Urology at the Wake Forest University School of Medicine, and director of the Wake Forest Institute for Regenerative Medicine. He is a practicing surgeon and researcher and in 2006 was the first to report implanting laboratory-grown organs in human beings. His lecture will focus on regenerative medicine and the incredible possibilities on the horizon for clinical cardiology.



links to practical applications — attendees will return to their practices with new tools, resources and skills to put to use in everyday interactions with patients.

Here are just a few of the exciting educational experiences ACC.10 and i2 Summit have in store for cardiovascular practitioners:

**Hands-On Learning Labs** — Located in Expo Hall B5, the Learning Labs will combine a presentation by a clinical or technical expert on a specific topic with a tutorial that leads attendees through procedures with a particular device, piece of equipment or workstation.

**The Doctor Is In** — After Meet the Experts and Lunch with the Experts sessions, there will be new, informal opportunities to meet with the faculty and to ask your pressing clinical questions.

**Joint International Sessions** — We've designed 15 joint sessions with international societies to meet the needs of clinicians in the host societies' countries.

ACC.10 and i2 Summit also are designed to be the most efficient meetings available for the busy practitioner: You will find education on a broad swath of clinically relevant cardiovascular topics, as well as cutting-edge science. Full Access registration allows you to get the most from both ACC.10 and i2 Summit, and special Joint ACC.10/i2 Summit sessions bring all professional attendees highlights from both meetings. Once again this year, ACC.10 and i2 Summit offer dedicated sessions to help you earn maintenance of certification (MOC) points in medical knowledge at no additional charge — simply sign up for these special sessions when you register.

Go to [acc10.acc.org](http://acc10.acc.org) today to learn more about the wealth of education available at ACC.10 and i2 Summit. Register now or begin planning your itinerary. I look forward to seeing you in Atlanta, March 14 – 16.

Mather is director of the Advanced Heart Failure & Cardiac Transplant Center at Jefferson Medical College in Philadelphia and co-chair of the Annual Scientific Session Program Committee.



## Atlanta Gets CardioSmart

By Paul L. Douglass, M.D., F.A.C.C.



**ACC** President **Alfred Bove, M.D., Ph.D., F.A.C.C.**, designated his presidential year “The Year of the Patient” — a year in which the ACC should focus on the needs of the patient in all its initiatives. Accordingly, ACC.10 and i2 Summit will be the site of a community outreach event designed to reach the most underserved patients in our host city, Atlanta, and throughout the state of Georgia.

The CardioSmart Atlanta Community Event will take place Saturday, March 13, from 9 a.m. to 1 p.m. at the Omni Hotel Atlanta Grand Ballroom. The ACC Georgia Chapter is organizing the event and recruiting volunteers to perform screenings, educational sessions and individual patient counseling.

The focus of CardioSmart Atlanta will be on hypertension, and primarily on African Americans with hypertension, in view of the tremendous prevalence of hypertension — and cardiovascular disease — in the African American community. We also will offer cholesterol, diabetes and BMI screenings.

The goal is to empower members of the community to make informed health care decisions and focus on prevention — not just intervention. Our take-home message is that everybody should be empowered with the knowledge to prevent cardiovascular disease. If you have it, you should have the knowledge to manage your disease and understand your treatment. As an organizer of the event, I believe if

people understand the risk associated with developing CV disease, they will be more receptive to a healthy lifestyle.

Educational sessions at CardioSmart Atlanta will cover healthy living, hypertension, atrial fibrillation, heart failure, sudden death in children and adolescents, congenital heart disease and other topics. A special program for the youngest patients will allow kids to interact with a nutritionist and physical trainer.



**“ The goal is to empower members of the community to make informed health care decisions and focus on prevention — not just intervention. Our take-home message is that everybody should be empowered with the knowledge to prevent cardiovascular disease. ”**

A second goal of CardioSmart Atlanta is to address the disparities in care that unfortunately exist in our country. If we were to remove the morbidity and mortality statistics for minorities and indigent people from our overall U.S. health statistics, the death rates would be comparable to other developed nations.

We as medical professionals really have to help our community understand that disparities in care and outcomes do exist. Everyone — from physicians to patients to regulators and legislators — has to be accountable for the disparities that exist in our country, and we have to do everything we can to try to eliminate them. We need to be certain we provide better health care for those who are

disenfranchised — they need better access to quality care.

One way to accomplish this is to reach out to patients in their communities and offer them knowledge, an incredibly powerful weapon in the fight against cardiovascular disease. If we can empower our communities to care for themselves and to change their lifestyles in a way that positively affects cardiovascular outcomes, it will fuel elimination of health disparities.

We are hoping the CardioSmart Atlanta program will become a template for other chapters and local groups to help them get more involved. Every chapter should be empowering members of their community to prevent and manage heart disease.

For more information on CardioSmart Atlanta, go to [www.cardiosource.com/cvn/index.asp?videoid=1369](http://www.cardiosource.com/cvn/index.asp?videoid=1369), where Dr. Bove and I share more about this exciting event. I hope to see you there in March!



Douglass is with Metropolitan Atlanta Cardiology Consultants. He is a member of the ACC Board of Trustees and the Georgia Chapter.

## CCS Coming of Age

By Michelle Gurvitz, M.D., F.A.C.C., and Jacqueline Kreutzer, M.D., F.A.C.C.



Gurvitz photo: Nancy LoVine

**C**ongenital Cardiology Solutions (CCS.10) returns for its third year in 2010, building on the tremendous success of CCS.08 and CCS.09. The CCS.10 pathway addresses the needs of congenital and pediatric cardiovascular specialists and also offers general cardiologists an important look at congenital heart disease (CHD).

The first two days of CCS.10, March 14–15, include symposia presentations, oral abstracts, and smaller, interactive, Meet the Experts sessions designed to meet the needs of all members of the care team.

### Symposia will cover —

- The left ventricle: How small is too small?
- Outpatient management of the Fontan patient
- Sexual issues in the adolescent and young adult with CHD
- Quality in pediatric cardiology and congenital heart disease: past, present and future perspectives
- The Great Debates: three debates focusing on Management of the dilated aorta in non-Marfan patients; Surgery vs. catheter-based intervention on the native coarctation; and Criteria for placement of implantable cardioverter defibrillators (ICDs) in congenital heart patients.

We also will have a symposium on Adult Congenital Heart Disease for the General Cardiologist II to follow last year's highly successful session.

One oral abstract session will highlight the most pertinent abstracts accepted for CCS.10, and other abstracts will be presented in moderated poster formats. The topics include outcomes of shunt vs. Sano modification for the Norwood procedure, the management of systemic atrioventricular valve regurgitation in congenitally corrected transposition and long-term outcomes after fetal aortic valve intervention.

Five Meet the Experts sessions will provide direct interaction with experts on topics such as hypertrophic cardiomyopathy in children, atrial arrhythmias in adult CHD, use of ventricular assist devices and development of multicenter research. These sessions will provide the audience with access to the leading experts in these areas and are sure to be filled with thought-provoking discussions on these challenging issues.



CCS.10 also features the inaugural McNamara Lecture in pediatric cardiology on Sunday, March 14. This lecture honors the late **Dan G. McNamara, M.D., M.A.C.C.**, and his tremendous contributions to the field of congenital heart disease. **Charles E. Mullins, M.D., F.A.C.C.**, professor of pediatrics at Baylor College of Medicine, will present this lecture.

### Spotlight Shines on RVOT Dysfunction

On Tuesday, the full-day CCS Spotlight session is devoted to interventional techniques for Right Ventricular Outflow Tract (RVOT) dysfunction. Attendees will enjoy live interventional cases from Toronto Hospital for Sick Children and Miami Children's Hospital. Other sessions also will provide updates on new trials involving transcatheter placement of pulmonary valves and other issues involving the right ventricle, outflow tract and pulmonary arteries.

The session will start with expert discussion on new perspectives on the treatment of RVOT dysfunction, including diagnostic evaluation (roles of magnetic resonance imaging and exercise

testing), indications for intervention, effect of pulmonary valve replacement on adults with congenital heart disease, and the anticipated role of an approved and generally available transcatheter pulmonary valve.

The live cases will include examples of transcatheter pulmonary valve implantation as well as other RVOT problems managed with catheter techniques. Live case sessions will be interactive and allow for participation of the audience with questions and discussion including the operators and moderators in the panel.

The CCS Spotlight program will end with a presentation by an expert interventionalist and surgeon on novel and future approaches in the management of RVOT dysfunction and will close with a debate on whether surgery or transcatheter therapy is superior for restoring pulmonary valve competence.

### Collaborative Strength

As always, the strength of the CCS program is that it is a part of the larger Annual Scientific Session, which encourages greater integration of knowledge among cardiovascular specialties. Our very special patients require an integrated approach by a variety of specialists, and ACC.10, i2 Summit and the CCS.10 pathway encourage that collaboration. There are sessions closely integrated with imaging and electrophysiology, among others. With an increasing number of children born with congenital heart disease surviving into adulthood, participating in CCS.10 is more important than ever for congenital and pediatric cardiovascular specialists. This program can make a real difference for our patients.

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Gurvitz is with Seattle Children's Hospital and is a member of the CCS.10 program committee and the ACC Adult Congenital and Pediatric Cardiology Section. Kreutzer is with the Children's Hospital of Pittsburgh and is chair of the CCS.10 spotlight committee and a member of the ACC Adult Congenital and Pediatric Cardiology Section.

## Respond to CMS Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) has launched its annual health care provider satisfaction survey of Medicare fee-for-service (FFS) contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS) offers Medicare FFS providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions and opinions about the services provided by their contractor. Survey questions focus on seven key business functions of the provider-contractor relationship: Provider Inquiries,

Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement.

CMS is sending the 2010 survey to approximately 30,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those health care providers selected to participate in this year's survey will be notified starting in January 2010. If you are chosen to participate, the ACC encourages you to do so and share your input with CMS.



## ACC Holds Media Briefing

The ACC held a special press briefing Dec. 11 in New York to promote news from the Prevention and Outcomes Focus Issue of the *Journal of the American College of Cardiology*. The press conference was well attended by national media, including *TIME* and the *Wall Street Journal*, as well as general health magazines, lifestyle titles, online outlets and trade media.

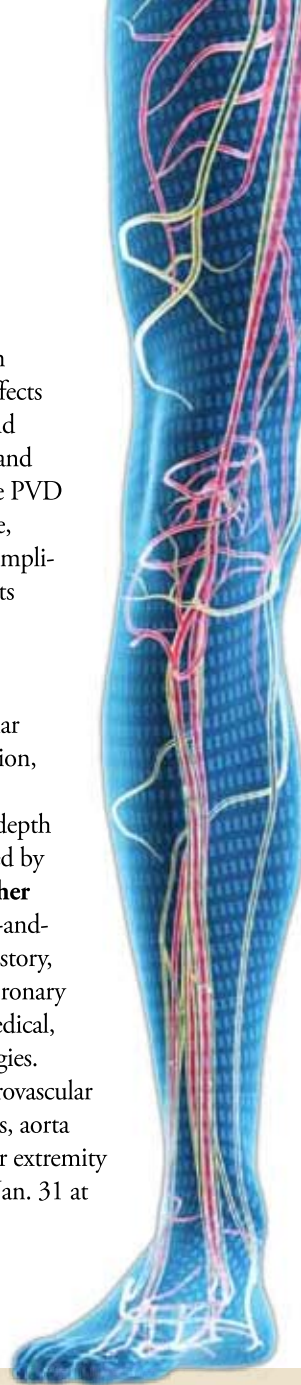
ACC President **Alfred Bove, M.D., Ph.D., F.A.C.C.**, and *JACC* authors shared with the assembled media the latest science on a variety of topics:

- Connection between Cardiovascular Disease and Menopause

## Educational Program Tackles Non-Coronary Vascular Disease

Peripheral vascular disease (PVD), often connected to cardiovascular disease, affects approximately 8 million Americans and is associated with a high degree of morbidity and mortality. At least half of the people who have PVD do not show any signs or symptoms; therefore, despite its prevalence and cardiovascular risk implications, only 20 to 30 percent of PVD patients undergo treatment.

Enroll today for the Clinical Practice of Peripheral Vascular Disease, an educational program specifically designed for cardiovascular specialists determined to improve the prevention, diagnosis and treatment of PVD. Join your colleagues in Phoenix Feb. 12 – 14 for an in-depth review of diagnosis and treatment strategies led by **Michael Jaff, D.O., F.A.C.C.**, and **Christopher White, M.D., F.A.C.C.** This interactive, two-and-a-half-day program will explore the natural history, epidemiology and pathophysiology of non-coronary vascular diseases, as well as evidence-based medical, endovascular and surgical management strategies. Topics covered will include carotid and cerebrovascular diseases, mesenteric and renal vascular diseases, aorta and lower extremity arterial diseases and lower extremity venous thromboembolic disease. Register by Jan. 31 at [acc.org](http://acc.org), or register on site.



- Effect of Weight Loss and Weight Regain on Cardiovascular Structure and Function
- Smoking Status and Long-term Survival after Heart Attack
- Atherosclerosis in Pre-Pubertal Obese Children
- Comparing Intensive with Moderate Statin Therapy
- Reduction in Recurrent Cardiovascular Events

The study on the link between cardiovascular disease and menopause in particular generated a great deal of consumer media attention, including an article in the *Wall Street Journal* on Dec. 29, "Protecting the Heart at Menopause."

## ACC/ACCF Announces Slate of Officers and Trustees

*Election of the 2009 – 2010 American College of Cardiology/American College of Cardiology Foundation (ACC/ACCF) Officers and Board of Trustees will occur during the Annual Business Meeting to be held at ACC.10, March 14 – 16, in Atlanta.*

### Officer Recommendations

The Board of Trustees recommends that these Fellows become the 2010 – 2011 officers of the College.

#### President

##### Ralph Brindis, M.D., M.P.H., F.A.C.C.



Brindis is the Senior Advisor for Cardiovascular Disease for Northern California Kaiser, Clinical Professor of

Medicine at the University of California, San Francisco (UCSF) and an affiliate faculty member of UCSF Institute of Health Policy Studies. Brindis graduated MIT in 1970 after which he obtained a Master's Degree in Public Health from UCLA in 1972. He graduated Emory Medical School Summa Cum Laude in 1977. All of his graduate medical training was performed at UCSF as a Resident and Chief Resident in Internal Medicine and also as a Cardiology Fellow.

Brindis is a practicing invasive cardiologist with an active practice of consultative cardiology. His major interest in process measures and outcomes assessment in cardiovascular disease has led him to assist in the creation and implementation of various Cardiovascular Guidelines for Northern California Kaiser.

Brindis presently serves as the President-Elect of the ACC. He previously has served as the ACC Governor of Northern California and as President of the California Chapter of the ACC. Brindis was Chief Medical Officer and Chair of the National Cardiovascular Data Registry (NCDR®) Management Board.

He also chaired the ACC Appropriateness Oversight Task Force developing Appropriate Use Criteria for non-invasive testing and coronary revascularization procedures in cardiovascular disease. He is the past Chair of the ACC Quality Strategic Directions Committee. Brindis was the 2007 recipient of the national ACC Distinguished Fellow Award. Brindis is an active volunteer in the American Heart Association serving on the Western Affiliate Mission Lifeline Task Force.

Brindis sits on the Cardiac Advisory Board of the State of California OSHPD initiative overseeing public reporting of hospital and physician specific CABG mortality. He also served on the National Blue Ribbon Advisory Committee for Cardiac Care for the Veteran's Administration and the VA Hospital National CABG Quality Oversight Committee. Brindis has over 100 publications in national peer-reviewed cardiovascular journals.

#### President-Elect

##### David R. Holmes Jr., M.D., F.A.C.C.



Holmes is the Edward W. and Betty Knight Scripps Professor in Cardiovascular Medicine at Mayo Clinic College

of Medicine and an interventional cardiologist in the Division of Cardiovascular Diseases and the Department of Internal Medicine at Mayo Clinic in Rochester, Minn. He graduated from Princeton University in 1967 and from Marquette University in 1971. His internship was at the Virginia Mason

Hospital in Seattle, and he completed his fellowship at Mayo Clinic in both internal medicine and cardiovascular diseases before beginning active duty naval service at the National Naval Medical Center at Bethesda, Md. Following completion of his tour of duty, he returned to Mayo Clinic as a consultant.

Holmes' special areas of interest include acute coronary syndromes, interventional cardiology, restenosis, vascular biology, risk outcomes analysis, telemedicine and simulator technology. He is involved in the development of new catheter design and new approaches for the treatment of patients with coronary artery and vein graft disease, atrial fibrillation, and valvular heart disease. Finally, he is involved in the development and application of percutaneous coronary intervention technology to non-coronary vascular beds and in training physicians in new technology.

Holmes has been active in many ACC activities, including serving as a member of the ACC Board of Trustees. Holmes served as chair of the i2 Summit Programming Committee for 2009 and played a major role in the development of all i2 Summit meetings.

Holmes has received numerous awards, including the ACC Distinguished Scientist Award (Clinical Domain) in 2004, and is a past president of the Society for Cardiovascular Angiography and Intervention. He has published more than 695 peer-reviewed original publications and serves on the editorial boards of many journals, including the *Journal of the American College of Cardiology*.



## Vice-President

### William Zoghbi, M.D., F.A.C.C.



Zoghbi is the William L. Winters endowed Chair of Cardiovascular Imaging at The Methodist DeBakey

Heart & Vascular Center (now affiliated with Weill Cornell Medical College) and Director of the Cardiovascular Imaging Institute at the Methodist Hospital in Houston.

Zoghbi was born in Beirut, Lebanon. After receiving his B.Sc. in Biology and Chemistry from the American University of Beirut, he entered medical school there only to have his plans interrupted by the outbreak of war. He completed medical school in the United States, trained in Internal Medicine and Cardiology at Baylor College of Medicine and joined the faculty in 1985.

Zoghbi is a leader in the field of echocardiography and Doppler ultrasound for heart disease. He has developed new techniques to evaluate valvular disorders and cardiac function. Studies in Zoghbi's laboratory improved the non-invasive evaluation of diastolic function with Doppler and refined the use of stress and contrast echocardiography for detection of ischemic heart disease. Zoghbi also is known for his research on myocardial hibernation and his development of 3D Doppler techniques to measure valvular regurgitation. He has authored more than 200 original publications in the field of cardiovascular imaging and has been invited to lecture on his work at every major cardiology conference around the globe. He chaired the development of national guidelines for evaluating native and artificial heart valves with cardiac ultrasound, which also have been endorsed internationally; he also co-chaired the ACC committee that wrote a monograph on how best to train the new generation of cardiologists in cardiovascular imaging.

Zoghbi has been actively involved with the ACC and the American Heart Association for more than two decades. Zoghbi has served as chair of the ACC Annual Scientific Session Program

Committee, served on the ACC Board of Trustees and was until recently the Treasurer of the ACC. He also has exerted considerable influence in recent years in the American Society of Echocardiography (ASE) through many educational endeavors, committees and leadership roles, not the least of which was his recent tenure as ASE president. Zoghbi has served on the editorial board of many prestigious medical journals including the *Journal of the American College of Cardiology*; he was associate editor of *Circulation*, and is currently associate editor of the new *JACC-Cardiovascular Imaging*.

## Board of Trustees

The Nominating Committee makes the following unanimous recommendations for Trustees of the College for a five-year term (2010-2015):

### John Brush, M.D., F.A.C.C.



Brush is a practicing cardiologist at Cardiology Consultants, Ltd., in Norfolk, Va., and a member of the

clinical faculty at Eastern Virginia Medical School. Brush graduated from Hampden-Sydney College in 1976 and earned his medical degree from the University of Virginia in 1980. He trained in Medicine at the University of Vermont School of Medicine in Burlington and underwent his Cardiology Fellowship training at Yale University School of Medicine. From 1985 to 1988, he was a Senior Investigator and staff cardiologist with the Cardiology Branch of the National Institutes of Health in Bethesda, Md. From 1988 to 1992, he was an Assistant Professor of Medicine at Boston University School of Medicine.

Brush's primary areas of clinical interest are catheter-based coronary revascularization and nuclear cardiology. He has focused on quality of care and outcomes research at the local, state and national level.

From 2005 to 2008, Brush chaired the College's Quality Strategic Directions Committee (QSDC). During his term as

chair, the QSDC initiated a streamlined document endorsement process, faster updates of guidelines with better coordination with performance measures, the development of appropriate use criteria (AUC) and an AUC pilot with United Healthcare, and a nationwide quality improvement initiative, the D2B Alliance. Prior to serving on the QSDC, he served on the ACC Task Force on Science and Quality of Care and chaired the Task Force's workgroup on migrating quality into everyday practice. He now serves on the QSDC's successor committee, the Clinical Quality Committee. He was a member of the Steering Committee for the D2B Alliance and now serves on the Steering Committee for the Hospital-to-Home Initiative. Brush also served as president of the Virginia Chapter from 2006 to 2009.

### Harlan Krumholz, M.D., F.A.C.C.



Krumholz is the Harold H. Hines Jr. Professor of Medicine and Epidemiology and Public Health in the Section of

Cardiovascular Medicine at Yale University School of Medicine. He received his B.S. from Yale College in 1980 and his medical degree from Harvard Medical School in 1985. He completed his residency and was chief resident at Moffitt Hospital, University of California San Francisco. Krumholz completed a cardiology Fellowship at Beth Israel Hospital, Harvard Medical School. He also received a Master's degree in Health Policy and Management from the Harvard School of Public Health in 1992.

Krumholz's research is focused on determining optimal clinical strategies and identifying opportunities for improvement in the prevention, treatment and outcome of cardiovascular disease, with an emphasis on under-represented populations. He is leading efforts with the Centers for Medicare and Medicaid Services (CMS) to develop national outcomes measures for public reporting of hospital performance. Krumholz's research has been funded by the National Institutes of Health, the Agency for

*continued on next page*

Healthcare Research and Quality, the Department of Defense and CMS.

Krumholz chaired the steering committee for the Door-to-Balloon Alliance for Quality and is chair of the steering committee for the Hospital-to-Home Initiative. He has participated in the development of multiple ACC/American Heart Association Guidelines and performance measures and in the development of appropriate use criteria for nuclear imaging. He is a member of the Institute of Medicine and has received multiple awards, including an Award of Meritorious Achievement from the American Heart Association, and has published nearly 500 peer-reviewed publications. He is founding editor of *Circulation: Cardiovascular Quality and Outcomes* and editor in chief of *Journal Watch: Cardiology*.

**Athena Poppas, M.D., F.A.C.C.**



Poppas is director of the echocardiography laboratory at Rhode Island Hospital and an associate professor of medicine at Brown

Medical School. She received a bachelor of science from Brown University and her medical degree from the University of Wisconsin Medical School. Poppas completed her residencies in internal medicine at University of Wisconsin Hospital and Clinics and in cardiovascular medicine at University of Chicago Hospital.

Poppas describes her work environment as a dynamic hybrid of clinical and academic medicine. As a member of a large hospital-based practice, she specializes in treating women with heart disease during pregnancy and focuses her research on echocardiography and the various facets of heart disease in women and the elderly. She has presented and published internationally on topics such as the links between cardiovascular function and cognition, cardiovascular adaptations to pregnancy and the role of echocardiography in new technologies, among others.

Poppas is on the board of the Rhode Island Women's Health Council. She consistently has been voted top Doctor for Women in Rhode Island. She received the Young Investigator Award from the American Heart Association for her research on cardiovascular disease in women.

Poppas is past chair of the ACC's Women in Cardiology Committee and currently a member of the live programming committee. She chaired and published the ACC Professional Life Survey and served as a co-director of the Women's Career and Leadership Development Conference. She is a former Governor of the Rhode Island chapter. Poppas is a fellow of the American Heart Association, serving as a member of the Women in Cardiology Committee, and also of the American Society of Echocardiography, serving on the scientific sessions program committee among others

**Robert Harrington M.D., F.A.C.C.,**



Harrington was born and raised in Somerville, Mass. He received his undergraduate degree in English Literature

from the College of the Holy Cross, Worcester, Mass. He attended Dartmouth Medical School and received his medical degree from Tufts University School of Medicine in 1986. He was an intern, resident and Chief Resident in internal medicine at the University of Massachusetts Medical Center. He was a Fellow in cardiology at Duke University Medical Center, where he received training in interventional cardiology and research training in the Duke Databank for Cardiovascular Diseases. In 1993, he joined the Duke faculty in the Division of Cardiology, where he is Professor of Medicine, an interventional cardiologist, and Director of the Duke Clinical Research Institute (DCRI).

His research interests include evaluating antithrombotic therapies to treat acute ischemic heart disease and to minimize the acute complications of percutaneous coronary procedures,

studying the mechanisms of acute coronary syndromes, understanding the risk stratification of patients with acute ischemic coronary syndromes, better understanding and improving the methodology of clinical trials. He is the recipient of an National Institutes of Health Roadmap contract to investigate "best practices" among clinical trial networks.

He has authored more than 300 peer-reviewed manuscripts, reviews, book chapters and editorials. He is an Associate Editor of the *American Heart Journal* and an editorial board member for the *Journal of the American College of Cardiology*. He is a Fellow of the American Heart Association, the Society for Cardiovascular Angiography and Intervention, the American College of Chest Physicians and the European Society of Cardiology. He currently chairs the FDA Cardiovascular and Renal Drugs Advisory Committee and serves as a member of the National Heart, Lung, and Blood Institute's study section for clinical trials, and the NHLBI Working Group on Clinical Trials Methodology.

Harrington has been active in the College since becoming a Fellow. He was a councilor for the North Carolina Chapter from 2000 to 2006. He has been a member of the ACS Data Standards Committee, the Live Programs Working Group and the Cardiovascular Research Committee. He served on the Annual Scientific Session Program Committee from 2002 to 2007 and chaired the 2006 Annual Scientific Session. He currently chairs the Clinical Expert Consensus Document Task Force and the Science and Clinical Policy Subcommittee, co-chairs the Education Oversight Committee and is a member of the Clinical Quality Committee. Harrington filled the vacancy left by Janet Wright, M.D., F.A.C.C., when she resigned her position on the Board to become staff senior vice president of Quality and Science at the College. He now has been nominated for his own five-year term.

## Coming This Spring

Watch for the launch of CardioSource 3.0, the ACC's new and improved Web portal, this spring. Designed with you in mind, this new site will be your source for the latest clinical content, as well as everything you need to know as a member of the College — all made easily accessible through the latest technology. Watch for more information in the ACC.10/i2 Summit Preview Issue of *Cardiology*.

## Register for Pediatric Exam

The American Board of Pediatrics 2010 Certifying Exam in Pediatric Cardiology will take place on Nov. 8. First time applicants may register for the exam from Feb. 2 to April 29. Prior registrants can register between March 16 and June 15. Applicants in the final month of each registration period will pay a late fee. Go to [www.abp.org](http://www.abp.org) to register and find additional information, including eligibility requirements and fees.

## Watch Your Mailbox

Coming next month is a special ACC.10/i2 Summit Preview issue of *Cardiology* magazine. This special issue will be packed with information on the science, education and professional development available to you in Atlanta this March. For more information or to register for ACC.10 and i2 Summit, go to [acc10.acc.org](http://acc10.acc.org).



## GENERAL CARDIOLOGY

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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:  
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Attn.: Sally Sparling, CEO  
2222 NW Lovejoy, Suite 606  
Portland, Oregon 97210  
[sallysparling@nw-ci.com](mailto:sallysparling@nw-ci.com)

### Washington University in St Louis

The Division of Cardiology at Washington University School of Medicine is conducting a search for two positions at the assistant/associate professor of medicine level. Positions are for a clinical cardiologist with a major focus on general cardiology and a minor focus on cardiac imaging, and a clinical cardiologist with a primary focus on noninvasive vascular medicine. Both have an opportunity to participate in clinical research and teaching. Candidates should be an MD or MD/PhD and be BC/BE in cardiology.

Washington University and Barnes Jewish Hospital are recognized nationally and internationally for research in medicine and science.

Applicants should email or mail cv and letter stating career goals to [dmann@dom.wustl.edu](mailto:dmann@dom.wustl.edu)  
660 S. Euclid Ave., CB 8086, St. Louis, MO 63110.

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The University of Texas Health Science Center in Houston is accepting applications for its Clinical Cardiac Electrophysiology Fellowship program for July 2010. This opportunity provides comprehensive training in all areas of clinical electrophysiology that includes ablation of Atrial Fibrillation, ventricular tachycardia and other complex arrhythmias, implantation of ICDs and Bi-Ventricular devices, at the Heart & Valve Institute in Memorial Hermann Hospital, a high-volume center with state of the art EP laboratories equipped with bi-plane fluoroscopy, CARTO and ESI mapping systems, intracardiac echocardiography and cryoablation.

Please submit cover letter and C.V. to Bharat K. Kantharia, MD, FRCP, FAHA, FACC, FESC, CCEP Program Director P.O. Box 20708, Houston, Texas 77225-0708, Phone: (713)500-6590, Fax: (713)500-6556.

University of Texas Health Science Center at Houston is an EO/AA employer. M/F/D/V. This is a security sensitive position and thereby subject to Texas Education Code § 51.215. A background check will be required for the final candidate. Hiring is contingent upon eligibility to work in the United States and upon appropriate credentialing and Texas State licensing. Women and Minority candidates are encouraged to apply.

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## 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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## Jan. 12

- Efficacy and safety of immediate angioplasty versus ischemia-guided management after thrombolysis in acute myocardial infarction in areas with very long transfers. Results of the NORwegian study on District treatment of ST-Elevation Myocardial Infarction (NORDISTEMI)
- Percutaneous Coronary Intervention After Successful Fibrinolytic Therapy for ST Elevation Myocardial Infarction: Better Late than Never

## Jan. 19

- Cholesterol-Lowering Interventions and Stroke: Insights From A Meta-Analysis Of Randomized Controlled Trials
- Normal Stress-Only Versus Standard Stress/Rest Myocardial Perfusion Imaging: Similar Patient Mortality with Reduced Radiation Exposure

## Jan. 26

- Geographic Disparities in Heart Failure Hospitalization Rates among Medicare Beneficiaries
- Stepping Outside of the Heart: Using Non-traditional Patient Characteristics to Understand and Improve Outcomes

## Feb. 2

- Randomized comparison of percutaneous coronary intervention with coronary artery bypass grafting in diabetic patients: one year results of the CARDia (Coronary Artery Revascularization in Diabetes) Trial
- Dynamic Cardiovascular Risk Assessment in the Elderly: The Role of Repeated Amino Terminal Pro-B-type Natriuretic Peptide Testing

## Feb. 9

- Optimizing Hemodynamics In Heart Failure Patients By Systematic Screening of LV Pacing Sites: The Lateral LV wall and the Coronary Sinus are Rarely the Best Sites
- Lead Extraction in the Contemporary Setting: The LEXIcon Study An Observational Retrospective Study of Consecutive Laser Lead Extractions

## Feb. 16

- The Absence of Coronary Calcification Does Not Exclude Obstructive Coronary Artery Disease or the Need for Revascularization in Patients Referred for Conventional Coronary Angiography
- NT-proBNP-Guided, Intensive Patient Management in Addition to Multidisciplinary Care in Chronic Heart Failure - A Three-Arm, Prospective, Randomized Pilot-Study



















## JACC cardiovascular Imaging

- Impact of Cardiac Contractility Modulation on Left Ventricular Global and Regional Function and Remodeling
- Bridging the Gap-Intr plaque Hemorrhage Identified as a Stimulator of Episodic Growth of Advanced, but Non-symptomatic Atherosclerotic Lesions
- Ultra-Low Dose Intra-arterial Contrast Injection for Ilio-femoral Computed Tomographic Angiography

## JACC cardiovascular Interventions

- Three Year Clinical Follow up of the XIENCE V Everolimus Eluting Coronary Stent System in the Treatment of Patients with de novo Coronary Artery Lesions. The SPIRIT II Trial
- Long-Term Clinical and Economic Analysis of the Endeavor Zotarolimus-Eluting Stent vs. the Cypher Sirolimus-Eluting Stent: Three-Year Results from the ENDEAVOR III Trial
- Clinical Outcomes Following Unrestricted Implantation of Everolimus-eluting Stents

## Educational Programs Calendar

	February 5 - 6, 2010 <b>4th Annual Heart of Women's Health</b> JoAnne M. Foody, M.D., F.A.C.C. Suzanne Hughes, M.S.N., R.N.	Washington, D.C.  		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.  
	February 12 - 14, 2010 <b>2nd Annual Clinical Practice of Peripheral Vascular Disease</b> Michael R. Jaff, D.O., F.A.C.C. Christopher J. White, M.D., F.A.C.C.	Phoenix  		May 20 - 22, 2010 <b>2010 Coronary Computed Tomography Angiography (CTA) Practicum</b> Gerald Blackwell, M.D., F.A.C.C.	Washington, D.C. 
	February 15 - 19, 2010 <b>32nd Annual Cardiology at Big Sky Meeting</b> Kim A. Eagle, M.D., M.A.C.C. Sidney Goldstein, M.D., F.A.C.C.	Big Sky, Mont. 		May 21 - 22, 2010 <b>Emergency Cardiovascular Care 2010: Enhancing Regional STEMI Systems of Care</b> Christopher B. Granger, M.D., F.A.C.C. James G. Jollis, M.D., F.A.C.C. Mayme Lou Roettig, R.N., M.S.N.	Chicago  
	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 		May 22 - 23, 2010 <b>Peripheral Vascular CTA Primer</b> Gerald Blackwell, M.D., F.A.C.C.	Washington, D.C. 
	March 13, 2010 <b>2nd Annual International Cardiovascular Conference: Focus on the Middle East</b> Douglas P. Zipes, M.D., M.A.C.C.	Atlanta 			

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)

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