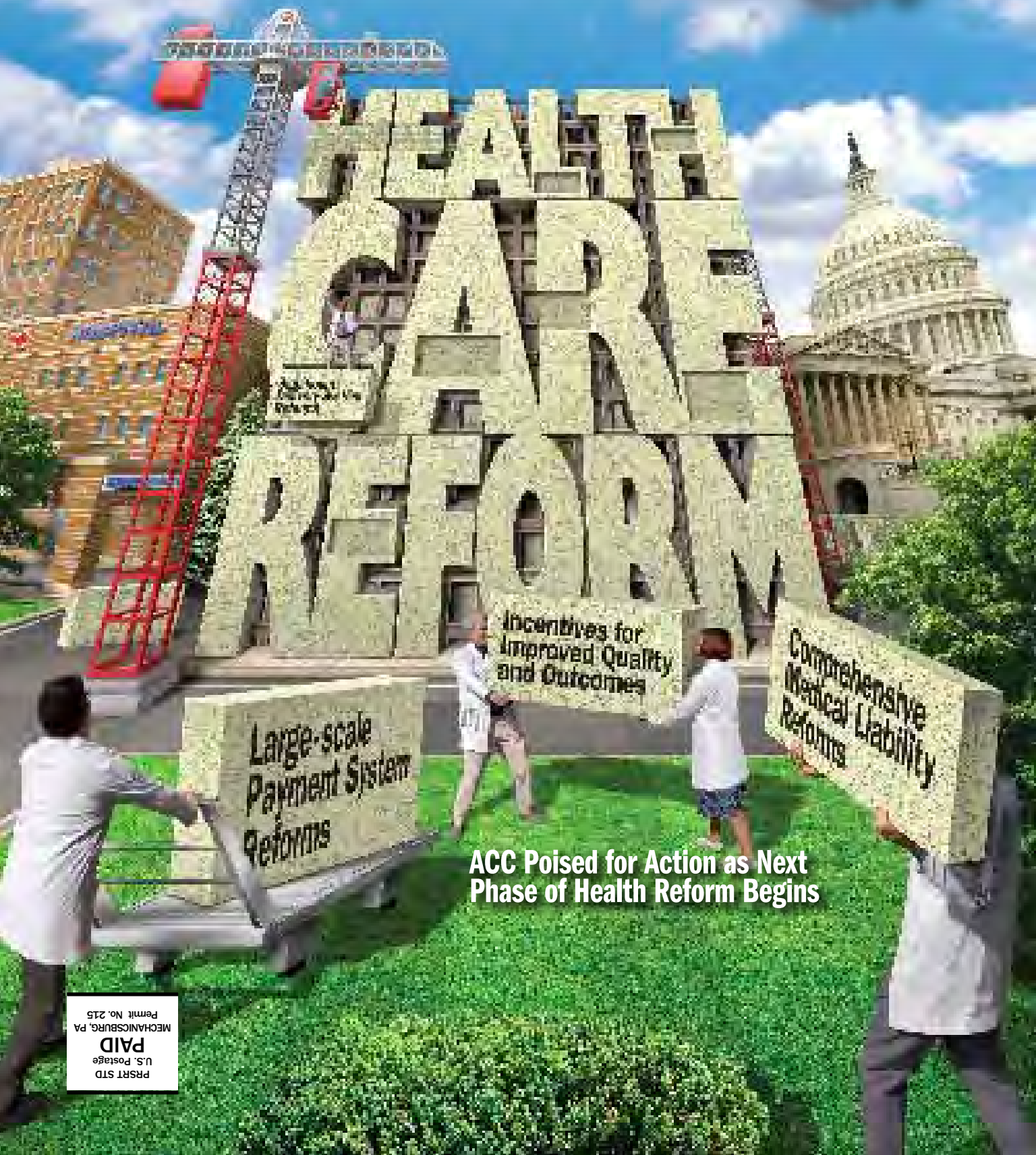




Cardiology

A MEMBER PUBLICATION OF THE AMERICAN COLLEGE OF CARDIOLOGY



ACC Poised for Action as Next Phase of Health Reform Begins

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In chronic angina Take a broader

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Indication

- ▶ Ranexa is indicated for the treatment of chronic angina.
- ▶ Ranexa may be used with beta-blockers, nitrates, calcium channel blockers, anti-platelet therapy, lipid-lowering therapy, ACE inhibitors, and angiotensin receptor blockers.

IMPORTANT SAFETY INFORMATION

Contraindications

- ▶ Ranexa is contraindicated in patients:
 - Taking strong inhibitors of CYP3A4 (eg, ketoconazole, itraconazole, clarithromycin, rifabutin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir)

- Taking inducers of CYP3A4 (eg, rifampin, rifabutin, rifapipin, phenobarbital, phenytoin, carbamazepine, and St. John's wort)
- With clinically significant hepatic impairment

Warnings and Precautions

- ▶ Ranexa blocks P₂Y₁₂ and prolongs the QTc interval in a dose-related manner.
- ▶ Clinical experience did not show an increased risk of proarrhythmia or sudden death.
- ▶ There is little experience with high doses (≥ 1050 mg or less daily) of ranexa, other QT-prolonging drugs, or potassium channel blockers resulting in a long QT interval.

Please see brief summary of prescribing information on adjacent page.

view

Ranexa is FDA approved as a first-line agent for treatment of patients with chronic angina.

- ▶ Established efficacy in a 12-week clinical trial
 - Clinical trial endpoints included angina frequency, exercise duration, nitroglycerin use, time to ischemia (1-min ST-segment depression), and time to angina*
- ▶ Hemodynamic neutrality
 - In controlled clinical trials, Ranexa caused minimal changes in mean heart rate (± 3 bpm) and systolic blood pressure (± 3 mm Hg).
 - No dose adjustment is required in patients with heart failure or diabetes†
- ▶ Established safety and tolerability

Redefine your treatment landscape



Ranexa
PICOLOINE BUTYRATE-RELEASE TABLETS
500mg/100mg

Adverse Reactions

- ▶ The most common adverse reactions ($\geq 1\%$) and more common than with placebo during treatment with Ranexa were dizziness, headache, constipation, and nausea.

Dosage and Administration

- ▶ Begin treatment with 500 mg twice daily and increase to the maximum recommended dose of 1000 mg twice daily, based on clinical symptoms.
- ▶ Limit the dose of Ranexa to 500 mg twice daily in patients on moderate CYP3A4 inhibitors (eg, diltiazem, verapamil, amlodipine, erythromycin, fluconazole, and grapefruit juice or grapefruit-containing products).

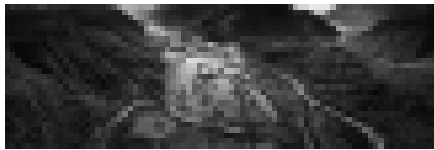
Drug Interactions

- ▶ Do not use Ranexa with CYP3A4 inducers or strong CYP3A4 inhibitors (see Contraindications) used by the date of Ranexa with moderate CYP3A4 inhibitors (see Dosage and Administration).
- ▶ P-gp inhibitors (eg, cyclosporin) may need to lower the dose of Ranexa based on clinical response.
- ▶ Doses of drugs transported by P-gp (eg, digoxin) or metabolized by CYP3A4 (eg, triazole antifungals and antipsychotics) may need to be reduced.

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www.abbott.com/ranexa





PHARMACEUTICALS

Brief Summary of Prescribing Information

INDICATIONS AND USAGE

INDICATIONS AND USAGE

CONTRAINDICATIONS

CONTRAINDICATIONS

WARNINGS

WARNINGS

ADVERSE REACTIONS

ADVERSE REACTIONS

DRUG INTERACTIONS

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Old Reliable in a New Era

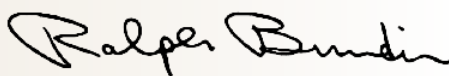
I am deeply honored and humbled to serve the American College of Cardiology and each of you at such an exciting – and uncertain – time for cardiology. My term as president began with the contentious, but unquestionably historic, passage of major health care reform legislation. With that legislation come many new questions for cardiovascular professionals. In this issue of *Cardiology* magazine, we examine those questions and outline some of what we believe remains to be done to ensure that reform has the desired positive impact for our patients, providers and our health care economy.

With all the uncertainty in medicine today, it's comforting to know that we can depend on ACC's unwavering commitment to the very best in education, science and quality. This issue demonstrates the outstanding results of that commitment. The authors of the newly released Guideline for the Diagnosis and Management of Patients with Thoracic Aortic Disease summarize the recommendations in this breakthrough document on one of the most catastrophic forms of cardiovascular disease. **Karen Alexander, M.D., F.A.C.C.**, **John Harold, M.D., M.A.C.C.**, and **Sue Zieman, M.D., Ph.D., F.A.C.C.**, discuss a new learning tool, *Essentials of Cardiovascular Care in Older Adults*, designed to ensure that cardiovascular specialists can effectively respond to the "Graying of America." **Christopher Granger, M.D., F.A.C.C.**,

James Jollis, M.D., F.A.C.C., and **Mayme Lou Roettig, R.N., M.S.N.**, offer a preview of Emergency CV Care, the must-attend educational program for transforming care for patients with ST-elevation myocardial infarction. **Mark Kremers, M.D., F.A.C.C.**, unveils the new and improved data elements in the just released "Peds and Leads" version 2 of our NCDR® ICD Registry™ and details the important expanded data it will capture.

Our steadfast dedication to our core values will help us to successfully adapt to whatever Congress and the Centers for Medicare and Medicaid Services may have in store in the near future.

I look forward to working with each of you as we face the uncertainties – and enjoy the excitement – of practicing cardiovascular medicine in a new era. I encourage you to contact me at any time with questions, concerns or guidance as we work together to deliver the highest quality care to cardiovascular patients.



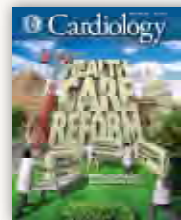
Ralph G. Brindis, M.D., M.P.H., F.A.C.C.
President

March - April 2010

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ACC Poised for Action as Next Phase of Health Reform Begins

The new U.S. health care reform law makes significant headway in expanding access to care for the millions of uninsured Americans – including those with heart disease. It extends Medicaid eligibility, increases the age limit for young adults on family plans and eliminates pre-existing condition exclusions for health insurance. The legislation also addresses chronic disease management, workforce shortages among health professions, prevention and wellness.



Incentives for
Improved Quality
and Outcomes

Comprehensive
Medical Liability
Reforms

Large-scale
Payment System
Reforms

The law also —

- Funds increased research into congenital heart disease (CHD) care, as well as a surveillance tool to better understand CHD prevalence and evaluate care.
- Increases the Physician Quality Reporting Initiative (PQRI) incentive payment for 2011 – 2014 by 0.5 percent and adds an appeals process and more timely feedback.
- Extends PQRI through 2014.
- Allows groups of providers who meet certain statutory criteria to be recognized as accountable care organizations and eligible to share in the cost-savings achieved by the Medicare program.



- Requires that the Department of Health and Human Services (HHS) develop a national, voluntary bundled payment pilot program to provide incentives for providers to coordinate care as of 2013.
- Creates the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality, including the use of registries and appropriate use criteria.
- Adds resources for HHS to strengthen and improve the development process for quality measures, as well as funding for HHS and Agency for Healthcare Research and Quality to study how to improve quality outcomes.

While the bill makes a start toward key ACC goals of expanding access and improving quality, it does include several onerous initiatives, including the creation of an “independent payment advisory board,” prohibitions on new and expanded physician-owned hospitals (hospitals in operation as of Dec. 31, 2010, are grandfathered in), the release of Medicare claims data for public reporting, and penalties for not participating in the PQRI program starting in 2015.

It also fails to address several of the principles that the ACC has deemed essential for real reform. It does not include large-scale delivery and payment system reforms that provide incentives for improvement of quality and outcomes, nor does it repeal the flawed

practice survival and transformation, as well as lead the profession toward systematic and measured reductions in cardiovascular morbidity and mortality and in ongoing improvements in personal and population-based prevention and health care outcomes. The ongoing fight against continuous Medicare payment cuts and a focus on patient value also are critical.

The ACC already is working across multiple areas to ensure appropriate use of diagnostic equipment, promote adherence to clinical guidelines and appropriate use criteria, improve care coordination through the use of clinical registries, and reduce hospital readmissions and racial and geographic disparities in care. In addition, the ACC will continue to forge carefully crafted

“ Now the real work begins. ”

ACC President Ralph Brindis, M.D., M.P.H., F.A.C.C.

sustainable growth rate (SGR) formula used to calculate Medicare physician payment. While the new law authorizes grants to states to pursue alternative medical liability reforms, it fails to implement medical liability reforms that have proven effective at reducing legal and defensive medicine costs.

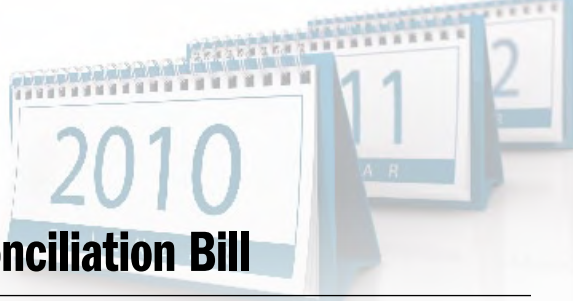
“Now the real work begins,” said ACC President **Ralph Brindis, M.D., F.A.C.C.**, in a statement immediately following the bill’s passage in the House. “The ACC is now poised to lobby for changes and lead the process of implementation — especially as it relates to professionalism, continuous quality improvement, patient value and payment innovation.”

According to Brindis, the ACC needs to focus on providing tools for

partnerships with Congress and other key stakeholders to develop a health care system that puts patients first and rewards — not penalizes — physicians and other medical professionals for their commitment to quality and evidence-based care.

“The ACC and its membership need to adjust the sails and set the standard for health care delivery in this new health care environment,” said Brindis. “Through the promotion of professionalism and improved systems of care, our goal at the ACC is to empower both cardiovascular care teams and their patients to participate in continuous system reform and innovation.”

Chronology of the Health Reform & Reconciliation Bill



The following chronology was excerpted from ACC's blog, The Lewin Report.

Immediately

- Health insurance reform implementation fund of \$1 billion is available to the Department of Health and Human Services (HHS) for moving forward with insurance reform regulations
- The right to maintain existing coverage is protected
- National efforts to combat health care fraud (not focused on physicians) will be funded and launched

Retroactive to Jan. 1

- Small business tax credit for covered employees becomes available

June 2010

- High-risk pools for individuals with pre-existing conditions will be formed
- A re-insurance program to cover early retirees is created

July 2010

- Immediate information will be available to consumers from HHS to identify most affordable coverage within a geography

Later This Year

- Prohibitions on lifetime or annual insurance limits for essential health benefits implemented for all private health insurance
- Coverage of new preventive services required by all insurers
- Extension of dependent coverage to unmarried adult children through age 26 through their parents' insurance is implemented
- Prohibitions of insurance discrimination based on salary implemented
- Required medical loss ratios (80 percent or more of the premium dollar must be spent on medical care) implemented
- New insurance appeals processes implemented
- Full coverage for pre-existing health conditions for enrollees under 19 implemented
- Patient protections including choice of provider and medical reimbursement data implemented
- Patient-Centered Outcomes Research Institute established
- \$1 billion invested in development of new therapies to diagnose and treat chronic disease
- Tax relief for health professionals and physicians for educational loan repayments available for those working in rural or underserved areas
- National Health Care Workforce Commission established
- Indoor tanning services tax implemented
- Comparative Effectiveness Research Outcomes Institute established

Within One Year

- Uniform explanation of coverage documents (uniform administrative forms) developed

2011

- Grants for wellness programs available
- Medical malpractice demonstration grants available to states
- Primary care scholarship and loan repayments
- Medicare Innovation Center established with \$10 billion to fund payment reform and quality improvement pilots
- Restrictions on physician ownership of specialty hospitals will be tightened, even though the law extends the deadline for existing hospitals to become Medicare providers through the end of 2010

This chronology continues at lewinreport.acc.org.

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My Post-Call List and the Need for Tort Reform

By Jon C. George, M.D.



“ So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. ”

From the Hippocratic Oath

Finally this summer, 11 years after I took the Oath on the first day of medical school, I finished my training in medicine, having specialized in interventional cardiology. In my enthusiasm to take some time off prior to starting my long awaited career, I prepared a long list of things I wanted to check off before entering the working world. I called this the Post-Call List, because it contained items that previously could not be entertained due to the demands and rigors of medical training. Included in this list were various cherished yet simple fantasies like sleeping in on a weekday morning, sipping a hot cup of chai and reading the newspaper in the city square, eating off a gourmet truck in the business district at lunch time, taking a fitness class in the afternoon at my gym, and so on. Also on that list was my desire to give back to the community by delivering charitable care at a free clinic in the area, but what I perceived as a simple act of voluntary service was shattered by my exposure to the harsh reality of today's medical liability system.

As I went from one free clinic to another, I was enlightened about their plight: These clinics are in desperate need of additional health care providers, but they lack the economic means to accommodate transient doctors. In other words, although the physicians are willing to provide services free of charge, there is a tremendous upfront cost to the clinic to obtain malpractice insurance for each provider due to the ongoing threat of medical liability litigation. Frivolous litigious behavior is publicly encouraged by large billboards, such as the one I am forced to witness on my commute to the free clinic, boldly marketing the Web site *www.WhoCanISue.com*.

The current medical liability system is costly and unproductive and requires revision as a critical component of any health system reform legislation. The inefficiencies of the tort system, escalating and unpredictable litigation awards, and the high cost of defending even frivolous lawsuits, contribute to the increase in medical liability insurance premiums, which are near all-time highs. In Pennsylvania, the malpractice insurance premium for a general internist

is almost \$3,000 up front for retroactive coverage, plus an additional \$1,000 annually for prospective coverage. As insurance becomes unaffordable, physicians are forced to alter or limit their services due to liability concerns, which impede patient access to care. Furthermore, defensive medicine, with extraneous testing and procedures, triggered by concern about malpractice liability, becomes a significant driver of growing health care costs. While these costs are difficult to estimate, trimming even 1 percent of health care spending would save around \$22 billion per year, according to a recent article in the *New England Journal of Medicine*.

The health reform bill the president signed in March fails to implement medical liability reforms that reduce legal and

These clinics are in desperate need of additional health care providers, but ... although the physicians are willing to provide services free of charge, there is a tremendous upfront cost to the clinic to obtain malpractice insurance for each provider due to the ongoing threat of medical liability litigation.

defensive medicine costs. To address liability reform, several medical societies, including the American Medical Association (AMA), have partnered to propose models based on California's Medical Injury Compensation Reform Act (MICRA), including a \$250,000 cap on noneconomic damages, sliding scale for attorney fees, collateral source rule reform, periodic payment for future damage awards and requirements to file a certificate of merit in any medical liability lawsuit along with expert witnesses. Other proposed alternatives include health courts, early disclosure and compensation programs, administrative determination of compensation models, mandatory expert witness qualifications, and liability protections for use of evidence-based medicine guidelines.

Today, I stand at the threshold of a career in interventional cardiology, having survived a prolonged period of medical training and rejuvenated over a short span of relaxing vacation. But as I review my Post-Call List, I see that I have checked off all but one item on the agenda: My charitable service at a free clinic was regrettably restricted to observation by the limitations imposed by a medical liability system that demands the need for reform.

George is director of clinical research at Deborah Heart and Lung Center in Brown Mills, N.J.

New Guideline Addresses Catastrophic Disease

The 2010 Guideline for the Diagnosis and Management of Patients with Thoracic Aortic Disease (TAD) published in March with recommendations on treating patients suffering from one of the most catastrophic forms of cardiovascular disease. The guideline was the subject of a “What’s New in Guidelines” session at ACC.10.



Loren Hiratzka, M.D., F.A.C.C., chair of the guideline writing committee, reminded the audience at the session that patients with TAD are subject to missed or delayed detection. “They may present with atypical symptoms and findings,



making diagnosis even more difficult, and widespread awareness has been lacking,” he said. Unfortunately, many patients are asymptomatic until an acute event occurs.

Imaging of the thoracic aorta is the only method to detect TAD and determine risk for future complications, but unfortunately it often is not covered by payers, even in cases of high risk and family history. Results of treatment for stable aortic diseases are far better than results of treatment for acute aortic dissection or rupture, Hiratzka said.

Luke Hermann, M.D., director of the Chest Pain Unit at Mount Sinai Medical Center in New York and a member of the writing committee, offered strategies



from the guideline for improving early diagnosis. “The risk tool we developed has three components,” Hermann said, including history,

presentation and physical exam findings. A high-risk history would include connective tissue disease, aortic conditions, family history of TAD and recent aortic manipulation. A high-risk presentation would be a patient with abrupt onset of severe pain described as ripping, tearing or stabbing. High-risk physical exam findings include pulse deficit, systolic blood pressure deficit, focal murmur or murmur of aortic insufficiency. If the patient has two or more high-risk features, an immediate imaging study is warranted.

Eric Isselbacher, M.D., F.A.C.C., from Harvard Medical School in



Cambridge, Mass., and another committee member, noted that there is an increasing incidence and awareness of familial and genetic mutation-based TAD, including Marfan Syndrome, and reviewed the recommendations for diagnosis

and follow-up of TAD in these patients, including an echo at the time of diagnosis and six-month follow-up to determine the rate of enlargement of the aorta.

The guideline also covers endovascular, surgical and anesthetic techniques for treating TAD, as well as the evolution of medical and gene-based treatment. Treatment recommendations in the guideline include:

- Aortic dissection involving the ascending aorta is a life-threatening emergency that should be treated surgically.
- Aortic dissection involving the descending thoracic aorta may often be managed with medications that control the blood pressure and heart rate, unless life-threatening complications develop. Additional medical therapy may include statins to lower elevated blood cholesterol levels.
- Minimally invasive endovascular techniques are an option in some patients with aneurysm or dissection of the descending thoracic aorta.

TAD Coalition to Raise Public, Provider Awareness

With the release of the TAD guidelines in March, a group of advocates has formed the TAD Coalition to raise public awareness of aortic diseases and their risk factors and help promote the guidelines to health care professionals. Specifically, the mission of the coalition is to:

- Increase public awareness of factors predisposing to thoracic aortic aneurysms and acute aortic dissections, including genetic and environmental factors
- Provide educational materials concerning the symptoms, clinical evaluation and medical management of thoracic aortic disease
- Improve the diagnosis and management of aortic aneurysms and acute aortic dissections in the emergency room setting

“The TAD Coalition is playing a critical role in helping to maximize the impact of the new thoracic aortic disease diagnosis and management guidelines,” said Loren Hiratzka, M.D., F.A.C.C., chair of the guideline writing committee. “While these new guidelines will inform and update the medical community, the TAD Coalition will inform the public of risk factors and symptoms for these aortic diseases. Together, we hope there will be better outcomes and, certainly, a reduction in the number of deaths from aortic dissection and rupture due to earlier diagnosis and improved medical management.”

For more information, including the members of the coalition, visit: www.tadcoalition.org.

The TAD guideline was developed in collaboration with the American Association for Thoracic Surgery, American College of Radiology, American Stroke Association, Society of Cardiovascular Anesthesiologists, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology, Society of Thoracic Surgeons, and Society for Vascular Medicine. The American College of Emergency Physicians and the American College of Physicians also were represented on the writing committee.

To view the full TAD guideline, go to content.onlinejacc.org/cgi/content/full/jacc.2010.02.015.

1. The goal of this guideline is to improve the health outcomes and quality of life for all patients with thoracic aortic disease. Thoracic aortic diseases are usually asymptomatic and not easily detectable until an acute and often catastrophic complication occurs.

2. Imaging of the thoracic aorta with computed tomographic (CT) imaging, magnetic resonance imaging (MRI), or in some cases, echocardiographic examination, is the only method to detect thoracic aortic diseases and determine risk for future complications. Measurements of aortic diameter should be taken at reproducible anatomic landmarks, perpendicular to the axis of blood flow, and reported in a clear and consistent format.

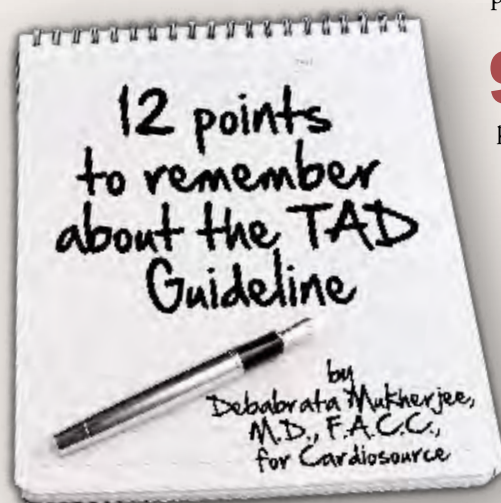
3. The identification and treatment of patients at risk for acute and catastrophic disease presentations (e.g., thoracic aortic dissection and thoracic aneurysm rupture) prior to such an occurrence are paramount to eliminating the high morbidity and mortality associated with acute presentations.

4. Aortic imaging is recommended at the time of diagnosis of Marfan syndrome or Loeys-Dietz syndrome to determine the aortic root and ascending aortic diameters, and six months thereafter to determine the rate of enlargement of the aorta. Annual imaging is recommended for patients with Marfan syndrome and if stability of the aortic diameter is documented. Loeys-Dietz patients should have yearly MRI from the cerebrovascular circulation to the pelvis.

5. Aortic imaging is recommended for first-degree relatives of patients

with thoracic aortic aneurysm and/or dissection to identify those with asymptomatic disease.

6. Providers should routinely evaluate any patient presenting with complaints that may represent acute thoracic aortic dissection to establish a



pretest risk of disease that can then be used to guide diagnostic decisions. This process should include specific questions about medical history, family history and pain features, as well as a focused examination to identify findings that are associated with aortic dissection.

7. Urgent and definitive imaging of the aorta using transesophageal echocardiogram (TEE), CT scanning, or MRI is recommended to identify or exclude thoracic aortic dissection in patients at high risk for the disease by initial screening.

8. Initial management of thoracic aortic dissection should be directed at decreasing aortic wall stress by controlling heart rate and blood pressure with beta-blockers or nondihydropyridine calcium channel-blockers

in those with contraindications to beta-blockers. If systolic blood pressures remain >120 mm Hg after adequate heart rate control has been obtained, then angiotensin-converting enzyme inhibitors and/or other vasodilators should be administered intravenously to further reduce blood pressure that maintains adequate end-organ perfusion.

9. Urgent surgical consultation should be obtained for all patients diagnosed with thoracic aortic dissection regardless of the anatomic location (ascending vs. descending) as soon as the diagnosis is made or highly suspected.

10. For patients with ascending thoracic aortic dissection, all aneurysmal aorta and the proximal extent of the dissection should be resected. A partially dissected aortic root may be repaired with aortic valve resuspension. Extensive dissection of the aortic root should be treated with aortic root replacement with a composite graft or with a valve sparing root.

11. Stringent control of hypertension, lipid profile optimization, smoking cessation and other atherosclerosis risk-reduction measures should be instituted for patients with small aneurysms not requiring surgery, as well as for patients who are not considered surgical or stent graft candidates.

12. For patients with degenerative or traumatic aneurysms of the descending thoracic aorta exceeding 5.5 cm, saccular aneurysms, or postoperative pseudoaneurysms, endovascular stent grafting should be strongly considered when feasible.



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Top Chapters of 2009 Awarded at Leadership Forum

Representing both U.S. coasts, the South and the Midwest, four ACC chapters were recognized with the top chapter awards at the fourth annual ACC Chapter Awards Program held during the 2010 Leadership Forum. Recognized for going above and beyond in their winning category, the award-winning chapters were singled out as those that best promote the mission of the ACC at the state grassroots level in the areas of State Advocacy, Education, Membership and Community, and Quality.

The Alabama Chapter, led by Governor **Phillip Haney, M.D., F.A.C.C.**, and Chapter Executive Dee Mooty, received the Chapter Recognition Award for State Advocacy for its 2009 patient project “Assault on Alabama Cardiovascular Mortality.” The project serves as grassroots education for Alabama residents about the impact of cardiovascular risk factors on the occurrence and course of cardiovascular disease. The goal is to note how recognition and intervention could improve outcomes among Alabamians. In 2009, the Alabama House of Representatives passed a special resolution recognizing the project and its efforts to reduce the high incidence of heart disease in the state. Honorable mentions for the State Advocacy award went to the California, Iowa, Maryland and Ohio Chapters.

The Chapter Recognition Award for Education went to the California Chapter, led by Governors **Dipti Itchhaporia, M.D., F.A.C.C.**, and **George L. Smith, M.D., F.A.C.C.**, and Chapter Executive Lianna Collinge. California provided education to more than 6,000 members in 2009. The chapter reached patients, leaders, legislators, affiliated partner groups and industry through a variety of publications and meetings in topic areas including science, prevention, legislative how-tos, leadership training and ACC core values. Honorable mentions for the Education award went to the Alabama, Iowa, Maryland and Puerto Rico Chapters.

Awarded for their strong 2009 Membership Campaign, the Illinois Chapter received the Chapter Recognition Award for Membership and Community. Chapter Governor **Jerome L. Hines, M.D., Ph.D., F.A.C.C.**, along with Chapter Executive Andy Shelp, led the chapter as it designed and implemented the campaign aimed at identifying and engaging non-ACC member cardiologists in the state. The chapter ultimately strengthened its communication network and reconnected cardiologists of Illinois to the College and the Chapter. The Illinois Chapter is revisiting this initiative in 2010. Honorable mentions for the Membership and Community award went to the California and Michigan chapters.

The North Carolina Chapter received the first ever James T. Dove Chapter Recognition Award for Quality. The prestigious award is named in honor of ACC Past President **James Dove, M.D., M.A.C.C.**, and his lifetime of achievement and professionalism in support of cardiovascular medicine. Led by Chapter Governor **Oscar R. Jenkins Jr., M.D., F.A.C.C.**, and Chapter Executive Beth Denny, the chapter established one of the most comprehensive reperfusion systems in the world, the Reperfusion of Acute Myocardial Infarction in Carolina Emergency Departments (RACE) system. Used as a model for other nationwide programs, RACE is based on the efforts and contributions of more than 100 hospitals, 700 emergency medical systems and thousands of health care professionals. The chapter implemented a “Top 10 To-Do List” and called for an effort to make the state the safest place to have a heart attack, demonstrating the overwhelming dedication of the chapter to innovation and meeting the College’s mission. Honorable mentions for the Quality award went to California, Ohio and West Virginia.

For more information about Chapter award winners, visit www.acc.org/chapters and click on Chapter Awards.



New Utah Chapter Building Relationships with State Lawmakers

One of the newest ACC chapters, the Utah Chapter, is making headway in its efforts to build relationships with state lawmakers and raise awareness of important public health issues facing Utah residents.

In their first-ever Lobby Day, Chapter members met with more than 30 lawmakers, urging passage of House and Senate bills that would increase tobacco taxes, as well as a bill that would ban smoking in cars while children are present. The smoking ban, which ultimately passed the House on Feb. 23, makes smoking inside a car when a child under the age of eight is present a secondary offense. It carries a fine of \$45 that can be offset by enrollment in a smoking cessation program.

Chapter members also hosted an informal reception with Utah's Lieutenant Governor Greg Bell (R), where smoking laws, possibilities for tort reform and raising public awareness of heart disease were on the table for discussion. In particular, Bell was interested in an Intermountain Medical Center study indicating that people with underlying coronary artery disease are 30 percent more likely to suffer a heart attack on "bad air" days.



"This was an important opportunity for us to raise awareness about the Utah Chapter and important cardiovascular health issues with state legislators," said Utah Chapter Governor **Brent Muhlestein, M.D., F.A.C.C.** "We were able to meet with almost every leader in the Utah House and Senate and hopefully planted the seeds for stronger relationships with these members going forward."

According to Muhlestein, Lobby Day participants came away with a clear feeling that they had made a difference. "We are already planning a return to Salt Lake City next year and will add a 'Heart Healthy Day' component to the event," he said.

Meanwhile, the Indiana Chapter held its second Lobby Day in February. More than 20 physicians and nurses attended the two-day meeting, during which they met with more than 40 legislators. As in Utah, smoking bans — particularly one banning smoking in public places — and medical liability reform were important topics of discussions with state lawmakers.





The ‘State’ of Medical Liability Reform

Current laws in nearly 30 states limit damages in medical liability cases. However, recent state Supreme Court decisions in Illinois and Georgia that overturn medical liability caps potentially could nullify the great strides medicine has made to increase competition among medical liability insurers, lower premium rates and provide greater access to care.

In February, the Illinois Supreme Court ruled that the state’s 2005 law limiting damages to \$500,000 for physicians and \$1 million for hospitals violated the state Constitution’s separation of powers between the legislature and the judiciary. On March 22, the Georgia Supreme Court unanimously ruled that a \$350,000 cap on noneconomic damages, including compensation for a plaintiff’s pain and suffering, violated the right to a jury trial as guaranteed under the Georgia Constitution.

The recent trend of states overturning constitutional malpractice caps is disturbing, especially in light of the effectiveness of these actions in curbing medical costs in the states. In Georgia, the 2005 liability law brought 1,000 more physicians to the state, decreased medical liability insurance costs by 18 percent and prevented premiums from increasing.

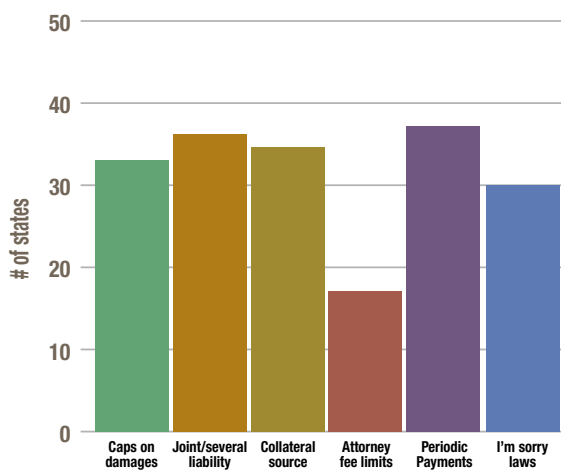
In Texas, the constitutional amendment limiting noneconomic damages to \$250,000 for physicians has been praised for improving access to care for patients, boosting the ranks of physicians and cutting liability insurance premiums. And on the federal level, a report released in October 2009 by the nonpartisan Congressional Budget Office estimated that liability reforms, especially damage caps, could save federal health care programs as much as \$41 billion over 10 years by curbing defensive medicine.

Unfortunately, there is little that can be done in terms of fighting these court decisions. The Illinois legislature is

working on a constitutional amendment that would prevent the state Supreme Court from striking down future reforms on medical malpractice passed by the General Assembly. Should this amendment be passed and approved by voters on Nov. 4, the legislature would almost certainly attempt to reinstate the overturned liability law. At press time, there is no word on what actions Georgia will take.

The American College of Cardiology, working with its state chapters, is committed to both promoting and defending effective liability reforms. On March 23 the Missouri Supreme Court ruled that damage caps on pain and suffering in medical malpractice awards cannot be applied retroactively.

State Liability Reforms



Source: State STATs, March 2010 Bulletin of the American College of Surgeons

The court’s ruling provided a victory for those injured before the law took effect, and effectively avoided the broader issue of whether lawsuit limits are a violation of other constitutional rights. The College also is awaiting a Kansas high court ruling on the \$250,000 noneconomic damage cap in all personal injury cases, including medical liability actions.

For more information on ACC efforts related to medical liability reform contact grassroots@acc.org.

FDA Update: Clopidogrel, Nitroglycerin and Zocor

The Food and Drug Administration (FDA) has notified health care professionals and patients that a Boxed Warning has been added to the prescribing information for Plavix (clopidogrel). For Plavix to work, enzymes in the liver (particularly CYP2C19) must metabolize the drug to its active form. In patients who are poor metabolizers of the drug, Plavix has less effect on platelets, and therefore less ability to prevent heart attack, stroke and cardiovascular death. According to the FDA, it is estimated that 2 to 14 percent of the population are poor metabolizers; the rate varies based on racial background. The Boxed Warning in the drug label will include information to:

- Warn about reduced effectiveness in patients who are poor metabolizers of Plavix. Poor metabolizers do not effectively convert Plavix to its active form in the body.
- Inform health care professionals that tests are available to identify genetic differences in CYP2C19 function.
- Advise health care professionals to consider use of other anti-platelet medications or alternative dosing strategies for Plavix in patients identified as poor metabolizers.

It would be irresponsible of the ACC to officially endorse a particular treatment strategy or offer other guidance on clopidogrel at this time, given the lack of definitive data. Randomized clinical trials are underway that will help address the change in treatment issue based on platelet response to clopidogrel, and we await these important results. The College's clinical documents team is examining the issue to determine how appropriately to address it.

In other FDA news, the agency has ordered Glenmark Generics of Mahwah, N.J., and Konec Inc. of Tucson, Ariz., to stop marketing unapproved nitroglycerin tablets. The FDA does not anticipate a supply problem for these products, nor does the agency anticipate a change in pricing. Pfizer Inc. markets FDA-approved sublingual nitroglycerin tablets in the same strengths and is able to supply the market with approved products. In addition, the FDA has notified health care professionals and patients of an increased risk of muscle injury in patients taking the highest approved dose of the cholesterol-lowering medication, Zocor (simvastatin) 80 mg, compared to patients taking lower doses of simvastatin and possibly other drugs in the "statin" class. For more information, go to www.fda.gov.

Pens with a Purpose

The ACC has partnered with the Texas Medical Association (TMA) on a petition drive to fight the flawed SGR and preserve patient access. The College was the first specialty society to partner with the TMA on this critical campaign. During one of the seven rallies held Monday across Texas to launch the campaign, TMA President William H. Fleming III, M.D., said: "We need more than Band-Aids. We need more than sutures. We need a complete transplant. This is all about Medicare patients' access to physicians' care. Congress created this problem, and only Congress can fix it." The goal of the campaign is to gather one million signatures from health care providers and their patients and share them with Congress and the president. To sign the online petition, go to: www.meandmydoctor.com.



Bet on Evolving Models of Cardiovascular Practice Symposium

This June, join the ACC in Las Vegas for the tools and real-world experiences you need to make better and smarter decisions regarding the hospital or health system integration process.

The Evolving Models of Cardiovascular Practice Symposium, which will take place June 3 - 4 at The Venetian Hotel, will explore the ins and outs of several integration models from the perspectives of legal, governance and integration experts as well as experienced managing physicians and practice administrators. Register today at www.acc.org/practiceopportunities.



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Patient Safety in Medical Imaging Getting Increased Attention

Nuclear imaging procedures have led to improvements in the diagnosis and treatment of numerous medical conditions, including heart disease. At the same time, these types of exams expose patients to ionizing radiation. In addition, radiation generated by fluoroscopic procedures has increasing relevance for the cardiovascular community as catheter ablation is used more frequently for the treatment of atrial fibrillation.

The U.S. Food and Drug Administration (FDA) and Congress increasingly are taking interest in the radiation issue as a matter of patient safety. The FDA is undertaking a new initiative focused on medical radiation exposure, while the House Energy and Commerce Subcommittee on Health held a hearing on therapeutic radiation earlier this year. While therapeutic radiation is not directly of concern to the cardiovascular community, it is likely that any policies considered by the Health Subcommittee to address safety could affect diagnostic imaging as well.

For example, during the House hearing, one option under consideration was legislation introduced in 2009 that would set minimum certification standards for individuals who perform the technical component of medical imaging or radiation therapy services. The “Consistency, Accuracy, Responsibility, and Excellence in Medical Imaging and Radiation Therapy (CARE) Act” excludes physicians, nurse practitioners and physician assistants from the certification requirements.

The American College of Cardiology is a long-time advocate for patient safety. The ACC has worked with the American College of Radiology and other specialties to develop training programs and requirements, appropriate use criteria (AUC), guidelines, and other quality-improvement tools that eliminate unnecessary procedures and make sure patients are receiving the most appropriate — and safest — treatment possible.

The ACC is working closely with the FDA to ensure that its new initiative reflects the efforts in which the College is engaged. In addition, the College continues to monitor congressional actions and ensure that patients are able to receive the highest quality of care based on science and practice experience, while effectively balancing the use of health care resources and patient safety.

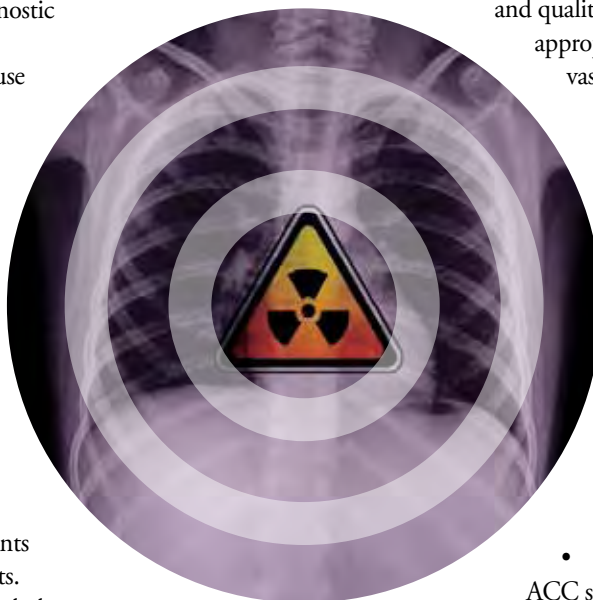
The following ACC activities also focus explicitly on reducing unnecessary patient medical radiation exposure:

- **Appropriate Use Decision Support Tools:** The ACC Foundation (ACCF) is establishing a partnership with a nationally recognized information technology vendor to provide an ACCF-branded cardiovascular imaging utilization review program to health plans, hospitals and physicians that will integrate computerized physician decision support with ACCF AUC education and quality improvement activities around appropriate patient selection for cardiovascular imaging.

- **Imaging in FOCUS:** FOCUS is a national quality improvement and innovation community designed to help imaging service providers best implement AUC at the point of care and ultimately reduce inappropriate imaging. FOCUS participants have access to AUC decision support tools, educational programs and self-assessment tools.

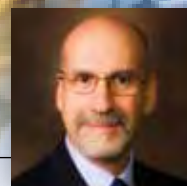
- **Imaging Accreditation:** The ACC supports mandatory imaging laboratory accreditation programs developed by physicians and other health care providers as a tool to ensure the quality and safety of imaging services. The ACC is a sponsoring organization of the Intersocietal Accreditation Commission (IAC), whose programs examine three key components of any imaging laboratory: the safety and accuracy of the imaging equipment, the training of the imaging technologists, and the training/certification/experience of the supervising and/or interpreting physician(s).

For more on the FDA's initiative go to: www.fda.gov/Radiation-EmittingProducts/RadiationSafety/RadiationDoseReduction/ucm199904.htm. For more on the ACC's AUC efforts, go to: www.acc.org/focus.



ICD Registry™ Expands to Include ‘Leads and Peds’

By Mark S. Kremers, M.D., F.A.C.C.



In January 2005 the Centers for Medicare and Medicaid Services (CMS) mandated that a national registry be formed to compile data on Medicare patients implanted with primary prevention implantable cardioverter defibrillators (ICDs). The Heart Rhythm Society (HRS) and the ACC Foundation (ACCF) partnered to develop Version 1 of the ICD Registry™

These Premier Centers enroll about 88 percent of the total number of implants tracked by the registry, and thus the data set is broad-based and representative of the larger clinical spectrum of ICD implants beyond just primary prevention in older patients. As such, the registry provides insights into this clinical arena that were previously impossible. The data collection also fosters use of

(PACES) approached the registry with the request that the registry be expanded to include data elements specific to the pediatric population. The Food and Drug Administration (FDA) recognized the potential value of the registry as a powerful tool to track implanted lead technology. Thus Version 2 includes a new section on leads used in ICD systems.

Version 1 of the ICD Registry has successfully fulfilled its initial mandate and its utility has extended beyond its inaugural vision. Nonetheless the ACCF and its partners recognized that there were omissions in the original data set. Development of Version 2.0 has been underway over the past 18 months to correct these oversights, clarify some data issues and delete some rarely used data elements.

under the auspices of the National Cardiovascular Data Registry (NCDR®). The registry began enrolling patients in 2006, and by April of that year, the NCDR ICD Registry became the sole repository of ICD implant data on Medicare recipients.

As of this writing, Version 1 of the ICD Registry had accrued over 500,000 records and was adding about 10,000 implants a month. About 77 percent of the 1,400-plus centers implanting ICDs in the U.S. have chosen to enroll all of their ICD implants, not just Medicare primary prevention cases.

the ICD Registry as a quality tool for benchmarking outcomes on both a local and national basis.

Version 1 of the ICD Registry has successfully fulfilled its initial mandate and its utility has extended beyond its inaugural vision. Nonetheless the ACCF and its partners recognized that there were omissions in the original data set. Development of Version 2.0 has been underway over the past 18 months to correct these oversights, clarify some data issues and delete some rarely used data elements. In addition, the Pediatric and Congenital Electrophysiology Society

Pediatric ICD implantations are estimated to constitute less than 1 percent of the volume of total ICD implantations. Thus far, with no provision in ICD Registry Version 1 for specific data elements appropriate for a pediatric population, implants in individuals less than 18 years of age have numbered less than 800 of the more than 500,000 implants tracked in the registry. This small number likely not only reflects the inadequacy of Version 1 for appropriately characterizing the pediatric patient but also suggests the potential value of the ICD Registry to this patient population. Experimental data in this patient population is sparse. The ICD Registry, while not a clinical study with a control arm and strict inclusion and exclusion criteria, still will yield important information. The large numbers of patients accrued can give a real world insight into clinical issues. As ICDs were developed for and validated in adult populations, the information derived from Version 2 of the ICD



Sustain the Gain

Special Sessions Address Gains, New Goals of Door-to-Balloon Initiative

Registry will provide valuable insights into the risk and benefits of this therapy in the unique pediatric population.

In the hopes of improving post-market lead surveillance, the FDA has assisted the ICD Registry with the addition of data elements to Version 2.0 to allow assessment of lead performance. In centers enrolling all patients, every lead used in ICD systems will be tracked at implantation, revision, removal or abandonment. Placement issues, functionality and structural integrity will be assessed at all ICD surgical procedures even if the leads are not manipulated. In Version 1, implantation of an ICD generator triggered entry into the registry. Now however, lead-only procedures also will be tracked and a second, shorter data form has been developed to address these procedures. Version 1 of the registry is mostly focused on the patient and procedure. Very little data is actually acquired about the ICD itself and product performance is not a significant focus. The inclusion of lead data will therefore broaden the focus of the registry to include product performance as a major outcome.

Version 2 of the ICD Registry is now live. Like Version 1, implementation of Version 2 likely will expose some imperfections in the data set and room to improve the registry still further. The opportunity to learn from ongoing clinical experience and improve the quality of care for ICD recipients, however, has never looked so promising.

Kremers is with MidCarolina Cardiology in Charlotte, N.C., and is a member of the NCDR ICD Registry Version 2.0 Working Group and the NCDR ICD Registry Steering Committee.

Since its launch in 2006, the ACC's D2B: An Alliance for Quality™ campaign has made great strides in helping hospitals reduce their door-to-balloon (D2B) times to meet the guideline-recommended time of 90 minutes or less.

To date, more than 1,000 hospitals across the U.S. and internationally are taking advantage of the D2B Alliance's six evidence-based strategies, supporting tools and online community to sustain the gains made in reducing D2B times. Two sessions during ACC.10 highlighted these gains, as well as addressed the next phase of the campaign, which involves the challenging task of spreading the systems approach to ST-elevation myocardial infarction (STEMI) care.

The first session — the D2B Sustain the Gain: Treatment Symposium — addressed STEMI benchmarks, length of primary PCI transfer, cooling systems for cardiac arrest and integrating new therapies. The second session covered false activation, cost-effectiveness of regional STEMI systems, EMS and catheterization lab collaboration, inter-hospital transfer systems and implementation of STEMI systems throughout ACC chapters. (More information on these sessions is available at www.D2BAlliance.org.)

Also during ACC.10, participants in the "This Is a Drill: Simulation Education Exercise to Test Teamwork and Leadership Skills in an Acute STEMI Door-to-Door Scenario" learned D2B success is all about the strengths or missed opportunities in communication. During this unique exercise, 10 cardiovascular professionals role-played from emergency department triage through catheterization using an endovascular simulator.

"With the use of video and the debriefing, this is where the learning really takes place when health professionals can see the dynamics of their interactions and how critical information is getting missed," said session chair **William R. Hamman, M.D., Ph.D.**, director of medical simulation and research, William Beaumont Hospitals, Royal Oak, Mich.

Participant **Don Ziperman, M.D., F.A.C.C.**, an interventional cardiologist at Community Hospital East in Indianapolis, who performed the simulated placement of a stent, said that hopefully the audience learned the necessity of having organization in triage, the ER and the cath lab. "[The] simulation also showed that there are some curves and you have to think on your feet while you are working," he said.



Cardiovascular Practice Recognition Program

The ACC is piloting a practice-level assessment and recognition program designed specifically to identify quality in cardiovascular practice. The College intends to offer this “Cardiovascular Practice Recognition Program” (CVRP) as a method for cardiovascular practitioners and health care purchasers to understand and evaluate quality cardiovascular care.

The CVRP will establish legitimate goals and targets for cardiovascular specialists and their practices to achieve in their professional development, clinical processes and operational infrastructure. In addition, it will provide a road map to guide performance improvement and practice transformation strategies, and bring consistency to market by standardizing the methodology for how cardiovascular practices are assessed and recognized.

The CVRP is intended as an evolving program that will change over time to encourage innovation, stimulate improvement and raise the bar for quality cardiovascular care. In the pilot phase of the CVRP, data will be collected, submitted and assessed at the practice level, the patient level and the individual cardiologist level. The intent is to gather enough data to validate

the meaningfulness of the metrics and criteria, determine scoring strategies, set thresholds and assign three levels of recognition. Any flaws in the design and procedures will be identified and addressed prior to full-scale launch.

Practices participating in the pilot are representative of a variety of cardiology practices today: small, medium, large; urban, rural, suburban; academic, hospital-based, private; with and without electronic medical records; etc. Pilot results will headline the Medical Directors’ Institute (MDI) Strategy Roundtable on June 29.

The practice-level assessment is intended to evaluate:

- Use of a Certification Commission for Healthcare Information Technology-approved electronic medical record
- Use of an electronic prescribing system

- Use of a patient satisfaction survey
- Use of accredited labs for noninvasive diagnostic imaging, echo and nuclear
- Successful participation in the 2007 and 2008 CMS Physician Quality Reporting Initiative (PQRI)
- Active participation in a nationally recognized CathPCI registry
- Active participation in a nationally recognized ICD registry

The patient-level assessment is intended to evaluate adherence to clinical performance measures provided for physicians by the ACC, the American Heart Association (AHA), and the Physician Consortium for Performance Improvement (PCPI) for Coronary Artery Disease, Hypertension, Heart Failure, and Atrial Fibrillation and Atrial Flutter.

The individual physician assessment is intended to evaluate each cardiologist in the practice as applicable:

- Current Cardiovascular Board (ABIM or ABP) Certification
- Current Cardiovascular Subspecialty Board (ABIM) Certification: EP
- Current Cardiovascular Subspecialty Board (ABIM) Certification: Intervention

- Current participation in Maintenance of Board Certification
- Current FACC or FAHA Designation
- Current Cardiovascular Subspecialty Designation
- Current Cardiovascular Subspecialty Certification
- Documentation of Continuing Medical Education
- Documentation of participation in interactive, online educational activities that focus on quality improvement or performance improvement

Practices that have signed the CVRP Pilot Practice Agreement to date are:

- W. Spencer Tilley Jr. M.D., F.A.C.C.; Greensboro, N.C.
- Premier Heart Care; San Luis Obispo, Calif.
- Emad Khaleeli, M.D. Inc; Torrance, Calif.
- Cardiac Electrophysiology Institute; Los Angeles
- Frist Cardiology; Nashville, Tenn.
- Pinehurst Cardiology Consultants PLLC; Pinehurst, N.C.
- Tennessee Heart, PLLC; Cookeville, Tenn.
- Heart & Vascular Center of Arizona; Phoenix
- Cardiovascular Associates; Elk Grove Village, Ill.
- The Heart Center; Poughkeepsie, N.Y.
- Cooper University Hospital; Camden, N.J.
- Illinois Heart and Vascular; Hinsdale, Ill.
- Henry Ford Heart & Vascular Institute; Detroit

Work on the CVRP began in June 2007 under the direction of the Performance Assessment, Recognition, Reward and Reporting Task Force. The task force and the CVRP work group were formed to ensure collaboration with cardiology subspecialty societies in the development and implementation of value-based purchasing initiatives and products within the College. Currently, the Clinical Quality Committee provides oversight and direction for the CVRP through its Partners in Quality Subcommittee.

Comments Highlight Concerns with New Federal Health IT Program

Over the last year, the ACC has been working with the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) to provide feedback on the new federal electronic health record (EHR) program that will provide physicians who demonstrate “meaningful use” of EHRs with annual payment incentives starting in 2011 and ending in 2015.

Most recently, the College has been focused on providing input about what constitutes “meaningful use.” In comments sent in early March to CMS and ONC on two separate rules related to implementation of the incentive program, the ACC highlighted the high costs of participation and the “exceedingly difficult and complex requirements” that likely will exclude a large number of eligible physicians from participating.

According to the letter, “the overall complexity of the regulation, the large number of physicians excluded from participating in the program, the failure to understand the current level of technology integration into physician practices even among those who are using EHR solutions, and the sea change of clinical, workflow, and administrative disruptions required to achieve the proposed meaningful use of EHR solutions will make it challenging, if not impossible, for physicians and hospitals to participate in the program as proposed.”

To address these issues, the letters go on to highlight a series of recommendations for improving the program, including extensive physician education around EHR adoption, reductions in administrative burdens, removal of components that would penalize physicians for failings of current EHR technology, and required use of decision-support tools. In addition, the letter urges “establishing a staged approach toward stringent requirements and measures to meet national health outcomes priorities” as the most effective method to ensuring widespread health IT adoption and improved patient care.

“The meaningful use bar should be high, but not so far high that it’s going to impede physicians from participating,” said Cathie Biga, CEO of Cardiovascular Management of Illinois, during a special session on this issue at ACC.10 in Atlanta. She echoed National Health IT Coordinator David Blumenthal’s statement during the ACC.10 Health IT Spotlight Session that the real issue is going to be interoperability. For more information on the EHR incentive program and the College’s latest comments, go to: www.acc.org/healthit.

“ The meaningful use bar should be high, but not so far high that it’s going to impede physicians from participating. ”

Cathie Biga, CEO of Cardiovascular Management of Illinois

Dynamic, Team-Based Program Tackles STEMI

By Christopher Granger, M.D., F.A.C.C., James Jollis, M.D., F.A.C.C., and Mayme Lou Roettig, R.N., M.S.N.

The 2009 ACC/American Heart Association Focused Update of the Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction (STEMI) added the development of regional systems of STEMI care as a Class I recommendation.

Emergency CV Care is designed to address the huge opportunity that exists in the U.S. to improve care for STEMI patients through better coordination and regional systems.

Emergency Cardiovascular Care 2010 is the educational program that can help you make the recommendation a reality.

The program takes place May 21 – 22 in Chicago and focuses on practical experience and solutions to the implementation of STEMI reperfusion systems.

Emergency CV Care is designed to address the huge opportunity that exists in the U.S. to improve care for STEMI patients through better coordination and regional systems.

Improved coordination begins at the earliest interaction with emergency medical services (EMS) and continues through transport, emergency department triage and reperfusion.

Emergency Cardiovascular Care brings together the entire team, from EMS

to nurse coordinators to emergency medicine, interventional cardiologists and hospital administrators. The faculty and participants represent a wide range of medical specialties. We interact in workshops and through case studies to build and refine systems to improve the proportion of eligible patients who

receive reperfusion therapy and the timeliness of the care delivered.

The format allows us to help individuals address their particular problems. There are so many opportunities to improve coordination, but they vary by patient, institution and region. For example, one participant may want to know the best way to transmit or interpret an electrocardiogram for a paramedic. There are many “best ways,” and the workshops allow that participant to work with the experts to identify the best solution for their situation. Attendees will get practical advice from other health care professionals who have experience in building reperfusion systems. For example, we will tell participants how to approach competing physician groups and build consensus regarding a uniform treatment approach.

We'll also talk about lessons and resources available through Mission Lifeline, as well as the ACC's Door-to-Balloon (D2B): Sustain the Gain program, that can be applied across the board.

There will be plenty of information for those just beginning to develop regional systems, but repeat

attendees will find many new developments and exciting additions to the program. Representatives from already-progressive STEMI systems will not be disappointed.

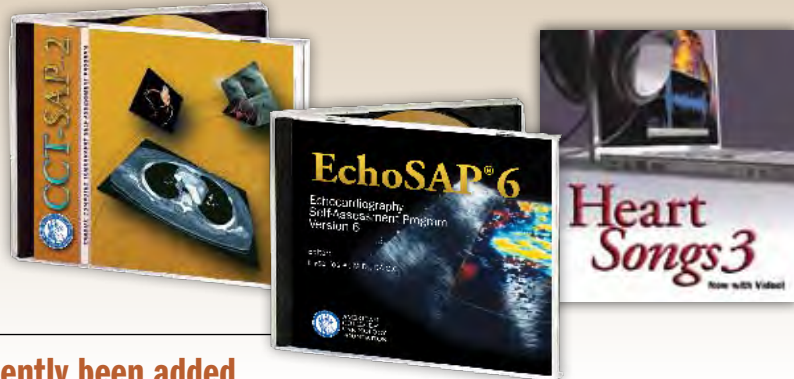
New this year will be poster sessions to encourage interactivity and present new and interesting data. We will explore regional management of cardiac arrest and some of the exciting new data that exist on that topic. A leader from the U.S. Department of Health and Human Services will talk about regional organization of emergency care as a priority for improving health care systems, and **Ralph Brindis, M.D., M.P.H., F.A.C.C.**, ACC president, will discuss the potential for STEMI systems to reduce health care costs.

In an exciting new session, **Cindy Grines, M.D., F.A.C.C.**, a pioneer of primary PCI, will singlehandedly take on yours truly, the program co-directors, in a debate on whether primary PCI is the right approach for every patient.

It has been most gratifying for us to hear from past attendees that this program has changed the care of STEMI patients in their communities. As cardiovascular practitioners and as educators, improving care for patients is our ultimate goal. We hope you will be a part of this remarkable event in 2010. We look forward to welcoming you to Chicago!

Granger is professor of medicine and director of the Cardiac Care Unit at Duke University Medical Center. He is a member of the ACC/AHA STEMI Guideline Writing Committee. Jollis is professor of medicine and radiology at Duke University Medical Center and chair of the D2B: Sustain the Gain Work Group. Roettig is Executive Director of Reperfusion in AMI in Carolina Emergency Departments (RACE). Granger, Jollis and Roettig are co-directors of Emergency Cardiovascular Care 2010.





New Educational Products

Three new educational products have recently been added to the ACC Foundation's (ACCF) suite of educational offerings, including CCT-SAP®2, EchoSAP®6 and Heart Songs 3 – which made its debut at ACC.10.

Cardiac Computed Tomography Self-Assessment Program Version 2

The latest edition of CCT-SAP incorporates a wide variety of clinical and technological updates. “The original CCT-SAP was done back in 2006, so the technology has vastly expanded in terms of what we know clinically and what the technical components are,” says **Allen Taylor, M.D., F.A.C.C.**, editor of CCT-SAP 2. “This product is now a tour de force of the latest and greatest that cardiac CT can offer.”



CCT-SAP 2 includes 17 new case studies designed to illustrate the didactic material with practical examples. It also incorporates updates to the interface, making it easier and more intuitive to use.

Taylor recommends CCT-SAP 2 for a wide range of professionals, from fellows undergoing a CT rotation to active practitioners who want an up-to-date review on the complete field. “Having worked on, written and read textbooks on this topic, CCT-SAP 2 rivals or exceeds the quality of any current textbook in the field,” Taylor says. “It’s current to the minute, it’s written by authoritative figures and it covers the full expanse of cardiovascular computed tomography. I learned a lot editing it.” For beginners, he recommends completing CCT-SAP 2 and then attending the ACCF/Society of Cardiovascular Computed Tomography Coronary CTA Practicum.

Echocardiography Self-Assessment Program Version 6

New echocardiographic technologies have emerged and become more widely available over the past decade, and EchoSAP 6 is designed to help you hone your skills in this evolving imaging modality. EchoSAP 6 lets you experience a comprehensive overview of the field in ways that appeal to different learning styles. A didactic syllabus provides an overview of echocardiography, including new sections on advanced and emerging technologies in the field, such as tissue-Doppler, strain and 3-D echo. Eighty image-rich case studies allow you to apply what you’ve learned. These case

studies are organized by disease category and address varying levels of expertise, including basic and advanced.

EchoSAP 6 includes the 50 case studies that debuted in EchoSAP 5, but the quality of the images in the cases has been improved (videos are larger and in higher resolution). EchoSAP 6 also will include 30 brand new case studies on more advanced topics.

Heart Songs 3

Heart Songs 3 is designed for “anybody who listens to patients with a stethoscope and wants to understand what they’re hearing,” says **Michael Barrett, M.D., F.A.C.C.**, editor of the popular auscultation program. “From entry-level med students to cardiovascular fellows and even cardiovascular educators, this product is ideal for a wide range of learners.”



Like its predecessors, Heart Songs 3 is based on psychoacoustic research that has shown intensive repetition of sounds to be key to producing a significant improvement in cardiac auscultation in a relatively short time. The latest version includes video, allowing users to listen to a murmur while examining images of phonocardiograms, CT scans and even video of color Doppler echocardiograms. “We added video because so many of our users are using iPods and iPhones, all of which feature video,” Barrett says. “A lot of people are visual learners so this made sense.” Heart Songs 3 also is available online and is easily downloadable to mobile devices.

The product made its debut at ACC.10 in the Heart Songs Learning Lab at the Exposition, where Barrett says more than 600 attendees enjoyed three Heart Songs programs: basic, advanced and basic echo. Barrett says many attendees came back each day to complete another program. Next year, he says, the Heart Songs editors hope to allow users to take a Heart Songs test on the iPod Touch as part of the program.

To learn more or to order, go to www.acc.org/products or contact the Resource Center at (800) 253-4636, ext. 5603.

FITs Go Head-to-Head at ACC.10

ACC Fellows in Training (FIT) came together on the final day of ACC.10 for a unique interactive presentation intended to serve as preparation for the cardiology boards. In the first-ever “FIT Case Bowl,” teams from Emory University, Cedars-Sinai Medical Center and Walter Reed Army Medical Center competed against each other in a series of peer-led questions.

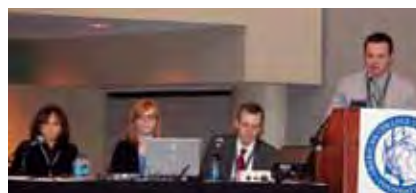
Three FITs who had recently passed their boards presented the questions: **Andrew Freedman, M.D.**, of National Jewish Medical Research Center in Denver, **Carolyn Lacey, M.D.**, of Travis Air Force Base in Fairfield, Calif.; and **Jason Palermo, M.D.**, of Beebe Medical Center in Lewes, Del. The questions were intended to mirror questions that the Case Bowl audience members might expect to see on their board exam. The teams took turns answering the questions and justifying their responses. The audience then locked in their answers by handheld voting device; any other questions were submitted via Twitter.

The structure of the session, which was moderated by ACC.10 Co-Chair **Michael Barrett, M.D., F.A.C.C.**, and **Sara Sirna, M.D., F.A.C.C.**, both of Temple University in Philadelphia, allowed for real-time feedback to the audience. If the audience answers were split between two or more answer choices, the presenters could explain in greater detail which answer was correct. Meanwhile, Barrett and Sirna watched the answers for any overall trends that needed to be addressed to improve the



Sara Sirna, M.D., F.A.C.C., and Michael Barrett, M.D., F.A.C.C., present certificates to Jeffrey Kunz, M.D., and Salvatore Carbonaro, M.D., winners of the FIT Case Bowl.

“ Through the Case Bowl, they were able to answer board-like practice questions written by peers who had recently taken and passed their boards. It’s a wonderful learning opportunity that is intended to engage with the audience in real time. ” **Michael Barrett, M.D., F.A.C.C.**,



The questioners.



The contestants.

audience’s understanding of the content.

“The Case Bowl was designed to get FITs engaged in beginning to study for their boards,” Barrett said. “Through the Case Bowl, they were able to answer board-like practice questions written by peers who had recently taken and passed their boards. It’s a wonderful learning opportunity that is intended to engage with the audience in real time.”

Although the scores were close, the contestants from Walter Reed Army Medical Center, **Salvatore Carbonaro, M.D.**, and **Jeffrey Kunz, M.D.** were the winners of the FIT Case Bowl. In addition to Carbonaro and Kunz, FIT

Case Bowl participants were:

- **Shervin Eshaghian, M.D.**, Cedars-Sinai Medical Center
- **Raza Orakzai, M.D.**, Cedars-Sinai Medical Center
- **Matthew Janik, M.D.**, Emory University
- **Ryan Jordan, M.D.**, Emory University

For more information on ACC’s FIT resources, including educational products and programs designed to help with cardiology boards, visit: www.acc.org/membership/Fellows/index.htm.



First Doctor of Pharmacy Named FACC

At the 59th Annual Convocation in March, Rhonda Cooper-DeHoff, Pharm.D., M.S., became the first doctor of pharmacy to be inducted as a Fellow of the American College of Cardiology.

Dr. Cooper-DeHoff is an associate professor in the Department of Pharmacotherapy and Translational Research, College of Pharmacy and Division of Cardiovascular Medicine, College of Medicine at the University of Florida in Gainesville, Fla. She earned her Pharm.D. degree from the University of California at San Francisco, School of Pharmacy in 1986 and completed a clinical residency there in 1987. In 2007, she graduated from the University of Florida with a master's degree in medical sciences, with an emphasis in clinical investigation.

Dr. Cooper-DeHoff's research interests include hypertension, metabolic syndrome and diabetes, and she is the principal investigator for the National Institutes of Health (NIH)-funded Career Development Award entitled "Metabolic Effects of Antihypertensive Drugs." She also was an investigator of the International Verapamil Trandolapril Study (INVEST), which evaluated hypertension treatments in elderly coronary artery disease patients, and she is a co-investigator on two NIH grants evaluating pharmacogenetic associations in hypertension. She presented results from INVEST in a Late-Breaking Clinical Trial session at ACC.10.

Cardiology caught up with Dr. Cooper-DeHoff to find out more about her career and this latest exciting achievement.

Cardiology: What do you count among the highlights of your career?

RCD: I think one of the true highlights of my career is having my research accepted for presentation in the Late-Breaking Clinical Trial category at the ACC.10 Scientific Session. This is truly an honor for me to have my research highlighted in this way.

Cardiology: Why is it so important for clinical pharmacists to be involved in the care of cardiovascular patients?

RCD: I believe clinical pharmacists with expertise in cardiovascular disease play a very important role in the overall care of patients with heart disease. They oversee medication therapy in the acute care and outpatient settings, which ensures correct use of drugs and doses, and educate members of the health care

team and patients regarding appropriate use of often complex medication regimens, actions which help to maximize favorable outcomes for our patients.

Cardiology: What does it mean to you to become a Fellow of the American College of Cardiology?

RCD: Becoming a Fellow of the American College of Cardiology is truly an honor. It means that my contribution to the scientific literature and to the care of cardiovascular patients has been recognized at the highest level, by the supreme cardiovascular organization.

CCA Member Get a Member Campaign

You can make a difference in a colleague's professional advancement and help provide the College's many resources to improve patient care at the same time. Refer a colleague for Cardiac Care Associate membership today!

By referring a colleague for ACC Cardiac Care Associate membership, you share clinical education, networking and leadership opportunities. Through the College's publications, Web sites and programs, you offer the latest cardiovascular care guidelines and patient education resources. The College values Cardiac Care Associates and their personal contact with cardiovascular patients as a vital part of the success of the cardiovascular team.

For every new member you refer to the ACC, you'll earn \$20 in discounts to put toward ACC educational products and programs. The College also will recognize top recruiters each month in *Cardiology* magazine and the Cardiovascular Team Section e-newsletter.

In addition, top recruits are eligible to win one of our three grand prizes:

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

Referrals should be sent to Kelli Bohannon at kbohanno@acc.org. Recruiters also may visit www.acc.org/ccarecruitment to find full program rules, recruitment tips, an application and lists of who is bringing cardiac care team members to the College.



CARDIOVASCULAR TEAM
American College of Cardiology • Member Section



Essentials of Cardiovascular Care in Older Adults (ECCOA): A Web-Based Curriculum for Fellows in Training

By Karen P. Alexander, M.D., F.A.C.C.; Susan J. Zieman, M.D., Ph.D., F.A.C.C.; and John G. Harold, M.D., M.A.C.C.

Each day we are reminded of the “Graying of America” and its implications for the future of health care. Current cardiovascular trainees will spend their careers caring for a progressively older patient base. Geriatric specialists, already in short supply, are being trained in insufficient numbers to assume the bulk of this

to older adults. Furthermore, the Accreditation Council for Graduate Medical Education (ACGME) specifically mandates that “cardiovascular trainees should gain general knowledge in geriatrics, with a familiarity with the effects of aging on cardiovascular disease and therapy . . . Programs should provide training in geriatrics to teach an under-

standing of changing demographics, alterations in clinical pharmacology, medication adherence, and issues of care considering multiple organ systems.” Cardiologists, Fellows in Training (FITs) and geriatricians have collaborated to develop and implement a new learning tool, Essentials of Cardiovascular Care in Older Adults (ECCOA), to meet those training needs.

While we all care for older adults, the extent to which we are truly equipped to optimize their cardiovascular outcomes is less clear. This begs the question of what is unique about this cohort? Consider that only 15 percent of Americans are aged 65 years or older, yet this age group comprises at least 60 percent of hospital admission for cardiovascular events. Moreover, over 80 percent of cardiac deaths occur in this cohort, underscoring their vulnerability and propensity for worse outcomes. Parallel to pediatric cardiology, significant age-related changes in cardiovascular physiology and drug metabolism contribute to their vulnerability. This is in addition to multimorbidity, polypharmacy, and altered disease presentation. The question remains, do we currently teach these complex issues in cardiology training programs? To answer this question, cardiovascular training program directors were surveyed to understand their perspectives on the current state of geriatric cardiology education. The vast majority agreed that cardiovascular training programs should include content in geriatric cardiology, while also stating that the current curriculum at their institutions was informal or did not exist.

ECCOA is an innovative curriculum that provides cardiology fellows with the tools they need to provide optimal care for older adults.

Consider that only 15 percent of Americans are aged 65 years or older, yet this age group comprises at least 60 percent of hospital admission for cardiovascular events. Moreover, over 80 percent of cardiac deaths occur in this cohort, underscoring their vulnerability and propensity for worse outcomes.

care. Rather, cardiovascular specialists will be in the forefront as heart disease remains, by far, the most common cause of morbidity and mortality in the older population. Skills needed to optimally care for this population are important for all providers to obtain. In recognition of this paradigm shift, the Institute of Medicine’s report, “Retooling for an Aging America” encourages all health care providers to equip themselves with the essential data, knowledge and tools to provide high-quality care

standing of changing demographics, alterations in clinical pharmacology, medication adherence, and issues of care considering multiple organ systems.” Cardiologists, Fellows in Training (FITs) and geriatricians have collaborated to develop and implement a new learning tool, Essentials of Cardiovascular Care in Older Adults (ECCOA), to meet those training needs.

While we all care for older adults, the extent to which we are truly equipped to optimize their cardiovas-

This Web-based curriculum for cardiology fellows and their teachers is funded by the John A. Hartford Foundation and is dedicated to improving health care for older Americans. The program uses case-based and interactive learning modules to improve knowledge, skills and confidence in providing optimal specialized care for older adults. ECCOA was developed in response to national mandates to improve the understanding and care of older adults put forth in ACGME post-graduate training guidelines and Cardiology Fellowship Guidelines. ECCOA was launched at ACC.09 in Orlando with the following goals:

- Raise awareness of age-specific changes and how they impact disease assessment and management.
- Appreciate evidence-based care of older adults.
- Identify and pursue gaps in our knowledge.
- Stimulate research efforts to fill the gap.
- Reduce morbidity and mortality through judicious and individualized care.

Through a case-based, interactive learning experience, ECCOA strives to deliver essential principles of aging physiology, pharmacology and geriatric syndromes, as well as specific aspects of cardiovascular syndromes in older adults. ECCOA was carefully designed to focus on aspects of cardiology where

age is relevant, and does not attempt to be a general review. The case-based format revolves around patient-centered application of guideline-based care. After an introduction and pretest, learners navigate among four core modules (Physiology, Pharmacology, Geriatric Care and Decision Making) and then proceed to 10 cardiovascular disease-based modules.

FITs have free access to ECCOA as part of the American College of Cardiology 'In-Service' modules (ACCIS) through www.cardiosource.com under products and ACC-in service. You must be logged into Cardiosource Plus to use the ACCIS program. All

Center for additional information.

Feedback from ECCOA users has been overwhelmingly positive. The case-based approach was particularly well-received, as it made the information relevant to clinical practice and the learning interactive. One fellow said, "The entire curriculum was a different approach to learning." Another fellow commented, "I think we all feel that we 'know' what to do for older adults, but when presented with actual cases, the areas of uncertainty are really highlighted." ECCOA is part of an overarching educational strategy at the ACC that embraces a motto of lifelong learning, implemented by

FITs have free access to ECCOA as part of the American College of Cardiology 'In-Service' modules (ACCIS) through www.cardiosource.com under products and ACC-in service.



ACC members, including FITs, have Cardiosource accounts. If you do not know your username and password, please contact the Resource Center at (800) 253-4636, ext. 5603. The ACCIS program was specifically designed for training programs to serve as a standard, in-service core testing and educational resource throughout residency and cardiology fellowship years. ACCIS includes tools to track ACGME outcomes and medical knowledge competency requirements. Because of the Hartford Grant (www.jhartfound.org/index.htm), all cardiology fellowship training programs currently have access to ACCIS regardless of whether their institutions have purchased the full Cardiosource Plus package. ECCOA also is available to geriatric training programs as long as those affiliated institutions have cardiology fellowship programs. Program Directors can contact the ACC Resource

the new learning portfolio. In addition, it is hoped that ECCOA may stimulate research interests in cardiovascular aging and disease outcomes. At a minimum, it will equip cardiology fellows with tools needed to better care for older adults. The ECCOA curriculum embraces ACC's major educational goal of developing e-learning opportunities. The College plans to develop more educational tools, portfolios and interactive references similar to ECCOA that will allow for self-assessment, self-direction and lifelong learning for cardiovascular professionals. See Alexander and Ziemann discuss ECCOA with ACC CEO Jack Lewin at www.cardiosource.com/accis_index.asp.

Alexander is a member of the Duke University Division of Cardiovascular Medicine faculty. Ziemann is a member of the Johns Hopkins Heart & Vascular Institute faculty. Harold is a member of the ACC Board of Trustees and an attending at the Cedars-Sinai Heart Institute.

Save the Date!

ACC's Legislative
Conference
2010

September 12-14

Fairmont Hotel
Washington, DC



JACC Having an 'Impact'

The JACC family of journals has had an exciting first quarter. *The Journal of the American College of Cardiology (JACC)* – *Cardiovascular Interventions* and *JACC – Cardiovascular Imaging* have been accepted by Thomson Scientific for inclusion in its Journal Citation Reports, from which an “impact factor” is calculated. The impact factor is a means of measuring the impact that articles in a given journal have had on the field by calculating an average number of citations per article. It is widely accepted



by academic institutions worldwide as a measure of the scientific excellence and prestige of a journal. We will be notified of the first Impact Factor for the new journals in June 2011, and that impact factor will be based on citations during 2010 to articles published during 2008 and 2009.

In addition, a paper by **Alberto Bouzas-Mosquera, M.D.**, et.al, “Prediction of Mortality by Exercise Echocardiography in Patients With Normal Exercise Echocardiographic Testing,” published in *JACC*, has been selected as the *Lancet* Paper of the Year. The editors of the *Lancet* said of the paper, “Improving prognostic accuracy for coronary artery disease has wide appeal to clinicians, patients, and those who organise and fund health services. Furthermore, the vast majority of cardiovascular deaths occur in low-income countries, so a low-technology, noninvasive, radiation-free, cost-effective investigation that can guide care is attractive.” Congratulations to Bouzas-Mosquera and his colleagues!



ACC, HRS Launch AFibProfessional.org

The ACC and the Heart Rhythm Society (HRS) have partnered on a new Web site, www.afibprofessional.org, to deliver specialized information for clinicians treating patients with atrial fibrillation (AF). The new site includes information from the HRS Practical Rate and Rhythm Management Pocket Guide with emphasis on patient outcomes and informed clinical decision making. Users also will find news, Cardiosource journal scans, Cardiosource Video News interviews with key opinion leaders, blogs, patient resources, editorials and more.

Edited by **Kenneth A. Ellenbogen, M.D., F.A.C.C.**, *AFibProfessional.org* is available free of charge to Cardiosource and HRSONline users. Go to www.afibprofessional.org to access this convenient resource for any clinician treating AF.

Register Today for Board Review

Whether you're preparing to take the American Board of Internal Medicine Board Exam for the first time or recertifying, the ACC Foundation Cardiovascular Board Review is designed to meet your needs. The course offers a comprehensive overview of current issues in cardiovascular medicine with four and a half days of study and interactive, simulated Board exams. Directors **Kim Eagle, M.D., F.A.C.C.**, and **Patrick O'Gara, M.D., F.A.C.C.**, and their renowned faculty will cover:

- General cardiology
- Coronary Artery Disease
- Risk factors
- Arrhythmias
- Basic CV pharmacology
- Cardiac testing
- Valvular heart disease
- ECHO and ECG interpretation with optional focused review sessions

Register today to attend the CV Board Review Aug. 31 – Sept. 4 in Chicago. Go to www.acc.org/education/programs.htm.

Don't Forget to Submit Your Medicare Enrollment Application

The Centers for Medicare and Medicaid Services (CMS) has made available a file that contains the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in Medicare's systems that contain an NPI). This file is downloadable by going to the Medicare provider/supplier enrollment Web site at www.cms.gov/MedicareProviderSupEnroll and clicking on "Ordering/Referring Report" on the left-hand side.

If you order or refer items or services for Medicare beneficiaries and are not on this list, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855I). If you reassign your Medicare benefits to a group or clinic, you also will

need to complete the CMS-855R. Medicare contractors are required to process 90 percent of the Internet-based applications they receive within 45 days of receipt, 95 percent within 60 days and 99 percent within 90 days. For more information on Internet-based PECOS, including step-by-step instructions on how to use PECOS I&A, visit www.cms.hhs.gov/MedicareProviderSupEnroll and select "Internet-based PECOS" from the navigation bar on the left side of your screen.

New Clinical Statements

The ACC Foundation and the American Heart Association (AHA) recently released a science advisory on Thiazolidinedione Drugs and Cardiovascular Risks, summarizing the data on thiazolidinediones and cardiovascular disease and offering practical recommendations for health care professionals seeking to reduce risks in patients with diabetes mellitus. To view the advisory, go to www.acc.org/qualityandscience/clinical/statements.htm. You also will find a new ACCF/AHA Scientific Statement on Prevention of Torsade de Pointes in Hospital Settings.

Member Dues

If you have not yet paid your membership dues for 2010, they are now past due. Visit www.acc.org/dues to pay today. Don't miss out on valuable membership benefits including access to the JACC journals, discounts on live events and self-assessment tools, access to the new CardioSource.org launching this summer, and much more!



Purchase Digital Library of ACC.10 & i2 Summit Sessions

Experience ACC.10 and i2 Summit with iScience 2010. iScience is a comprehensive digital library of presentations from the 59th Annual Scientific Session and i2 Summit, which includes more than 90 sessions totaling hundreds of hours of content. iScience features —

- Presenters' slides including full-motion video and live audio
- Key educational sessions including Late-Breaking Clinical Trials and highlights from all 11 learning pathways
- Sessions available online, on DVD and as MP3 files for listening to audio presentations on-the-go
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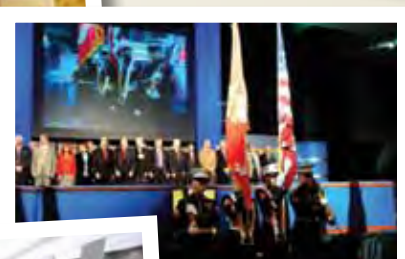
To learn more, go to www.sessions2view.com/acc_library.

We Have a Winner!

Congratulations to **Gwen Goldfarb**, executive director of the Ohio, Indiana and West Virginia Chapters of the ACC, and winner of our ACC.10 and i2 Summit Facebook photo contest. Goldfarb snapped the winning shot of Ohio Chapter members paying homage to their home state at the ACC.10 All-Chapter Reception on Sunday, March 14, in Atlanta. ACC fans on Facebook selected her photo as the winner out of dozens submitted. She will receive an Amazon Kindle™ loaded with a year's subscription to *Journal of the American College of Cardiology*.

Runners up in order of votes were:

- “Gladys Knight’s Chicken and Waffles in Downtown Atlanta,” submitted by **Nathaniel Boyer, M.D.**, of Albuquerque, N.M.
- “ACC 2010,” submitted by **David Hsi, M.D., F.A.C.C.**, of Rochester, N.Y.
- “Conference Center Hiking,” submitted by **Barton Schoenfeld, M.D., F.A.C.C.**, of Chatham Center, N.Y.



Need Science from ACC.10 & i2 Summit?

This year the ACC is launching a new product to allow members to experience ACC.10 and i2 Summit science. CME Conference Coverage offers summaries of the most relevant abstracts and late-breaking science from the ACC.10 General Cardiology Learning Pathway and i2 Summit. The summaries are available now, and beginning in May, you also can download expert analyses and recaps:

- **Capsule Summaries:** A summation of the key data from a single study, presented in a standardized format, including tables and study design schematics. The data are reported as presented at the meeting rather than from the published abstract so the most up-to-date data “from the podium” are provided.
- **Expert Analyses:** An in-depth analysis of key studies on a particular pathway by three opinion leaders, who meet as a panel to discuss and debate the clinical implications of each study.
- **Expert Recaps:** A multimedia CME activity consisting of downloadable slides summarizing key studies with streaming audio narration by a faculty member who is an expert in that specific pathway.

To learn more, go to www.cardiosource.com/acc10coverage.

Non-Invasive Cardiologist



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Forbes and Fortune Small Business Magazine rank Billings, Montana – the Best

Practice medicine in a city ranked as one of the **Best Small Places for Business and Careers** (Forbes, 2009) and the **Best Small City which to Start a Business** (Fortune Small Business Magazine, November 2009).

Non-Invasive Cardiology

Award winning St. Vincent Healthcare in Billings, MT, seeks well-trained compassionate physician for cardiology program. St. Vincent Healthcare was recently recognized by the American College of Cardiology Foundation with the NCDR ACTION Registry-GWTG Gold Performance Achievement Award for 2009 (one of only 121 hospitals nationwide).

As part of an aggressive Service Line expansion of Vascular Services, St. Vincent Healthcare is creating a Cardiovascular Center which will be responsible for nuclear studies, echo studies, holter studies, outreach and a heart failure center.

- Physician would be employed by St. Vincent Healthcare and be embedded in affiliated practice of Montana Heart Institute.
- Physician would be initially employed for two years and have opportunity to become partner at Montana Heart Institute.
- 4 day work week with one day of outreach per week.
- Excellent Salary structure.
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Find out more, email **Colleen Martin** at colleen.martin@svh-mt.org or call 406-237-4003.



POST DOC RESEARCHER FOR HUMAN CARDIOVASCULAR PHYSIOLOGY LABORATORY

Cedars-Sinai Medical Center, one of the nation's premier healthcare institutions, continues to expand our Heart Institute Investigative team. We are currently looking to fill a funded, two-year research fellowship starting July 2010. This individual will join a growing program focused on human cardiovascular physiology, with a special emphasis on vascular regulation and cardiomyopathy in patients with muscular dystrophy under the supervision of Dr. Ronald Victor. The individual will have the opportunity to apply for career development awards. Significant opportunities for publication will be available.

The ideal candidate has earned an MD from an accredited medical school and is looking for further training in human cardiovascular research. Prior training in cardiology is preferred. Applicants must be board eligible in Internal Medicine and will need to have a CA medical license.

Cedars-Sinai Medical Center, a state-of-the-art, 952 bed, tertiary acute care academic medical center is committed to excellence in compassionate patient care, research, and community programs to improve the lives of our patients.

If you are interested in this outstanding opportunity and want to join a world class cardiovascular research program, please apply on-line to requisition number 3318 at: <https://www.cedars-sinaiclinicalandacademicjobs.com>

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THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON
MEDICAL SCHOOL

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.

Cardiology opening in Beautiful East Tennessee

Come enjoy the beautiful scenery and a wonderful family friendly area near the Great Smoky Mountains National Park!

You'll practice general and invasive cardiology with Mercy Health Partners in a busy cardiology practice in Jefferson City, TN, only 30 minutes from Knoxville. Our practice currently has one invasive cardiologist and one nurse practitioner.

New physician will provide clinical outpatient services and inpatient consultations at the new 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. This is a salaried position with incentive compensation, excellent benefits, mal practice, CME allowance, and morning/afternoon/evening rotations.

Jefferson City sits in the foothills of the Great Smoky Mountains where many people come to enjoy the beauty, quality of life, and year round fishing. With nice parks, lakes and many great recreational opportunities are abundant. Just 30 minutes away is Knoxville, which is known as the heart of the Upcountry of Tennessee, including South Eastern Conference sports arenas and professional theatre, opera, art museums and an excellent symphony orchestra. It is a wonderful area to work and family living.

Debbie Corbett, Karen McKinney, Regional Director, Physician Recruitment
Mercy Health Partners, Tennessee Region
Phone: (865) 248-4528 Fax: (865) 248-4528
Email: karen.mckinney@mercy.com

The University of Texas Health Science Center at Houston/Memorial Hermann Heart and Vascular Institute is seeking individuals to expand our program in Cardiac Electrophysiology. The positions are at senior and junior levels and provide an opportunity to work in a highly interactive environment to develop a strong clinical and academic electrophysiology team. This team would be part of a large multi-disciplinary cardiovascular group with sophisticated and dedicated cardiac imaging, heart failure, interventional and clinical physicians. Development of the program provides flexibility for the applicant so that clinical and/or basic electrophysiology research can be performed in concert with clinical programmatic development. A medical degree and board certification or eligibility in Clinical Cardiac Electrophysiology will be required for both the senior and entry level positions.

Please submit cover letter and C.V. to
Anne Dougherty, M.D., Director, Cardiac Electrophysiology
P.O. Box 20708, Houston, Texas 77225-0708
Phone: (713)500-6553, Fax: (713)500-6556

University of Texas Health Science Center at Houston is an EEOAA 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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April 13

- Understanding the Role of Endothelial Progenitor Cells in Percutaneous Coronary Intervention
- Preventing Leg Amputations In Critical Limb Ischemia With Below The Knee Drug Eluting Stents: Paradise Trial

April 20

- Microvascular Obstruction: Underlying Pathophysiology and Clinical Diagnosis
- Effects of polyunsaturated omega-3 fatty acids on responsiveness to dual antiplatelet therapy in patients undergoing percutaneous coronary intervention (OMEGA-PCI)

April 27

- Differences between β -blockers in patients with Chronic Heart Failure and Chronic Obstructive Pulmonary Disease. Randomized Crossover Trial
- Combined Heart Failure Diagnostics Identify Patients at Higher Risk of Subsequent Heart Failure Hospitalizations: Results from PARTNERS HF Study

May 4

- Therapy for ST Elevation MI Patients Who Presented Late or are Ineligible for Reperfusion Therapy
- Contemporary Mortality Risk Prediction for Percutaneous Coronary Intervention: Results from 588,398 Procedures in the National Cardiovascular Data Registry

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Imaging

April










- The Sensitivity of Transcranial Doppler Versus Intra-Cardiac Echo in the Detection of Right-to-Left Shunt
- Diagnosing Patent Foramen Ovale - Too Little or Too Much?

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Interventions

April

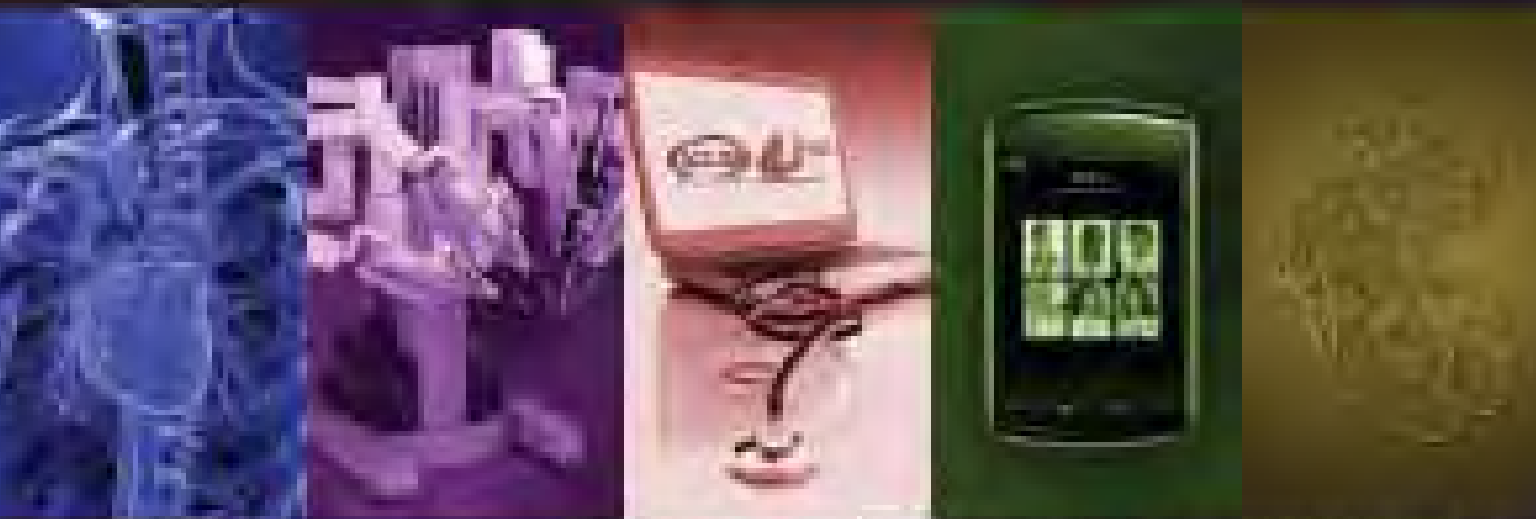
- Sirolimus-Eluting Stents vs. Paclitaxel-Eluting Stents for the Treatment of Coronary Artery Vasculopathy
- The Relationship and Threshold of Stent Length with Regard to Risk of Stent Thrombosis After Drug-Eluting Stent Implantation

Educational Programs Calendar

	April 22, 2010 Convergence of Type 2 Diabetes and Cardiovascular Disease; In conjunction with Society of Vascular Nursing 28th Annual Convention Donna Polk, M.D., F.A.C.C.	<i>New Orleans</i>
	April 24, 2010 Convergence of Type 2 Diabetes and Cardiovascular Disease Donna Polk, M.D., F.A.C.C.	<i>Toronto</i>
	May 6 - 8, 2010 32nd Annual Recent Advances in Clinical Nuclear Cardiology and Cardiac CT Featuring Case Review with the Experts Daniel S. Berman, M.D., F.A.C.C. Guido Germano, Ph.D., M.B.A., F.A.C.C. Jamshid Maddahi, M.D., F.A.C.C.	<i>Washington, D.C.</i> CME TECH
	May 20 - 22, 2010 2010 Coronary Computed Tomography Angiography (CTA) Practicum Gerald Blackwell, M.D., F.A.C.C.	<i>Washington, D.C.</i> CME
	May 21 - 22, 2010 Emergency Cardiovascular Care 2010: Enhancing Regional STEMI Systems of Care 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.	<i>Chicago</i> CME CE
	May 22 - 23, 2010 Peripheral Vascular CTA Primer Gerald Blackwell, M.D., F.A.C.C.	<i>Washington, D.C.</i> CME
	June 1 - 3, 2010 Teaching Skills Workshop for Emerging Faculty Rick Nishimura, M.D., F.A.C.C. Elizabeth Klodas, M.D., F.A.C.C.	<i>Washington, D.C.</i> CME
	June 11 - 13, 2010 3rd Annual West Coast Cardiovascular Forum Valentin Fuster, M.D., Ph.D., M.A.C.C.	<i>San Francisco</i> CME CE
	August 19, 2010 ACCF Study Session for ABIM Maintenance of Certification: Interventional Cardiology Updates 2009 and 2010 Joseph D. Babb, M.D., F.S.C.A.I., F.A.C.C. James E. Tcheng, M.D., F.A.C.C., F.S.C.A.I., F.E.S.C.	<i>Dallas</i> CME MOC
	August 20 - 22, 2010 ACCF/SCAI Premier Interventional Cardiology Overview and Board Preparatory Course Joseph D. Babb, M.D., F.S.C.A.I., F.A.C.C. James E. Tcheng, M.D., F.A.C.C., F.S.C.A.I., F.E.S.C.	<i>Dallas</i> CME

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

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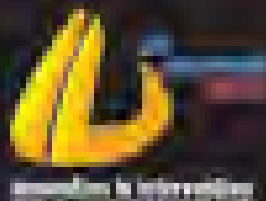
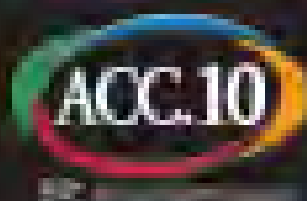
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