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Cardiology

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In chronic angina

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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 CYP3A (eg, ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir)

- Taking inducers of CYP3A (eg, rifampin, rifabutin, rifapentin, phenobarbital, phenytoin, carbamazepine, and St John's wort)
- With clinically significant hepatic impairment

Warnings and Precautions

- ▶ Ranexa blocks I_{Kr} 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 (> 1000 mg twice daily) or exposure, other QT-prolonging drugs, or potassium channel variants 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-mm ST-segment depression), and time to angina¹
- ▶ Hemodynamic neutrality
 - In controlled clinical trials, Ranexa caused minimal changes in mean heart rate (< 2 bpm) and systolic blood pressure (< 3 mm Hg)²
 - No dose adjustment is required in patients with heart failure or diabetes²
- ▶ Established safety and tolerability

Redefine your treatment landscape

 **Ranexa**[®]
RANOLAZINE EXTENDED-RELEASE TABLETS
500 mg · 1000 mg

Adverse Reactions

- ▶ The most common adverse reactions (> 4% 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 CYP3A inhibitors (eg, diltiazem, verapamil, aprepitant, erythromycin, fluconazole, and grapefruit juice or grapefruit-containing products).

Drug Interactions

- ▶ Do not use Ranexa with CYP3A inducers or strong CYP3A inhibitors (see Contraindications); modify the dose of Ranexa with moderate CYP3A inhibitors (see Dosage and Administration).
- ▶ P-gp inhibitors (eg, cyclosporine): may need to lower the dose of Ranexa based on clinical response.
- ▶ Doses of drugs transported by P-gp (eg, digoxin) or metabolized by CYP2D6 (eg, tricyclic antidepressants and antipsychotics) may need to be reduced.

1. Chaitman BR, Pepine CJ, Parker JO, et al. Effects of ranolazine with atenolol, amlodipine, or diltiazem on exercise tolerance and angina frequency in patients with severe chronic angina: a randomized controlled trial. *JAMA*. 2004;291:309-316. 2. Ranexa (ranolazine extended-release tablets) [package insert]. Palo Alto, CA: Sept 2009.



Ranexa®

RANOLAZINE EXTENDED-RELEASE TABLETS
500 mg · 1000 mg

Brief Summary of Prescribing Information

These highlights do not include all the information needed to use Ranexa safely and effectively. See full prescribing information for Ranexa.

Ranexa (ranolazine) extended-release tablets

1. INDICATIONS AND USAGE

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.

2. DOSAGE AND ADMINISTRATION

2.1 Dosing Information

Initiate Ranexa dosing at 500 mg twice daily and increase to 1000 mg twice daily, as needed, based on clinical symptoms. Take Ranexa with or without meals. Swallow Ranexa tablets whole; do not crush, break, or chew.

The maximum recommended daily dose of Ranexa is 1000 mg twice daily.

If a dose of Ranexa is missed, take the prescribed dose at the next scheduled time; do not double the next dose.

2.2 Dose Modification

Dose adjustments may be needed when Ranexa is taken in combination with certain other drugs [see *Drug Interactions (7.1)*]. Limit the maximum dose of Ranexa to 500 mg twice daily in patients on diltiazem, verapamil, and other moderate CYP3A inhibitors. Down-titrate Ranexa based on clinical response in patients concomitantly treated with P-gp inhibitors, such as cyclosporine.

3. DOSAGE FORMS AND STRENGTHS

Ranexa is supplied as film-coated, oblong-shaped, extended-release tablets in the following strengths:

- 500 mg tablets are light orange, with GS1500 on one side
- 1000 mg tablets are pale yellow, with GS11000 on one side

4. CONTRAINDICATIONS

Ranexa is contraindicated in patients:

- Taking strong inhibitors of CYP3A [see *Drug Interactions (7.1)*]
- Taking inducers of CYP3A [see *Drug Interactions (7.1)*]
- With clinically significant hepatic impairment [see *Use in Specific Populations (8.6)*]

5. WARNINGS AND PRECAUTIONS

5.1 QT Interval Prolongation: Ranolazine blocks I_{Kr} and prolongs the QTc interval in a dose-related manner.

Clinical experience in an acute coronary syndrome population did not show an increased risk of proarrhythmia or sudden death. However, there is little experience with high doses (> 1000 mg twice daily) or exposure, other QT-prolonging drugs, or potassium channel variants resulting in a long QT interval.

6. ADVERSE REACTIONS

6.1 Clinical Trial Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

A total of 2,018 patients with chronic angina were treated with ranolazine in controlled clinical trials. Of the patients treated with Ranexa, 1,026 were enrolled in three double-blind, placebo-controlled, randomized studies (CARISA, ERICA, MARISA) of up to 12 weeks duration. In addition, upon study completion, 1,251 patients received treatment with Ranexa in open-label, long-term studies; 1,227 patients were exposed to Ranexa for more than 1 year, 613 patients for more than 2 years, 531 patients for more than 3 years, and 326 patients for more than 4 years.

At recommended doses, about 6% of patients discontinued treatment with Ranexa because of an adverse event in controlled studies in angina patients compared to about 3% on placebo. The most common adverse events that led to discontinuation more frequently on Ranexa than placebo were dizziness (1.3% versus 0.1%), nausea (1% versus 0%), asthenia, constipation, and headache (each about 0.5% versus 0%). Doses above 1000 mg twice daily are poorly tolerated.

In controlled clinical trials of angina patients, the most frequently reported treatment-emergent adverse reactions (> 4% and more common on Ranexa than on placebo) were dizziness (6.2%), headache (5.5%), constipation (4.5%), and nausea (4.4%). Dizziness may be dose-related. In open-label, long-term treatment studies, a similar adverse reaction profile was observed.

The following additional adverse reactions occurred at an incidence of 0.5 to 2.0% in patients treated with Ranexa and were more frequent than the incidence observed in placebo-treated patients:

Cardiac Disorders – bradycardia, palpitations

Ear and Labyrinth Disorders – tinnitus, vertigo

Gastrointestinal Disorders – abdominal pain, dry mouth, vomiting

General Disorders and Administrative Site Adverse Events – peripheral edema

Respiratory, Thoracic, and Mediastinal Disorders – dyspnea

Vascular Disorders – hypotension, orthostatic hypotension

Other (< 0.5%) but potentially medically important adverse reactions observed more frequently with Ranexa than placebo treatment in all controlled studies included: angioedema, renal failure, eosinophilia, blurred vision, confusional state, hematuria, hypoesthesia, paresthesia, tremor, pulmonary fibrosis, thrombocytopenia, leukopenia, and pancytopenia.

A large clinical trial in acute coronary syndrome patients was unsuccessful in demonstrating a benefit for Ranexa, but there was no apparent proarrhythmic effect in these high-risk patients.

Laboratory Abnormalities

Ranexa produces small reductions in hemoglobin A1c. Ranexa is not a treatment for diabetes.

Ranexa produces elevations of serum creatinine by 0.1 mg/dL, regardless of previous renal function. The elevation has a rapid onset, shows no signs of progression during long-term therapy, is reversible after discontinuation of Ranexa, and is not accompanied by changes in BUN. In healthy volunteers, Ranexa 1000 mg twice daily had no effect upon the glomerular filtration rate. The elevated creatinine levels are likely due to a blockage of creatinine's tubular secretion by ranolazine or one of its metabolites.

7. DRUG INTERACTIONS

7.1 Effects of Other Drugs on Ranolazine: Ranolazine is primarily metabolized by CYP3A and is a substrate of P-glycoprotein (P-gp).

CYP3A Inhibitors

Do not use Ranexa with strong CYP3A inhibitors, including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir. Ketoconazole (200 mg twice daily) increases average steady-state plasma concentrations of ranolazine 3.2-fold [see *Contraindications (4)*].

Limit the dose of Ranexa to 500 mg twice daily in patients on moderate CYP3A inhibitors, including diltiazem, verapamil, aprepitant, erythromycin, fluconazole, and grapefruit juice or grapefruit-containing products. Diltiazem (180–360 mg daily) and verapamil (120 mg three times daily) increase ranolazine steady-state plasma concentrations about 2-fold [see *Dosage and Administration (2.2)*].

Weak CYP3A inhibitors such as simvastatin (20 mg once daily) and cimetidine (400 mg three times daily) do not increase the exposure to ranolazine in healthy volunteers.

P-gp Inhibitors

Down-titrate Ranexa based on clinical response in patients concomitantly treated with P-gp inhibitors, such as cyclosporine [see *Dosage and Administration (2.2)*].

CYP3A and P-gp Inducers

Avoid co-administration of Ranexa and CYP3A inducers such as rifampin, rifabutin, rifapentin, phenobarbital, phenytoin, carbamazepine, and St. John's wort. Rifampin (600 mg once daily) decreases the plasma concentration of ranolazine (1000 mg twice daily) by approximately 95% by induction of CYP3A and, probably, P-gp.

CYP2D6 Inhibitors

The potent CYP2D6 inhibitor, paroxetine (20 mg once daily), increases ranolazine concentrations 1.2-fold. No dose adjustment of Ranexa is required in patients treated with CYP2D6 inhibitors.

Digoxin

Digoxin (0.125 mg) does not significantly alter ranolazine levels.

7.2 Effects of Ranolazine on Other Drugs: *In vitro* studies indicate that ranolazine and its O-demethylated metabolite are weak inhibitors of CYP3A, moderate inhibitors of CYP2D6 and moderate P-gp inhibitors. Ranolazine and its most abundant metabolites are not known to inhibit the metabolism of substrates for CYP 1A2, 2C8, 2C9, 2C19, or 2E1 in human liver microsomes, suggesting that ranolazine is unlikely to alter the pharmacokinetics of drugs metabolized by these enzymes.

Drugs Metabolized by CYP3A

The plasma levels of simvastatin, a CYP3A substrate, and its active metabolite are each increased about 2-fold in healthy subjects receiving simvastatin (80 mg once daily) and Ranexa (1000 mg twice daily). Dose adjustments of simvastatin are not required when Ranexa is co-administered with simvastatin.

The pharmacokinetics of diltiazem is not affected by ranolazine in healthy volunteers receiving diltiazem 60 mg three times daily and Ranexa 1000 mg twice daily.

Drugs Transported by P-gp

Ranexa (1000 mg twice daily) causes a 1.5-fold elevation of digoxin plasma concentrations. The dose of digoxin may have to be adjusted.

Drugs Metabolized by CYP2D6

Ranolazine or its metabolites partially inhibit CYP2D6. There are no studies of concomitant use of Ranexa with other drugs metabolized by CYP2D6, such as tricyclic antidepressants and antipsychotics, but lower doses of CYP2D6 substrates may be required.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy—Pregnancy Category C: In animal studies, ranolazine at exposures 1.5 (rabbit) to 2 (rat) times the usual human exposure caused maternal toxicity and misshapen sternbrae and reduced ossification in offspring. These doses in rats and rabbits were associated with an increased maternal mortality rate. There are no adequate well-controlled studies in pregnant women. Ranexa should be used during pregnancy only when the potential benefit to the patient justifies the potential risk to the fetus.

8.3 Nursing Mothers: It is not known whether ranolazine is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions from ranolazine in nursing infants, decide whether to discontinue nursing or to discontinue Ranexa, taking into account the importance of the drug to the mother.

8.4 Pediatric Use: Safety and effectiveness have not been established in pediatric patients.

8.5 Geriatric Use: Of the chronic angina patients treated with Ranexa in controlled studies, 496 (48%) were ≥ 65 years of age, and 114 (11%) were ≥ 75 years of age. No overall differences in efficacy were observed between older and younger patients. There were no differences in safety for patients ≥ 65 years compared to younger patients, but patients ≥ 75 years of age on ranolazine, compared to placebo, had a higher incidence of adverse events, serious adverse events, and drug discontinuations due to adverse events. In general, dose selection for an elderly patient should usually start at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease, or other drug therapy.

8.6 Use in Patients with Hepatic Impairment: Ranexa is contraindicated in patients with clinically significant hepatic impairment. Plasma concentrations of ranolazine were increased by 30% in patients with mild (Child-Pugh Class A) and by 60% in patients with moderate (Child-Pugh Class B) hepatic impairment. This was not enough to account for the 3-fold increase in QT prolongation seen in patients with mild to severe hepatic impairment [see *Contraindications (4)*].

8.7 Use in Patients with Renal Impairment: In patients with varying degrees of renal impairment, ranolazine plasma levels increased up to 50%. The pharmacokinetics of ranolazine has not been assessed in patients on dialysis.

8.8 Use in Patients with Heart Failure: Heart failure (NYHA Class I to IV) had no significant effect on ranolazine pharmacokinetics. Ranexa had minimal effects on heart rate and blood pressure in patients with angina and heart failure NYHA Class I to IV. No dose adjustment of Ranexa is required in patients with heart failure.

8.9 Use in Patients with Diabetes Mellitus: A population pharmacokinetic evaluation of data from angina patients and healthy subjects showed no effect of diabetes on ranolazine pharmacokinetics. No dose adjustment is required in patients with diabetes.

Ranexa produces small reductions in HbA1c in patients with diabetes, the clinical significance of which is unknown. Ranexa should not be considered a treatment for diabetes.

10. OVERDOSAGE

High oral doses of ranolazine produce dose-related increases in dizziness, nausea, and vomiting. High intravenous exposure also produces diplopia, paresthesia, confusion, and syncope. In addition to general supportive measures, continuous ECG monitoring may be warranted in the event of overdose.

Since ranolazine is about 62% bound to plasma proteins, hemodialysis is unlikely to be effective in clearing ranolazine.

Please see full prescribing information at www.Ranexa.com.

To report SUSPECTED ADVERSE REACTIONS, contact Gilead Sciences, Inc, at 1-800-GILEAD-5, or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Rx only

Manufactured for: Gilead Sciences, Inc, Foster City, CA 94404 USA
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Reading the Tea Leaves

What is the future of private practice cardiology? The dramatic cuts to Medicare physician payment this past year, as well as the passage of the Patient Protection and Affordable Care Act of 2010, are having (and will continue to have) undeniable impacts on the practice of cardiology. This issue of *Cardiology* takes a look at these impacts through the lens of the College's first-ever "Practice Census." This survey of more than 2,000 practices across the country highlights the trend toward hospital integration and practice mergers. It also provides direct feedback on impacts of the 2010 Medicare physician payment cuts and illustrates the tough choices practices have had to make in order to remain viable and continue to serve patients. These choices have included everything from reducing staff salaries and benefits to limiting patient services. Based on these survey data, ACC CEO **Jack Lewin, M.D.**, and **Gregory S. Thomas, M.D., M.P.H., F.A.C.C.**, provide commentaries, respectively, on the future of fee-for-service and private practice as we know it.



Armed with data from the census, nearly 300 cardiovascular professionals descended on Capitol Hill in early September as part of the ACC's 2010 Legislative Conference. Don't miss the overview of the conference in the "Advocacy" section. This year's conference was the largest ever and I personally was excited to see so many practice administrators, cardiac care associates and fellows in training. As we move forward with health care reform implementation, it is increasingly important to ensure the entire cardiovascular care team is speaking with one voice. Also in the "Advocacy" section you'll find an overview of some of the health reform implementation battles taking place at the state level. You will also not want to miss the article authored by **David Blumenthal, M.D., M.P.P.**, **Donald Berwick, M.D., M.P.P.**, and yours truly about meaningful use of electronic health records as a pathway to higher quality and effective care.

Speaking of higher quality and effective care, this issue also includes a profile of Baylor University's successful efforts to reduce cardiovascular-related hospital readmissions. Baylor is participating in the ACC's Hospital to Home initiative, which aims to reduce heart failure and acute myocardial infarction readmissions by 20 percent by 2012. It is our hope that hospitals across the country will take the lessons learned from hospitals like Baylor to continue to improve the quality of care for patients and reduce costs to the health care system. You also will not want to miss two articles on studies coming out of the recent European Society of Cardiology meeting on the RealiseAF study and use of clopidogrel in patients with decreased CYP2C19 function.

While we may not be able to clearly read the tea leaves to find out what our future holds, one thing is certain - we as a profession will not be going away. While we all may need to adjust our tactics to meet the needs of evolving practice models, our commitment to transforming cardiovascular care and improving heart health through continuous quality improvement, patient-centered care, payment innovation and professionalism remains the same. My hope is that you'll read through this issue and see all that the College is doing to fulfill this commitment.

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



September - October 2010

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ACC Practice Census

Provides View of Current State of Cardiology

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ACC Practice Census Provides View of Current State of Cardiology

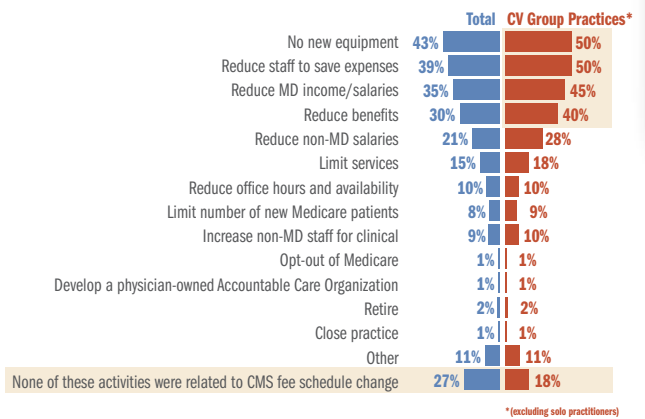
A new American College of Cardiology (ACC) survey of more than 2,400 practices provides a comprehensive snapshot of the current state of cardiology given the changing health care landscape. Respondents from 49 states and Puerto Rico provided valuable insight into the various ways the changes are forcing many private practices to take drastic actions to remain viable.

Over the last year, the survey found that more than half of all practices have taken some form of cost-cutting action as a direct result of the cuts in reimbursement for cardiovascular services included in the 2010 Medicare Physician Fee Schedule. The first and largest wave of activity is directed at the staff level, with half (50 percent) of cardiovascular group practices reporting a reduction in staff to save expenses. In addition, 40 percent of survey respondents said they have reduced staff benefits, while 45 percent have reduced salaries for physicians and clinical staff (28 percent). A small percentage (3 percent) of survey respondents has chosen to retire or close the practice altogether. While some survey respondents indicated an increase in non-physician clinical support staff (10 percent), the total number of new staff fails to compensate for the more than 2,600 nurses, nurse practitioners, CV techs and pharmacists that practices reported needing to lay off.

The second wave of actions more directly impacts patients. Survey participants reported limiting services (18 percent), reducing hours and availability (10 percent), and limiting the number of new Medicare patients (9 percent). Among the services eliminated: free blood pressure checks, in-office blood work, Coumadin management, urgent care appointments, outpatient clinic availability and charity care. In addition, survey respondents estimated that more than 12,253 patients will be affected by limitations on the number of new Medicare patients.

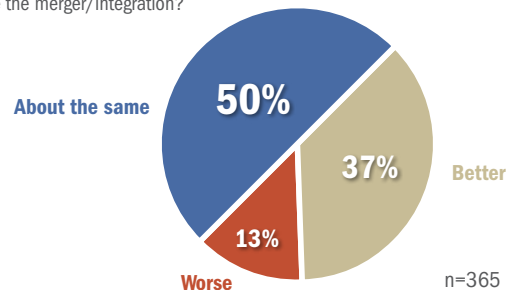
“Private group practices are significantly more likely to have initiated cost cutting activities,” says ACC President Ralph Brindis, M.D., M.P.H., F.A.C.C. “Patients are being pushed to hospitals to receive services which results in higher co-pays, longer turn-around in treatment, and increased costs of care. If the pocketbook

Response to CMS Cuts



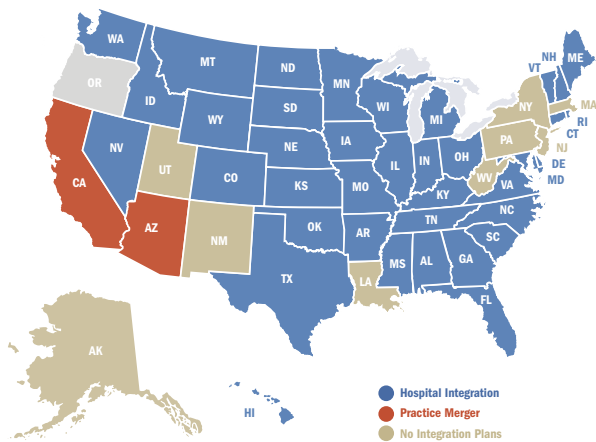
State of Practice Post-Integration

Q: You indicated that your practice has merged with another practice or integrated into a hospital system. Would you say your changed practice setting is better, worse or about the same as it was before the merger/integration?

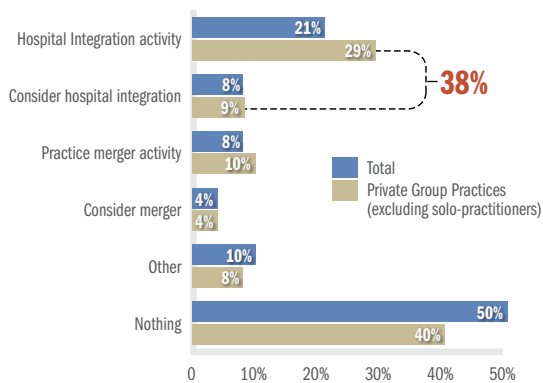


Practice Alignment Evolution Across the U.S.

Based on number of cardiologists



Changing Practice Landscape



continues to be tightened, practices will be forced to further limit patient services.”

According to the survey, nearly half of those practices surveyed in Montana indicated a cut in physician salaries, while one-third (33 percent) said they have reduced staff and benefits. Half of all of the practices in South Dakota have purchased no new equipment and reduced staff and physician salaries. In Florida, more than half of the practices surveyed said they have reduced both staff benefits (51 percent) and staff (53 percent) to save expenses. Nearly half (48 percent) reduced physician salaries.

Private practices have also been forced to re-evaluate their business models and look for options that improve the quality and efficiency of their practices, while also providing additional revenue. This has resulted in a trend toward hospital integration or practice mergers. According to the survey, nearly 40 percent of private group practices are currently integrating with hospitals or merging with other practices. Meanwhile, 13 percent of all cardiovascular practices are considering hospital integration or a merger in the next three years to help stem the financial burden.

“Nearly every state in the country is involved in (or considering) hospital integration,” says Brindis. “The good news, to date, is that the majority of practices having merged with another practice or integrated into a hospital system say their practice setting is about the same or better as it was before integration or the merger. However, the jury is still out on whether these statistics will hold up over the long term.”

The ACC will be using the survey data to help determine next steps in meeting member needs in terms of team-based care, quality improvement tools, educational programs and other resources. The survey results will also help inform advocacy efforts related to payment reform and health care reform implementation.

“The changing practice structure has the potential to profoundly affect the physician/patient relationship, patient care and costs,” says Brindis. “These changes also will have impacts on professional societies like the ACC. Our job will be to continue to track the changes in cardiovascular practice and use the results to have in place the needed support and tools for our F.A.C.C. constituency to ensure patient access to quality, evidence-based care.”

*The ACC’s 2010 Practice Census was conducted from May 5 through Aug. 9 by email and telephone. A total of 2,413 unique practices from 49 states and Puerto Rico participated in the study. The response rate was 31 percent.

Is Fee for Service Dead? By Jack Lewin, M.D.



Over the past year, nearly half of ACC private practice members have sold their practices to become employees of hospital systems, and many more are heading in that direction. Ongoing Medicare cuts, particularly those included in the final 2010 Medicare Physician Fee Schedule, have forced the hands of many practices struggling to remain viable.

For those private practices remaining, a shift away from the traditional fee-for-service (FFS) payment model over five to 10 years will likely be critical to ongoing viability for a number of reasons. First, many health care organizations, group practices, and integrated systems have already started shifting their reimbursement strategies away from a reliance on FFS payments as a result of what I like to call the “SGR debacle.” The sustainable growth rate (SGR) formula currently used to calculate Medicare physician payment has failed for nearly a decade to keep up with increases in business and administrative costs. Not to mention, it continues to promote

investment for services rendered? The main reason is fear of change. Most physicians, aware of how poorly the past FFS decade has treated them, and how seemingly ineffective all the combined advocacy efforts of professional societies have been to turn the negative trends around, understandably think any new system will simply be a disguised form of the next scheme.

It’s true – there is no guarantee that a new system will be any better. We’ve been double crossed in the past by bogus payment methodologies created by insurers or Medicare to support profit or budgetary goals. The SGR is a good example. Even if Congress was willing to finance a 10-year moratorium from its ever-growing projected cuts (now at 21 percent), nobody in Congress or the administration is proposing to track actual increases in business or practice costs as a minimum increase in a new formula model. Private insurance is no better. Despite all of the advocacy activity medicine puts into trying to influence CPT codes, RVUs and FFS payment

“... a growing number of policy leaders, including many in Congress and the White House, would just as soon see fee for service as we currently know it dead.”

volume rather than quality and effectiveness. SGR cuts are also a double-whammy, because most private insurance payments track Medicare.

Second, a growing number of policy leaders, including many in Congress and the White House, would just as soon see fee-for-service as we currently know it dead. New models that include bundled payments, episodes of care, global payments, new versions of capitation or salary combined with productivity and quality incentives are all being promoted as possible replacements.

Third, the most inefficient element of the current FFS model is how much it costs practices to pay for back-office billing costs. Given that most insurance companies manage to come up with literally millions of coding options, and each company is different from the next, it’s getting harder to find a minimum wage office worker who is able to memorize six million codes. This doesn’t even begin to touch upon all of the games insurers have played to underpay or fail to pay for countless services.

So why should we cling to something so archaic, expensive to manage and disappointing in terms of return on

rates, the track record over the past decade is abysmal.

However, the handwriting is on the wall. The trend away from traditional FFS payment methodology for most physicians seems certain over the next five to 10 years, whether we like it or not. The administrative costs and complexities of FFS do not factor well into an ideal and streamlined future of health care.

Fee-for-service may still make sense with respect to one-time service needs, such as emergency room visits, minor health problems, elective procedures. But even these kinds of health care services are under serious consideration for bundled or global payment strategies. A procedure like angioplasty and stent placement is now fairly frequently being priced to include hospital, physician, and necessary or predictable follow up care. Emergency room and episodic primary care services can be concluded in a per-member/per-month primary care or medical home payment arrangement, and just about all of the experts believe chronic diseases should be paid in some form of global payment, bundle or episode-of-care fashion.

Two of the newest innovations in health care delivery,

“...the handwriting is on the wall. The trend away from traditional FFS payment methodology for most physicians seems certain over the next five to 10 years, whether we like it or not. The administrative costs and complexities of FFS do not factor well into an ideal and streamlined future of health care.”

namely concierge medicine and pharmacy-based “minute clinics,” may also present new models for FFS reimbursement. For those concierge physicians that use a balanced billing or independently determined service fee, FFS creates a viable office practice concept. But many concierge physicians elect instead to be compensated by a “retainer model” allowing the patient to bill for insurance independently if they have coverage. Not to mention, for a large number of private practices, concierge practice models are likely not an option.

We need to be open to exploring new options with the hope that other payment arrangements will allow practices to continue to provide quality, appropriate care to patients. The key to success will lie with physician leadership. While we certainly should be cautious about new models that are created unilaterally by the same constituencies and/or entities that have treated physicians poorly to date, with the right leadership we can design future payment models that both treat physicians well and promote the high quality care patients deserve.

We should be in the driver’s seat, creating new models. We don’t have to be afraid of the future—let’s create it. While FFS will exist in some fashion for some years to come, the traditional model is dying. Longer-term viability for the majority of practices will be based upon new systems that provide incentives for improving quality and value. There are paths to more positive outcomes and we need to get tough and figure out how we will protect private practices, academic and hospital-based practice, and all cardiovascular care in this unbelievably challenging environment for doctors, care teams and patients.

Lewin is CEO of the American College of Cardiology.

Commentary

Dear Editor,

I find it disturbing that more time was not spent in the July–August 2010 issue discussing the recess appointment of Dr. Donald Berwick to head CMS. I find it very surprising that ACC CEO Jack Lewin is quoted in a very small side bar segment in support of Dr. Berwick. As an everyday cardiologist whose entire life is based on the whims of CMS payment and health care decisions, I do not know how his appointment will affect how cardiologists deliver care. More importantly, Dr. Berwick is now in charge of the world’s largest health care system and there was no public discourse on his thoughts, views, and plan of potential action. CMS claims to listen to the concerns of physicians, but their actions in payment cuts and continued regulation are a continued hindrance to the nation’s physicians to deliver quality care to our patients. We need to know more about Dr. Berwick and why it seems the ACC is in support of his recess appointment.

Sincerely,

Ruple J Galani, M.D.
Jacksonville, Florida

Editors Note:

The American College of Cardiology believes we need a strong physician leader who understands medicine and exemplifies professionalism at the helm of Medicare right now. Berwick, a pediatrician by training, is a good friend of the ACC and the College has worked closely with him during his tenure at the Institute for Healthcare Improvement on projects like the D2B Alliance and most recently Hospital to Home. The other candidates rumored as alternatives to Berwick were not physician leaders and arguably less likely to understand the difficulties facing health care providers, particularly cardiologists, at this time. ACC members interested in learning more about Berwick are encouraged to visit the ACC in Touch blog for an overview of his speech at the ACC’s 2010 Legislative Conference held Sept. 12-14 in Washington, D.C.

What are your thoughts on the future of private practice? Join the discussion at www.cardiosource.org/cardiologycldiscussion and let us know what you think.



What is the Future of Private Practice Cardiology?

By Gregory S. Thomas, M.D., M.P.H., F.A.C.C.

Since the echo cuts in 2009 and the nuclear cuts in 2010, cardiologists have jumped to join their local hospital in stampeding numbers. While this move has stabilized income for many cardiologists, is this trend optimal for their patients or for cardiologists themselves? For those who have already signed up, please prove me wrong but I have some concerns.

It is the differential in noninvasive reimbursement that provides the bulk of the opportunity for hospitals to pay cardiologists salaries commensurate with historical figures. Is doing so, however, an efficient use of health care dollars? While cardiologists in private practice currently make little, break even or even lose money on noninvasive imaging, they were able to make enough profit to remain independent prior to the cuts of 2009-10. Yet, the cost of delivering these services was roughly a third less than hospitals received prior to 2009. Using a back of the envelope calculation, if we convert from hospital based testing, which was used 50 percent of the time in 2006¹, to perhaps 80 percent of the time in 2011, the system will lose an estimated \$600 million annually. Applying this same analysis to echocardiography doubles or triples this burden.

Where will this money come from? In an ironic twist, as half of all testing is in the Medicare population, half will come from physicians themselves. Outpatient hospital costs come from Medicare Part B, not Part A, which covers inpatient care. Physician fees come from Medicare Part B; a sum of money is required to be budget neutral. Because of this zero sum game, as we increase the cost of noninvasive testing because of a site of service change, there will necessarily be less money available to pay physicians within the Medicare physician fee schedule.

On May 7, CMS agreed that they

“Physicians have traditionally placed a great value on their independence. The self confidence needed for a physician to prescribe medicine, order a test or perform an operation or procedure encourages this value. With hospital employment some independence is necessarily lost. How will this loss impact cardiologists after the honeymoon period has worn off? Upon expiration of a salary guarantee? On job satisfaction and professionalism?”

had made an error in their calculation of practice expense for physician based myocardial perfusion imaging (MPI). In doing so they retroactively increased payment by \$65. This increase is retroactive to Jan. 1, though CMS has not yet announced how they will make these retrospective payments. In September 2010, CMS will convene a “refinement panel” to reevaluate the decrease in physician payment component of MPI. In their Proposed Rule for the 2011 Medicare Physician Fee Schedule released on July 2, CMS significantly increased outpatient MPI reimbursement and increased echocardiography minimally. (This presumes that the SGR cut scheduled for December 2010 is again deferred.) Unfortunately, previously determined cuts in echocardiography reimbursement are to be “phased in” in 2012 and 2013, however.

Private payers took advantage of the CMS mandated new codes for echocardiology and nuclear imaging to implement their own huge cuts in reimbursement. This was generally done unilaterally without discussion with the cardiology groups with whom they had contracted for these services. Any yearly increase the groups had negotiated for medical inflation was wiped out and then some by these unexpected and un-negotiated cuts. It is now time to go

back to payers, as individual practices and as the ACC, educating them about the costs of providing these services and the scaling back of Medicare cuts that CMS is now implementing.

Physicians have traditionally placed a great value on their independence. The self confidence needed for a physician to prescribe medicine, order a test or perform an operation or procedure encourages this value. With hospital employment some independence is necessarily lost. How will this loss impact cardiologists after the honeymoon period has worn off? Upon expiration of a salary guarantee? On job satisfaction and professionalism?

Ten to 15 years ago the trend was for hospitals and even venture capitalists to buy primary care practices. In many communities, such arrangements failed when their expected financial return on investment did not materialize.

While CMS actions have spurred this most recent move to the hospital, the new Patient Protection and Affordable Care Act (PPACA), has also created new opportunities. Section 1899 of the PPACA memorializes accountable care organizations (ACOs) into law. In describing the makeup of an ACO, three of the five specified structures in the law are physician based: group practices, physician Independent Practice Associations (IPAs) and

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partnerships or joint ventures (JVs) between physicians and hospitals. The regulations to be released in proposed form in fall 2010 will flesh these out but it is apparent that hospitals were not meant to have a monopoly on ACOs. ACOs provide the promise of sharing the savings between the ACO and CMS if the cost curve can be bent for the global cost of caring for Medicare patients. As the stroke of a physician's pen or keyboard determines much of the cost of medical care, physician empowered ACO's have the greatest chance to succeed². As a substantial percentage of Medicare costs are cardiovascular, the cardiologist's role here is paramount.

How can cardiologists participate in the opportunity that ACOs seek to provide? Working together with other private groups could provide the size needed to create an ACO or to participate as an equal with a local hospital in creating a joint ACO. In California, a coalition of 11 local groups of diverse specialties has come together to form the Orange County Health Professionals Alliance, a "group of groups." This alliance of practices comprising 150 physicians has become a strategic presence in the region attracting the interest of hospitals, IPAs and payers in how the group could form the basis of an ACO or participate in other shared savings models.

Another key element of the PPACA is bundled payments to physicians and hospitals for common diagnoses and procedures. While full integration with the hospital is one option to provide care through this reimbursement model, independent cardiology groups can negotiate with their local hospital(s) to participate as well.

Proactive cardiology groups will seize the opportunities that ACOs, bundled payment models and similar opportunities provide. The efficient care with a close eye on overhead costs that private practice cardiology groups can provide will be their strong point

in payment models that attempt to bend the cost curve. The cost of supporting the overhead of a general purpose hospital will likely prove to be a disadvantage in shared savings models.

Dynamic personalities are attracted to becoming cardiologists. Translating this dynamism into leadership within private practice groups working as and with ACOs and within bundled payment mechanisms will be necessary for enhanced survival. For those cardiologists who have joined the hospital in an employment model, leadership

“ Integrated delivery systems held out as a model in the health reform debate, Geisinger and the Mayo, Cleveland and Billings clinics are all physician led. While we will have to adapt, the need for cardiologists to lead cardiology care delivery has never been more critical. ”

that creates the potential for continued professionalism and job satisfaction, both of which lead to outstanding patient care, will be required. Integrated delivery systems held out as a model in the health reform debate, Geisinger and the Mayo, Cleveland and Billings clinics are all physician led. While we will have to adapt, the need for cardiologists to lead cardiology care delivery has never been more critical.

1. **Imv 2007 Nuclear medicine market summary report.**
Des Plaines, IL. Oct 2007.

2. **Miller HD. Pathways for physician success under healthcare payment and delivery reforms.** American Medical Association and Center for Healthcare Quality and Payment Reform. June 2010.

Thomas is part of an 11-member cardiology division of a 55-physician internal medicine practice in Mission Viejo, Calif. He is a clinical professor of medicine at UC Irvine, the former ACC representative to the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and a past president of the American Society of Nuclear Cardiology.

More Research Needed to Assess ARBs and Cancer Risks

By Frederick A. Masoudi, M.D., M.S.P.H., F.A.C.C.

Angiotensin-receptor blocker (ARB) agents reduce the risk of cardiovascular mortality, myocardial infarction and stroke in patients with hypertension and established heart disease. However, a recent provocative study published this past June in *Lancet Oncology* suggests these drugs may increase the risk of cancer.

This meta-analysis of controlled, randomized clinical trials found that ARBs were associated with significant increased risks for new cancers, as compared with patients receiving other treatments or placebo.

These data raise important questions for further investigation. For example, telmisartan was the study drug for 85.7 percent of patients receiving an ARB in those trials with data on cancer outcomes. Further investigation to determine if specific drugs increase cancer risks and/or if certain patients are at increased risk for cancers will be important.

As of July 15, the U.S. Food and Drug Administration announced that it will conduct a more comprehensive review of ARB data to do just this. Part of this regulatory review will also include any unpublished data on ARBs.

In the interim, the *Lancet* study does not diminish the importance of treating hypertension or left ventricular systolic dysfunction with effective drug regimens, which in some cases may include the use of ARBs. Current recommendations in the ACC/American Heart Association guidelines for STEMI, NSTEMI/unstable angina, and heart failure remain current in that they generally support ACE inhibitors as first-line therapy for patients who tolerate this drug class. In general, ARBs are recommended for patients with limited tolerance for ACE inhibitors.

Also importantly, patients who are prescribed ARBs should not stop taking them based upon this recent study, but rather work with their care providers to determine the best medication regimen.

Masoudi is an Associate Professor of Medicine (Cardiology) at Denver Health Medical Center and the University of Colorado and a member of the ACCF Clinical Quality Committee.

Updated Performance Measures Aim to Increase Cardiac Rehabilitation Referrals

Cardiac rehabilitation services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30 percent of eligible patients¹ in the United States.

In an effort to encourage health care providers to refer eligible patients to a cardiac rehabilitation program and ultimately improve cardiac rehabilitation referral and enrollment rates, the American Association of Cardiovascular and Pulmonary Rehabilitation and the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures recently updated two performance measures on cardiac rehabilitation for referral to cardiac rehabilitation/secondary prevention services. The original performance measures were published in 2007.

The updated cardiac rehabilitation performance measures focus on the referral of patients to cardiac rehabilitation programs from the inpatient and outpatient settings. In the inpatient setting, "all patients hospitalized with a primary diagnosis of an acute myocardial infarction (MI) or chronic stable angina (CSA), or who during hospitalization have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation are to be referred to an early outpatient cardiac rehabilitation (CR)/secondary prevention program."

Similarly, all patients evaluated in an outpatient setting who within the past 12 months have experienced MI, CABG surgery, PCI, cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient CR program for the qualifying event/diagnosis are to be referred to such a program.

In both cases, health care providers and health care systems will report the percentage of eligible patients they refer to cardiac rehabilitation programs. Identifying all eligible patients will require that a timely, accurate, and effective system be in place. Clear communication between the hospital or outpatient clinical practice team and the cardiac rehabilitation program will be key to successful implementation of these measures, improved utilization of cardiac rehabilitation services by appropriate patients, and reduced morbidity and mortality rates in patients with the qualifying diagnoses listed above.

The cardiac rehabilitation referral measures have been endorsed by the National Quality Forum and are currently being considered for use by the Centers for Medicare and Medicaid Services. More information on the updated cardiac rehabilitation performance measures is available on CardioSource.org under "Science & Quality."

1- Cortes O, Arthur HM. Determinants of referral to cardiac rehabilitation programs in patients with coronary artery disease: a systematic review. *Am Heart J.* 2006;151:249-56.

RealiseAF Study Provides International, Observational Profile of AF Patients

A new study presented at the European Society of Cardiology conference in Stockholm, looks to thoroughly encompass contemporary, international and representative information on patient characteristics and management of outpatients with the whole spectrum of atrial fibrillation (AF).

According to the RealiseAF study, presented by **Philippe Gabriel Steg, M.D., F.A.C.C.**, professor of cardiology, director, Coronary Care Unit, Hopital Bichat-Claude Bernad in Paris, much of the information on patients, management and outcomes of AF often has limitations. For example, much

evidence-based guidelines. All patients had a history of AF, with at least one AF episode documented within 12 months of being enrolled in the trial.

Results from the registry showed AF was frequently not controlled and frequently symptomatic. Also, patients with control of their AF didn't necessarily have control of the symptoms - more than 55 percent of those with controlled AF had at least one symptom such as fatigue, chest pain or palpitations.

AF was frequently associated with comorbidities - 77 percent of patients had at least one - and multiple CV risk factors, including smoking, obesity, hypertension and physical inactivity.

increases the risk of stroke five-fold. AF is responsible for between 15 and 20 percent of all strokes, which account for one in 17 deaths in the United States, and ranks third among all causes of death, behind heart disease and cancer.

Similar to the trends reported in the 2006 guidelines document, in March 2010, a survey of ACC's "CardioSurve" research panel found that 62 percent reported the incidence of AF on the rise in their practices and approximately 18 percent of their patients being treated for AF. Stroke prevention, followed by rate control, was the most popular way of treating AF.



In this survey, cardiologists expressed confidence in their ability to treat AF using cardioversion, anticoagulation strategies, rate control, pharmaceutical therapies and rhythm control. They said they were less confident in their understanding of cardio-ablation and cardio-mapping techniques.

of the data is drawn from randomized controlled trials which are highly selected and usually stem from North America or Western Europe. Also, the information is usually accumulated in-hospital or on the occasion of an event (stroke, cardioversion) and is not current, as practice and epidemiology are rapidly changing. The information also often only pertains to certain types of AF.

To overcome the limitations for a more complete look, more than 10,000 patients from 26 countries including many European countries, and also Mexico, Turkey, India, Algeria and Venezuela were enrolled in the registry between October 2009 and May 2010 to evaluate their cardiovascular risk profile and how well their AF is controlled. The study also evaluated AF management strategies, characteristics and whether practice is consistent with

AF patients were also at high risk of hospitalization and CV events such as stroke or acute coronary syndrome. According to the ACC/AHA/ESC 2006 Guidelines for the Management of Patients with Atrial Fibrillation, over the past 20 years there has been a 66 percent increase in hospital admission for AF due to an aging population and a rising prevalence of chronic heart disease.

Current statistics estimate that of the 466,750 deaths due to disorders of heart rhythm, AF and flutter mortality rates totaled 11,555 with a reported prevalence of greater than 2.2 million. The lifetime risk for development of AF is one in six and as high as one in four for men and women 40 years of age and older.

What makes AF so clinically and economically costly is the fact that it

In this survey, cardiologists expressed confidence in their ability to treat AF using cardioversion, anticoagulation strategies, rate control, pharmaceutical therapies and rhythm control. They said they were less confident in their understanding of cardio-ablation and cardio-mapping techniques. Pharmacological, rhythm, anti-coagulation and ablation treatments are areas that panelists said they would like to expand their knowledge.

Conclusions from the RealiseAF study highlight the need for newer therapies (antiarrhythmic and antithrombotic agents) to manage AF with a view to improve CV outcomes as well as a need for greater education to promote better adherence to guidelines.

For more information visit the Atrial Fibrillation Community at afibprofessional.org.

Baylor Hospital Exemplifies ACC's Hospital to Home Program

As efforts continue to better measure hospitals' performance and hold them accountable for patient care, the newest analysis by the Centers for Medicare and Medicaid Services (CMS) shows that thousands of hospitals around the country continue to have higher-than-average readmission rates for heart failure, heart attack and pneumonia.



In addition, with the onset of health care reform, health care practitioners face a major challenge: how to reduce 30-day readmissions for these conditions—or risk losing Medicare reimbursement. To meet this challenge, practitioners need concrete steps to accomplish this reduction and tools to support patients in managing their care.

One facility that has specific strategies and where patients are leaving and rarely coming back is Baylor Heart and Vascular Hospital in Dallas. Baylor, which is enrolled in the American College of Cardiology's Hospital to Home (H2H) initiative (see sidebar), sits at the top of CMS' list for the lowest readmission rates for heart failure patients for the second year in a row. The hospital's readmission rate is 17.3 percent, compared to the national average of 24.5 percent.

Nancy Vish, R.N., Ph.D., N.E.A.-B.C., F.A.C.H.E., president and CEO, said the focus on improving the core processes started in 2002. "It is the partnership between the multidisciplinary team, physicians, medical leadership, and administration that make the processes at Baylor Heart and Vascular Hospital such a success," she said.

"Our goal has always been low readmission rates," said Cecilia Lijauco, R.N., M.S.N., director of health care improvement and head of Baylor's readmission efforts. "We want to do what's right – and what's right for heart failure patients is also right for every patient, so we work to improve quality across the board."

Lijauco said one key to the hospital's success lies with the follow-up. After patients are discharged, they receive two follow-up phone calls – the first 24 to 48 hours after discharge, the second 10 days after discharge.

The first call is to schedule follow-up appointments and make sure patients understand their discharge instructions including medications and diet. If there is a problem – for example a patient can't afford medication – Baylor provides a free two-week supply. A social worker then helps with prescription assistance through county or pharmaceutical programs. The second phone call checks patients' symptoms and if they completed their

follow up appointment. If any symptom issue is identified, the nurse will alert the patient's physician.

Another component in Baylor's success involves daily 3 p.m. meetings that incorporate all departments, including the charge nurse, pharmacy and patient care areas. They discuss the next day's plan, which patients are scheduled to come in and how best to care for them. They also talk about current patients and any issues, such as possible discharge delays or needs, family issues or any complications during a procedure.

The hospital also began daily 10 a.m. meetings to talk about the needs of current patients. Paul St. Laurent, R.N., M.S.N., A.P.N., nurse practitioner, who created the morning meeting when he began working at Baylor last year, said the critical component is it involves the nursing staff, who have the most hands-on access to patients and who will go to a patient's bedside during the meeting, if necessary, to manage any problems that come up. Lijauco directly links this year's continued decline in readmission rates to the implementation of this meeting.

"Identifying patients is critical," said St. Laurent. "We

constantly talk to doctors to find out more information about our patients, who are very complex. We are a cohesive team who can very quickly act to make sure everything is stable.”

Kevin Wheelan, M.D., chief of medicine at Baylor said the outcomes are a product of a multidisciplinary team, from office staff to the in hospital teams. Transparency of data, frequent review of the data by multiple committees, and holding people accountable are key elements, he said.

Other hospitals around the country are beginning to take notice of Baylor and its efforts. The hospital has shared its best practices for heart failure readmission reduction with hospitals across the U.S. via webinars, national conference presentations and site visits hosted for health care systems.

The CMS mortality and readmission measures are based on Medicare claims records from more than 4,600 hospitals between 2005 and 2008. This is the second year that CMS included readmissions data on its Hospital Compare website. Up until 2009, only mortality data was posted.

FDA Restricts Use of Rosiglitazone; Halts TIDE

Drug to be withdrawn in Europe

The U.S. Food and Drug Administration (FDA) on Sept. 23 announced it will significantly restrict the use of the diabetes drug rosiglitazone (Avandia) to patients with Type 2 diabetes who cannot control the disease with pioglitazone (Actos) or other medications. These new restrictions are in response to data that suggest an elevated risk of cardiovascular events, such as heart attack and stroke, in patients treated with Avandia.

The FDA also ordered GlaxoSmithKline (GSK) to convene an independent group of scientists to review key aspects of the company's clinical trial known as RECORD, which studied the cardiovascular safety of Avandia compared to standard diabetes drugs. During the course of the FDA's review of the RECORD study, important questions arose about potential bias in the identification of cardiovascular events. The FDA is requiring this independent review to provide additional clarity about the findings. In addition, the agency has halted GSK's clinical trial known as TIDE and rescinded all of the regulatory deadlines for completion of the trial. The TIDE trial compares Avandia to Actos and to standard diabetes drugs. The FDA may take additional actions after the independent re-analysis of RECORD is completed.

Meanwhile, the *Washington Post* reports that the FDA decision was coordinated with European drug regulators, who announced that they were completely withdrawing the drug's approval.

More information is posted on the ACC in Touch blog .

H2H: Providing Opportunities for Lower Readmissions

The American College of Cardiology's Hospital to Home (H2H) initiative aims to improve the transition from inpatient to outpatient status for individuals hospitalized with heart disease.

Ultimately, the goal of H2H is to reduce heart failure and acute myocardial infarction readmissions by 20 percent by December 2012.



The H2H initiative focuses on

three core concepts:

1. **Post-discharge medication management.** Patients must not only have access to the proper medications, they need to be properly educated on how to use them.
2. **Early follow-up.** Discharged patients should have a follow-up visit scheduled within a week of discharge, as well as the means of getting to that appointment.
3. **Symptom management.** Patients must recognize the signs and symptoms that require medical attention, as well as the appropriate person to contact if those signs/symptoms appear.

The H2H initiative provides opportunities for hospitals with some of the lowest readmission rates in the nation – like Baylor, Providence Hospital in Mobile, Ala., and St. Vincent Heart Center of Indiana in Indianapolis to share strategies that fall under these domains and help others meet their

readmission reduction goals. The online, rapid learning community is actively engaged in a listserv, discussion board and share innovations through the Process Profile on the newly redesigned H2H website.

For more information about the H2H Quality Initiative, or to enroll in this initiative free of charge, visit www.H2HQuality.org.

Lowest Readmission Rates

Baylor Heart and Vascular Hospital, Dallas	17.3%
Dixie Regional Medical Center, St. George, Utah	18.0%
Providence Hospital, Mobile, Ala.	18.3%
St. Patrick Hospital, Missoula, Mont.	18.7%
Greenville Memorial Hospital, Greenville, S.C.	18.9%
Portneuf Medical Center, Pocatello, Idaho	18.9%
Presbyterian Hospital, Albuquerque, N.M.	19.1%
Sarasota Memorial Hospital, Fla.	19.2%
McKay-Dee Hospital Center, Ogden, Utah	19.3%
Parkview Medical Center, Pueblo, Colo.	19.3%
St. Vincent Heart Center of Indiana, Indianapolis	19.3%
Tallahassee Memorial Hospital, Fla.	19.3%

Source: Centers for Medicare and Medicaid Services. Data are as of July 7.



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CHAPTER



Results of New Study Could Disprove FDA Clopidogrel Warning

New results from a study presented at the European Society of Cardiology conference in Stockholm possibly disproves earlier studies and a U.S. Food and Drug Administration warning of the reduced effect of clopidogrel in patients with decreased CYP2C19 liver enzyme function, which was said to cause higher rates of cardiovascular events after acute coronary syndrome (ACS) and percutaneous coronary interventions (PCIs) than patients with normal CYP2C19 function.

The new study, conducted by **Guillaume Pare, M.D. M. Sc.**, director Genetic and Molecular Epidemiology Laboratory, McMaster University in Ontario, and published in the *New England Journal of Medicine* (Paré G, Mehta S, Yusuf S, et al.), showed decreased CYP2C19 function has no effect on cardiovascular events in the patients studied.



Just over 6,000 patients from two large randomized trials that demonstrated benefits of clopidogrel versus placebo in preventing cardiovascular (CV) events in acute coronary syndromes (ACS) and atrial fibrillation (AF) were genotyped for three single nucleotide polymorphisms (*2, *3, *17) that define the major CYP2C19 alleles.

In 5,059 ACS patients from the CURE trial, clopidogrel compared with placebo significantly reduced the primary efficacy outcome, irrespective of genetically determined metabolizer phenotype. By contrast, gain-of-function carriers derived increased benefit from clopidogrel treatment as compared with noncarriers. The effect of clopidogrel on bleeding did not vary by genotypic subgroups. In 1,156 AF patients from the ACTIVE trial, there was no evidence of interaction either on efficacy or bleeding between treatment and metabolizer phenotype, loss-of-

function carrier status or gain-of-function carrier status.

“What is clear is we have two patient populations where loss of function has no effect,” said Pare. “This shows for sure genetic warnings should be restricted and begs further data to make sure we really know what’s going on with treatment options.”

Clopidogrel (marketed as Plavix) is given to reduce the risk of heart attack, unstable angina, stroke and cardiovascular death in patients with cardiovascular disease. It works by decreasing the activity of blood cells called platelets, making them less likely to form blood clots. For the drug to work, enzymes in the liver (particularly CYP2C19) must convert the drug to its active form. Patients who are poor metabolizers of the drug do not effectively convert it to its active form. In these patients, there’s less ability to prevent heart attack, stroke and cardiovascular death. It is estimated that 2 percent to 14 percent of the population are poor metabolizers; the rate varies based on racial background. In March, the FDA issued its third “boxed warning” about the diminished effectiveness of clopidogrel.

“I think the black box warning shows we should have further discussion – these results will fuel a debate about clopidogrel,” said Pare.

“There are huge areas of uncertainty and more data will be needed. It’s a cautionary tale and we need to take a step back and look globally and move cautiously in the future.”

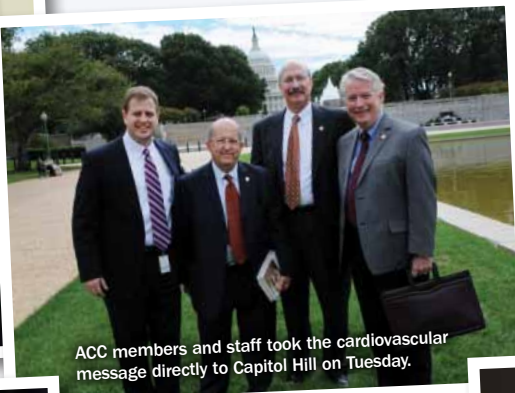
A writing committee of the American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) published a clinical alert soon after the FDA’s warning similarly advising against final conclusions until further studies are conducted.

The ACCF/AHA clinical alert cautioned that the number of patients affected by this genetic polymorphism is in the minority. The genetic variability of CYP enzymes and perhaps other genetic polymorphisms may affect platelet function and for this minority of patients, the impact can be quite serious, but the studies supporting this finding are essentially sub studies drawn from larger trials related to other issues, the alert said. This means that, for the most part, CV professionals should rely on their clinical judgment and adhere to the recommended guidelines for clopidogrel dosage.

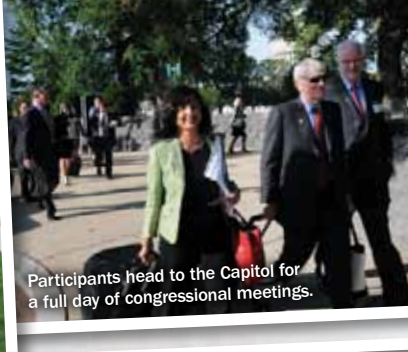
And while genetic testing is commercially available to patients at risk for poor outcomes with the use of clopidogrel or those responding poorly to treatment with clopidogrel, insurance companies will not cover the costs of the expensive tests. So although pharmacogenomic testing is the focus of ongoing trials, it is still in the early stages and there is little solid information about its predictive value. In other words, we have pieces of information that help us connect the dots and that’s what the clinical alert attempts to do, but the science of personalized medicine isn’t there yet.



The Legislative Conference provided many opportunities for participants to network with colleagues and ACC leaders.



ACC members and staff took the cardiovascular message directly to Capitol Hill on Tuesday.



Participants head to the Capitol for a full day of congressional meetings.



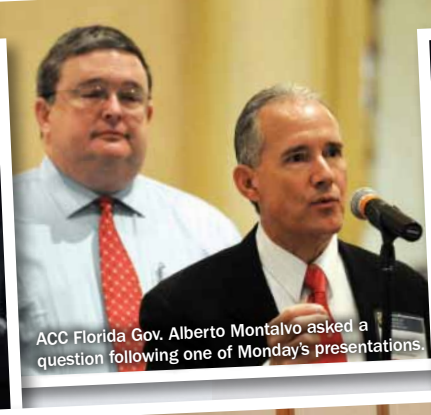
ACC CEO Jack Lewin presented on the ACC's 2010 Practice Census Results.



Congressional staff spoke about health care reform implementation and payment reform.



Rep. Charles Gonzalez of Texas told members they were their own best advocates.



ACC Florida Gov. Alberto Montalvo asked a question following one of Monday's presentations.



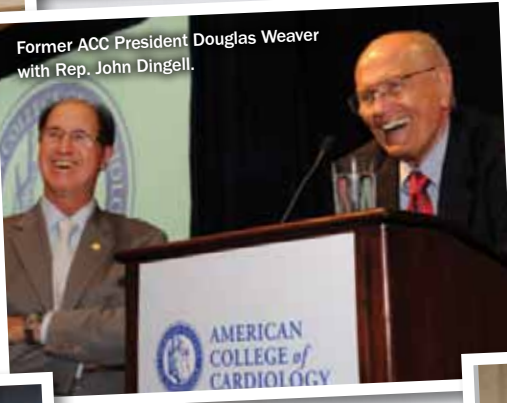
ACC PAC Chair Howard "Bo" Walpole presented PAC awards during Sunday night's dinner.



ACC President Ralph Brindis kicked off this year's conference, which largely focused on health reform.



A record number of Practice Administrators attended this year's conference.



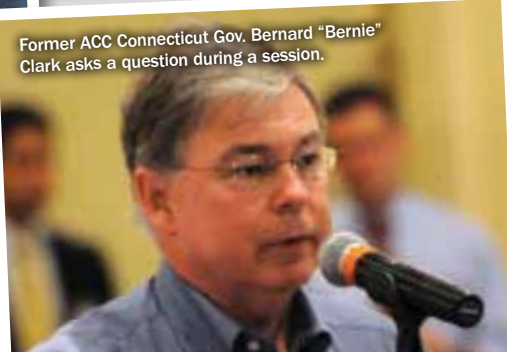
Former ACC President Douglas Weaver with Rep. John Dingell.



ACC Texas Gov. David May and Rep. Michael Burgess



The ACC's Cardiovascular Leadership Institute sponsored advocacy training for new attendees.



Former ACC Connecticut Gov. Bernard "Bernie" Clark asks a question during a session.



ACC President Ralph Brindis with this year's CCA attendees.



ACC's Michigan Chapter was well represented at this year's conference.



ACC President Ralph Brindis with Fellows in Training.



New CMS Administrator Donald Berwick speaks on his plans for the agency.



Rep. Charles Gonzalez awarded President's Award for Distinguished Public Service.



Political strategist Karl Rove signs autographs at a special PAC luncheon on Tuesday.

Legislative Conference 2010: The Future of Cardiology

Nearly 300 members from 48 states and Puerto Rico came to Washington, D.C., Sept. 12-14 for the American College of Cardiology's 2010 Legislative Conference. This year's conference focused primarily on health reform implementation; continuing to educate Congress about the impact of the 2010 Medicare Physician Fee Schedule cuts; and payment reform opportunities.

Participants heard from congressional staffers about what they see happening in 2010 and beyond in terms of health reform implementation and reforming the sustainable growth rate (SGR) formula. Donald Berwick, M.D., M.P.P., the new CMS administrator, spoke on Monday afternoon about the ways the medical community and CMS can work together to achieve the "triple aim" of better health care (quality), better health and lower costs.



ACC's Legislative Conference 2010

"Only the people that give the care can actually change the care," he said. "Without complete partnership with the delivery and clinical providers in this country, we will not realize the full potential of our health care system."

ACC staff and leaders were also on hand to discuss the results of ACC's 2010 Practice Census (see story on page 4) and to provide leadership and advocacy training as part of the College's Cardiovascular Leadership Institute. In addition, the ACC's Political Action Committee held several events, including the 4th Annual Texas Hold 'Em Tournament and a special luncheon with political strategist Karl Rove. Rep. Charles Gonzalez (D-Tex.) also received the President's Award for Distinguished Public Service for his efforts to mitigate the impacts of the 2010 Medicare Physician Fee Schedule.

The conference culminated with face-to-face meetings with lawmakers and/or their staff. In a guest post on the ACC in Touch blog, ACC Fellow in Training Justin Bachman, M.D., wrote: "It's clear that everyone [was] concentrating on being reelected and issues such as the sustainable growth rate (SGR) won't be tackled so close to election day. However, most of the offices seemed receptive to signing on to Rep. Gonzalez's new legislation."

For complete coverage of the conference, visit the ACC in Touch blog at blog.cardiosource.org/?tag=/2010legconf. You can also share your experiences via CardioSource Communities. To view photos from the conference (and post your own), go to the ACC in Touch Facebook page.



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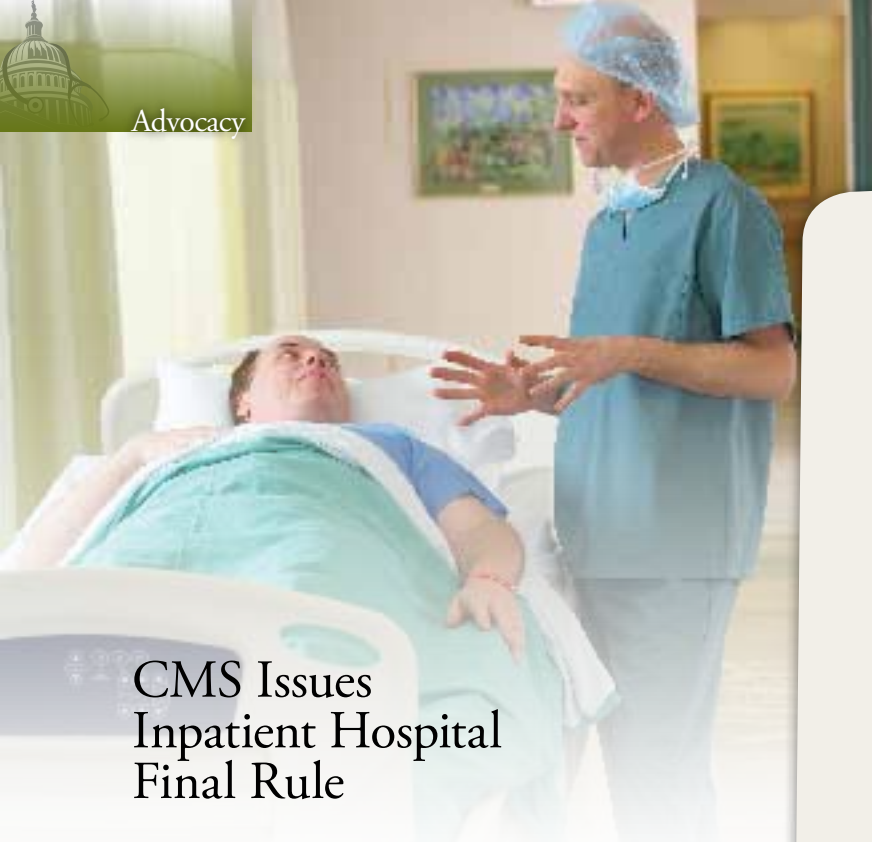
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CMS Issues Inpatient Hospital Final Rule

The Center for Medicare and Medicaid Services (CMS) has published its final rule as part of its 2011 update to policies and payment rates for inpatient services furnished in hospitals.

CMS did not finalize a proposal requiring hospitals to report a quality measure that was generated from one of four registries. One of the proposed registries had been the ACC-NCDR ICD registry, which is the data repository for implantable cardioverter defibrillator (ICD) procedures. This registry is currently required for use for all Medicare patients receiving the service for primary prevention purposes as part of decision to provide coverage with evidence development.

The CMS decision not to finalize was partially based on opposition from hospitals that were concerned about costs of registries to hospitals. CMS will instead look to consider performance measures that may be determined by registries, but calculated through other means. Also, because CMS did not require a single registry measure (rather giving an option of four,) there would be no way to adjust payment for performance on these measures. CMS says it did not intend to require hospitals to have to participate in registries in which they do not already participate.

ACC continues to believe that registries offer opportunities to improve the care process in ways that measures based on chart abstraction do not. We will work with CMS to better understand ways that these important tools can receive the incentives that will increase their use in the Medicare population.

Advocacy Briefs

ACC Submits Comments on 2011 Medicare Physician Fee Schedule

The ACC has submitted formal comments to the Centers for Medicare and Medicaid Services on the proposed 2011 Medicare Physician Fee Schedule. The comments provide feedback on several elements of the rule of importance to the practice of cardiology, including practice expense RVUs, potentially "misvalued codes" under the fee schedule, equipment pricing, remote cardiac monitoring services, imaging self referral, the Physician Quality Reporting Initiative (PQRI), e-prescribing and more. The comments also reiterate the continued impact of the 2010 rule's cuts on cardiovascular practices across the country. Read the full comments on CardioSource.org in the Practice Management section under "Coding and Billing."

First EHR Certification Bodies Named

The Office of the National Coordinator (ONC) for Health Information Technology has named the first organizations authorized to test and certify electronic health records (EHRs). The Certification Commission for Health Information Technology (CCHIT) and The Drummond Group were announced as the initial Authorized Testing and Certification Bodies (ATCBs).

This step is a critical component of the federal EHR incentive program. In order to qualify for incentive payments, practitioners must be using an EHR that has been certified by an ATCB. The next step will be for CCHIT and The Drummond Group to begin certifying EHRs.

The ACC encourages practitioners who have been using CCHIT-certified EHRs to still verify that their system is certified for the federal incentive program, since certification does not automatically carry over from one program to another. For more information on the certification program, visit www.healthit.hhs.gov/certification.

Highmark Launches Pre-certification Program

Doctors performing myocardial perfusion imaging, will now have to receive prior authorization from Highmark Inc. before prescribing the test for a patient.

The policy change is seen as evidence of a continuing national health debate about how much radiation exposure is safe for patients. Health providers are already required to get prior authorization from Highmark to schedule other types of radiology scans, such as CT scans, and other nuclear tests, such as PET scans. Other health insurers require the same prior authorization, as well.

For more information on radiation safety visit the "Imaging" issues section under CardioSource.org/Advocacy. For information and resources on ACC's Appropriate Use Criteria for imaging visit CardioSource.org/Focus.

Health Reform Implementation Poses Challenges for States

With the passage of federal health reform, states are preparing for the most sweeping changes in health care in 30 years. The process is daunting, given that states are responsible for meeting basic federal requirements outlined in the law, some of which have strict deadlines that may or may not work with state legislative cycles. In addition, many state budgets are being squeezed forcing them to find ways to staff and finance health reform.

During a recent Capitol Hill briefing sponsored by the Alliance for Health Reform and the Robert Wood Johnson Foundation, Brian Webb, manager of health policy and legislation for the National Association of Insurance Commissioners (NAIC), said state concerns can be summarized into two words: money and time.

To date, many states have started developing state-based infrastructures to address implementation issues, including creating task forces or appointing officials responsible for moving forward with federal requirements. In Colorado, for example, the governor has issued an executive order to organize all agencies and planning involved in reform. The order created an interagency board, appointed a director of health reform implementation, and established an inter-departmental implementation council.

On the flip side, legislators in at least 40 states have also proposed legislation to limit, change or oppose selected state or federal actions. In Missouri, 77 percent of citizens recently voted against allowing the government to penalize citizens for refusing to purchase private health insurance. In Virginia, the state is suing the federal government to avoid implementing the law. On Aug. 2, the United States District Court for the Eastern District of Virginia rejected a motion by the government to dismiss the suit.

As a result of the challenges facing states and the various state reactions to health reform implementation, the American College of Cardiology (ACC) and its state chapters are working with state lawmakers, insurance commissioners and other officials to protect the interests of cardiovascular care providers and the patients they serve.

The ACC this past year joined the National

Conference of State Legislatures (NCSL) in order to play a bigger role in state-level conversations about health care reform. At the recent NCSL Annual Meeting, the ACC and state chapter leaders heard from state lawmakers about their concerns for continued federal funding and state autonomy to administer Medicaid Programs, particularly the State Children's Health Insurance Program (SCHIP). While physician ownership, regulation of in-office procedures and medical liability issues were not on the official meeting agenda, ACC staff was also able to attend sessions and alert legislators of the importance of addressing these issues in order to provide patient access and quality care.

Prevention is another major area where the ACC and state chapters are playing increasingly larger roles. States are eager to avail themselves of funding to reduce smoking through quitlines and education and to reduce childhood obesity through improved school nutrition and physical education programs. In numerous states, ACC leaders have already worked with legislators and health care stakeholders to establish community education programs to improve health by establishing tobacco cessation and wellness programs. Efforts are underway to take these programs to the next level and/or bring similar programs to other states.

“Health reform brings with it many opportunities for the ACC and its Chapters to work with state lawmakers and other officials to develop and pilot programs that ensure patient access to quality cardiovascular care,” said ACC BOG Chair **Richard Kovacs, M.D., F.A.C.C.** “The key is to continue building relationships with lawmakers through programs like ‘Cardiologist for a Day’ bringing the legislators into the practice and experiencing firsthand the value of the Cardiology Professional. We need to work with payers and state officials to educate them about our guidelines and appropriate use criteria and resources like Hospital to Home and FOCUS. The ACC Chapter should be the source of unbiased information about quality cardiovascular care at the state level.”

Brian Webb, manager of health policy and legislation for the National Association of Insurance Commissioners (NAIC), said state concerns can be summarized into two words: money and time.



For more information on ACC Chapters, go to CardioSource.org and click on “ACC.”



Cardiology Practices Among Top EHR Adopters

In 1994, Nobel Prize winner and economist Kenneth Arrow understood the growing significance of information technology in shaping the economy. The same is true for the effect that information technology is having on health reform.

Over the last several years, the adoption and implementation of health information technology (IT) has reached new heights. A survey released by SK&A in February 2010 found a 36 percent EHR adoption rate in U.S. medical offices compared to 33 percent last year at the same time.

Some of this growth can be attributed to the U.S. government's health IT strategy, which includes financial incentives for adoption and use of EHRs. However, according to recent surveys, type of medical specialty and practice size are also playing roles in adoption and use. Surveys of cardiologists over the course of this year suggest that in general the bottom line impact of EHR to the business also remains a powerful determinant in acquisition.

In terms of medical specialty, SK&A research reveals that allergy/immunology, general surgery, and general practice are less likely to have an EHR. According to the ACC's recent Practice Census survey, cardiology practices are among the specialties more likely to be using EHRs. The majority (59 percent) of census respondents reported that their main location is already using an EHR. Additionally, another 26 percent indicated that they will adopt an EHR within the next

one to two years.

Practice size also plays an important role in adoption rate. According to the ACC's Practice Census, large practices (50 percent) and medium-size practices (41 percent) are more likely to have an EHR in place, while just over one-third (34 percent) of small practices have adopted an EHR. However, small practices represent a growth segment for EHRs as more

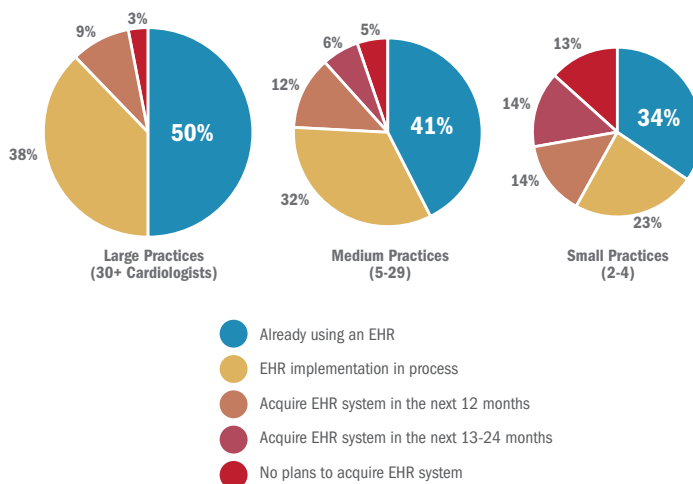
than one-quarter of them (28 percent) expect to adopt an EHR in the next one to two years.

John Glaser, vice president and chief information officer of Partners Healthcare in Boston, recognizes the challenges that universal EHR adoption will present. "The implementation plans are good plans. Change of this magnitude will bring very real progress, but it will also bring a period of time that will be bumpy," he said. "The strategy is ambitious, multifaceted

and sophisticated. This journey faces many uncertainties and will not be easy."

For more information on health IT adoption visit the ACC's resource center at CardioSource.org/healthIT. You can also view a special interview with ACC CEO Jack Lewin, M.D., and David Blumenthal, M.D., national coordinator for Health IT, on the federal EHR incentive program.

EHR Adoption by Practice Size





Meaningful Use of Electronic Health Records: A Pathway to Higher Quality and Effectiveness of Care

By David Blumenthal, M.D., M.P.P., Donald Berwick, M.D., M.P.P. and Ralph Brindis, M.D., M.P.H., F.A.C.C.

For many years, health care providers have been hearing about the benefits of health information technology (IT), particularly the adoption of electronic health records (EHRs). Health policy leaders have pointed to gains in quality, safety and effectiveness of care that had been achieved by pioneer adopters. Bipartisan political support has increasingly been expressed. And at innumerable conferences, the question has been repeated: “Are we finally at the ‘tipping point’ for EHR adoption?”

So far, the reaction among the medical profession has been cautious. It is providers who must carry out the transition to EHRs, and the change poses significant implementation challenges and financial commitments. For smaller practices in particular, early adoption has involved a number of unknowns. Fears of making a substantial financial investment in a particular EHR vendor that could fail as a business, or selecting a vendor that would not meet the physician's changing EHR needs, has often led to EHR “purchase paralysis.” Cardiologists have been among the earliest adopters of EHRs and leaders in health IT adoption. But overall, only about two out of 10 physicians are now employing EHRs; and for smaller practices, the proportion is even lower.

For several reasons, however, we believe that the uncertainties and hesitancy that have marked EHR

adoption so far can and will change over the next two years, as clinicians become more and more aware of the potential for significant improvement in clinician performance and patient care that is possible with the support of EHR systems. As has been demonstrated over and over again, EHRs will help us do our jobs better.

In addition, there are new factors that will also help speed adoption and use in the near term. First of these is a set of new financial incentives, offered through Medicare and Medicaid and backed by new federal programs of technical assistance. Under the Health Information Technology Economic and Clinical Health (HITECH) Act, adopted last year, up to \$27 billion in incentive payments over 10 years is available to eligible professionals and hospitals that demonstrate “meaningful use” of certified EHR technology. Eligible health profes-

sionals who use EHRs can qualify for incentive payments totaling as much as \$44,000 per clinician under Medicare or \$63,750 under Medicaid. At the same time, a new nationwide system of Regional Extension Centers (RECs) will provide assistance, especially to smaller practices.

Second, in tandem with the financial incentives, is an even more important element: a new conceptual structure called “meaningful use,” that will help guide the health care system and individual providers in achieving success in the use of EHRs. “Meaningful use” aims at three objectives. To begin with, it is a set of objectives and measures that providers must meet to qualify for incentive payments. Similarly, it defines the functionalities that EHR products must include to be certified, so that providers can invest with confidence. Most important, “meaningful use”

objectives serve to lay out a pathway to success in our national transition to an electronic health care environment. In place of uncertainty for the provider and incompatibility among EHR products, “meaningful” use outlines the essential steps to success for clinicians and then ensures that certified EHR systems will support those steps.

The “meaningful use” approach was developed in detail through an open and inclusive federal rule-making process. It was structured as a multi-stage process to be phased in over 10 years, with less

In place of uncertainty for the provider and incompatibility among EHR products, meaningful use outlines the essential steps to success for clinicians and then ensures that certified EHR systems will support those steps.

demanding goals in the first years and a rising bar over time.

Final meaningful use rules for the Stage 1 years (2011-2012) were announced on July 13. The final rules accommodated initial provider concerns about the feasibility of Stage 1 objectives. While the goals remain ambitious, the Stage 1 objectives are designed to be achievable by the average practitioner. These objectives help ensure that the most important elements of EHR-based care will be introduced into the provider setting in an orderly fashion. In this way, they build the foundation for greater improvements in care over time.

For example, core objectives in Stage 1 begin with the most basic of requirements. Patient demographics, vital signs, and a beginning problem list of current and active diagnoses must be created in an EHR for most patients in a practice. While this may be elementary, such uniformity in data entry and ready availability of patient information can actually represent an important new foundation to support safety and effectiveness in care coordination, teamwork and patient hand-offs.

Other core objectives for Stage 1 include initiation of medications and medication allergy lists for most

patients. Entry of such basic data in structured formats lays the groundwork for decision support and clinical guideline tools that ultimately will help clinicians to consistently deliver up-to-date evidence-based care, avoid errors and accurately document care decisions.

In addition, Stage 1 core objectives require practitioners to begin using e-prescribing and computer provider order entry (CPOE) for a portion of their medication orders. These are steps that begin to change workflow patterns, and that can be challenging for any

practice. But it is these uses that harness the computing power of EHR systems and will ultimately be transformative for quality and effectiveness of care. Stage 1 objective levels are designed to be achievable and to enable the average small practice to begin the journey now toward full exploitation of EHR capabilities over time.

Other core objectives include the ability to begin sharing summaries of office visits and instructions with patients in electronic formats; to begin testing and using electronic exchange of information, including privacy and security protections; and to begin reporting clinical quality measures to CMS or states, a process that will ultimately expedite and simplify quality reporting and clinician benchmarking.

All of these objectives are of value in the practice of cardiology, where clear communication between care settings is crucial; where patients are at often risk for medication errors or confusion; where patients’ drug information for anticoagulation and other purposes is so important; and where the ability to consolidate multimedia in a single medical record (including lab tests and imaging results of many kinds) is so promising.

The ACC has long been a leader among professional organizations in encouraging its members to move toward adoption and use of EHRs. The College continues to work closely with the Office of the National Coordinator for Health and Information Technology and CMS to ensure that concerns of cardiologists are addressed. Additionally, the ACC has made resources available to assist cardiology practices as they consider investing in EHR systems. The College has created an online EHR selection toolkit, as well as a cardiology-focused analysis outlining the EHR incentive program requirements. Next year at ACC.11 in New Orleans, two health IT spotlight sessions will help members just as registration for the federal incentive payment program is underway.

For cardiologists, as for other health providers, the time for widespread EHR adoption and use has truly arrived. The incentive payment program especially rewards those who take action during Stage 1. And the path laid out to become a “meaningful user” of EHRs provides not only guidance and achievable goals for individual practitioners, but also assurance that certified EHR systems will do the job, as well as system-wide alignment toward improved quality and effectiveness for health care in the U.S.

In past years, the ACC has suggested that EHR adoption was not a question of “if” but “when.” Today, the best response is clear: the time for action is now. For the practitioner, Stage 1 of the EHR incentive program, beginning in 2011, provides achievable goals, guidance for success, leadership among colleagues, an orientation toward the future, and most of all better care and outcomes for your patients.

Additional information on the Medicare and Medicaid EHR incentive programs may be found at www.cms.gov/EHRIncentiveProgram or CardioSource.org/healthit.



Blumenthal



Berwick



Brindis



New CV Practice Improvement Pathway to Assess and Recognize Commitment to Quality Improvement

As the health care delivery system evolves from one based on volume to one based on value, the American College of Cardiology (ACC) has identified a need for practices to be able to demonstrate their commitment to continuous quality improvement and their achievement of established quality thresholds.

In an effort to meet this need, the ACC will launch the Cardiology Practice Improvement Pathway (CPIP) later this year. The pathway, formerly the Cardiovascular Practice Recognition Program (CVRP), is designed specifically to enhance and instill quality in cardiovascular practice and to:

- Help practices establish relevant quality goals and targets
- Provide a road map to guide performance improvement activities
- Bring consistency to market by standardizing the methodology for how cardiovascular practices are assessed and recognized.

CPIP, which will be available via the College's new Lifelong Learning Portfolio, will provide cardiology practices with the opportunity to learn about their practice patterns at the group level and to understand how they measure up against the quality goals and targets established by their medical specialty society. Practices will receive immediate feedback on their performance with recommendations for developing and implementing quality improvement plans based on their results.

Based on feedback from the CVRP pilot program, CPIP is initially organized within three domains to demonstrate a practice-level commitment to continuous quality improvement: clinical, structural, and professional. The clinical measures are the measure sets developed and specified by the ACC with the American Heart Association and the American Medical Association's Physician Consortium for Performance Improvement for Hypertension, Stable Coronary Artery Disease, Heart Failure and Atrial Fibrillation/Atrial

Flutter. The structural metrics are intended to identify and evaluate the implementation of practice-level systems that are believed to promote quality care (e.g. use of electronic medical records and prescribing systems; participation in clinical registries; and use of accredited labs for diagnostic imaging). The professional metrics are intended to evaluate the practice-level commitment to professionalism by identifying the status of each individual cardiologist with regard to board certification, subspecialty certification, continuing medical education and fellowship designation.

Ultimately, CPIP will allow practices to:

1. Meet requirements for American Board of Internal Medicine Maintenance of Certification (MOC) Part IV (application in process), and
2. Apply for special cardiovascular practice recognition from Bridges to Excellence (BTE).

The BTE recognition component was developed by the ACC. Practices can choose to apply for BTE recognition by submitting their CPIP assessment data to an independent professional assessment organization. Practices that meet the performance thresholds for recognition established by the ACC will receive the co-branded ACC/BTE Cardiology Practice Recognition. BTE recognition is currently rewarded by several national health plans with quality designation, including: Aetna Aexcel; Anthem Blue Precision; and United Premium Designation. CIGNA will include BTE-recognized physicians and practices in their CIGNA Care Designation in 2012. Many regional Blue Cross and Blue Shield Plans use BTE Recognition in their pay-for-performance programs.

In addition, the ACC and BTE are working on multiple fronts with health plans and employer coalitions to develop new payment models that will help BTE-recognized cardiology practices to participate in value-based payment and performance-based contracting programs administered by health plans, employer groups, and the Centers for Medicare and Medicaid Services.

Stay tuned for more information on CPIP on the "Science and Quality" section of *CardioSource.org*. Questions can also be directed to cpip@acc.org.



Cardiac Rehabilitation: Your Journey Back to Heart Health

In January 2010, the ACC undertook an initiative to bridge an important gap in patient education: cardiac rehabilitation.

With funding from the Keeping PACE: Patient-centered ACS Care Education and credo initiatives, ACC went to the Duke Center for Living in Durham, N.C., to speak with three recovering heart patients about how cardiac rehabilitation has helped change their lives.

The resulting video, *Cardiac Rehabilitation: Your Journey Back to Heart Health*, can be viewed at www.cardiosmart.org/cardiacrehab.aspx. It brings professional education, quality improvement/registry data and the patient together in a powerful and profound way.

Cardiac Rehabilitation was designed to show patients what to expect from a cardiac rehabilitation program; to help them understand the importance of attending a program; and to remind them about requesting a cardiac rehabilitation referral. The video provides key insights into what patients will learn at a cardiac rehabilitation program, as well as some of the barriers patients often face, and what can be done to overcome those barriers.

"There's no question cardiac rehabilitation makes a major impact on people's quality of life," **William Kraus, M.D., F.A.C.C.** says in the video. "If your doctor didn't mention it to you, it's because your doctor forgot. It's not okay not to go to cardiac rehab because your doctor didn't refer you."

ACC will be showcasing this video throughout 2010 and 2011 at various cardiac events throughout the country. Members interested in obtaining a DVD copy of the video can contact Melissa Ketchum at mketchum@acc.org.

A special thank you to **Ileana L. Piña M.D., F.A.C.C.**, Dr. William Kraus and the staff at the Duke Center for Living for their work in producing this video.

Education Briefs

ACC Becomes Co-Sponsor of TCT Symposium

Beginning in 2011, the American College of Cardiology (ACC) will become an official co-sponsor of Transcatheter Cardiovascular Therapeutics (TCT), the annual medical and scientific symposium of the Cardiovascular Research Foundation (CRF). The future meetings will be known as "Transcatheter Cardiovascular Therapeutics in Partnership with ACC." CRF and ACC have had an existing partnership agreement since 2008, whereby CRF helps coordinate the interventional content at the Innovations in Interventions (i2) Summit at



ACC's Annual Scientific Sessions meeting. The enhanced partnership involves sharing content and distribution of educational materials. The two organizations will form a physician-led "Collaborative Council" of senior physician leaders which will meet regularly to review progress towards established objectives and to set the strategic direction of the affiliation. ACC and CRF staff will also meet regularly to share best practices, consider joint procurement of vendors, consider reciprocal exposition space at annual meetings, and explore collaboration around industry training programs.

Risk Management Institute

Cardiovascular physicians and practices now have access to cardiology case-based risk management education tools and information with the launch of the ACC Foundation Risk Management Institute (ACCRMI). The goal of ACCRMI is to help cardiovascular physicians and practices increase patient safety and reduce the risk of medical professional liability (MPL) claims. ACCRMI's education tools draw from real life in cardiovascular medicine because they are built from data regarding trends analysis gathered from closed medical professional liability claims involving cardiovascular disease treatment. To help develop the ACCRMI, the Physician Insurers Association of America (PIAA) shared information with ACC from closed claims between 1986 and 2008.

ACCRMI participants will have access to several tools, including:

- Case studies with cardiology specific medical-legal commentary
- Educational modules with CME/CE credit and access to an online forum
- E-alerts on time-sensitive risk management topics
- E-bulletins filled with real-life applications of techniques and procedures to reduce risk and limit exposure to professional liability claims.

Participants will also be eligible for discounts on insurance from partnering companies and significant discounts on programs from Emmi™ Solutions, which offers patient communications tools. The ACCRMI has formed a strategic partnership with the Risk Management and Patient Safety Institute (RM&PSI) - a national leader in clinical risk management practices and patient safety programs for health care institutions and providers. The ACCRMI has also partnered with ProMutual Group, along with its subsidiaries MHA Insurance Company and Washington Casualty Company. Subscribers may receive up to a five percent premium credit on professional liability insurance for risk management education each renewal year based on hours of education completed.

The ACCRMI exemplifies ACC's strong and active commitment to assisting cardiologists with the improvement of their individual practices, the enhancement of quality and patient outcomes and the visibility of cardiology as a medical resource for the general public.

To learn more about the ACCRMI, visit CardioSource.org/rmi.

Snowmass Registration

Cardiovascular specialists and other medical professionals interested in general cardiology management can register for the American College of Cardiology Foundation's 42nd Annual Cardiology Conference in Snowmass, Colo.

Jan. 10-14. The conference is an in-depth review and update on the latest diagnostic, therapeutic and preventative approaches to cardiovascular disease. Learn more and register at CardioSource.org/cvconfsnowmass

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Transforming STEMI Care Through Medical Simulation

By Pat Lucken F.N.P.-C., C.P.H.Q.

Simulation is emerging across the country as a promising technology with multiple medical applications. Evolving from the aviation world, medical simulation looks to improve communication between teams while they navigate through emergency and other medical situations in a safe, educational environment.

This past March, attendees at the ACC's 2010 Annual Scientific Session in Atlanta were able to experience simulation first-hand in the "This is a Drill: Simulation Education Exercise to Test Teamwork and Leadership Skills in an Acute STEMI Door-to-Door Scenario."

At the time, session chair William Hamman, M.D., Ph.D., noted that the video and debriefing associated with simulation exercises is "where the learning really takes place – when health professionals can see the dynamics of their interactions and how critical information is getting missed."

Recently, St. Mary Medical Center, a 186-bed facility in Apple Valley, Calif., participated in its own endovascular coronary simulation involving a STEMI scenario. Led by a cardiologist who was also a former airline pilot, the day began with a nurse actor portraying a person suffering chest pain in a hotel room. Local EMS agencies participated and ran the call just as they would a real 9-1-1 response.

Once in the emergency department (ED), the actor patient - wearing blue tinged baby oil to make him look convincingly ill - was evaluated by the medical team. He was sent to the cath lab, where the cardiologist received feedback about the patient's condition,

including the sizing of the simulated vessel.

The scenario, which was audio and videotaped for later critique by the team, showed where there was room for improvement, including:

- Having EMS use a standard hep lock to start the field IV, in order to ensure compatibility with hospital tubing.
- Defining standard roles in the ED for a scribe nurse and a hands-on nurse.
- Incorporating a checklist into the standard PCI flowmap to ensure cath lab preparation is complete. This check list includes documenting clothing and hair removal, procedural consent, copies of the 12-lead EKG, two IV lines, proper pacing pad placement and STEMI box.
- Implementing an overhead "Code STEMI" page for ancillary departments. (This has been Beta tested

and the response times are less than two minutes.)

- Creating a STEMI box that contains all needed equipment.
- Discontinuing the practice of applying nitropaste in favor of IV nitroglycerin, which is easier to titrate.

The hospital also found that while the actor patient was diagnosed and treated successfully during the simulation, key information was not always handed off between teams, despite repeatedly obtaining the patient's history throughout the process flow. In



Scenes from the simulation drill performed during ACC.10 in Atlanta

addition, there were many transfers of gurneys and EKG monitors from the field to the cath lab, which added time.

The learning has not stopped there. St. Mary Medical Center is using simulation to teach the public how to handle emergency situations. During the public sessions, a volunteer from the audience or an EMS crew pretends to develop chest pain and people in the audience are taught when to call 9-1-1 and what to do while waiting. The sessions have helped to strengthen ties between the community, EMS and the facility while providing life saving information.

Lucken is the director of Cardiac Service Line at St. Mary Medical Center.

Message from the Chair

BOG Meeting ‘Kicks Off’ ACC’S 2010 Legislative Conference

By Richard Kovacs, M.D., F.A.C.C.



As cardiology continues to change, the goal of the ACC and its chapters is to keep members informed of the national and local trends that are impacting the practice of cardiovascular medicine. The College’s Board of Governors met in September for its third and final regularly scheduled meeting of the year to discuss these trends and learn about ACC efforts to help members meet the challenges associated with these trends head on.

The meeting kicked off with a first look at the recent ACC 2010 Practice Census (see page 4). This chapter-led survey resulted in more than 2,400 responses from practices in 49 states and Puerto Rico. These results will be used to educate Congress and other policymakers about the national and state-level impacts of ongoing Medicare cuts and health reform implementation.

BOG members were also able to discuss and share strategies related to other issues of importance to states including local coverage determinations, radiology benefit managers and the public reporting of PCI data. Also key, members were given inside looks into

ways the College is paving the way to address national and state-based trends. Whether it’s harnessing technologies that put guidelines at the bedside, working with health plans to develop a tool that focuses on ensuring appropriate use of medical imaging, or developing a “Cardiovascular Practice Improvement Pathway” that recognizes quality, evidence-based care, the College has a number of new initiatives underway to meet the needs of members. In addition, the PINNACLE Network and Registry are working to ensure data-driven system development, increased adherence to practice guidelines, provide lifelong learning opportunities and ensure appro-

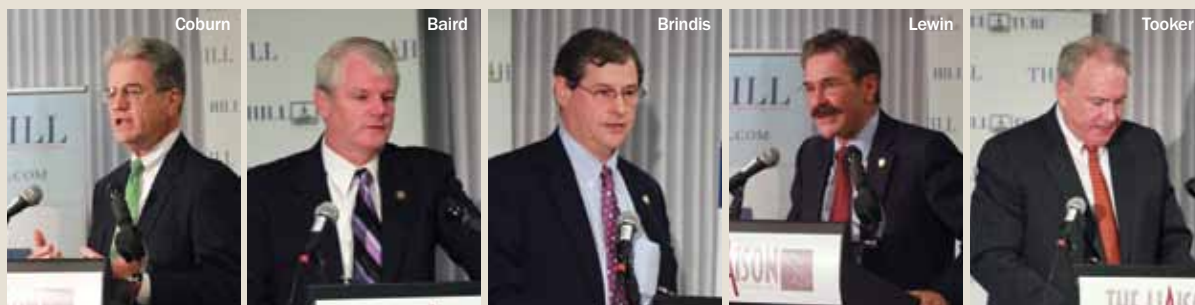
priate payment and recognition.

Guest speakers, including Joshua Seidman, Ph.D., director of the Meaningful Use Group for the Office of the National Coordinator, were also on hand to provide insight into other areas of interest to cardiology. Seidman provided answers to questions about the new federal EHR incentive program. In addition, **George Diamond, M.D., F.A.C.C.**, and **Sanjay Kaul, M.D., F.A.C.C.**, of Cedars Sinai spoke on the subject of “From Clinical Trial Evidence to Practice Guidelines: Lost in Translation.” Their presentation encouraged discourse around the challenges associated with the development of clinical guidelines.

The College has many opportunities to lead and help shape the new health care landscape. Much of the work in terms of implementation will take place at the state level. Coming out of this meeting – on a football Sunday no less – I believe the College is prepared to carry the ball into the end-zone.

ACC and The Hill Host Payment Policy Breakfast

The American College of Cardiology (ACC) and *The Hill* newspaper hosted Senator Tom Coburn (R-Okla.) and Rep. Brian Baird (D-Wash.) for a discussion on physician payment reform on Capitol Hill. Other speakers included ACC President **Ralph Brindis, M.D., M.P.H., F.A.C.C.**, ACC CEO **Jack Lewin, M.D.**, and American College of Physicians CEO John Tooker, M.D., M.B.A., M.A.C.P. The event highlighted ACC efforts to lead the way in payment reform by creating better models of care for patients and using innovative tools for enhanced quality management.





The ACC Board of Governors: An Evolution of Leadership

The evolution of the ACC's Board of Governors (BOG) has been that of power, downfall and resurrection. In 1951 the BOG emerged as a leadership body within the ACC with representatives from 22 ACC chapters. In its infancy the board quickly gained esteem, so much so, that other leadership bodies at the time felt it was becoming too great a governing power. In the fall of 1954 a choice was made to dissolve the BOG, abolishing the chapters in the process.

Over the course of the next few years, however, the College gained in prestige and importance and membership applications from physicians vying for F.A.C.C. accreditation proved to be overwhelming. A few short years after it was disbanded, the BOG was reinstated in an administrative capacity to analyze and process membership applications. Thirty-five ACC governors were appointed by the Board of Trustees to pour over their peers' applications looking for those deserving of the F.A.C.C. designation.

It wasn't until the mid-1980s that governors started to regain their status as College leaders. With the emergence of new chapters and talk of health care reform under then President Bill Clinton, the BOG was needed to help the ACC reconnect with its members and to serve as the eyes, ears and voice of cardiovascular professionals across the country.

Today, with more than 60 members, the BOG continues to help ensure that the ACC remains a credible and viable entity at the local and national level. The job of each governor is to ensure the College is doing all it can to support member education, advocate for sound health care policies and ensure quality care both now and for future generations. As health care changes, for good or bad, the BOG is the conduit for ensuring the practice of cardiology evolves along with these changes. At the end of the day, the ultimate goal is to ensure practice viability and timely, quality care for patients with heart disease.

The full history of the Board of Governors can be found online at www.cardiosource.org/boghistory.

Don't Forget to Vote!

ACC governors have been elected by the membership since 1966. Elections for nearly one-third of governorship occur every fall with a three year rotation for each state. This year, the Board of Governors (BOG) and Cardiac Care Associate (CCA) Liaison elections are open from Oct. 19 to Nov. 16.

In 2010, BOG elections will be held in Alabama, Northern and Southern California, the District of Columbia, Illinois,

Louisiana, Maryland, Montana, New Jersey, Upstate and Downstate

New York, Ohio, Ontario

Canada, South

Carolina, Tennessee,

Virginia, West Virginia

and Wyoming.

Visit www.Cardio-Source.org/Elections

for more information

and details on the

election process, or contact

National ACC Chapters staff at

202-375-6657.

Disclaimer: All ACC members are eligible to vote in the BOG elections. Only CCAs can vote in CCA Liaison elections.

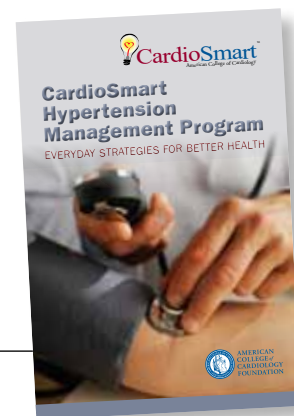


Hawaii CHAPTER

Hawaii has become the latest chapter to join the American College of Cardiology. During the September Board of Governors' meeting, Hawaii Governor **Joana Magno, M.D., F.A.C.C.**, made the Hawaii Chapter official. With the addition of this new chapter, all 50 states and Puerto Rico now have ACC chapter representation. Stay tuned for a profile of the Hawaii Chapter in the Nov./Dec. issue of *Cardiology*.

ACC Welcomes Saudi Arabian Chapter

Saudi Arabia has applied for, and been recommended for chapter status by the ACC Executive Committee. Saudi Arabia will become the 8th ACC International Chapter, joining Brazil, China, Israel, Turkey, Germany, Malaysia and the UK/Ireland. The ACC's international chapters provide a venue for members to meet and discuss issues relevant to the practice of cardiology in their home country. Like all ACC chapters, they also offer leadership opportunities and a forum for mentoring and networking with colleagues. The ACC is working with many of the international chapters to identify opportunities for educational partnerships, registry development, research collaborations and quality initiatives.



California Serves as Testing Grounds for New CardioSmart Hypertension Management Program

When parents are in the hospital with a newborn baby, they are given numerous instructions and advice about what to do and how to care for their child. They leave with a goodie bag of supplies and once home, say “Now what?” But, in the bag are tangible reminders to help guide them through, such as informational pamphlets, formula and diapers.

The American College of Cardiology Foundation (ACCF) has created a new pilot program called the CardioSmart Hypertension Management Program it hopes will offer similar tools to help cardiology patients better manage their health, medication and treatment plans and make the advice given to them by their physicians actionable.

“In those bags parents get from the hospital are simple things, but they’re helpful in making the transition – we don’t have that for heart patients,” said **Elizabeth Klodas, M.D., F.A.C.C.**, director of Cardiovascular Imaging at Cardiovascular Imaging Consultants in Minneapolis.

The CardioSmart Hypertension Management Program features a free, interactive resource on *CardioSmart.org* which includes educational modules, a blood pressure tracking/management tool, and support information – all designed and developed by ACC members. The program allows physicians to actively engage patients in their own health management and help them succeed in attaining their blood pressure goals.

The program is scheduled to begin its six-month pilot phase in California this fall and hopes to enroll 5,000 patients. If proven successful, ACC wants to expand the program into the rest of the states and Washington, D.C. The California Healthcare Foundation gave \$150,000 to help fund the program and pharmaceutical company Forest Laboratories gave \$100,000. The Preventive Cardiovascular Nurses

Association provided educational content. ACC has also partnered with Peoplechart Corporation in the development of CardioSmart disease management tools.

Klodas said from its inception, CardioSmart was going to be more than just an informational website for patients - it is meant to be an interactive resource, and the hypertension management program is a way to do that.

“It’s about how your physician [or nurse] telling you something then translates into action,” she said. “We can have all of these lovely guidelines but if patients aren’t engaged, the end result doesn’t change. We need to get people involved in their own health.”

George L. Smith, M.D., F.A.C.C., ACC Northern California governor and senior partner at Northern California Medical Associates, said there is no question patients will want to enroll in the hypertension program and believes it will be a useful tool for them. His concern, which echoes feedback from his colleagues and also what Klodas

has heard from other cardiologists, is time. Patients will have the time to participate, but doctors don’t have extra time to spare, he said.

“In projects like this, those of us on the ground immediately see practical problems and the real concern is about how much involvement doctors will have. If it adds too much of a burden for doctors, it won’t work. This program, however, is designed to be user friendly for physicians and members of the practice as well as patients,” he said.

In moving forward, Smith and Klodas said they hope the project will expand beyond cardiovascular specialists to nurses and primary care physicians and their practices – the ones who see a larger number of high blood pressure patients, and only a small segment of whom are being targeted for the pilot.

CardioSmart Hypertension Management Program Overview

The pilot is designed to help patients diagnosed with hypertension attain blood pressure levels recommended by the JNC-7 guidelines. The program will:

- Clearly identify each patient’s goals for target blood pressure
- Educate them about the risks associated with high blood pressure and how levels can be decreased through lifestyle changes and medication adherence
- Explain how to self-monitor and record blood pressure readings
- Describe how to work with a health care provider in managing the condition
- Provide incentives for ongoing participation

ACC Partners with Consumer Companies on Patient-Centered Projects

In support of its efforts in patient-centered care, the American College of Cardiology (ACC) is partnering with The Coca-Cola Company, Colgate-Palmolive and General Mills as part of the CardioSmart National Care Initiative. The College has begun engaging national sponsors to support its efforts to promote active patient participation in their care and to empower individuals at risk to make better, more heart-healthy lifestyle choices. Working with national consumer products companies is just one way in which the College plans to deliver heart-healthy strategies to patients as well as to those who are at risk for heart disease. Other elements include

- Delivering patient-centered tools to physicians' offices in order to provide added value to the traditional office visit;
- Providing a comprehensive, web-based platform with information on disease management and smart, practical tools that empower patients to participate in their own care; and
- Developing a series of community-based events that provide everyday strategies to improve heart health.

Additional supporters of a selection of the CardioSmart-related initiatives outlined above include: AstraZeneca, Boehringer Ingelheim Pharmaceuticals, Inc., Boston Scientific, Bristol-Myers Squibb/sanofi Pharmaceuticals Partnership, Daiichi Sankyo, Inc. and Lilly USA, GlaxoSmithKline, Medtronic, Merck, Novartis, Pfizer, sanofi-aventis, Takeda Pharmaceuticals North America, Forest Laboratories, Inc., and the California Health Care Foundation. ACC has also partnered with Peoplechart Corporation in the development of CardioSmart disease management tools.

The ACC has established a set of policies related to the selection of and partnership with sponsors associated with the CardioSmart program. Visit the "About ACC" section of *CardioSource.org* to view the full policy (www.cardiosource.org/CardioSmartPartnershipPolicies).

Stay tuned for more details on this initiative in the Nov.-Dec. issue of *Cardiology*.

Registration for ACC.11 & i2 Summit Opens in September

The American College of Cardiology's 60th Annual Scientific Session and Expo and Innovation in Intervention: i2 Summit will take place April 2 - 5, 2011 in New Orleans.

ACC.11 will feature cutting-edge science, innovation, education, networking and intervention. Highlights include 11 learning pathways, interactive learning experiences, Lifelong Learning and recertification opportunities and revolutionary interventional cardiology. The i2 Summit 2011 will emphasize the translation of evidence-based science and clinical trial data into daily interventional practice, and will feature "Late Breaking Clinical Trials," challenging case reviews, live case procedures and a renewed emphasis on taped cases with expert panel interpre-

tation. Attendees are encouraged to arrive early to take advantage of Saturday's pre-conference symposiums.

Registration for ACC members opens Sept. 14 and non-member registration opens Sept. 28. New this year, ACC members can take advantage of a special ACC.11 and i2 Summit "Full-Access Passport." The passport includes:

- Special full access registration rates
- Exclusive early registration and hotel selection

- VIP seating in the main tent room
- Access to the VIP Member Lounge, featuring a relaxing place to meet with colleagues and check e-mail, personalized assistance with restaurant recommendations and reservations, tickets to local events and attractions, travel and hotel assistance and more with the Member Concierge Service
- Dedicated on-site member registration

For more information on ACC.11 and i2 Summit visit www.accscientificsession.org.



60th Annual Scientific Session & Expo



innovation in intervention
ACC in partnership with CRF

April 2 - 5, 2011 • NEW ORLEANS
Exhibits: April 3 - 5

Be a Part of the Science

Abstract Submissions for ACC.11 and i2 Summit 2011 is open Aug. 30 through Oct. 14. In addition, don't miss this opportunity to present at ACC.11. Apply online for the Young Investigators Awards by Oct. 14. For more information, visit: www.cardiosource.org/researchawards.

Board of Trustees Meeting Focuses on Deliverables

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



The American College of Cardiology Board of Trustees (BOT) meeting was held in Maine in August. All BOT physicians were present, as were many of the key members of ACC staff.

As a general rule, there are several principles for any successful BOT meeting: specific crucial issues to be addressed need to be identified ahead of time; the members of the Board need to have material for discussion prior to the meeting; there should be open active involvement and dialogue by all participants; frank and open discussion is very important; the discussions should always be respectful of every one and their individual opinions; opportunities for learning should be offered and eagerly accepted; and there should be attempts to reach consensus but unanimity is not required. In regards to this later issue, if any Board is considering real fundamental issues, the relevance of the following quote is important.

“If two people agree on absolutely everything, you may be sure that only one is thinking.”

LYNDON B. JOHNSON

The summer BOT meeting met and exceeded all of these criteria. In terms of the latter requirement, we reached consensus on many issues.

These are challenging times in modern medicine – not just for cardiovascular disease. The BOT discussed the issues of advocacy, the future of medical care with accountable care organizations (ACO), the role of the cardiovascular specialist, the central importance of science and education as a core value for members and our patients, the complexities of conflict of interest (COI), the role of registries, the interaction with

other medical societies, and the global role and mission of ACC. Each of these topics was discussed as an overall group and then in small breakout sessions.

A crucial issue was the need to define deliverables. A huge amount of talent and great ideas were present at the BOT; however without deliverables, given that all of us have “great memories

These are challenging times in modern medicine – not just for cardiovascular disease... A huge amount of talent and great ideas were present at the BOT... great ideas may never surface in reality and are not enough. We need to deliver.

but just short,” great ideas may never surface in reality and are not enough. We need to deliver. Given the fact that ACC resources are not limitless, except “our vision and our ambitions which are not bounded by anything except our ability to imagine,” the BOT also tried to provide some guidance to staff about tiers of importance.

Multiple deliverables were identified:

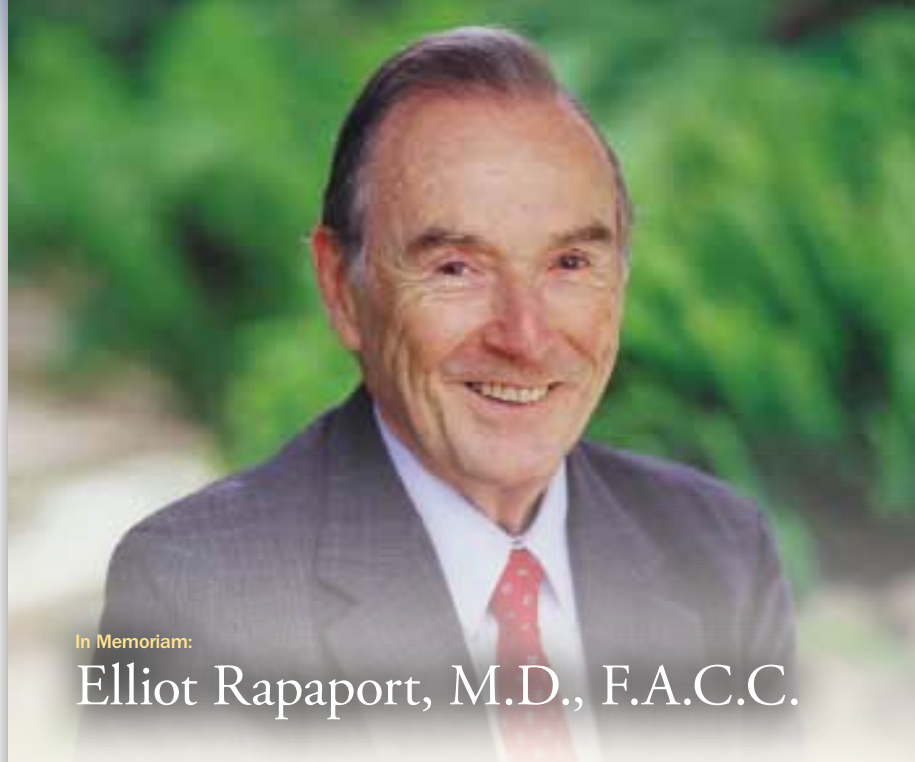
- **Just-in-time strategies** have changed dramatically because the technology has improved so substantially. We reviewed technology that can be used to transform and transfer guidelines and other documents into a handheld easily searchable device that would offer the physicians the chance to query information just before seeing the patient. This would be of great member value and is being researched to be presented at the December BOT meeting. One BOT member described the technology as “... the keys to the Kingdom for member value.”
- There is a **Presidential Task Force**
- There is great interest in **the continued relationship between ACC and CRF**. This partnership has been exceedingly valuable for the i2 Summit. A closer relationship is being actively explored with the development of potential business plans.
- There was free and open discussion about **the crucial nature of guidelines**. These form an incredibly important source of information and an incredible amount of expertise. A committee with the American Heart Association (AHA) chaired by **Alice Jacobs, M.D., F.A.C.C.**, is evaluating several pilot projects to optimize a guideline process to ensure its scientific rigor as well as its relevance. A report will be given at the BOT meeting in December related to that.
- We had an extensive discussion on **the central role of registries**. NCDR has been magnificent in terms of its scientific value. ACC needs to continue to work on approaches to expanding funding and staff and modernize these registries. These efforts will allow us to utilize state-

evaluating the PINNACLE registry and addressing issues such as the deliverability of this registry, the issue of defining standards for electronic medical records, making sure that data collection is seamless in terms of workflow, and the resources required to implement this incredibly important registry for widespread use.

of-the-art information technology and enhance this incredible resource. A presentation by the NCDR management board is requested for December.

- The issue of **corporate relationships** was discussed in detail. This winds up being a potentially controversial issue but it has important ramifications for both our patients as well for the ACC alone. ACC is continuing to work with the PCP3 committee on developing optimal interaction strategies.
- The issue of **conflict of interest** has been raised and continues to have important implications for the documents and guidance of ACC. There is continued great interest in this field both from ACC staff and leadership, our membership, as well as the regulators. This will be an ongoing discussion that will continue at the BOT meeting in December.
- The importance of **science and education** was also emphasized. It is absolutely a crucial core value of ACC. Substantial discussion was entertained about how to bring these back to make them center place in ACC by reinvigorating abstracts and other educational formats and enhancing the relationship with AHA in terms of science. Upcoming program directors, Drs. **Rick Nishimura, M.D., F.A.C.C.** and **Patrick O’Gara, M.D., F.A.C.C.** for ACC and **Robert Harrington, M.D., F.A.C.C.** and **Elliott Antman, M.D., F.A.C.C.** from AHA will continue to work closely together on science and education.

It was an incredibly interesting and important board meeting that was characterized by free open discussion with active participation. There was no shortage of wonderful ideas. A crucial step is to prioritize these great ideas and implement them to optimize member value, societal value, and most



In Memoriam:

Elliot Rapaport, M.D., F.A.C.C.

Elliott Rapaport, M.D., F.A.C.C., a Distinguished Fellow of the American College of Cardiology (ACC) with accomplishments in cardiology that spanned more than a half century passed away on Sept. 5. He was 85 years old.

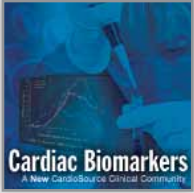
Rapaport earned his medical degree from the University of California, San Francisco (UCSF) in 1946 and went on to complete his internship and residency at the University of California Hospital in San Francisco (UCSF). He then completed a research fellowship and United States Public Health Service postdoctoral fellowship at the UCSF School of Medicine and a second research fellowship at Peter Brent Brigham Hospital, now Brigham and Women’s Hospital, in Boston. The culmination of his training led Rapaport back to San Francisco and the San Francisco General Hospital (SFGH) where he spent the majority of his career.

Rapaport established the division of cardiology at SFGH and served as its chief for more than 30 years. He also served as chief of staff and acting chief of medical service for SFGH as well as serving as the associate dean of the UCSF School of Medicine based at SFGH for 13 years where he led the expansion of numerous research programs and laboratories. In 2001, he became emeritus professor of medicine at UCSF School of Medicine and remained involved in the cardiology service at SFGH.

During his tenure as a researcher, he was known to have made influential contributions to the development of the indocyanine green dye and the thermodilution methods of measuring vascular blood flow and cardiac output. This illuminated the understanding of a number of cardiovascular diseases. Rapaport was also centrally involved in the development of the assays of creatine kinase and its isoenzymes used around the world for the diagnosis of acute myocardial infarction.

A true leader in the field, Rapaport became a Fellow of the ACC in 1976, served five years as editor-in-chief of the American Heart Association (AHA) journal, *Circulation*, and served terms as president of the AHA and the World Heart Federation. Despite being known for his perennial modesty, he was well decorated with awards including the honor of becoming a Distinguished Fellow of the ACC in 2009. He served on many ACC committees during his time as a member, including the *JACC* editorial board and several guidelines committees.

New on *CardioSource.org*



Integrate biomarkers into everyday clinical practice and enhance patient care with the **Cardiac Biomarkers Clinical Community**, at biomarkers.cardiosource.org. This new resource offers interactive case studies, expert commentary, "Question of The Month" polls, and more. Want to discuss cardiac biomarkers with your peers? You can also join the Biomarker Community at www.cardiosource.org/My-CardioSource/My-Communities.aspx



Participate in the free Performance Improvement activity **A New ERA: Evidence-based Stroke and Symptom Reduction in Atrial Fibrillation**. You can to earn up to 20 AMA PRA Category 1 Credits™ or contact hours for nursing professionals, as well as 20 MOC part IV points. Go to www.cardiosource.org/PIAfib.aspx to take part in this activity.



Are you a practice administrator looking to network online? Join the **Practice Administrator Group** on CardioSource Communities to exchange ideas, ask questions and network with other practice administrators. Visit www.cardiosource.org/My-CardioSource/My-Communities.aspx to join.



Starting in November 2010, the *Journal of the American College of Cardiology* (JACC) will be available on the iPad! This new **JACC iPad app** will offer everything you have come to expect from your weekly issue, enhanced with editor-selected resources from CardioSource. Visit www.cardiosource.org/JACCipad.aspx to learn more and sign-up for email updates.



How Can We Improve *CardioSource.org*? Site users offer their suggestions in the **"Technical Issues" forum in CardioSource Communities**, including improving groups and forums and site navigation. Give us your feedback at www.cardiosource.org/My-CardioSource/My-Communities.aspx



Increase patient safety and reduce medical professional liability claims risks with the **Risk Management Institute**. The institute provides practices with patient safety education created specifically for cardiovascular specialists, by cardiovascular specialists. To learn more or subscribe, visit www.cardiosource.org/RMI.



ACC Launches **credo Webcast on Healthcare Disparities**. Visit www.cardiosource.org/CREDO to learn about the need for credo and how it can work for you. Through stimulating webcasts, expert faculty will provide evidence-based presentations regarding the racial and ethnic disparities in cardiovascular outcomes.

Call for Committee Nominations and Applications

Volunteers are at the heart of the College's work. The ACC's strength is the result of the time, effort and dedication provided by those who volunteer to serve their colleagues and help cardiovascular professionals learn, advance and heal. If you would like to participate in the College's Committees and Councils, now is the time to let the ACC know. All College Fellows, Fellows in Training and Cardiac Care Associates are encouraged to nominate and/or apply. Applications are due Oct. 31. Applicants will be selected by ACC President-Elect **David R. Holmes, Jr., M.D., F.A.C.C.**, this fall and notified of their selection in January 2011.

To view the list of Committees with openings and to nominate and/or apply, please login at the Member Center on *CardioSource.org*. Applicants will be asked to list professional experience and practices outside of the College, honors and awards, most important publications, and any experience or qualifications that may qualify them for a requested committee. In addition, all applicants are required to submit a letter of reference from an ACC member.

For questions about the process, please contact Amanda Stout at 202-375-6342 or volunteers@acc.org.

CHIEF, DIVISION OF CARDIOLOGY-



THE UNIVERSITY
of TEXAS
HEALTH SCIENCE CENTER
AT HOUSTON

The University of Texas Medical School at Houston

is seeking applications and nominations for the position of Chief, Division of Cardiology.

This individual will be responsible for developing and coordinating the clinical, educational, and research programs of the Division, and effectively interfacing with the programs throughout the UTHSC-H system. The clinical practice encompasses large hospital systems and numerous outpatient clinics. The cardiovascular research community at The University of Texas-Houston and the Texas Medical Center is large, diverse, and known for cutting edge discovery. Strong leadership qualities, administrative skills, board certification in cardiology, and evidence of significant and consistent accomplishments in research, clinical service, and teaching are required. Qualified applicants must be able to obtain licensure in the state of Texas. The Division has grown exponentially in research and clinical activities over the past 4 years and is looking for an applicant to continue this trajectory.

Interested candidates should send a letter of interest, CV, and list of three references to:

**David D. McPherson, M.D., Chair Search Committee,
Division of Cardiology, Chief, Internal Medicine,
University of Texas-Houston Medical School, 6431 Fannin, MSB 2.156, Houston, TX 77030
E-mail: David.D.McPherson@uth.tmc.edu**

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About

Writing for Cardiology

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

Upcoming in

JACC

JACC cardiovascular Imaging

September 28

- Occupational, Commuting and Leisure-time Physical Activity in Relation to Heart Failure among Finnish Men and Women

October 5

- Comparison of Zotarolimus-Eluting Stents with Sirolimus-Eluting and Paclitaxel-Eluting Stents for Coronary Revascularization: The ZEST Randomized Trial
- Coenzyme Q10, rosuvastatin and clinical outcomes in heart failure: a pre-specified substudy of CORONA

October 12

- Testosterone therapy in women with chronic heart failure: a pilot double-blind randomized placebo controlled study
- Stress Testing After Coronary Revascularization: Too Much, Too Soon

October 19

- Prior Aspirin Use and Outcomes in Acute Coronary Syndromes
- Coronary Artery Calcification, an Improvement in Risk Classification, Need for Re-Appraisal?

October 26

- Long-Term Clinical Outcome based on Aspirin and Clopidogrel Responsiveness Status after Elective Percutaneous Coronary Intervention. A 3T/2R Trial substudy
- Risk Stratification for Sudden Cardiac Death: A Puzzle Beyond P-values

October

- The Impact of Endurance Exercise Training on Left Ventricular Torsion
- Prognostic Value of Global Magnetic Resonance Myocardial Perfusion Imaging In Women With Suspected Myocardial Ischemia and No Obstructive Coronary Artery Disease: Results From The NHLBI-Sponsored Women's Ischemia Syndrome Evaluation (WISE)
- Extent of Thoracic Aortic Atheroma Burden and Long-term Mortality after Cardiothoracic Surgery. A Computed Tomography Study
- Comparison of the Extent and Severity of Myocardial Perfusion Defects Measured by Computed Tomographic Coronary Angiography and Single Photon Emission Computed Tomographic Myocardial Perfusion Imaging

JACC cardiovascular Interventions

October

- Safety with ZES vs. PES in De Novo Coronary Lesions
- Vascular Response After DES in Patients with Diabetes
- Antiplatelet Effect of Increased Clopidogrel Dosing
- Same-Day Discharge After Uncomplicated Transradial PCI

Register Now for Evolving Models of Cardiovascular Practice Symposium

Registration is now open for the next Evolving Models of Cardiovascular Practice Symposium, which will be held in Naples, Fla., Nov. 5 and 6. The conference looks to help physicians and/or practice administrators make the best decisions for their practice given the changing health care environment. Participants will learn about various practice alignment and integration models from experienced managing physicians and practice administrators, legal and governance experts and will receive critical information on policies, proposals and the practical implications of change. Learn more and register at CardioSource.org/evolvingmodels.

Educational Programs Calendar



October 7 - 9, 2010

2010 Heart Valve Summit: Medical, Surgical and Interventional Decision-Making

David H. Adams, M.D., F.A.C.C.
Steven F. Bolling, M.D., F.A.C.C.
Robert O. Bonow, M.D., M.A.C.C.
Howard C. Herrmann, M.D., F.A.C.C., F.S.C.A.I.

Chicago
CME CE



January 10 - 14, 2011

42nd Annual Cardiovascular Conference at Snowmass

Spencer B. King, III, M.D., M.A.C.C.

Snowmass, Colo.
CME CE



January 21 - 22, 2011

5th Annual Heart of Women's Health

Joanne M. Foudy, M.D., F.A.C.C.
Suzanne Hughes, M.S.N., R.N.

Washington, D.C.
CME CE



October 21 - 24, 2010

2010 Foundations for Practice Excellence: A Core Curriculum for the Cardiovascular Clinician

Eileen M. Handberg, Ph.D., A.R.N.P., F.A.C.C.
Joseph S. Alpert, M.D., F.A.C.C.

Washington, D.C.
CE



February 11 - 13, 2011

3rd Annual Clinical Practice of Peripheral Vascular Disease

Michael R. Jaff, D.O., F.A.C.C.
Christopher J. White, M.D., F.A.C.C.

Phoenix
CME CE



December 3 - 4, 2010

How to Become a Cardiovascular Investigator

Valentin Fuster, M.D., Ph.D., M.A.C.C.

Washington, D.C.
CME



February 21, 2011

33rd Annual Cardiology at Big Sky

Kim A. Eagle, M.D., M.A.C.C.
Sidney Goldstein, M.D., F.A.C.C.

Big Sky, Mont.



December 10 - 12, 2010

43rd Annual New York Cardiovascular Symposium: Major Topics in Cardiology Today

Valentin Fuster, M.D., Ph.D., M.A.C.C.

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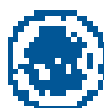


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