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Cardiology

A MEMBER PUBLICATION OF THE AMERICAN COLLEGE OF CARDIOLOGY



Health Care Reform 2010

Risks and Opportunities

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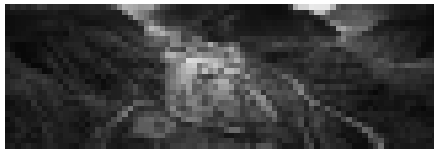
- ▶ Ranexa is contraindicated in patients:
 - Taking strong inhibitors of CYP3A4 (eg, ketoconazole, itraconazole, clarithromycin, rifabutin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir)

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Warnings and Precautions

- ▶ Ranexa blocks P₂ and prolongs the QTc interval in a dose-related manner.
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- ▶ There is little experience with high doses (≥ 1050 mg in four daily) or exposure to other QT-prolonging drugs, or potassium channel blockers resulting in a long QT interval.

Please see brief summary of prescribing information on adjacent page.



PHARMACEUTICALS

Brief Summary of Prescribing Information

INDICATIONS AND USAGE

INDICATIONS AND USAGE

CONTRAINDICATIONS

CONTRAINDICATIONS

WARNINGS

WARNINGS

ADVERSE REACTIONS

ADVERSE REACTIONS

DRUG INTERACTIONS

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The ACC Wants You!

As I speak to ACC members across the country and around the world, I hear many reactions to the changing face of cardiovascular medicine: Many are excited by the rapidly evolving science and technology that are the hallmark of our specialty. Some are concerned by the uncertainties inherent in health care reform. Others are angry about cuts to reimbursement. I have one response: Get involved with the ACC. Whether you want to advocate for payment, help shape the future of health care or harness the greatest potential of cardiovascular science, the College is the place to be. The more involved you become, the more you'll benefit from your membership. The call for applications for ACC and ACC Foundation committee members now is open. I encourage you to get more involved by applying for an open committee position (or nominating a deserving colleague). See p. 29 for more details.

This issue of *Cardiology* magazine illustrates the broad scope of our work at the ACC — and the many opportunities for member volunteers to make a real difference in health care.

Our cover story takes a closer look at the Patient Protection and Affordable Care Act, telling you how reform may affect cardiovascular practice in the coming years. ACC CEO **Jack Lewin, M.D.**, shares his perspective about how we as a College and a specialty should

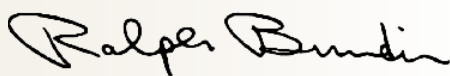
respond in order to thrive in an era of health care reform. Health care management consultant **Alex Hunter** and Piedmont Heart Institute CEO **Michele Molden** offer practical advice for physicians as they adapt to the changing environment.

Also in this issue, Past President and Trustee **Doug Weaver, M.D., M.A.C.C.**, discusses the new Council of Medical Specialty Societies Code for Interactions with Companies. He tells us how the ACC helped shape the policy and addresses member concerns about the code and how it will affect relationships with industry.

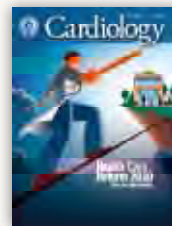
Margo Minissian, A.C.N.P.-B.C., M.S.N., C.N.S., details how ACC members are working with nonprofit WomenHeart to help educate women about heart disease, and **Kay Blum, Ph.D., C.R.N.P.**, encourages ACC members to incorporate high-quality palliative care for end-stage heart failure patients into their practices. **Mary Norine Walsh, M.D., F.A.C.C.**, chair of our Patient-Centered Care Committee, lays out her committee's plans for educating patients and their families through a new CardioSmart campaign.

Also in this edition, you will read about how the National Cardiovascular Data Registry is playing a key role in implementing comparative effectiveness research, and you will learn more about the College's cutting-edge new website, CardioSource.

I hope you will be involved in one or many of the exciting initiatives included in this issue, and I hope you'll consider becoming more involved in the ACC by participating on a committee. Don't forget to apply before July 31. Thank you for all you do to make the College — and our cardiovascular community — such a powerful force for quality health care.



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



May - June 2010

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What the Reform Law Means for Cardiology

To provide affordable, quality health care for all Americans and to reduce the growth in health care spending, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

October 29, 2010

With the reform and reconciliation bills signed into law, there are several provisions that will have an impact on cardiovascular practice over the next several years. The following is an overview of the key provisions:

The Physician Quality Reporting Initiative (PQRI)

The new law extends PQRI through 2014, with an incentive payment increase of 0.5 percent for 2011 to 2014. The program is improved with the addition of an appeals process and more timely feedback. In addition, Maintenance of Certification program participation was added as a participation option, including an additional 0.5 percent incentive payment. PQRI continues to serve as an opportunity for practices to receive incentive payments from Medicare.

Beginning in 2015, physicians who are not successful participants in PQRI will receive penalties. The penalty is 1.5 percent for 2015 and 2 percent for 2016. The ACC has expressed opposition to penalties for unsuccessful participation in PQRI and will continue to do so. PQRI has considerable administrative issues and kinks that have prohibited physicians from successfully participating.

Physician Feedback Program

Starting in 2012, the Department of Health and Human Services (HHS) will provide reports to physicians comparing their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. This provision is an expansion of a program currently underway at CMS, in which the ACC has been actively engaged. The ACC supports confidential feedback reports that appropriately assign responsibility and allow physicians to act to improve quality.

Imaging Equipment Use Rate

In 2011, the Centers for Medicare and Medicaid Services (CMS) will increase the utilization rate assumption from the current 50 percent to 75 percent in calculating reimbursements for medical imaging services on "high cost" equipment (equipment that costs more than \$1 million). This will result in lower payments for cardiac CT and MR services in 2011. Under the physician fee schedule, the utilization rate was set to rise to 90 percent in 2013. PPACA overrules the fee schedule and locks the rate at 75 percent for these services.

Physician Compare

HHS will establish a “Physician Compare” website in 2011 with information on physicians enrolled in Medicare. By 2013, the Secretary of HHS must implement a plan for making available through the website information on physician performance that provides comparative information on quality and patient experience measures.

The ACC supports responsible public reporting that is based on actionable, current, clinically sound and scientifically valid reporting measures. The ACC always emphasizes that clinical data is far superior to claims data for performance measurement and has urged caution and the use of appropriate safeguards in moving forward with public reporting based on Medicare claims/administrative data. The ability of physicians to be aware of reports and able to address inconsistencies should be safeguarded. While the ACC believes the new health reform law provides protection to physicians in this area, the College is closely following implementation efforts as there is substantial regulatory development that must occur.

Medical Liability

Starting in 2011, HHS will award five-year demonstration grants to states to develop, implement and evaluate alternative medical liability reform initiatives, such as health courts and early-offer programs. In addition, medical liability protections under the Federal Tort Claims Act will be extended to free clinics. The ACC will work with ACC chapters as this provision is implemented. The ACC continues to advocate for federal enactment of proven, meaningful liability reforms.

Accountable Care Organizations

By 2012, the Department of Health and Human Services (HHS) will establish a “Medicare Shared Savings Program” that allows groups of providers who meet certain statutory criteria to be recognized as accountable care organizations (ACOs) and be eligible to share in the cost-savings achieved by the Medicare program. Eligible ACOs would be groups of providers and suppliers that have an established mechanism for joint decision making, including: practitioners in group practices; networks of practices; partnerships or joint ventures between hospitals and practitioners; and hospitals employing practitioners.

The ACC supports opportunities that allow entities to virtually integrate and share savings, including ACOs. The ACC will closely monitor implementation of this provision, particularly for opportunities that facilitate participation by physicians in small independent practice.

Bundled Payments Pilot

As of 2013, HHS will develop a five-year national, voluntary bundled payment pilot program to provide incentives to hospitals, physicians and other providers to improve patient care and achieve Medicare savings. The ACC supports pilots to test different payment models, including bundling.

Specialty Hospitals

Physician-owned hospitals that do not have a provider agreement prior to Dec. 31 are prohibited. Physician-owned hospitals with a provider agreement prior to Dec. 31 are allowed to continue Medicare participation subject to certain reporting requirements.

The ACC opposes the ban on new physician-owned facilities and restrictions placed on current facilities. The ACC supports physician ownership in facilities, equipment or services that benefit patients through the delivery of appropriate, high quality medical care. The ACC believes all facilities should strive to enhance quality of care, efficiency and patient access, while ensuring that ownership interests are directed to improving the delivery of care through implementation of quality systems and measures.

Continued on next page

Continued from previous page

Independent Payment Advisory Board (IPAB)

The IPAB is a 15-member board tasked with developing and presenting proposals to the president and Congress, starting in 2014, to extend the solvency of Medicare, slow cost growth, improve quality of care and reduce national health expenditures. In years when Medicare costs are projected to be unsustainable, IPAB's proposals automatically will be implemented unless Congress approves alternatives that achieve the same level of savings. IPAB's members will be appointed by the president and approved by the Senate for six-year terms. Members could include individuals with national recognition for expertise in health finance and economics, actuarial science, health facility management, and other related fields, including physicians/other health professionals, experts in pharmacoeconomics or prescription drug benefit programs, employers, third-party payers, individuals skilled in health-related research and interpretation, as well as representatives of consumers and the elderly. Hospitals are exempt from payment modification proposals from IPAB until 2020.

The ACC is concerned by the authority granted to an independent body of unelected officials to determine payment cuts for physicians. Physicians already are subject to an expenditure target and other potential payment reductions as the result of the Medicare physician payment formula. The College believes it does not make sense to subject physicians to expenditure targets while at the same time exempting large segments of Medicare providers who are subject to no target at all. The ACC believes that because the IPAB has broad discretionary authority to make radical changes in the structure of the Medicare program, its recommendations should require an affirmative vote by Congress before they can be implemented. Congress should retain the ability to achieve a different level of savings than proposed by the IPAB to adjust for new developments that warrant spending increases, and maintain its ultimate accountability for the sustainability and stability of the Medicare program. The ACC is closely following IPAB implementation and looking for opportunities to encourage modification.

Sunshine Provisions

Beginning in 2012, pharmaceutical companies and authorized pharmaceutical distributors will need to report to the government the names of practitioners to whom they provide samples of prescription drugs, the specific drug they have provided, the practitioner's contact information and signature.

By 2013, manufacturers of pharmaceuticals, devices, biologicals and supplies will be required to disclose information regarding payments made to health care professionals. The types of payments implicated include consulting fees, honoraria, research funds, grants, support for continuing medical education, gifts, entertainment and others. The information will be made available to the general public later that same year. The ACC supports disclosure of potential conflicts of interest.

Claims Submission

Previously, practitioners had three calendar years from the date of service to file claims. The new law requires that all claims for services be filed within one calendar year after the date of service, unless an exception is made by CMS. For services furnished before Jan. 1 where claims have not yet been filed, those claims must be filed no later than Dec. 31.

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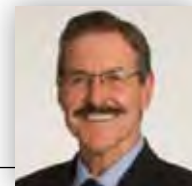
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Health Reform 2010: Risks and Opportunities

By Jack Lewin, M.D.

Given the partisan environment and the lack of a public majority of support for national health reform, it's almost a miracle that the Patient Protection and Affordable Care Act (PPACA) passed in March. Whether you appreciate or hate the nearly 3,000 pages of complexity it contains, one has to respect the tenacity and courage of President Obama in being willing to risk his legacy, popularity and even his chances of a second term to muscle this historic bill through a bitterly divided Congress.

You can't un-ring this bell. It would take a majority of 60 Republicans in the Senate (there are 40 now) and a Republican president to repeal it. Of course, over a dozen state attorneys general have filed suit to get the courts to block the law's implementation, but my sense is that reform will proceed despite them.

America arguably has the best health care in the world, at least when things work at their best. Unfortunately, all too often that is not the case. Today's U.S. health care system is, in reality, a non-system, with major access problems for 50 million citizens. The status quo is uneven quality, patient safety and care coordination; and it is far more costly than it needs to be in terms of return on investment (ROI). Extolling the virtues of the status quo, given its massive and growing contribution to the national debt and to economic non-competitiveness in a global economy, is virtually unpatriotic. But change is risky and unnerving, and the implementation of the PPACA will certainly be a rocky five- to 10-year course of amendments, modifications and market-driven changes in how health care is delivered and financed. The insurance reforms in the bill that eliminate underwriting based on illness, lifetime coverage limits, coverage denials and excessive profit-taking are long overdue.

Interestingly, Wall Street has given a preliminary but clear thumbs-up to how private insurance companies, hospital systems and cardiovascular care

will fare financially in this changing future. The markets have taken notice that the government alone will spend an additional \$1.1 trillion over the next decade to fund:

- coverage of the uninsured
- expanded pharmaceutical and other coverage in Medicare and federal programs
- new small business subsidies
- prevention services
- workforce training and incentives
- more research
- substantial information technology and payment innovation experimentation

Somebody's going to get that money. There will be winners and losers here, of course. I believe the winners will be those who succeed in innovating, and the losers will have clung to the status quo. But, there is a nagging and legitimate fear that reform will have little or no impact on reducing unnecessary spending, waste, fraud and rising national debt: a house of cards.

We can make sure that the future evidences more patient-centered value. The ACC realized years ago that the nation had to move beyond the status quo to more aggressively deal with the country's problems in health care access, quality, cost and ROI. The current convoluted and flat physician payment systems, legal costs and singular use of price controls to ineffectively

reduce rising costs already have just about killed off the private practice of cardiology. Ironically, the risks we fear about reform already are with us today. We need to focus on the opportunities that change could now bring for those who act together to redesign delivery and payment. Our redesigned system should reward quality and prevention; be more patient-centered and team-driven; promote registries and health information technology to measure progress in clinical care; reduce waste; and promote science, research and more rapid clinical innovation.

Health care reform is here. It needs to be. There are inherent risks and opportunities, likely victims, and potential winners. The College understands it must largely be focused on the opportunities. Ultimately, that is lucky for you. And, incidentally, if you can find a way to see things this way, what an amazing time this is to be in health care!

Lewin is CEO of the American College of Cardiology. Share your thoughts on this article at LewinReport.acc.org



Strategies for Cardiologists in the Face of Health Care Reform

By Alex Hunter and Michele Molden



“It’s not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change.”

Although Charles Darwin did not have the U.S. health care system in mind when he penned these words, the concept certainly applies as cardiology practices navigate the changes required to thrive under health care reform.

Overview

If you are like many of your peers, our bet is that you’ve been considering various strategies and alternatives that enable your cardiology practice to confront decreasing reimbursement and growth in practice overhead for many years. Responding to clinical and business change is part of what you do for a living.

When viewed in this light, the health care reform law has merely confirmed what many cardiologists and cardiovascular administrators already had determined: In order to sustain quality cardiovascular care, the private practice business model must change.

Motivated by the combined forces of health care reform and market pressures, cardiologists and health system leaders are aggressively evaluating strategic alternatives and options that would result in new physician-hospital integration models and relationships.

Among other changes, the new law will result in significant reimbursement reductions. In addition, the law calls for alternatives to Medicare’s current fee-for-service model with methods such as bundled payments and the banding together of providers into accountable care organizations. These new cost-saving, quality-improving methods will likely necessitate physicians and hospitals aligning much more closely.

Lessons Learned

Often, while these integration discussions are in process, cardi-

ologists and hospital leaders turn their attention to selecting the “right” integration model. Of course, there are many physician-hospital models to consider: practice acquisition combined with subsequent employment, co-management relationships and professional service agreements, among others.

These considerations are important, but there’s more to a successful partnership that avoids the potential pitfalls of integration. While you are evaluating how to best (re)define a partnership with a hospital and other cardiologists, make sure that all sides are clear on the following fundamental components of the new integrated relationship:

Goals/Objectives. Although all parties may initially envision a range of positive outcomes to be

achieved through integration, there must be relative consensus around the answer to the question:

“What primary goal, or vision, can we accomplish together that we could not achieve independently?”

As hospitals/health systems answer this question, they will realize that true alignment with a cardiology group not only will change the culture of the organization, but also will shift the strategy for the system. If hospitals can relinquish control of the integrated cardiovascular organization, they will realize the potential of shared management and decision-making.

The change for physicians is no less dramatic, but it is more personal. Instead of an organization existing to achieve physicians’ professional and personal goals, the new model requires physicians to adopt a system-oriented strategy and serve a broader organizational vision.

Physician compensation. Our experience is that a well-structured relationship between a health system and cardiology



group has ample capacity to yield competitive incomes for physicians.

The compensation model should include selected metrics for volume and productivity, but it also must recognize the importance of achieving system goals and objectives related to the delivery of cardiovascular services.

Volume-based compensation models risk creating a “transaction-based” culture between the hospital and the physicians (not to mention that they will be challenging as market incentives shift toward more qualitative, outcomes-oriented metrics under reform).

Clarity around roles and responsibilities. Once the transaction is complete, cardiologists and administrators can find the exhilaration related to “finishing the deal” quickly dissipates in the face of the daily challenges of operations and working together.

Essential to the long-term success of the new entity is clarity around the nuts and bolts of daily decision-making

related to operational matters like staffing, billing and collections functionality, EMR implementation, and compliance.

Before the ink is dry, both sides must have a clear sense of how “day one” post-transaction operations will function, including:

- Who has input and/or voice on which decisions?
- Who has “final call?”
- How will physicians participate in decisions on matters that affect their clinical practice?

Operational and management issues likely will provide the first early test of the strength of the new integrated relationship.

Cardiologists and hospital leaders who are able to establish a very clear understanding about all of these variables are in an excellent position to reap the financial and clinical rewards inherent in genuine physician-hospital integration.

Hunter is president of EthosPartners Health Care Management Group, an Atlanta-based health care management and consulting firm. Molden is president and CEO of Piedmont Heart Institute in Atlanta.

In order to sustain quality cardiovascular care, the private practice business model must change.

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ACC Working to Address Expansion of Imaging Pre-authorization Programs



The American College of Cardiology (ACC) has been meeting with health plans and advocating for more efficient and less burdensome alternatives to existing prior notification and approval programs for cardiac imaging.

Just last month, the College sent a letter to Sen. Rockefeller (D-W.V.) supporting his investigation into inappropriate pre-authorization denials for cardiac stress testing by Blue Cross Blue Shield of Delaware and MedSolutions. In addition, the College is developing an alternative plan to radiology benefit managers (RBMs) based on use of appropriate use criteria. The alternative solution would transparently reduce inappropriate imaging, while limiting hassles for doctors and reducing costs to health plans.

In the meantime, several large health plans are expanding their existing prior notification and approval programs to new cardiac diagnostic modalities beginning this summer and fall. The affected modalities include echocardiography, nuclear cardiology, diagnostic cardiac catheterization and electrophysiological device implantations (ICD and pacemakers). The requirements vary by insurer, member plan and

service market and ACC members are strongly encouraged to familiarize themselves with the requirements in order to ensure proper payment. Programs that will be expanded include:

AETNA: As of May 15, all outpatient elective stress echocardiography and diagnostic cardiac catheterizations require prior authorization.

Anthem BCBS (WellPoint): All outpatient elective echocardiography will require prior authorization. This will take effect Sept. 1 (Connecticut, Colorado, Nevada, Georgia, New Hampshire, Maine), Nov. 1 (Ohio, Indiana, Kentucky, Michigan, Wisconsin) or is not yet determined (California).

Highmark BCBS (Pennsylvania): Starting Sept. 1, all outpatient, non-emergency imaging procedures (nuclear cardiology and stress echocardiography) will require prior authorization.

UnitedHealthCare (UHC): UHC will expand its prior notification program to include all outpatient, inpatient and emergent diagnostic cardiac catheterization and electrophysiology implantation procedures beginning July 1 (Florida, Montana, North Carolina, Ohio, Wisconsin) or at a yet-to-be-determined date.

Please continue to use the ACC's imaging hassle form located on the "Practice Management" section of *CardioSource.org* to report any issues with pre-authorization so that College leaders and staff can better advocate on members' behalf.

Joint Letter Addresses Potential Coverage for Certain MRA Indications

The ACC, American College of Radiology, American Society of Neuroradiology, North American Society for Cardiovascular Imaging, and the Society for Cardiovascular Magnetic Resonance have drafted comments that support the Centers for Medicare and Medicaid Services' (CMS) Proposed Decision Memo for Magnetic Resonance Angiography (MRA). The Proposed Decision Memo examines the current evidence to determine whether certain indications for MRA that are not covered by Medicare should be covered. The memo discusses allowing local Medicare contractors to use their discretion to cover use of MRA for additional indications. The letter indicates the groups' support of the CMS reconsideration. Their proposed approach allows physicians a "flexibility ... to utilize the appropriate MRI / MRA technique based upon a patient's unique clinical situation."

New CT/CMR Expert Consensus Documents Now Available Online

The ACC Foundation released two expert consensus documents in May on cardiovascular magnetic resonance and coronary computed tomographic angiography. Read the ACCF/ACR/AHA/ASNC/NASCI/SAIP/SCAI/SCCT 2010 Expert Consensus Document on Coronary Computed Tomographic Angiography and the ACCF/ACR/AHA/NASCI/SCMR 2010 Expert Consensus Document on Cardiovascular Magnetic Resonance on *CardioSource.org* in the Science & Quality section.

ACC Representation on Important CPT Panel

Ken Brin, M.D., F.A.C.C., has been re-appointed for a four-year term on the AMA's CPT Editorial Panel, which is responsible for managing CPT codes — the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. This panel meets three times a year to discuss issues associated with new and emerging technologies as well as difficulties encountered with procedures and services and their relation to CPT codes. Dr. Brin began serving on the panel in 2006 and has established himself as a leader and strong consensus builder. Appointments to this influential panel are coveted among specialty societies and highly competitive.



Registries TRANSLATE into CER Advantage

The National Cardiovascular Data Registry (NCDR®) registries are emerging as powerful tools for comparative effectiveness research (CER). The TRANSLATE-ACS Study, led by Duke Clinical Research Institute (DCRI) in collaboration with the ACC, is a longitudinal, observational study of acute coronary syndrome (ACS) that relies on the NCDR CathPCI Registry® for much of its data collection. The overall goals of TRANSLATE-ACS are to examine in-hospital and longitudinal outcomes of ACS patients managed with percutaneous coronary intervention (PCI), and to assess post-discharge care patterns and treatment adherence. In particular, the study will look at how physicians are making treatment choices among approved antiplatelet therapies; factors influencing adherence to these medications; and real-world effectiveness, safety and costs in a broad-based patient population.

CathPCI Registry®

TRANSLATE-ACS intends to enroll approximately 17,000 ST-elevation myocardial infarction (STEMI) and NSTEMI patients treated with PCI and discharged on an adenosine diphosphate (ADP)-receptor inhibitor (clopidogrel, prasugrel, ticlopidine). For sites already participating in CathPCI, many of the data elements collected for TRANSLATE-ACS will be automatically imported from the registry. Patients will be followed centrally via telephone up to 15 months after discharge to assess patterns of treatment and even rates.

This study, headed up by **John Messenger, M.D., F.A.C.C.**, and **Tracy Wang, M.D., F.A.C.C.**, and **Eric Peterson, M.D., M.P.H., F.A.C.C.**, at Duke, complements ongoing ACC efforts to expand the role of registries in CER and conduct CER using a continuum of information from the inpatient to outpatient settings.

Recruitment for TRANSLATE-ACS is underway, so if you are interested in participating or would like to get more information about the study, e-mail DCRI at TRANSLATE-ACS@mc.duke.edu.

Comments on Radiation Dose for Fluoroscopically Guided Interventional Procedures



The ACC recently submitted comments on the draft report of the National Council on Radiation Protection and Measurements (NCRP) on radiation dose management for fluoroscopically guided interventional procedures. According to the letter, "The pragmatic approach that the report takes to radiation safety, balancing the intended benefits of the procedure against the radiation risk, is commendable. The College appreciates the effort made by the NCRP to include recommendations that highlight ways to measure radiation dosage, while also addressing the challenges in accurately doing so at the patient level." The letter also addresses several concerns held by the ACC about the report, including the inclusion of fluoroscopy time, lack of discussion regarding automatic time-outs that de-activate the unit, under-emphasis of the role of indirect support staff and lack of discussion of the role of registries in tracking radiation dose by procedure.

CMS Correction Means Increased Payments for Imaging Services

The Centers for Medicare and Medicaid Services (CMS) in May released a technical correction to the 2010 Medicare Physician Fee Schedule that resulted in payment increases for myocardial perfusion imaging (MPI) codes, cardiac computed tomography (CT) codes and cardiac catheterization codes, retroactive to Jan. 1. The correction notice also included a minor increase in the Medicare conversion factor (from 36.066 to 36.0791) effective June through December.

The corrections to MPI and CT codes address errors made in incorporating RUC recommendations on direct practice expenses (e.g., medical supplies, equipment time) for these services. The errors included incorrect practice expense values for CPT codes 75571 – 75574 and 78451 – 78454. For example, the corrected national average payment for 78452 (single photon emission computed tomography MPI, multiple) is \$439, compared to the \$379 published in the November Final Rule. The American Society of Nuclear Cardiology, the Society of Nuclear Medicine and the American Medical Association (AMA) identified the errors in the SPECT codes. The Society of Cardiovascular Computed Tomography and the ACC worked with CMS to correct errors in the cardiac CT codes.

The correction notice also includes changes to malpractice RVUs for cardiac catheterization services. In the fee schedule, CMS agreed with ACC, the Society for Cardiovascular Angiography and Interventions and the AMA that cardiac cath services should be assigned malpractice RVUs based on the higher surgical risk factor. However, the published RVUs and payment rates did not correctly reflect that policy change. With this notice, CMS has corrected its error. The payment changes — for example, an increase from \$235 to \$253 for 93510-26 (Left heart catheterization, professional component) — reflect the higher risk associated with invasive procedures.

As of this issue of *Cardiology*, CMS still is drafting instructions for local Medicare carriers, contractors and providers to implement the corrections. CMS must complete and release these instructions before local Medicare carriers can correctly reprocess claims with the new updated payment rates. In the interim, the ACC recommends that members not refile claims until CMS provides these additional instructions.

Meanwhile, the College continues to apply pressure to CMS to address the other imaging cuts included in the 2010 Medicare rule. Most importantly, the ACC continues to press for a phase-in of the bundled nuclear codes and is working with members of Congress and CMS to help them understand the extent of the cuts, their impact on practices and the need for a formal policy that phases in cuts of a certain magnitude over time.

For more information and updates, visit the “Advocacy” section of *CardioSource.org* and click on the “Physician Payment” issue.

Are You in Compliance with Lab Accreditation Requirements?

Under the “Medicare Improvements for Patients and Providers Act of 2008” (MIPPA), suppliers furnishing the technical component of advanced imaging services must be accredited by a designated accreditation organization for purposes of reimbursement as of Jan. 1, 2012. For more information on the requirements and how to prepare, visit the “Advocacy” section of *CardioSource.org* and click on the “Imaging” issues.

ACC Comments on Self Referral Provisions Included in Health Reform Law

The Patient Protection and Affordable Care Act of 2010 (PPACA) includes several near-term requirements that have the potential to increase the burden on physician practices that provide imaging services. The ACC last month sent a letter to the Centers for Medicare and Medicaid Services (CMS) urging the agency to implement several of these requirements in a manner that minimizes the costs and administrative burdens on cardiovascular practices. The letter provides specific recommendations on the following:

- The PPACA requires the creation of a protocol for physicians to self-disclose violations of the physician self-referral (Stark) law. Given that most Stark law violations are inadvertent and constitute merely technical violations of the law, the College is urging CMS to develop a disclosure protocol that provides “leeway for those who have attempted to comply; believed to a reasonable degree of certainty that they were, in fact, in compliance; and reasonably seek to remedy the situation when they determine a violation has been committed.”
- The PPACA requires physicians making self-referrals for magnetic resonance, computed tomography and positron emission tomography services to inform their patients at the time of referral about their ownership or other financial interest in imaging equipment, as well as provide them with the option of obtaining the service elsewhere. Physicians will need to provide a written list of other imaging centers that provide the service in the area in which the patient lives. The ACC is urging CMS to create a standardized notice with information on how physicians should disclose ownership interests and how lists of alternate providers are to be compiled. The ACC believes it is critical that the list of alternate sources be for the same service for which the patient has been referred, and that CMS develop a standardized, consistent method for providing accurate information to patients.

To read the complete letters, go to QualityFirst.acc.org.

SGR Update

As this issue of *Cardiology* went to press, Congress was expected to vote any day on new legislation that could provide a short-term fix to the Sustainable Growth Rate (SGR) formula and stop the 21 percent cut slated for June 1. The fate of this bill was far from certain, particularly in the Senate, where leadership still was working to muster enough votes. The ACC continues to support a permanent solution to the flawed SGR formula, but also believes Congress must take action to avert the June 1 cuts. Stay tuned to the ACC Advocate newsletter and/or CardioSource.org for the most up-to-date information and calls to action. Meanwhile, the subject of payment reform will also be an important component of this year’s Legislative Conference, Sept. 12 – 14 in Washington, D.C. Visit the “Meetings” section of CardioSource.org to register for this event and take advantage of an opportunity to not only learn more about this issue, but also educate your members of Congress about the impact of continued Medicare cuts on cardiovascular practices and patients.

Delaware Investigates Prior Authorization Programs

Over the last couple months, Blue Cross Blue Shield (BCBS) of Delaware, MedSolutions and Aetna have made headlines for denying a number of patients cardiac stress tests in cases where physicians said they were warranted. In one case, a denial was almost fatal, while in another a patient had to pay out of pocket for her diagnostic test. For the past year, the Delaware Chapter of the ACC has been advocating for the state’s insurers to permit appropriate imaging testing based

upon current appropriate use criteria and not



Delaware
CHAPTER

allow MedSolutions to dictate major clinical decisions. Both the Delaware Insurance Commissioner and Sen. Jay Rockefeller of West Virginia have launched investigations of BCBS and MedSolutions’ pre-authorization practices.

At a national level, the ACC has met with Sen. Rockefeller’s Commerce Committee staff to address the College’s concerns with the current prior authorization process, highlight the importance of properly using appropriate use criteria and guidelines and identify opportunities to assist with the congressional investigation. ACC members and practices in Delaware are strongly encouraged to notify the Delaware ACC Chapter and submit stories to the insurance commissioner if patients are inappropriately denied by this prior authorization process. Send your cases to Elliott Jacobson, Office of Delaware Insurance Commissioner at Elliott.jacobson@state.de.us.

New Health Reform Law Brings Medicare Enrollment Changes

The new health reform law includes several provisions that affect both Medicare and Medicaid enrollment.



Under the law, the Centers for Medicare and Medicaid Services (CMS) must expand the current Medicare provider enrollment process to include additional methods of screening practitioners starting in 2011. CMS is required to conduct licensure checks and is permitted to conduct criminal background checks, fingerprinting, unscheduled and unannounced site visits, and other mechanisms that can be used to screen potential providers of Medicare services for fraudulent or otherwise criminal behavior. While the law originally also required the collection of an application fee for both individual and institutional providers, such as hospitals or skilled nursing facilities, the fee is no longer required for individual providers. Currently enrolled practitioners making changes to their enrollment application will be subject to the new screening process beginning in 2012.

The new health reform law also permits CMS to require certain sectors or categories of enrolled providers to establish compliance programs as a condition of Medicare enrollment.

CMS will be required to determine the core elements of such a compliance program. CMS also will be allowed to establish temporary moratoria on the enrollment of different provider types if it determines that it is necessary to combat fraud and abuse.

The law also dictates that these new measures be included as part of provider enrollment in state Medicaid programs. In addition to the requirements detailed above, state Medicaid programs also must require that ordering and referring physicians be enrolled in their program and that the National Provider Identifier (NPI) of ordering or referring physicians be included on claims. This is a new requirement for the Medicaid program, and states will need to revise their provider agreement processes to collect this information.

CMS in May released an interim final rule on Medicare and Medicaid provider enrollment that addresses these NPI requirements. Under the rule, all practitioners enrolling in the Medicare or Medicaid programs as of July 6 must include their NPI in their application materials. NPIs also must be included on all Medicare and

Medicaid claims, along with the ordering or referring practitioner's legal name.

The ACC recommends that members ensure their Medicare provider enrollment information is current and accurate. If it is not, enrollment applications should be submitted as soon as possible, but certainly by July 6 (see related article on new ordering and referring policies). Practitioners who enrolled in Medicare prior to 2003 and have not updated enrollment records since that time are likely not to have an enrollment record in the Medicare provider enrollment database. To ensure that one is created, a Medicare provider enrollment application (CMS-855 form) must be completed. Medicare contractors are reported to be experiencing higher than normal volumes of Medicare provider enrollment application submissions as a result of the new changes. Please contact the ACC if you experience sustained delays of six months or more. For more information, visit the "Practice Management" section of CardioSource.org and click on "Coding and Billing."

New CMS Rule Revisits Ordering, Referring Policies



An interim final rule released by the Centers for Medicare and Medicaid Services (CMS) in May revisits an issue regarding ordering and referring providers that was included in the 2010 Medicare Physician Fee Schedule.

CMS last summer issued changes requiring an individual ordering or referring an imaging or laboratory service to be a physician or other health care professional able to enroll in Medicare and permitted to order or refer for the service. According to CMS, claims that did not contain the name of an enrolled ordering or referring provider would not be paid beginning in January. However, based on concerns raised by the ACC and others, CMS agreed to push the implementation date to January 2011.

The new rule makes several changes to the previously announced policy, including moving the implementation date from January 2011 to July 6, 2010. It also requires that individuals ordering or referring patients for “specialist services” be enrolled. While it is unclear at this time what is meant by specialist services and whether this changes which services now require orders or referrals, practitioners who traditionally have not billed Medicare for services but may have ordered or referred Medicare patients for services (including practitioners working for the Department of Defense and Veterans Administration) must now be enrolled.

Additionally, in the original ordering and referring policy, practitioners who were not in the Medicare provider enrollment database but were in the contractor’s master file were allowed to continue to order and refer for Medicare imaging and laboratory services. Under the new regulation, practitioners must be in the Medicare provider enrollment database in order to order and refer for Medicare services.

The ACC anticipates that CMS will release additional guidance on this issue in the near future. At this point, the ACC recommends that members ensure that their Medicare provider enrollment information is current and accurate. Referral sources should be encouraged to do the same. In addition, the ACC continues to urge CMS to delay implementation of this provision

until the implications are fully understood and all practitioners are properly enrolled in Medicare. The ACC also continues to request that CMS issue guidance and instructions as soon as possible to allow for the education of physician practices and their staffs and any changes in claims submission that must occur. For more information on this policy and Medicare enrollment requirements, go to the “Practice Management” section of *CardioSource.org* and click on “Coding and Billing.”

Red Flags Rules in Effect June 1

The Federal Trade Commission’s (FTC) “Red Flags” identity theft rules are slated to take effect on June 1. In an effort to address the growing risk of identity theft, the FTC released rules in November 2007 requiring all financial institutions and “creditors” (including health care providers) to develop and implement a written program to protect consumers by identifying potentially suspicious “red flags” that may signal identity theft. The ACC, the American Medical Association (AMA) and other medical associations have strongly opposed the inclusion of physicians as creditors and have repeatedly been able to delay the rule’s implementation date. Most recently, the AMA, the American Osteopath Association (AOA) and the Medical Society of the District of Columbia filed a lawsuit on this point.

The ACC will keep you informed regarding any late-breaking developments in this area. However, given the fast-approaching deadline, the ACC strongly recommends that practices prepare a written identity theft detection and prevention program. The AMA and Medical Group Management Association have developed Red Flags Rule guidance documents and sample policies that can be modified, which can be accessed at the MGMA Red Flags Rule Resource Center (www.mgma.com/policy/default.aspx?id=22932), and the AMA Red Flags Rule Physician Resources (www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml).

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

Chair, Board of Governors

Richard Kovacs is a professor of Clinical Medicine at the Indiana University School of Medicine, Krannert Institute of Cardiology. He is a clinical cardiologist and serves as the Clinical Director for the Division of Cardiology at Indiana University.

Kovacs received his BA from the University of Chicago in 1976 and his M.D. from the University of Cincinnati in 1980. He was a resident in Internal Medicine at the Indiana University (IU) School of Medicine from 1980 to 1982 and a cardiology fellow at IU from 1982 to 1985. He served as

“ Going forward, we want to make sure the BOG is flexible, nimble and prepared to meet the next challenge – wherever that comes from. ”

both Chief Medical Resident and Chief Cardiology Fellow at IU. He joined the IU Cardiology faculty in 1986. In 1990 he accepted a position as Director of Medical Research at Methodist Hospital of Indiana and practiced clinical cardiology with Storer Schmidt and Associates.

In 2000, he moved to Eli Lilly and Company as Senior Clinical Research Physician, where he focused on the assessment of drug safety. He returned to the full-time IU faculty in 2003, and continues to consult for Lilly and other organizations interested in drug safety.

Kovacs has been a Fellow of the American College of Cardiology since 1987. He currently serves as Councillor for the central region of the Indiana Chapter of the ACC. He has served on the National ACC ECG/Pacemaker Committee and chaired various sessions at the ACC Annual Scientific Sessions. He was clinical chair of the International Life Sciences/Health and Environmental Sciences Institute QT study group. Locally, he serves on the hospital Peer Review Committee and Pharmacy and Therapeutics Committee.

He has published extensively on the topic of basic cardiac electrophysiology, with a recent emphasis on the ECG evaluation of non-cardiac drugs for pro-arrhythmia potential.

Cardiology recently talked with Kovacs about his outlook for the year ahead, the challenges that face cardiovascular specialists, and how the Board of Governors (BOG) and local ACC chapters can help to overcome them.



As incoming chair of the BOG, what are your plans for the year?

The BOG faced many challenges last year. The forces producing those challenges have not lessened. We still are faced with threats to practice viability and patient access. We now see practices moving into hospital relationships. I don't believe this movement will lessen the challenges to cardiology in the long run. We still need to bring the best care to our patients. Challenges are very local — although integration with the hospitals went rapidly in my home state of Indiana, in Maryland the situation is entirely different. Going forward, we want to make sure the BOG is flexible, nimble and prepared to meet the next challenge — wherever that comes from. We need to continue Dr. [John Gordon] Harold's emphasis on communication.

I also have a special interest in Fellows in Training. I want to involve them more in the College through the chapters and the BOG.

What do you feel are some of the most pressing issues Chapters will face during the next year?

Providers in states with high percentages of Medicare patients will feel the Medicare cuts most severely. The SGR cuts remain unsolved and challenge the entire house of medicine. We need to continue to fight these cuts. Indiana faces a challenge from private insurers to precertify even common tests like echocardiograms, a time-consuming and inefficient task. We are working with the insurance companies to find a better way to apply ACC appropriate use criteria to this problem and save staff time. Finally, we have enormous opportunity to revamp our system of maintenance of certification. The ACC is working with the American Board of Internal Medicine (ABIM) to address the multiplicity of board exams, the expense and the burden of the 10-year cycle. Many experts feel that the process of recertification should be a continuous one, based in the real practice of medicine. I look forward to the new ideas coming from the ABIM and the ACC. I think the chapters will be integral in any new maintenance of certification process.

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Palliative Care in Heart Failure

By Kay Blum, Ph.D., C.R.N.P.



Almost six million Americans suffer from heart failure. Cardiovascular researchers are working hard to discover new and better medications, genetic markers and mechanical devices that offer hope for an eventual cure for heart failure. It is easy to get caught up in the excitement and the possibilities inherent in the search for the newest interventions, but transplant, left ventricular assist devices (LVADs) and stem cell therapies are available only to a few because of age, comorbidity, lack of insurance, inadequate self-care ability or lack of a caregiver. The truth is that few of those almost six million patients will live to reap the benefits of all of this exciting research and development. However, this is not a cause for despair.

Palliative care encourages families to be involved in the care of the patient, to help when cognitive impairment, fatigue and breathlessness interfere with pharmacologic therapies and adherence.

The heart and soul of palliative care is the relief of symptoms, relief of suffering, and improvement or maintenance of quality of life. There is much that the heart failure practitioner can do to improve the lives of the people we care for who are living daily with this sometimes oppressive syndrome.

We can relieve dyspnea through the use of diuretics, nitrates and even chronic inodilator therapy in order to make everyday activities easier and restore a sense of independence and freedom. We can teach and coach patients and family caregivers to encourage self-care activities that control water-weight gain and increase activity and endurance. Palliative care encourages families to be involved in the care of the patient, to help when cognitive impairment, fatigue and breathlessness interfere with pharmacologic therapies and adherence. Palliative care practitioners are actively involved in helping patients and families have important end-of-life discussions that may prevent unwanted interventions. In addition to physical symptom relief, palliative care providers help relieve significant psychological pain: We facilitate discussions to help patients and their loved ones express feelings and achieve reconciliations.

The Challenges

Of course there are challenges inherent in outstanding palliative care. Aggressive management of volume to reduce

congestion and the dyspnea, orthopnea and paroxysmal nocturnal dyspnea caused by the congestion is a double-edged sword in that it advances the physiologic process at the price of symptom relief. Aggressive afterload reduction often improves symptoms at the cost of lowered blood pressures associated with increased mortality — especially when accomplished by chronic inodilator therapy.

The balance between the cost and benefit of these therapies, even in the hands of experienced heart failure specialists, is difficult at best. In fact, most people with heart failure are not managed by heart failure specialists, but by internal medicine and family practice physicians, nurse practitioners and physician assistants, who may find this clinical management inordinately time-consuming and occasionally confounding and discouraging.

Palliative care should be delivered by experienced cardiovascular care providers who can focus on now, and what is, rather than the future and what may be. Unfortunately, palliative care is not often considered and, if considered, is seen as a last resort. Why is this when the philosophy of palliative care is so beneficial to those for whom a cure is not possible?

The association of palliative care with cancer and hospice may be one reason why heart failure providers have been slow to embrace a plan of care that acknowledges that there is no cure. But palliative care philosophy and practice are independent of hospice, though they are of benefit for hospice patients, as well. Palliative care is not about hopelessness, it is about being hopeful about mitigating the limitation of symptoms in one's daily life. Every practice that cares for heart failure patients should incorporate palliative care. It is a prescription for the most appropriate intervention for these patients and can make the life patients have left to live as productive and comfortable as possible. As providers, we can prescribe palliative care as optimistically and as passionately as we prescribe LVADs, knowing that we are offering life-affirming coaching, attention and support. We can begin to see the possibility of a good death, defined as living fully whatever life is left. We can acknowledge that death is inevitable for us all, but that we can continue to live within that acknowledgement.

Living with heart failure is hard, but palliative care can alleviate much of the burden for patients and their families.

Blum is an assistant professor at the University of Maryland School of Nursing in Baltimore.



ACC Members Help Women Patients Find Answers with WomenHeart

By Margo Minissian, A.C.N.P.-B.C., M.S.N., C.N.S., and Lisa Clough

Women succumb to heart disease more than all other diseases combined. We are making strides in providing excellent medical and therapeutic strategies. But what can we offer patients to improve their quality of life as well as heighten awareness?

At Cedars-Sinai Medical Center in Los Angeles, the Women's Heart Center primarily sees chest pain patients who are seeking second, third or fourth opinions. Many of these women suffer from ischemic heart disease and myocardial infarctions (MI) with open arteries. When we initially see them, they typically are symptomatic and have decreased satisfaction with their quality of life. We provide advanced diagnostic testing, such as adenosine magnetic resonance imaging and coronary reactivity testing, which allows us to tailor their medication regimen and provide relief of their symptoms. Under the direction of **Noel Bairey Merz, M.D., F.A.C.C.**, director of the Women's Heart Center, many of these women find their answers.

Many women seen at the Women's Heart Center have careers and small children at home and are trying to understand why heart disease happened to them — all while trying to care for themselves and their families. Health care providers are constantly looking for new resources for their patients. Many women ask if we offer a support group. We do provide psychosocial services, such as a certified psychologist, a cardiology case-worker, yoga classes, meditation and cardiac rehab, but the

women want and need more.

Since 2006, we have answered their call for more support by referring patients to WomenHeart: The National Coalition for Women with Heart Disease, the nation's only patient

a patient support group in their area, and can find support in an online community and Sister Match program.

We encourage women to apply for the annual WomenHeart Science & Leadership Symposium at Mayo Clinic



WomenHeart Champions Janet Wolf, Evan McCabe, Diane Travis-Teague, and support group member Danielle Cole, who all spoke to a group of 150 nursing students at Santa Barbara City College.

advocacy organization solely devoted to advocating for the 42 million American women living with or at risk for heart disease. Through WomenHeart, women heart patients find the latest information on women and heart disease, can locate

in Rochester, Minn. Since 2002, more than 465 woman heart disease survivors from around the country have spent four rigorous days learning the science of heart disease and how to become community educators and advocates

for women and heart disease. Women accepted for the program commit to returning to their local communities to educate other women about the importance of prevention, early detection, accurate diagnosis and proper treatment. Many of these WomenHeart Champions go on to receive additional training to run local peer-led patient support groups.

“The partnership between the Women’s Heart Center in the Cedars-Sinai Heart Institute and WomenHeart has allowed us to reach many more women in our mission of improved heart health, education and research,” says Bairey Merz.

Cedars-Sinai patients who have been accepted into this prestigious program through its competitive application process have quickly put their training in action. WomenHeart Champion Toshawa Andrews is a 35-year-old mother of three who has suffered seven MIs from an unknown etiology this year. Although she has a reduced ejection fraction, Andrews is a figure skater who has ventured back out on the ice and started an outreach program for women who suffer from cardiovascular disease.

In just a few months since becoming a WomenHeart Champion, Diane Travis-Teague already has organized and hosted five events in the Santa Barbara region. Her most recent event was sponsored by Mary Kay Southern California and had an audience of 217. She recounted her difficult battle with heart disease and answered audience questions at the event that was originally scheduled for two hours. Three hours later the sponsor suggested a second session.

Evan McCabe feels one of her most significant contributions as a WomenHeart Champion is the introduction of the “Pinot and Prevention” party to the Santa Barbara area. Using

Santa Barbara’s well known pinot noir wines and studies that have shown that moderate consumption of alcohol is beneficial, McCabe hosts these in-home events where women enjoy a glass of wine while listening to McCabe talk about the prevalence of heart disease in women, prevention techniques, and how to recognize the



WomenHeart Champion Toshawa Andrews and Margo Minissian at the Brentwood Country Club, where Andrews gave her inaugural presentation.

“The coming together of these women with heart disease is amazing. They bond as heart sisters almost the minute they meet one another, then spend the next four days learning, living and supporting each other, gaining new strength each day until they become WomenHeart Champions.”

Sharonne Hayes, M.D., F.A.C.C.,

signs and symptoms. In addition to hosting “Pinot and Prevention” parties, McCabe is a WomenHeart support network coordinator and has advocated for the HEART for Women Act in Washington, D.C.

“The coming together of these women with heart disease is amazing,” says **Sharonne Hayes, M.D., F.A.C.C.**, director of the Women’s Heart Clinic

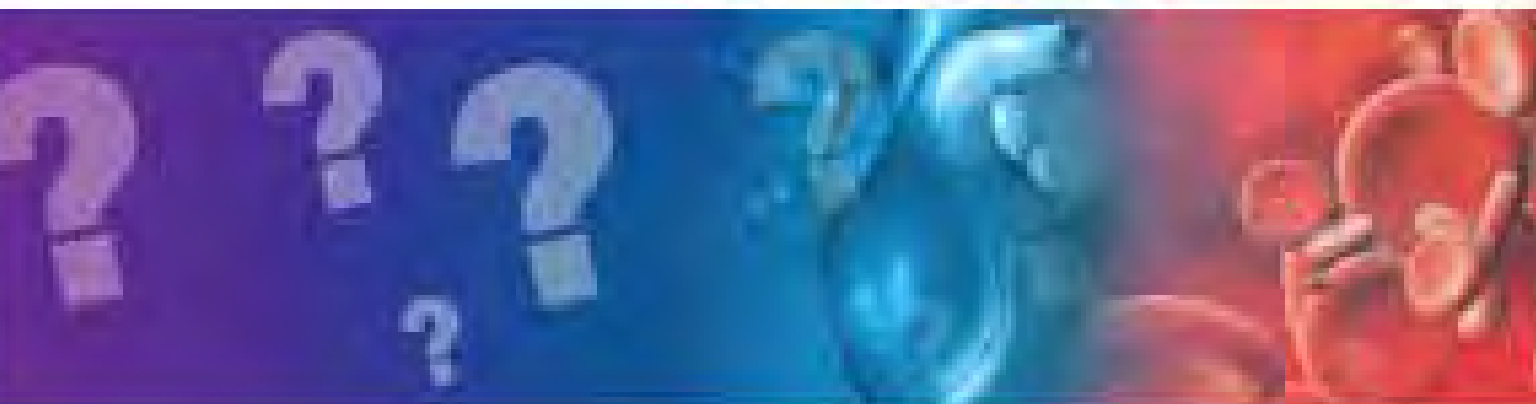
at Mayo Clinic and medical director of the WomenHeart Science & Leadership Symposium. “They bond as heart sisters almost the minute they meet one another, then spend the next four days learning, living and supporting each other, gaining new strength each day until they become WomenHeart Champions.”

We encourage all physicians and health care providers to refer their patients to www.womenheart.org to become more educated about women’s heart disease and to locate a support network near them. WomenHeart invites all health care professionals to refer women heart patients who they believe would make effective community leaders and national spokespeople to apply for the 2010 WomenHeart Science & Leadership Symposium at Mayo Clinic. Applications are available on the WomenHeart website, and the deadline for application is June 18.

If you are interested in serving as the medical director for a WomenHeart Regional Patient Symposium, please contact Charyl Delaney at cdelaney@womenheart.org or 202-464-8742.

Minissian is a cardiology nurse practitioner, Cedars-Sinai Heart Institute, Women’s Heart Center, and cochair of the CVT Council. Clough is director of Communications & Marketing, WomenHeart: The National Coalition for Women with Heart Disease.

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Journal Scan Now Includes Nursing Journals

By Suzanne Hughes, M.S.N., R.N.

CardioSource has added scans of several nursing journals to its Journal Scan, a popular feature led by **Kim Eagle, M.D., F.A.C.C.**, and his team of Journal Scan editors. On a weekly basis, the Journal Scan team chooses the most important articles for CardioSource users from more than 25 cardiovascular journals. The editors draft concise summaries and points to remember, and these are promptly posted to the website. With the huge volume of information out there, it's difficult to read everything, and many members use Journal Scan to keep them up to speed on the latest research, or to advance their knowledge of a subspecialty area outside their core area of focus.

In recognition of the growing number of nurses and advanced practice nurses in the Cardiac Care Associate membership, Journal Scan now is including two to three scans a month of important papers published in the *Journal of Cardiovascular Nursing*, *Heart and Lung: The Journal of Critical Care*, *Nursing Research* and other journals focused on cardiovascular nurses. We also have enlisted the participation of our Pharm.D. colleagues to provide scans of articles;



Rhonda Cooper-DeHoff, Pharm.D., F.A.C.C., recently provided a summary from *Pharmacotherapy* regarding a physician/pharmacist collaborative intervention.

Nurses in clinical practice are interested in a wide variety of information. The cardiac nursing journals are a source of information on nursing and multidisciplinary research. We hope the new nursing

Journal Scans will provide value to these busy and critical members of the cardiovascular care team.

Hughes is director of health education and nursing research at Robinson Memorial Hospital in Hudson, Ohio.



CVN Posts 100th Heart Minute

CardioSource Video Network's 100th Heart Minute posted in May. The latest episode, featuring **Peter Block, M.D., F.A.C.C.**, was a look at the RESOLUTE All Comers Trial, presented at EuroPCR as a late-breaking clinical trial. RESOLUTE is a comparison of two drug-eluting stents. This Heart Minute and others are available for viewing on CardioSource.org.



Jump-Start Certification Process with CTA Practicum

Register now for the fall 2010 ACCF/Society of Cardiovascular Computed Tomography Coronary CTA Practicum to be held Sept. 9 – 11 at Heart House in Washington,

D.C. Remember that space is limited so register early. Go to CardioSource.org, click on Certified Education, Courses and Conferences.



TAD Guidelines Webinar Now Online

Did you miss the Thoracic Aortic Disease (TAD) Guidelines Webinar held on May 19? The same great content is now archived online with highlights from the recently released TAD guidelines from moderator **Loren Hiratzka, M.D., F.A.C.C.**, and presenters **Dianna M. Milewicz, M.D., Ph.D.**; **Luke K. Hermann, M.D.**; and **Lars G. Svensson, M.D., Ph.D.** Go to wcc.webeventservices.com/eventRegistration/EventLobbyServlet?target=registration.jsp&cb=&tile=false&eventid=208401&sessionid=1&key=C946C0F9EABAFEBF5E9B58BD8B0468ED&cb=blank&sourcepage=register.

CardioSmart: A Focus on Patient-Centered Care

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



Most ACC members have heard of CardioSmart – in fact, you may have recommended *CardioSmart.org* to your patients as a great website for learning more about cardiovascular conditions. But CardioSmart is much more than just a website. CardioSmart is the term for ACC's patient-centered activities, and it encompasses a number of efforts at outreach to our patients that the ACC is making on behalf of its members.

Research has shown that patients are overwhelmed with health information. There is an abundance of sometimes conflicting information available to patients and their families, particularly online. In spite of this volume of information, it often is difficult to find reliable, targeted information that reflects evidence-based diagnosis and treatment. As we have less and less time to spend face-to-face with patients, this information void has become more apparent.

In response, the ACC has launched a nationwide CardioSmart campaign that supports guideline-based cardiovascular care. The cornerstone of the campaign is the trusted relationship between cardiologists and other members of the cardiovascular care team and their patients. The goal is to make CardioSmart resources an extension of the provider-patient interaction and to provide tools that augment the information provided during an office or hospital visit. With CardioSmart resources, your patients will have an opportunity to become more engaged in the management of their vascular health, and have greater opportunities for optimal outcomes.

The CardioSmart initiative will extend beyond the office



visit with community events, Web-based education, tracking modules and discounts for heart-healthy products. One such community event, CardioSmart Atlanta, was sponsored by the Georgia Chapter and held in conjunction with ACC.10/i2 Summit. The event included blood pressure screenings, cooking demonstrations, heart healthy kids' activities and loads of educational presentations and products. CardioSmart Atlanta will serve as a template for similar community events in other chapters.

The *CardioSmart.org* website will continue to be a key component of the campaign.

The site offers information on risk factors, specific conditions, as well as on diagnostic tests and treatments patients may encounter; online blood pressure tracking; a video library; patient stories; and more. With you directing your patients toward these tools and activities, the goal is greater patient engagement, both in their relationship with you and the other members of the cardiovascular care team, and in their own health. Beyond the website, ACC will be working with national partners to help deliver CardioSmart strategies to people at risk for heart disease.

One such partnership has already been formed with

Beyond the website, ACC will be working with national partners to help deliver CardioSmart strategies to people at risk for heart disease. One such partnership has already been formed with General Mills.



GENERAL MILLS

General Mills. Because of this company's commitment to health and wellness, a partnership with CardioSmart seemed like a natural. The first initiative in the partnership will be greater support for information on *CardioSmart.org*, with linkage to the Bell Institute of Health and Nutrition (www.bellinstitute.com), which is a health professional resource for nutrition education to promote healthy living. The Bell Institute sponsors educational efforts including continuing education programs for professionals and develops patient education materials on topics such as whole grains, heart health and weight management. The partnership with General Mills was vetted by members of the Patient Centered Care Committee who are charged with reviewing the details of all of the College's activities with regard to corporate partner support of CardioSmart. It is our hope that our corporate partners will leverage their considerable reach to communicate with and help engage a broad population of our patients.

Pilot Phase

The ACC is piloting a CardioSmart hypertension program in California, designed to produce measurable improvement of patients' understanding of their cardiovascular health, as well as improved hypertension outcomes. The pilot, which involves the work of

many members of the California Chapter, depends on ACC members to recruit patient participants.

ACC members will provide patients with unique login information for *CardioSmart.org* and patients will then complete an online hypertension education module and begin tracking their blood pressure online with the CardioSmart tracker. Patients will receive electronic prompts and reminders as well as opportunities to earn rewards — pedometers, t-shirts, coupons, product samples, etc.

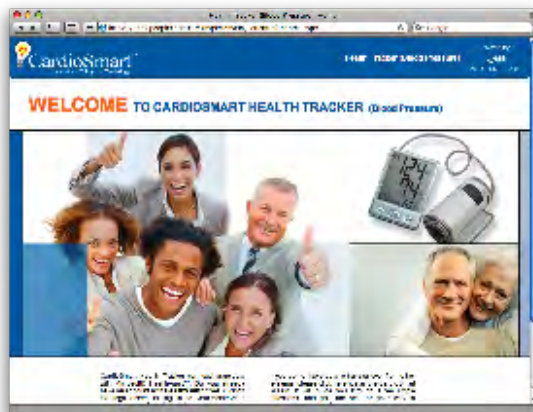
Key metrics are physician/practice adoption and patient enrollment rates, as well as the sustainability of the program in terms of patients' willingness to track blood pressure for an extended period and use various tools and educational resources. The benchmark of patients' blood pressures compared to guideline-recommended targets will serve as an outcome measure.

Stay tuned for more information on the pilot and its outcomes in the months to come, as well as information on the evolution of the CardioSmart campaign. The broadening of the CardioSmart initiative signals a new ACC focus on patient-centered care and acknowledges

the needs of members in providing timely and accurate tools and information to their cardiovascular patients.



CardioSmart's partnership with General Mills includes linkage to the Bell Institute of Health and Nutrition website.



The CardioSmart Health Tracker allows patients to track their blood pressure online.

Walsh is a member of the Board of Trustees and chair of the Patient-Centered Care Committee. She is medical director of the Congestive Heart Failure and Cardiac Transplantation Programs at St. Vincent Hospital and director of Nuclear Cardiology at The Care Center, LLC, in Indianapolis.

Global Collaboration

ACC leaders have been racking up the airline miles recently with trips to Malaysia, Qatar and Saudi Arabia, among others. “It’s remarkable to see the social and technological progress in the Middle East and Asia over the past decade, but it’s also amazing and heartening to observe the high quality of care being provided in these jurisdictions by our cardiovascular colleagues,” says Jack Lewin, M.D., ACC CEO. “We all have so much to learn from each other, and we’re only beginning to envision the kinds of information exchanges that technology will allow in the future.”

Check out photos from recent international trips, including ACC President Ralph Brindis, M.D., M.P.H., F.A.C.C., and Past President Doug Weaver, M.D., M.A.C.C., during trips to Malaysia and Saudi Arabia. Also included are shots from Lewin’s trip to Doha, Qatar, along with Jim McClurken, M.D., F.A.C.C. (ACC.10 program chair); Rick Nishimura, M.D., F.A.C.C., and Carole Warnes, M.D., F.A.C.C. (ACC trustees); Ziyad Hijazi, M.B.B.S., M.P.H., F.A.C.C.; Fred Masoudi, M.D., M.S.P.H., F.A.C.C. (NCDR® board); Doug Zipes, M.D., M.A.C.C.; David Hayes, M.D., F.A.C.C.; Sid Smith, M.D., F.A.C.C.; and others.

ACC President Ralph Brindis, M.D., M.P.H., F.A.C.C., poses with Sim Kui-Hian, M.B.B.S., F.A.C.C., head of the new ACC Malaysia Chapter.



Above: Fred Masoudi, M.D., M.S.P.H., F.A.C.C. (fourth from right), and Jack Lewin, M.D., CEO (fifth from right), pose with dignitaries at a meeting of the Gulf Heart Association in Doha, Qatar.

ACC President Ralph Brindis, M.D., M.P.H., F.A.C.C. (front row, fourth from left), attends Convocation ceremonies at the Annual Scientific Meeting of the National Heart Association of Malaysia.



Above: Past President Doug Weaver, M.D., M.A.C.C. (right), and President Ralph Brindis, M.D., M.P.H., F.A.C.C. (second from right), pose with His Excellency, the Saudi Minister of Health Abdullah bin Abdul Aziz Al-Rabiah (third from right) during a special meeting to discuss quality. Brindis and Weaver were attending the Scientific Conference of the Saudi Heart Association.



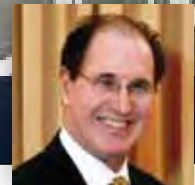
Hani Najm, president of the Saudi Heart Association, and Jack Lewin sign an agreement on registry collaboration during the Gulf Heart Association meeting in Doha, Qatar



From left: Khalid Al-Habib, Hani Najm, Jack Lewin and Fred Masoudi share a discussion during the Gulf Heart Association meeting in Doha, Qatar.



New Code Safeguards Our Integrity



By W. Douglas Weaver, M.D., M.A.C.C.

The Council of Medical Specialty Societies (CMSS) recently released its Code for Interactions with Companies, a document designed to “guide medical specialty societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions.” The ACC, as a leader in transparent, ethical relationships with industry, not only signed on to this code, but played a pivotal role in developing it.

“Our integrity and the combined knowledge of our membership are the real proprietary property of the College... The ACC is committed to never compromising this standard.”

The College has been working to strengthen its policies on relationships with industry (RWI) for several years. During our 2008 Industry Forum, assembled leaders from the ACC, other societies, Congress, industry, and the Food and Drug Administration discussed the potential for a single, consistent policy for specialty societies to use to self-regulate RWI. The College committed to leading the charge on this policy. In the spring of 2009, ACC General Counsel Tom Arend began meeting with other specialty organizations to work on a joint document.

The College has had great concern for some time about ensuring that proper firewalls be established between educational grants and other funding provided by industry. The ACC also has long had rigorous policies in place for members of writing committees for our scientific documents. These policies help ensure that our relationships with drug and device companies never influence the scientific or educational materials produced by the College. For the past two years, we have been transparent

about all industry funding received by the organization — this is available to all on our website (www.cardiosource.org). Many of our policies have been incorporated into the CMSS Code for Interactions with Companies.

The Code does not include many significant changes from common practice for most medical specialty societies, but it does codify certain principles. For example:

- No officer may have a direct RWI during his or her tenure.
- All volunteer leaders must disclose any RWI (as members of the

ACC Board of Trustees, Board of Governors and committee chairs have).

- The need for an educational activity must be independently determined and documented before solicitation of any funding for educational support.

To learn more, visit www.cmss.org and click on “CMSS Policies” and “Code for Interactions.”

Some ACC members find the code too strict and believe it will preclude the involvement of noted cardiovascular experts in the development of scientific documents and education. However, we now live in an era in which an RWI could compromise the value of our practice guidelines and other scientific documents — one of the richest assets of the College. We have removed any person with a relevant RWI from the writing committee of that part of the document, and the CMSS code requires that the majority of the members of a writing committee be free of any relevant RWI. Industry support will not be used for development, printing or distribution of clinical practice guidelines. This is a strict approach, but one that I believe is necessary to the continued credibility of our important work.

Others believe the CMSS code is not strict enough; some would even go

Coming in June: Expanded ACC Blog

so far as to advocate for a completely “pure” approach, in which specialty societies would not accept any funding from industry. I believe this is an unrealistic position. Public funding for research and continuing medical education (CME) is scarce. Industry funds scientific publications, research grants, CME, quality of care projects and more. Without funding for these meaningful endeavors, we would be crippled in many of our educational and quality improvement efforts.

RWI can be managed to benefit the development of science and to educate physicians and patients. Many of the recent new discoveries in cardiovascular medicine have come about as a result of physicians working with industry to develop and test a new therapeutic drug or device. The explosion of new information continues to increase, now doubling every two years, and we must disseminate that new material through CME. Education remains the cornerstone of our mission as a medical professional society, and we have a duty to produce quality CME, free of industry influence, for our members.

The development of the CMSS Code is a great beginning for medical specialty societies and our partners in industry: It offers us a singular approach to managing our relationships. It will not, however, be the last time we visit this issue. Our integrity and the combined knowledge of our membership are the real proprietary property of the College. We must always reflect and assure both ourselves and others that any and all of our efforts are aimed to benefit our members and, ultimately, our patients and society. The ACC is committed to never compromising this standard.

Weaver is past president of the ACC, a member of the Board of Trustees and head of the Division of Cardiovascular Medicine at Henry Ford Hospital in Detroit.

ACC's blog is expanding! The Lewin Report, your hub for cardiology-related health policy news, in June will begin to feature expanded quality and clinical news coverage and will be called the ACC in Touch blog.

The ACC in Touch blog will have two new authors: ACC President **Ralph Brindis, M.D., M.P.H., F.A.C.C.**, and ACC Board of Governors Chair **Richard**

Kovacs, M.D., F.A.C.C. With

more authors and

subject areas on

the ACC in Touch blog, you will be “in touch” with your leadership more than ever.

Visit the blog in June to ask them your questions, leave feedback and more: blog.cardiosource.org.



ACC in TOUCH blog
AMERICAN COLLEGE OF CARDIOLOGY

Congratulations!

C.A. Sivaram, M.B.B.S., F.A.C.C., recently received the Edgar W. Young Lifetime Achievement Award for long-term dedication to medical education. This award is presented annually by the University of Oklahoma College of Medicine Student Council.

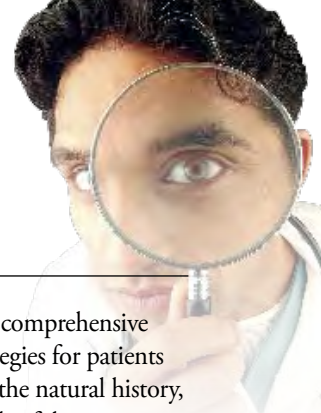
Help Select the College's Future Leaders

Please submit your recommendations to the Nominating Committee for the slate of Officers and Trustees for the American College of Cardiology (ACC) and the American College of Cardiology Foundation (ACCF), who will be elected at the Annual Business Meeting in March 2011 in New Orleans. Officers and Trustees can serve in both organizations for the duration of their terms.

Fellows and Cardiac Care Associates in good standing are invited to recommend candidates for the positions of Vice President, President-Elect and up to five ACC/ACCF Trustees. The Vice President will serve a one-year term and traditionally advances to the office of President-Elect. Each Trustee will serve a five-year term.

The process for nominating a candidate, the job descriptions for Officers and Trustees, and the Conflict of Interest policy are included in a guide that can be found at www.acc.org/membership/member/Nomination_submit_guide.pdf





Education Puts 'Focus On' ACC.10 Content

The ACC Foundation has added ACC.10 and i2 Summit 2010 content to three "Focus On" products: Focus on Acute Coronary Syndromes (ACS) 2, Focus on Valvular Heart Disease and Focus on Vascular Disease. The Focus On products combine content from key scientific and clinical meetings with self-assessment questions, online syllabus texts and more. They are presented in a convenient online format.

Created by dozens of experts, **Focus on Acute Coronary Syndromes (ACS) 2** caters to a variety of learning styles. Whether you like to learn by reading, answering questions or listening to lectures, Focus on ACS has content to meet your needs. It also includes ABIM-style self-assessment questions and case studies.

Focus on Valvular Heart Disease is designed to increase learner competency in three key areas:

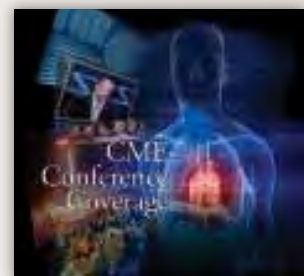
1. Assessing the severity of valvular heart disease and the effect of valve lesions on ventricular function and patient outcome
2. Understanding the timing of interventions for valve lesions based on patient symptoms, severity of valve lesion, and other hemodynamic effects of valve lesions (e.g. pulmonary hypertension, atrial fibrillation)
3. Understanding the potential role for medications to reduce progression or complications of valve lesions

Focus on Vascular Disease provides a comprehensive analysis of the diagnosis and treatment strategies for patients with peripheral vascular disease. It explores the natural history, epidemiology, pathophysiology and methods of diagnosis of non-coronary vascular diseases, as well as evidence-based medical, interventional and surgical management strategies. Topics covered include carotid and cerebrovascular diseases, aortic, mesenteric and renal vascular diseases, and lower extremity vascular — including venous thromboembolic disease.

All three products now include lectures from ACC.10 and i2 Summit 2010 in addition to content from ACC.09 and i2 Summit 2009. For more information, go to CardioSource.org and select Certified Education, eLearning & Products.

ACC.10 and i2 Summit CME Conference Coverage: Expert Recaps Now Available

CME Conference Coverage offers a digital review of ACC.10 and i2 Summit, including summaries of presented studies, analysis from cardiovascular thought leaders and streaming audio from ACC.10 and i2 Summit faculty members:



Capsule Summaries: A summation of the key data from a single study, presented in a standardized format, including tables and study design schematics. The data are reported as they were presented at the meeting rather than from the published abstract so you get the most up-to-date data "from the podium."

Expert Analyses: An in-depth analysis of key studies on a particular pathway by three opinion leaders, who met as a panel to discuss and debate the clinical implications of each study.

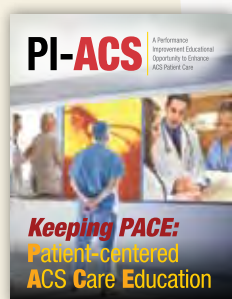
Expert Recaps: A multimedia CME activity consisting of downloadable slides summarizing key studies with streaming audio narration by a faculty member who is an expert in that specific pathway.

Expert recaps just became available in May. For more information, go to www.cardiosource.org/Certified-Education/eLearning-and-Products/Conference-Coverage.aspx.

Keeping PACE with Quality

ACC's first Performance Improvement (PI)-CME initiative, Keeping PACE, launched in May. Patient-centered ACS Care Education is a revolutionary educational activity that bridges continuing education, quality improvement and registry data.

Participants customize their own learning experience based on ACTION®-GWTG™ Registry data from their hospitals. They review the data and conduct a self assessment, develop a plan for improving performance and participate in at least one targeted educational initiative. Finally, they reassess their performance data to measure progress. For more information, go to www.cardiosource.org/Certified-Education/eLearning-and-Products/PI-ACS.aspx or contact Melissa Ketchum (mketchum@acc.org) or Laura Lee Hall (lhall@acc.org).



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Summer's Blockbuster Premiere: CardioSource.org Launches in June

The ACC is debuting the all-new *CardioSource.org* in June with outstanding content, streamlined access and advanced customization.

The new *CardioSource* combines two major websites, the *Cardiosource.com* clinical portal and *acc.org*. User feedback has shown that the two sites created a somewhat confusing and disjointed online experience. Members must go to *Cardiosource.com* to access clinical information and to *acc.org* to access institutional content.

The new *CardioSource.org* combines organizational information and clinical content in one site, designed to be the most comprehensive source for all things ACC- and cardiology-related. Members and other ACC constituents now will be able to access all the content they trust from the College — guidelines, case studies, expert opinions, clinical studies, continuing medical education (CME), journal



scans, advocacy information, practice management resources, membership information, the latest news from the College and more — from one convenient site.

Of course, with the huge scope of information that will be available on *CardioSource.org*, the College has paid special attention to building a site structure that is intuitive and organized, making it easy to find the content users

need. We have combined areas that were

redundant on the two sites and streamlined information.

The new *CardioSource.org* also features an advanced search function that not only searches the full text of *CardioSource* news, clinical trial reviews and clinical images, but also all of ACC's online education modules, *JACC* journals, guidelines and clinical statements, Braunwald's *Heart Disease* online textbook, and important journals like *Heart Online* and *Heart Rhythm*.

The new *CardioSource.org* will not only be more convenient, but also better tailored to users' needs.



The new CardioSource also will make it easier to manage your CME, with the debut of ACC's Lifelong Learning Portfolio, which will provide members and customers guidance in managing and tracking education and Maintenance of Certification activities throughout their professional career.

Member-driven, Member-centric

A new CardioSource Steering Committee will govern the site, overseeing policies and strategy. The committee is comprised of members representing patient-centered care activities and the major content areas of *CardioSource.org*: Science and Quality, Publications, Membership/Practice Management, Education and Advocacy. The committee is charged with working closely with ACC staff to —



A Customized User Experience

The new *CardioSource.org* will not only be more convenient, but also better tailored to users' needs. Members will be able to log in for a customized experience that delivers information according to specifications and preferences you set, including customization of your MyCardioSource home page. You will be able to tag your interests in order to populate your individual MyCardioSource home page with news and links relevant to your priorities. MyCardioSource also will track CME and include convenient links to your dedicated Learning Portfolio.

The site also incorporates CardioSource Communities, designed to allow users to network with peers and discuss the latest news and content on CardioSource. Participants can use the CardioSource Communities feature to organize groups around topics, exchange ideas, upload photos and plan events. You will be able to create a CardioSource Communities profile to connect to other users and converse with peers around the world.

- Establish overall ACC Web themes, content areas and messages
- Oversee functionality and service offerings, including integrating and coordinating content and service offerings to avoid duplication of effort
- Explore new business models and strategic partnerships, including expanding *CardioSource.org* into other interactive media channels
- Ensure consistency across the site, while maintaining flexibility for each area as needed
- Maintain close relationships with “parent” committees with oversight responsibility for specific content areas
- Coordinate the strategy and policy of *CardioSource.org* and the scientific periodicals with other ACC in-house communications such as *Cardiology*, newsletters and more
- Administer a consistent advertising policy
- Use Web usage reports and site analytics to inform decisions relative to the site
- Ensure member satisfaction and value

The new *CardioSource.org* site is slated for official launch in June.

Lobby Day Showcases Power of Patient-Physician Partnership

In April, the ACC collaborated with longtime partners the Adult Congenital Heart Association, the Children's Heart Foundation and Mended Little Hearts on the fourth Congenital Heart Lobby Day in Washington, D.C. ACC's Adult Congenital and Pediatric Cardiology (ACPC) Section championed the College's involvement in this advocacy effort, which was specifically focused on funding legislation.

Almost 120 participants, including patients, family members, pediatric cardiologists, adult congenital cardiologists, CCA members and surgeons, made close to 140 visits on Capitol Hill.

The February 2009 Lobby Day advocated for passage of the Congenital Heart Futures Act, which was introduced by **Sen. Richard Durbin** (D-Ill.) in 2009 and passed as part of the Patient Protection and Affordable Care Act of 2010, demonstrating the power of patient-physician partnership. This year's effort advocated for funding for the Congenital Heart Futures Act — \$7.25 million dollars for the Centers for Disease Control and

Prevention to support data collection to better understand congenital heart disease (CHD) prevalence and to assess the public health impact of CHD. The \$7.25 million would include \$3.75 million for a pilot adult surveillance system and \$3.5 million to add CHD into the existing birth defects surveillance system.

A robust surveillance system would help cardiologists by providing population-based data on the prevalence of CHD, as well as providing a mechanism to assess appropriate care of CHD and patient trends.

The ACPC Section believes it is important for all cardiologists and surgeons involved in care of CHD patients to become involved with advocacy efforts to promote lifelong quality care for the nearly 2 million CHD patients living in the United States. The Section thanks everyone involved in the Lobby Day efforts, in particular the ACC Texas, Ohio

and California Chapters, which funded activities including a welcome reception, breakfast and refreshments, in addition to providing travel funds.



'Practical' Options Available in New Online Bookstore

The ACC has partnered with **Greenbranch Publishing** to offer ACC members discounted rates on Greenbranch's industry-leading medical practice management books and journals.

Greenbranch titles include *The Journal of Medical Practice Management* and books such as *Secrets of the Best-Run Practices* by Judy Capko. Visit the new online Practice Management bookstore at www.acc.org/greenbranchbooks.

Clarification

In the March/April issue of *Cardiology*, we told you about **Rhonda Cooper-DeHoff, Pharm.D., F.A.C.C.**, who became a fellow of the American College of Cardiology (FACC) at the 59th Annual Convocation in Atlanta. We incorrectly identified Cooper-DeHoff as the first doctor of pharmacy to become a fellow. Instead, she is the first doctor of pharmacy who advanced from Cardiac Care Associate membership to fellowship. Three other doctors of pharmacy also are FACCs.





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GENERAL CARDIOLOGY

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[The following text is heavily blurred and illegible.]

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Portland, Oregon 97209
sallyspurling@nwi.com



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In addition, the Chief will be supervising educational experiences for fellows in cardiology and direct cardiology staff for coordination of effective clinical service provision to both inpatients and outpatients.

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June 8

- Imaging Atherosclerotic Plaque Inflammation by FDG PET - Ready for Prime Time?
- Two-year Clinical and Angiographic Outcomes from a Randomized Trial of Polymer-Free Dual Drug-Eluting Stents versus Polymer-Based Cypher and Endeavor Drug-Eluting Stents

June 15

- Prognostic value of plasma fibrinolysis activation markers in cardiovascular disease
- Randomized Trial of Paclitaxel- versus Sirolimus-Eluting Stents for Treatment of Coronary Restenosis in Sirolimus-Eluting Stents - Intracoronary Stenting and Angiographic Results: Drug Eluting Stents for In-Stent Restenosis 2 (ISAR-DESIRE 2)

June 22

- Warfarin Genotyping Reduces Hospitalization Rates: Results from the Medco-Mayo Warfarin Effectiveness Study (MM-WES)
- Angiographic versus Functional Severity of Coronary Artery Stenoses in the FAME Study

June 29


- Risk Factors for Venous Thromboembolism: State-of-the-Art
- Cardiac Performance Measure Compliance in Outpatients: The American College of Cardiology and National Cardiovascular Data Registry's PINNACLE Program









- Impact of Pressure Recovery on Echocardiographic Assessment of Aortic Stenosis in Asymptomatic Patients: A SEAS Substudy
- Determining Aortic Valve Stenosis Is Severe: Back-To-The-Future. Physical Examination And AVAI/ELI \leq 0.6 cm²/m²

April

- Long-term clinical results following stenting of the Left Main Stem - Insights from RESEARCH and T-SEARCH Registries
- Five Year Outcomes Following PCI with DES Implantation vs. CABG for Unprotected Left Main Coronary Artery Lesions: The Milan Experience

Educational Programs Calendar

	August 19, 2010 ACCF Study Session for ABIM Maintenance of Certification: Interventional Cardiology Updates 2009 and 2010	<i>Dallas</i> CME MOC
	Joseph D. Babb, M.D., F.S.C.A.I., F.A.C.C. James E. Tcheng, M.D., F.A.C.C., F.S.C.A.I., F.E.S.C.	
	August 20 - 22, 2010 ACCF/SCAI Premier Interventional Cardiology Overview and Board Preparatory Course	<i>Dallas</i> CME
	Joseph D. Babb, M.D., F.S.C.A.I., F.A.C.C. James E. Tcheng, M.D., F.A.C.C., F.S.C.A.I., F.E.S.C.	
	August 31 - September 4, 2010 The ACCF Cardiovascular Board Review for Certification and Recertification	<i>Chicago</i> CME
	Kim A. Eagle, M.D., M.A.C.C. Patrick T. O'Gara, M.D., F.A.C.C.	
	September 4, 2010 ACCF Study Session for ABIM Maintenance of Certification: Cardiovascular Disease Updates 2009 and 2010	<i>Chicago</i> CME MOC
	Rick A. Nishimura, M.D., F.A.C.C. Patrick T. O'Gara, M.D., F.A.C.C.	

	September 9 - 11, 2010 2010 ACCF/SCCT Coronary CTA Practicum	<i>Washington, D.C.</i> CME
	Allen J. Taylor, M.D., F.A.C.C., F.A.H.A.	
	September 23 - 25, 2010 Arrhythmias in the Real World 2010	<i>Washington, D.C.</i> CME CE
	Peter N. Smith, M.D., F.A.C.C. Arthur J. Moss, M.D., F.A.C.C. Kelley P. Anderson, M.D., F.A.C.C.	
	October 7 - 9, 2010 2010 Heart Valve Summit: Medical, Surgical and Interventional Decision-Making	<i>Chicago</i> CME CE
	David H. Adams, M.D., F.A.C.C. Steven F. Bolling, M.D., F.A.C.C. Robert O. Bonow, M.D., F.A.C.C. Howard C. Herrmann, M.D., F.A.C.C., F.S.C.A.I.	
	October 14 - 16, 2010 2010 ACCF/SCCT Coronary CTA Practicum	<i>Washington, D.C.</i> CME
	Wilfred Marmuya, M.D., Ph.D., F.A.C.C.	

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

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