



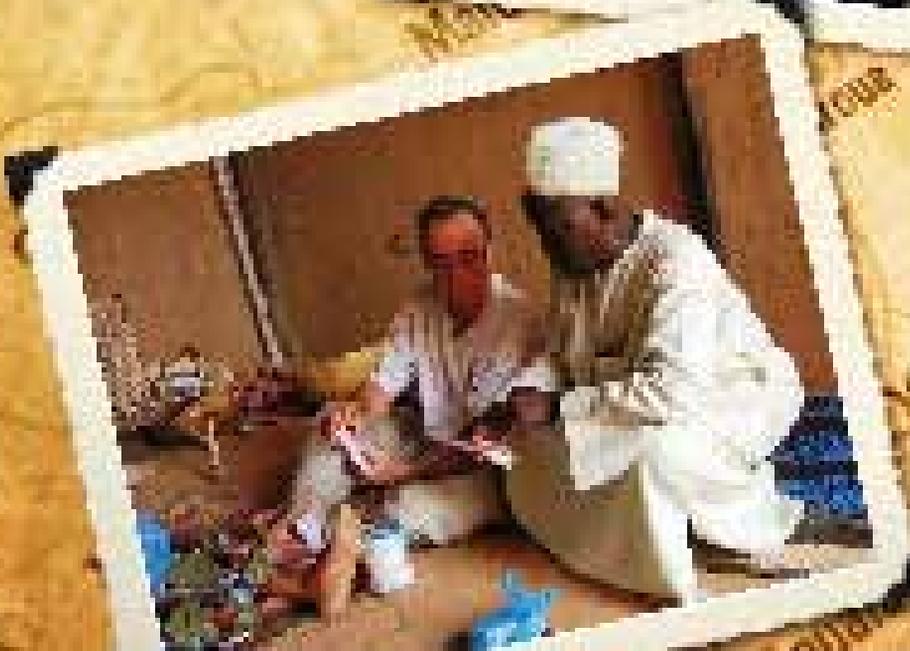
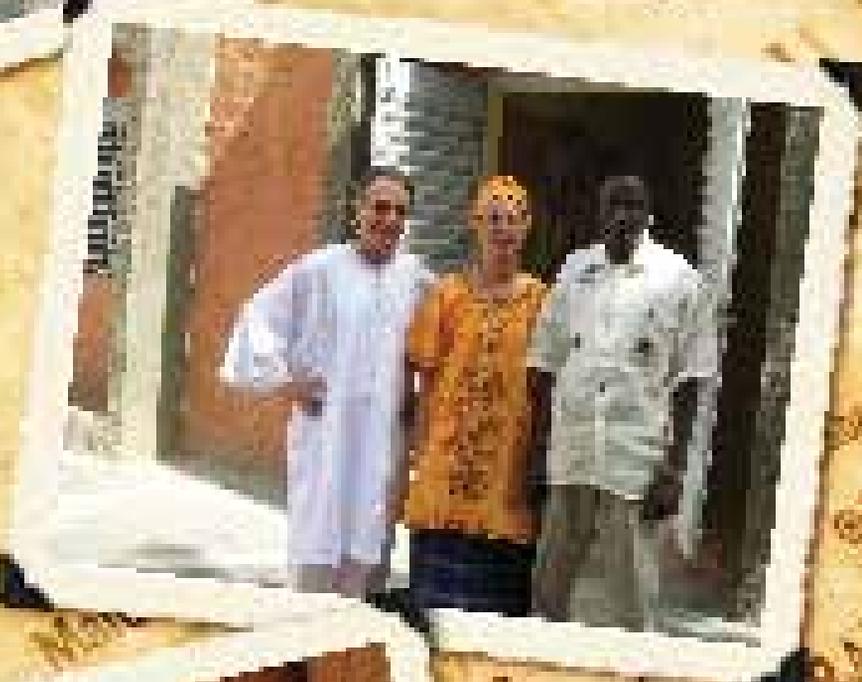
FEBRUARY 2009 VOLUME 38 NUMBER 2

Cardiology

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**Serving
the Poor
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Country:**

A Heartbeat in Africa



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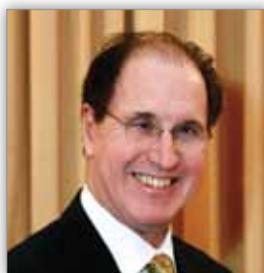


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Reform Concerns Afloat in Sea of Need



The ACC just finished with its second Health System Reform Summit at Heart House in Washington, D.C. Our goals with the meeting included refining and amending the principles of health care and payment reform first established by the ACC's Blue Ribbon Panel and the 2008 Health System Reform Summit. We hoped also to come to consensus on what ACC's focus should be for both the short- and long-term and what our message to legislators and government administrators should be.

We know that our health care system is broken in many places and fixing it will very difficult. The issues are complex and varied depending on the "shareholder." Payment systems for providers need to be fixed; the current rumble is that the SGR will not be fixed (resulting in a 20 percent decline in reimbursement on Jan.1, 2010) without some modifications on the pay for quantity paradigm to pay for value one. Although the ACC is prepared to make a value and quality proposition, many other professional societies are not. We can't be sure where this will go.

The College has worked and is working hard on many fronts to deal with many of the issues. Our many Quality initiatives, such as the clinical practice guidelines, performance measures, appropriate use criteria and the registries are ways and tools to increase the quality of care. In my own mind, however, we aren't going to hit the mark until these measures, as well as decision support tools, are part of our regular workflow. Auditing charts and filling out separate datasheets is just not going to get us to 100 percent compliance. However, I am gratified to hear the policy wonks state that the College is far out in front of many other professionals and is on the right track. The work that all of us and staff have done in the past three years has had an impact – the wonks know our name and we are at the table in health system reform discussions.

At this year's summit we faced a situation with even greater implications. Our nation is in its worst recession in many decades. People are losing their jobs (at a current rate of 500,000 per month), and even some health care providers are finding themselves included in the ranks of the unemployed. Others have their salaries and positions "frozen." Job losses and the increasing number of people in the "working poor" category are generating a steady growth in the number of uninsured and under-insured people, and patients are not going to see their physicians or are not taking their medications.

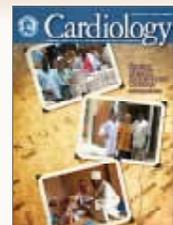
Given the above, the articles in this month's *Cardiology* about those who are volunteering their services become even more significant. Whether it is in the U.S. or elsewhere, these retired physicians and still-active volunteers are giving back to society at an especially important time. Granted, there are obstacles to volunteering medical services, perhaps the solutions provided in these articles could be generated in more states and regions. I can only hope that we are all inspired by these stories and will make the time to give to those in need.

W. Douglas Weaver, M.D., F.A.C.C.
ACC President

Cover photos: (top to bottom)

Dr. Humphrey with nursing technician and head nurse M. Boubacar receiving medication shipment;
Drs. Humphrey and Barquero with Dr. Moussa Boukari;
Dr. Humphrey with senior nurse M. Zacaria on home visit.

February 2009



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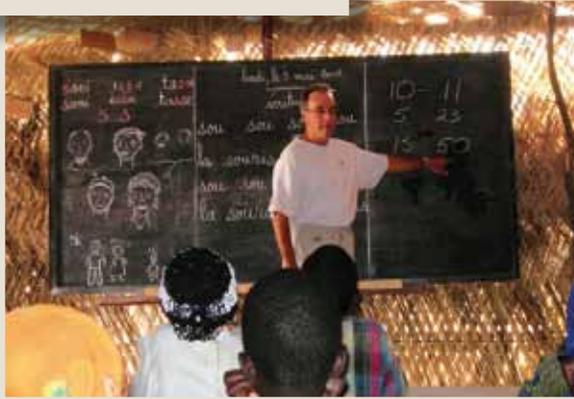
In November 2008 *Cardiology*, we asked members to tell us how they have continued to serve in medicine after their retirement. Some have volunteered their services here in the United States. Others have chosen locations outside of the U.S. Perhaps what is most interesting is the unrealized need in many circumstances for a cardiologist. This issue includes some of their stories and a commentary from George Rodgers, M.D., F.A.C.C., who is chair of the ACC Workforce Task Force.



Serving the Poor in the Poorest Country: A Cardiologist in Africa

*Photos on this page: (left to right)
Dr. Humphrey in the lab reading the day's malaria smears
Dr. Humphrey making rounds with M.Boubacar, R.N., and Dr. Boukari*

By Stephen H. Humphrey, M.D., F.A.C.C.



Photos on this page: (clockwise from upper left) Dr. Barquero with child from malnutrition ward; Dr. Humphrey with M. Zacaria and young friends.; Dr. Humphrey teaching English in a local KAMRA school

I retired from my practice of general and interventional cardiology in June 2006. From April 2007 through July 2008, my wife and I served as physician volunteers in the Niger Republic. We were posted in a 54-bed “bush” hospital in the southeastern corner of the country, about 60 miles from Lake Chad and near the Nigerian and Chadian borders. We worked with another U.S. physician volunteer, a United Nations surgeon and two local physicians. My wife, who is a generalist with a master’s degree in tropical medicine, and I took care of the medicine, pediatric and malnutrition inpatients and outpatients. Other team members handled surgical and obstetrical cases.

Our presence in Niger was under the auspices of the Kirker African Medical Relief Association (KAMRA), a small non-profit based in South Carolina. We went totally as volunteers and paid all our expenses including transportation, evacuation/health insurance and living expenses and received no salary. The Niger government provided us with housing including paid utilities and a truck, although we paid for fuel and a driver. My wife and I opted for a small motorcycle to cut fuel expenses.

Niger – A Country with So Much Need

Niger is arguably one of the poorest countries on the planet. With fewer than 400 practicing physicians in the country, physicians are needed everywhere, especially in the countryside. There are unimaginable shortages of medications and vaccines, general hospital supplies and durable medical equipment. The transition from a high-tech cardiology hospital and practice to a bush hospital with only an EKG, stethoscope, a handful of basic lab tests and the nearest X-ray 60 miles away posed significant challenges. Add to that a host of diseases I had never encountered before and one can understand that my first six months there were really another internship.

Malaria with all its complications, schistosomiasis, tuberculosis (TB), malnutrition and HIV disease were with us constantly. We saw tetanus and endured epidemics of diphtheria and measles. Perhaps the biggest surprise to me was that there is much for a cardiologist to do here, some of my dubious colleagues notwithstanding. Hypertension is absolutely epidemic and, of course, untreated. Congestive heart failure was very common, not only as a complication of malaria, but also due to a high incidence of idiopathic,

continued on next page

Staying Busy and Happy

Mike Sarche, M.D., F.A.C.C., attends at the Stout Street Clinic in Denver, Colo., 2 1/2 days a month. He also gives CME presentations for their salaried providers. The clinic is owned and administered by the Colorado Coalition for the Homeless, which receives state, federal and private financing.

“They had never had a cardiologist before,” says Sarche, “so I didn’t know if I was needed. But since I started about 14 months ago, I’m busy every minute that I’m there.” Because Colorado mandated about 11 years ago that insurers provide coverage for physicians doing non-compensated professional work, his malpractice is granted, gratis, by COPIC, Colorado’s leading insurer.

He also interprets echocardiograms one day per week for his old employer and occasionally lectures internal medicine residents at a local hospital.



Photos on this page: (clockwise from upper right) Drs. Barquero and Humphrey on sand dunes at village edge; Drs. Humphrey and Barquero with other staff in front of hospital administration building; Dr. Humphrey with medicine nursing staff.

“ It is not difficult to make a difference. Many times just making the correct diagnosis and initiating or modifying simple medical therapy can have an enormous impact. ”

hypertensive and peripartum cardiomyopathies. Rheumatic heart disease was common as well, and each week brought new cases to my clinic. There were even a few cases of coronary artery disease.

By the end of our stay there, 80 percent of the cases I saw in my outpatient clinic were cardiology-related, and it was easier to help a lot of these people than you might suppose. With a relatively small formulary of donated generic drugs and a little thought, we were able to treat many patients successfully.

Many of the large non-government organizations (NGOs) appropriately have had to focus their efforts on AIDS, TB, leprosy, malaria and other protozoal diseases and malnutrition. Unfortunately, this means little or no attention has been given to the emerging epidemic of hypertension and other easily treated cardiac problems in the developing world.

There is much for retired cardiologists to do as volunteers. Everywhere physicians are in short supply, not just in the third world. Large areas of this country are underserved, and the uninsured population continues to grow. It is not difficult to make a difference. Many times just making the correct diagnosis and initiating or modifying simple medical therapy can have an enormous impact. The ways to serve as a volunteer are limited only by the imagination. The satisfaction to be found in volunteering is enormous.

Humphrey and his wife, Orietta Barquero, M.D., continue to volunteer for international medicine assignments and plan to be in Ecuador in Fall 2009.

Interested in Volunteering?

An excellent resource used by Stephen Humphrey is provided by the *New England Journal of Medicine* at www.nejmjobs.org/career-resources/physician-volunteer.aspx. Once you join the volunteer community, it's easy to begin networking and discover many other interesting opportunities, says Humphrey.

If you know of other resources, please send them to *Cardiology* (adees@acc.org), and we will list them in a future issue.

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Consider What You Can Donate

“ I have been volunteering at the Naples Senior Friendship Center, where I established a cardiology service, for several years now. Yes, there are indigent in Naples, Fla., and recently the new patient applications have been averaging 20 per week. Apart from a few paid administrative staff, the rest of us are volunteers. We have 27 retired physicians, six dentists and a few nurses. The clinic is open five days a week, and it serves low-income individuals over the age of 50.

From a cardiac standpoint, one problem is the immediate availability of history, physical examination and an ECG. Without adequate insurance coverage, patient referrals for Echo and stress tests, holters and elective diagnostic caths are difficult to arrange and often not timely. A local volunteer organization — P.L.A.N. or the Physician Led Access Network — helps by contracting with physicians for services in return for sovereign immunity, but again services are not always timely.

The other issue is medication. We are dependent on donations for pharmaceuticals. The ACC could go a long way to educating its members that there are indigent clinics out there that could use donations of excess samples given to physicians' offices. ACC members could also identify indigent clinics in their local area and perhaps volunteer some time or organize a group for easier access to specialty diagnostic testing for those of limited means.

In our present economy with increasing costs and decreasing reimbursement, consideration for non-reimbursed services to the under- and uninsured is difficult, but certainly possible. ”

**Lawrence K. Harris, M.D.,
F.A.C.C., F.R.C.P.C.**
Naples, Fla.

Debate Continues on NPs

“ I read with interest Dr. Trant's letter and the reply from Dr. Sharma in the January 2009 issue of *Cardiology*. I passionately agree with Dr. Trant and do not believe Dr. Sharma's reply should close the debate. As a board-certified cardiologist, trained in the early 80s, I have seen my training and experience gradually become less relevant as a veritable industry of credentialing for different diagnostic and therapeutic skills has arisen, making the process of keeping up incredibly onerous. One has to wonder what the purpose of our original specialty training was.

It is becoming difficult to maintain privileges in techniques that we have mastered and in which we have done our best to keep up with new advances. Therefore, it is tremendously frustrating to see how we undermine our own specialty by allowing non-physicians to gradually assume our duties. I do not see this as progress at all, and I believe it makes a mockery of the lengthy process by which we got to where we are. ”

S. Fernando Soto, M.D., F.A.C.C.
Prescott, Ariz.



1949 Fourteen physicians meet in the office of Franz Groedel, M.D., to form the American College of Cardiology.

Making the Case for Volunteerism

By George P. Rodgers, M.D., F.A.C.C.

It is estimated that 47 million Americans are uninsured, and a sizeable portion of these individuals have heart disease.

Until we have substantial health care reform, this number may increase as many Americans lose their jobs.

With these numbers, there is a great need for volunteerism among our cardiovascular workforce. However, this article is not necessarily a call to action, but a sobering reminder of the difficulties we face with regards to expanding the volunteer delivery of cardiovascular care.

Several years ago I scaled back my cardiology practice so I could devote more time to research and other endeavors. One of my endeavors was to work as a volunteer at the People's Community Clinic in Austin, Texas. The work at the clinic has been a wonderful opportunity to give back to my community by using the skills that I spent years developing. It has been gratifying to be able to serve those who are financially vulnerable and struggling to stay at work while dealing with their chronic diseases. Many of these individuals number among the "working poor" — they earn too much to be on Medicaid but not enough to afford private insurance.

I work one evening (four hours) a month and typically see 12 patients who are referred by the clinic's full-time primary care physicians. The patients come from a variety of backgrounds ranging from waitresses and bartenders to taxi drivers to out-of-work attorneys and graduate students. I see higher percentages of patients with diabetes, obesity, rheumatic and congenital heart disease than in my private practice.

The uniquely vulnerable situation of these patients creates other difficulties in treating them. For example, performing subsequent testing and imaging can be difficult and may require creative problem-solving. Two years ago I noticed that fewer than 25 percent of the patients I had referred for echocardiograms had actually done them. This was despite highly discounted rates from philanthropic hospitals and practices in the community. We solved this problem by borrowing a portable echo from a local cardiology group every month when I am there. An echo technician, also a volunteer, joins me at the clinic and does all of the echoes. Yes, it's good to have results immediately for a patient, but even more important — we have solved the transportation, communication and financial issues that deterred patients in the past.

Shortages Create Difficulties in Giving Time

The three years at People's Community Clinic have provided some of the most gratifying experiences that I've had in cardiology. However, I recognize that my situation is unique, and it is difficult for most cardiologists to volunteer their time in this manner.

In my work with the Cardiovascular Workforce Task Force, we surveyed a large portion of the private and academic practices in the U.S. and found shortages of 1,685 general cardiologists, 1,941 interventional cardiologists and 660 electrophysiologists. These shortages are in contrast with an active adult cardiology workforce of 23,862. The survey was based on open positions for these cardiologists.

Our interpretation of this information was that the workforce has far more demand than it is able to handle comfortably. The current cardiovascular workforce appears to be 18 percent smaller than it should be and is already burdened with a heavy workload. Adding hours of volunteerism in community clinics that serve the working poor appears unrealistic and probably unthinkable because our workforce is already stressed to the limit.

Malpractice Insurance, a Barrier

The other major barrier to volunteerism affects the estimated 510 retired but still healthy cardiologists who are perhaps willing to work in a volunteer capacity. No doubt many of them are volunteers. However, retired physicians face the barrier of medical malpractice insurance, and Good Samaritan laws in most states do not adequately protect volunteers from the threat of lawsuits. In several states — for example, Illinois, Florida, New York and Pennsylvania — medical malpractice insurance premiums may run as high as \$30,000 or more per year. For someone who is retired, that amount may be untenable.

Certainly, there is a need for volunteerism and many opportunities exist for volunteers. However, given the barriers of an overworked active workforce and high medical malpractice premiums for retirees, I see volunteerism as a viable option for a limited number of cardiologists. Yet, if one is in the select few who have the time and the opportunity, it is a tremendously worthwhile and gratifying endeavor.

Rodgers is the chair of ACC's Cardiovascular Task Force.





What Governance Models Reveal about a Practice

By Owen J. Dahl, F.A.C.H.E., C.H.B.C

As we look at the cardiology practice of the future, governance of the business itself is critical because the premise is that the medical practice is a business. Governance is the process through which key strategic and policy decisions are made and resources are requested, selected, and allocated. The overall steps for the success or failure of the business reside in a practice's governance, and the governing authority is typically defined in the corporate by-laws or operating agreement.

There are typically three models of governing bodies with variations within each model of the framework defined here. In the first, the solo physician assumes full responsibility for all decisions, seeking input from advisors but has ultimate authority and control. A variation is the group practice that was started by one physician who maintains control and exercises either direct decision-making or veto power for any decisions that are made. In this case the other "owners"

or employees may provide input and support the decision but do not have authority in making the actual decision. For purposes of definition, we will call this the autocratic perspective. This can be spelled out in legal documents with a minimum of 51 percent ownership for the one individual, or it may be implied and allowed to exist.

The second model is the use of the entire ownership group as a board. This is common with a smaller number of physicians but may exist in groups even greater than 10. This group-think process has many pitfalls including: collective rationalization, an illusion of unanimity or acceptance of poor information. The group can lose sight of all the possible options as the discussions ebb and flow, suffer from a lack of norms or formal decision-making process and put pressure on dissenters who may yield but fail to support or implement the decision with passive aggressive behavior. This model is complex, politically motivated and is almost the opposite of

CEOPR Model

	Define	Clinical	Corporate
Culture	Perceptions, mission, values, ethics, focus	Independence, patient care vs. money	Support, open, honest, communication, trust
Expectations	Of whom External – patient, managed care organization, referring physician Internal – other physicians, staff, self	Quality of life, cure, full recovery, palliative care, compliance with guidelines	Bottom line, short term or long term, patient satisfaction
Organization structure	Hierarchy, flat, teamwork, who decides, delegation, reorganization, turnover of key staff	Clinical guidelines, committee, evidence based	Executive committee, tight or loose
Politics	Vested interest, spin, hidden agenda, passive aggressive	Research base, criteria, who does what, patient recruitment and schedule	Authority, respect, control, power base
Resources	Time, capital, too few or wrong staff/equipment, training, staffing	Diagnostic tests – in office, EMR	Budget, FTEs, ROI

the first model. In other words, it is truly democratic.

The third model sits between the other two and makes use of an executive committee (EC) and possibly other committees. The committee is granted, usually in a legal document, authority to act on behalf of the group within a defined set of parameters. Actions by a committee may require review and ratification by a higher level committee, such as, a clinical protocol committee or executive committee. The executive committee actions would then be ratified by the entire board. The board may be the only source for major decisions such as adding an associate. Usually these decisions are based upon the recommendation of the EC. The EC role makes this model a representative democracy.

Clarifying Model Impact

Governance issues surface on the business and clinical side in a practice. A practice's decisions about which protocols to use, which diagnostic tests offer the best tools, etc., are critical to its future. Some clinical issues may be counter to a business decision, which creates even more problems as the balance of patient care and business survival are considered. This is why it is important to identify the governance process and its issues.

I have chosen to use the acronym, CEOPR, and its explanations to help identify and break down the process.

- **Culture** – How does this practice work or to use non-scientific phraseology, how does it feel? This helps to clarify the independent nature of physicians and the values that are part of the corporation.
- **Expectations** – It is important to clarify the expectations from an internal and external perspective. What are the desires of the various stakeholders involved with the practice?
- **Organization structure** – How are things organized, who makes the decisions and who is responsible for what?
- **Politics** – Every organization has its political side, which refers to any hidden agendas and power struggles and the kind of influence one member may have over another, etc.
- **Resources** – Without adequate resources, it is impossible to address any success level for the organization.

The CEOPR model works with similar yet distinct issues in the areas of clinical as well as corporate governance. The table to the left provides more detail and a comparison.

Whether for internal or external purposes, it is important that practices clarify their governance models. Doing so promotes better decision-making by all involved.

Dahl is a management consultant in Woodlands, Texas.



UHC Extends Reconsideration Date for Physician Program

UnitedHealthcare has extended the reconsideration request date for the UnitedHealth Premium® physician designation program to Feb. 11, 2009. This date gives physicians in the 37 states where the program has launched an extended timeframe to review their assessment report, seek clarification and, if necessary, request reconsideration of their designation. Physicians who do not want the results shown in their designation letter to display on UnitedHealthcare's Web sites until they receive the outcome of their reconsideration should postmark his or her request by Feb. 11, 2009. More information is available at unitedhealthcareonline.com.

HHS Sets 2013 as ICD-10 Compliance Date

The Department of Health and Human Services (HHS) on Jan. 15 released the final rule for the transition to the International Classification of Diseases, Tenth Revision (ICD-10). The rule sets a compliance date of Oct. 1, 2013, to ICD-10, which includes more than 155,000 codes to accommodate a host of new diagnoses and procedures. The proposed rule had suggested a compliance date of Oct. 1, 2011. In its comment letter, the ACC strongly suggested to HHS that a later compliance period was necessary because a 2011 compliance date would lead to significant short-term difficulty for the health care community and reduce the long term benefits. The two-year delay of the transition in the final rule is a response to these concerns and the concerns of other groups that also supported a longer transition period. More information is available on the CMS Web site: cms.hhs.gov.

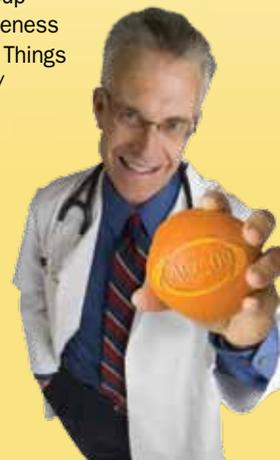
ACC.09 Sessions That Address Administrator Needs



At ACC.09, practice administrators will find an interesting selection of Special Sessions on topics that don't quite fit in the topic pathways or that relate to specific ACC activities, such as the Annual Business Meeting or the Annual Convocation.

For practice administrators, ACC, MedAxiom and the Medical Group Management Association (MGMA) have put together a four-hour program on Sunday, March 29. Programs topics include — Clinical: PQRI, Program Development, E-Rx, Quality; Operational: Workforce Impact; Financial: Joint Enhancements, MSOs, Product-Line Management, Group Purchasing, Insurance; Embedding Appropriateness Criteria: Is Your Practice Ready?; and Top Ten Things That Are Done Right and Wrong During Deals/Negotiations.

On Monday, March 30, Medical Legal Issues in Cardiology takes place from 2 to 3:30 p.m. For more information about these and other programs, go to acc09.acc.org. **Register by Feb. 18 to take advantage of the Advanced Registration discounts.**



Clinical Documents: Reducing the Gap Between Science and Practice

by Joseph Drozda, M.D., F.A.C.C.

Payers, lawmakers, physicians and patients continue to search for ways to increase the value of health care. Providing the highest quality of care means practitioners must stay abreast of the latest clinical evidence and best practices for applying these findings. However, even for the most scholarly of practicing physicians, attempting to stay current with the abundance of research available is a daunting task.

Recognizing this, the ACC Foundation (ACCF) offers a series of clinical documents that include guidelines, appropriate use criteria and performance measures to assist physicians in translating clinical research into everyday practice.

Guidelines

For the last 25 years, the ACCF has partnered with the American Heart Association (AHA) to create clinical practice guidelines to assist physicians in providing the highest quality of care. These guidelines carefully synthesize available evidence to assist physicians in clinical decision-making by recommending a range of generally acceptable approaches for the diagnosis, management or prevention of specific diseases or conditions.

Guidelines are based primarily on a review of clinical trial results combined with expert opinion. While recommendations are written for typical patient settings, guidelines still require clinical judgment to be adapted to the care of individual patients. Currently, the ACCF and AHA spend more than a million dollars a year to support development and updates to more than 2,800 recommendations in 18 published guidelines.

Appropriate Use Criteria

Appropriate use criteria, formerly appropriateness criteria, define “when to do” and “how often to do” a given procedure in the context of scientific evidence, the health care environ-

ment, the patient’s profile and a physician’s judgment. Appropriate use criteria provide practical tools to measure variability in cardiovascular procedures and to look at use patterns. The criteria support an efficient use of medical resources, while providing quality, appropriate care.

Because of their patient-centered approach, it is hoped that appropriate use criteria will be used to guide future research and lead to patient education. In addition, physicians, payers and medical facilities can use the criteria to assess practice patterns, design ordering protocols and/or provide the basis for quality improvement activities.

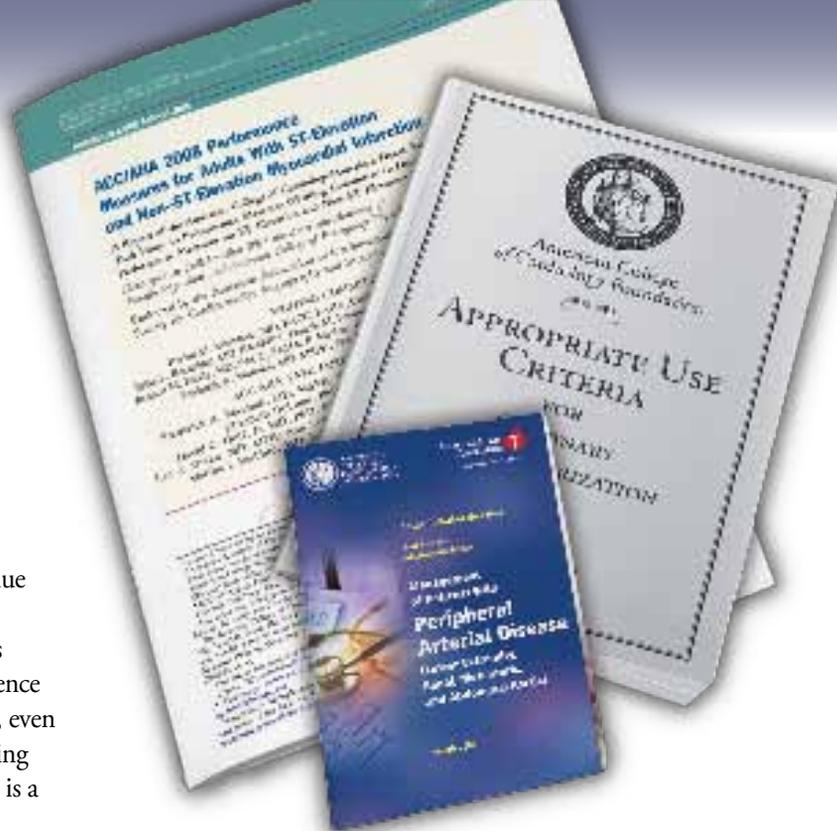
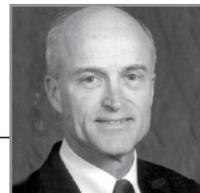
Performance Measures

Performance measures, also completed in partnership with AHA, are specific clinical measures that indicate evidence-based care for physicians. They capture aspects of care recommended in ACCF/AHA guidelines that are proven to improve patient outcomes and that can be measured in valid, actionable and feasible ways.

Performance measures will play a crucial role as state- and federal-level efforts to measure quality and publicly report outcomes expand. Because they involve physicians from the outset of the process, performance measures improve the accuracy of what constitutes “quality” cardiovascular care.

For more information about guidelines, performance measures, appropriate use criteria and other clinical documents, visit www.acc.org and click on “Quality and Science” then “Clinical documents.”

Drozda is chair of ACC’s Clinical Quality Committee.



1965 The ACC moves from New York to Bethesda, Md., to be closer to the National Institutes of Health. Our first home in Maryland is on the campus of the Federation of American Societies for Experimental Biology. The College does not break ground for Heart House Bethesda until 1975.

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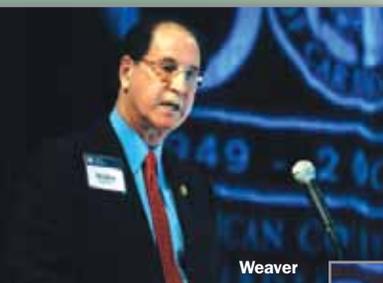
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ACC Health System Reform Summit Focuses on Professions' Role

The ACC held its 2009 Health System Reform Summit on February 1-2 in Washington, D.C. More than 125 health care professionals, policymakers, industry representatives, payers and others gathered for two days to discuss the roles and responsibilities of health care providers and issues surrounding patient access to care, payment reform and defining and measuring quality and value.

In his opening remarks, ACC President **Doug Weaver, M.D., F.A.C.C.**, said that the two constituencies most affected by health care reform — patients and physicians — are ironically often on the menu, but missing from the table. “The purpose of this meeting,” said Weaver, “is more than getting the profession and the patient heard in the national health care reform discussion. It’s about determining our accountability and our responsibility in reform.”

The 2009 Summit aimed to build on the key health care reform principles drafted by the ACC’s Blue Ribbon Panel and presented at the 2008 Summit. Since the first Summit, the ACC has worked to engage lawmakers, payers and others around the principles and the concept that the role of physician specialty communities is to “transform health care from the inside out.”

“I think we have come a long way in making the case that only health care providers can best ferret out waste and unnecessary or inappropriate care,” said **James Dove, M.D., M.A.C.C.**, co-chair of the Blue Ribbon Panel and ACC immediate-past president. “However, there is still a lot of work to be done.”

Participants at the 2009 Summit heard from key congressional staff on legislative efforts at the national level and opportunities for physician involvement. In addition, California Health and Human Services Secretary **Kimberly Belshe** and **Paul Wingle** of the Massachusetts Commonwealth Health Insurance Connector presented their views on state reform issues based on their efforts to cover the uninsured in California and Massachusetts, respectively.

ACC President Comments on Prasugrel Before FDA Panel

ACC President **Douglas Weaver, M.D., F.A.C.C.**, provided public comments at the Feb. 3 meeting of the Food and Drug Administration's (FDA) Cardiovascular and Renal Drugs Advisory Panel on a new drug application for prasugrel hydrochloride. The panel unanimously recommended approval to treat patients with either unstable angina, NSTEMI or STEMI. They suggested that use of prasugrel should be limited in individuals age 75 and older or with a history of stroke.

In his comments, Weaver said that studies have found the effectiveness of prasugrel in reducing the rates of recurrent non-fatal myocardial infarction, rehospitalization for ischemia and stent thrombosis is clinically meaningful. However, he said that "if the drug is approved, additional studies should be conducted to ensure its safety and to ensure that it is prescribed to those patients who might benefit," which can be completed most prudently through a post-market registry outside of the manufacturers' typical post-market analyses. More information can be found at FDA.gov.

President Signs State Children's Health Insurance Program Legislation

President Obama signed into law legislation providing a \$32.8 billion expansion of the State Children's Health Insurance Program (SCHIP). The expansion would provide health care coverage for 7 million children in lower-income families and is partially funded through a tobacco tax, which the ACC supports. The House on Jan. 14 had passed a version of the bill, which included as a funding mechanism a ban on physician self-referral to hospitals in which they have an ownership interest. That provision, which the ACC did not support, was left out of the final legislation.

HHS Recognizes Three Health IT Standards

The Department of Health and Human Services (HHS) on Jan. 21 formally recognized three new interoperability specifications for electronic health records, personal health records and electronic quality monitoring, effective Jan. 16. This is the second step of a two-step process in which the HHS secretary accepts specifications and then one year later recognizes the specifications. The Health-care Information Technology Standards Panel now recognizes as standards: IS04 Emergency Responder Electronic Health Record Version 1; IS05 Consumer Empowerment and Access to Clinical Information via Portable Media Version 1; and IS06 Quality Version 1. HHS called the recognition process "critical to advancing both federal and private sector use of health IT standards."

Economist **Len Nichols, Ph.D.**, director of the health policy program at the New America Foundation, discussed ways in which the new administration and Congress can provide the private sector with incentives to provide affordable, quality health care. According to Nichols, the current health care system's incentive structure is "deeply flawed" — and some profit from the flawed structure. He noted that behavioral choices affect health and health costs and that the system cannot afford "business as usual" trajectories. "Change is impossible but necessary," he added.

Author and Harvard Business Professor **Regina Herzlinger** offered an interesting perspective on payment reform models, while **Darren Willcox** of the Coalition to Advance Health Care Reform, **Bill Novelli**, CEO of AARP, and Helen Darling from the National Business Group on Health discussed the need for patients to take more responsibility and become more involved in their health and health decisions. **Douglas Wood, M.D., F.A.C.C.**, of Mayo Clinic, **Glenn Steele**, president and CEO of Geisinger Health System, and **Francois de Brantes**, CEO of Bridges to Excellence all agreed that we need to seek value and that pursuing quality will enable us to reduce costs.

In the wrap-up session, ACC's current presidential team commented on the findings of three break out sessions held throughout the Summit. ACC Vice President **Ralph Brindis, M.D., F.A.C.C.**, stressed the importance of our showing willingness to work with CMS on appropriate use and openness to conducting comparative effectiveness research by using real-time registries. "In particular, we need to mature our ambulatory registry efforts, as conducted through the IC³ Quality efforts, so that quality can be measured in all places where care is provided," Brindis said.

During the final session, attendees clarified essential issues for the College — the issues on which we must focus soon, define better and reach consensus. "If this conference shows anything, Weaver said, "it is that there is no shortage of ideas and there is a sense of urgency. ... None of this is easy, but if we can do it convincingly, we will be ready for when patients want to know more; we will be on our way to improving quality, and we will be role models for other specialties."

Coverage of the ACC's Health System Reform Summit is available at:

- lewinreport.acc.org
- qualityfirst.acc.org

Chart EP Sessions and More with Online ACC.09, i2.09 Program

By Claudio D. Schuger, M.D., F.A.C.C.

Now that the Program Planner for ACC.09 and i2.09 is open, visitors to the meeting Web sites will be able to take a look at the actual sessions and their presenters and plan their itinerary. The program planner is easy to use and very informative, and visitors can choose to look at sessions by date, topic pathway or session type.

Generalists and specialists alike may want to take a few minutes to scan the topic pathways because they demonstrate how program planners tried to balance the needs of topic specialists with those of general cardiologists. Our goal was to build a program that would appeal to the general cardiologists and update their knowledge, help fellows in training learn more about a field and provide specialists with exciting original science, important updates and the opportunity to meet with the best and the brightest in the field.

Example of Balance

The topic pathway for Cardiac Arrhythmia is a good example of the program's balance. General cardiologists who wish to maintain their proficiency in electrophysiology (EP) will find sessions on issues that they encounter frequently with their patients. The topics include state of the art information on atrial fibrillation (AF), management of and treatment options for patients with AF, following the guidelines for treating AF, and anti-coagulation issues with AF, including genotype-dosing interactions.

Specialists and generalists alike will find the sessions on the state of the art in Cardiac Resynchronization Therapy (CRT) in heart failure and other CRT topics extremely



informative. The topics include when to refer patients, which patients to refer and with those patients who are non-responders, what do we know and what can we expect in the future for improving these patients. This is a very important field in which EP and HF specialists interact and collaborate so these sessions provide a great opportunity for the two groups.

Extensive International Scene

We are really pleased with how the effort to internationalize ACC.09 has gone. At the International Lunch Symposia, Monday, March 30, representatives from 14 societies will join ACC colleagues on the podium to discuss various topics, including myocardial ischemia, delivering CV care in different health care systems, stem cell therapy for heart failure/myocardial infarction, mitral valve and percutaneous aortic valve treatments and many other topics. The societies, which represent all continents, include the Brazilian Society of Cardiology, British Cardiovascular Society, Cardiac Society of Australia and New Zealand, Cardiological Society of India, Chinese Society of Cardiology/Chinese College of Cardiovascular Physicians, the Pan African Society of Cardiology, Saudi Heart Association, Japanese Circulation Society and the Canadian Cardiovascular Society. The European contingent also includes the French Society of Cardiology, German Cardiac Society, Hellenic Cardiac Society, Italian Society of Cardiology and the Spanish Society of Cardiology. The symposia run from 12:15 p.m. to 1:45 p.m. on Monday, March 30.

Placing Science into a Clinical Context

Our approach toward original abstract sessions is perhaps the clearest example of how we have tried to balance this year's program. Original science sessions will be guided by a moderator/expert who, at the end of the individual presentations, will summarize the science and provide an analysis of its impact or meaning for the clinician. As clinicians, we all need to be aware of what is happening in the field; however, with our busy schedules, the information is more useful if it is placed a clinical context.

If you haven't registered yet for ACC.09 or i2 Summit 2009, go to acc.09.acc.org or i209.acc.org soon. Advance registration with discounted fees ends Feb. 18.

Schuger is one of the ACC.09 co-chairs.



Videocast Your Questions with You-Que: What Will You Ask?

Again at ACC.09, attendees and non-attendees alike will have the opportunity to ask questions using ACC's You-Que, an online video streaming feature for uploading self-made videocasts. Featured Session #656: Atherosclerosis Update. For details, go to acc09.acc.org/edu/Topic-Pathways/Pages/You-QueatACC09.aspx.





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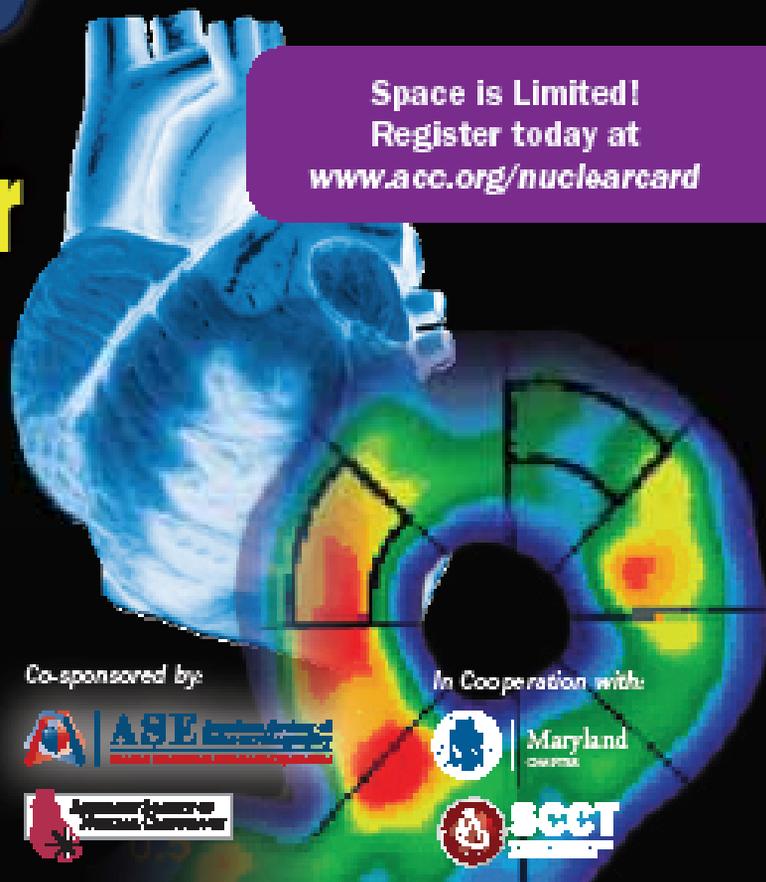
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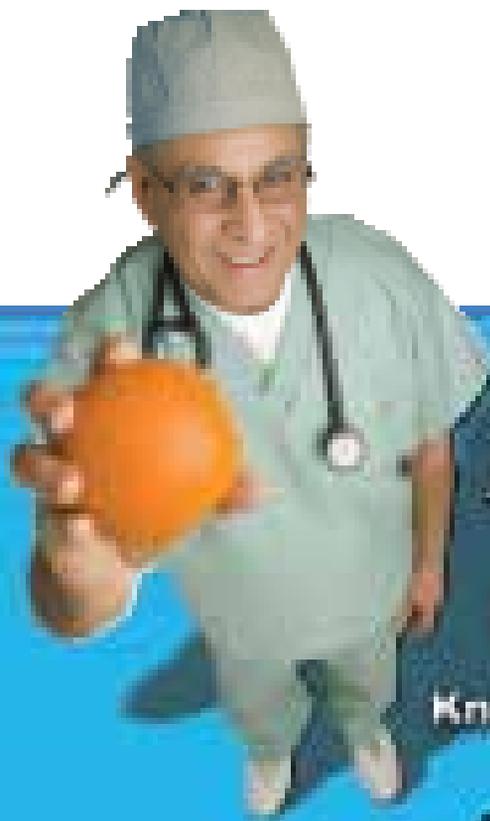
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Chapters Recognized for Outstanding 2008 Achievements

Since the first chapter was launched over 20 years ago, ACC chapters have gone above and beyond to support the cardiology community at the local level in the areas of advocacy, education, quality improvement and networking. In recognition of their superior efforts to increase the value of ACC membership, 27 chapters have been recognized for their outstanding achievements in 2008.

Award highlights:

- The **California** Chapter received an award for launching a new series of patient-centered events, with eight scheduled in late 2008 and early 2009. The first of this series had more than 110 attendees and was featured in local and national media outlets.
- ACC's **Massachusetts** Chapter stood out in 2008 for meeting several advocacy goals, including defeating a bill to restrict physician referral for imaging and collaborating with other groups to amend a bill that would have eliminated pharmaceutical education grants.
- The **West Virginia** Chapter deserved an outstanding achievement award for its 2008 annual meeting, which was attended by more than 40 percent of its members. The event built awareness of the Chapter and served as an educational tool for hot topics in cardiology and new ACC programs.

In addition, three chapters earned the HERO ("Heroic Efforts creating Results and Opportunities) award for their superior efforts in 2008. The winners of this award — **Ohio, Alabama and Puerto Rico** — made significant advances in the College's mission through exemplary enhancement of member value, education, advocacy and quality of patient care. These Chapters will be recognized in future issues of *Cardiology* for this distinction.

The award winners are as follows:

Large Chapter Award Winners Chapters with more than 500 members		Medium Chapter Award Winners Chapters with 150-500 members			Small Chapter Award Winners Chapters with less than 150 members	
California	New York	Alabama	Kentucky	Missouri	Iowa	Puerto Rico
Florida	Ohio	Arizona	Louisiana	North Carolina	Mississippi	West Virginia
Illinois	Texas	Connecticut	Maryland	Virginia	Oregon	
Michigan		Georgia	Massachusetts	Washington		
		Indiana	Minnesota	Wisconsin		



1961 E. Grey Dimond, M.D., M.A.C.C., leads a delegation of ACC physicians to the Philippines and Taiwan for the College's first

International Circuit Course. Dr. Dimond equates the Circuit Course to a "medical Peace Corps." More than 2,500 physicians attend the first course. Over the next five years, the program travels to 44 countries.



Pawliw-Fry

Baldwin

Forum Highlights Success for Chapters, Meaning of Leadership

The ACC held its Leadership Forum on Jan. 30 and 31 in Washington, D.C. Veteran and incoming ACC Governors and Trustees met to exchange ideas and experiences. The Governors and Trustees heard from **J.P. Pawliw-Fry, Ph.D.**, of the Kellogg Graduate School of Management, on redefining leadership and learned strategies and techniques to increase engagement within their chapter membership and board. ACC President-elect **Alfred Bove, M.D., Ph.D., F.A.C.C.**, addressed the Forum and introduced the coming "Year of the Patient." This patient-centered initiative centers on strengthening the patient-physician relationship, and its programs will run throughout the College as well as the chapters. Additionally, ACC CEO **Jack Lewin, M.D.**, discussed the current operating environment of medicine and the pending threats and opportunities found in 2009.

U.S. Navy Lt. **Andrew Baldwin, M.D.**, appeared as a special guest during the Chapter Awards ceremony. Baldwin awarded plaques to winning chapter leadership. Baldwin, a former star of the ABC hit show, "The Bachelor: An Officer and a Gentleman," currently serves as a Navy medicine advocate at the Bureau of Medicine and Surgery in Washington, D.C.



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Special Clinical Pharmacology Program Precedes ACC.09

By Janet B. Long, M.S.N., A.C.N.P.

For the fourth year, the ACC Foundation is pleased to be able to offer another eight-hour session dedicated to pharmacology education credits for physicians, nurses and pharmacists. The 4th Annual Clinical Pharmacology program is scheduled for Saturday, March 28, at the Rosen Centre in Orlando, prior to the opening of ACC.09. The choice of topics this year is varied, reflecting the diverse and complex issues that many of us face in treating our patients. Presenters will cover HIV treatment, transplant medications, diabetes and antidepressants with discussion of the effects in cardiovascular patients, pharmacologic actions and possible drug interactions with other cardiovascular drugs. We have a distinguished faculty that includes —

- **Donna Polk, M.D., F.A.C.C.**, director of preventive cardiology and of Women's Heart at Hartford Hospital, Conn.
- **David Parra, Pharm.D., B.C.P.S.**, clinical pharmacy specialist in cardiology, West Palm Beach Veterans Administration Medical Center, Fla.

- **Robert Talbert, Pharm.D., F.C.C.P., B.C.P.S.**, professor of pharmacy and head of the division of pharmacotherapy, College of Pharmacy at the University of Texas Health Science Center at Austin
- **Rhonda Cooper-DeHoff, Pharm.D., M.S.**, research associate professor and assistant director of clinical research, Shands Hospital, University of Florida at Gainesville
- **Anthony Busti, Pharm.D.**, Dallas VA Research Unit and adjunct professor, Baylor University, College of Graduate Nursing and Texas Woman's University, College of Graduate Nursing, Dallas

As in the past, speakers will present their specialty topic for one hour and follow with one hour of case studies on the topic. During the case study presentations, attendees are encouraged to ask questions and discuss their thoughts. In past years, audience participation has led to a rich exchange of knowledge with thought-provoking dialogue among professionals that has included not only the evidence-based science behind patient care, but clinical observations, too. The session format also includes an audience response system to enable the asking of specific questions during the presentations.

It has truly been an honor and pleasure to work with the College on this valued program that has grown since its first iteration four years ago. I encourage you to register in advance, and I look forward to seeing you at the program.

Long, who is director for the program, is co-director, Cardiovascular Risk Reduction Program, Rhode Island Cardiology Center, Providence

Note: CME, CNE credits and continuing education credits for pharmacists will be awarded as part of this program. For details and to register, go to www.acc.org/education/programs/programs.htm.



1996 The ACC debuts its first site on the World Wide Web.



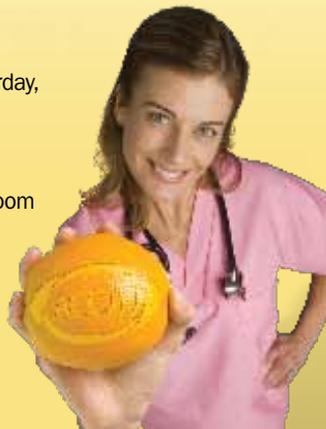
CCA Special Events at ACC.09

CCA Community Room

Location: Orange County Convention Center, Rm. 204C Dates open: Saturday, March 28 – Tuesday, March 31

CCA Reception

Location: Peabody Hotel, Plaza Ballroom Date & Time: Sunday, March 29, 6:30 – 7:30 pm



Heterogeneity of Post-MI Depression – the Importance of Identifying Relevant Subtypes

By Elisabeth J. Martens, Ph.D., and Peter de Jonge, Ph.D.

Depression and heart disease are the two leading disorders with the strongest contributions to the global burden of disease. Depression is a common co-morbid disorder with acute myocardial infarction (MI), and both depression and MI are associated with decreased quality of life, thereby imposing a significant economic load on society. In recent years, much attention has been given to depression following MI and its effects on cardiovascular (CV) prognosis. The overall consensus is that although some exceptions have

of the reasons may be the heterogeneity of depression following MI, with some depression types being cardiotoxic but not responsive to treatment and others being non-cardiotoxic but responsive.

Recent evidence suggests that subtypes of depression in MI patients may be differentially associated with subsequent CV prognosis. First, the timing of the onset of depression, with regard to the MI, seems of particular interest. Dickens and colleagues reported an increased long-term cardiac mortality in patients who develop depression after

depression before the MI respond to antidepressive medication. For example, the SADHART results suggest that sertraline was effective at treating recurrent depression but not first-ever depression in post-MI patients.

Which Symptoms Apply?

Second, it has been observed that individual symptoms of post-MI depression may be differentially associated with CV prognosis.⁹ Somatic/affective symptoms, such as sleeping problems and fatigue, which are far more dominant in cardiac patients than in psychiatric patients with depression¹⁰, may be more cardiotoxic than cognitive/affective symptoms including shame, guilt and negative self-image. Even though somatic/affective depressive symptoms were confounded by somatic health status, the association between somatic/affective symptoms and CV prognosis remained after controlling for MI severity and somatic comorbidity. This suggests that these somatic/affective symptoms may be an important target for intervention, although this intervention may be different from interventions derived from general psychiatry.

Traditionally, cognitive behavioral therapy — the first-line intervention that was applied in the ENRICH trial — is focused on cognitive/affective aspects of depression, but these symptoms may be the least cardiotoxic.

Depression that existed before the MI did not convey any additional risk of mortality.

been published, a twofold increased risk of new fatal or nonfatal CV events is present for patients with post-MI depression.¹

Several large scale randomized controlled trials have been undertaken (ENRICH², SADHART³, CREATE⁴, MIND-IT⁵) in which post-MI depression was targeted. Although we had hoped that treating depression would result in an improved CV prognosis, these studies have not provided much evidence to support this position. The effect on depression itself has been minor, and any effects did not translate into CV benefits. One

suffering MI.⁶ Depression that existed before the MI did not convey any additional risk of mortality.

Other studies confirm that the association between post-MI depression and prospective CV events is due to those episodes that develop just after the cardiac event.^{7,8} This is not the type of depression we often see at psychiatric inpatient or outpatient clinics, where the overwhelming majority of patients consists of those with recurrent episodes.

Several studies have reported that only patients with a history of depression and/or onset of

Editor's query: Much is said about post-MI depression as perhaps a clinically important cause of medication nonadherence and nonadherence to other risk factor modification efforts. In your research, did you find much information on this topic?

Author response: A lot of work needs to be done in this important area. Dr. Martens is currently working on a paper on this topic. She and Dr. de Jonge recommend these two important studies:

- Gehl A, Haas D, Pipkin S, Whooley MA. Depression and medication adherence in outpatients with coronary heart disease: findings from the Heart and Soul Study. *Arch Intern Med.* 2005 Nov 28;165(21):2508-13.
- DiMatteo MR, Lepper HS, Croghan TW. Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence. *Arch Intern Med.* 2000 Jul 24;160(14):2101-7.

Impact of HD Severity

The extent to which the association between depression and CV prognosis is to be attributed to heart disease severity has also been the object of debate. Some studies have found that almost half of the variance in the association is explained away when left ventricular ejection fraction (LVEF) is added to the prediction models.¹¹ Others have observed a dose-response like association between LVEF at the time of MI and subsequent risk of depression¹², although some heterogeneity in findings is seen here as well. If the association between post-MI depression and cardiac prognosis is confounded by MI severity, this might explain the limited effects of antidepressant treatment.

A better understanding of the syndrome of depression in post-MI patients, together with the investigation of which depressive symptoms incur the most cardiotoxic effects, is crucial to modify the depression-mortality link by means of therapy, be it psychological, pharmacological or a combination thereof.

Martens is assistant professor of medical psychology, Tilburg University, the Netherlands, and de Jonge is professor of medical psychology, Tilburg University, and professor of psychiatric epidemiology, University of Groningen, the Netherlands.



Martens



de Jonge

References:

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ACCEL

Cardiocerebral Resuscitation Gaining Over CPR

In the United States, sudden cardiac death (SCD) accounts for more than 300,000 deaths annually. The most common cause of SCD is ventricular fibrillation; consequently, time to defibrillation is the most important determinant of survival. However, in the absence of a defibrillator, cardiopulmonary resuscitation (CPR) improves a victim's chances of survival while awaiting arrival of emergency personnel.

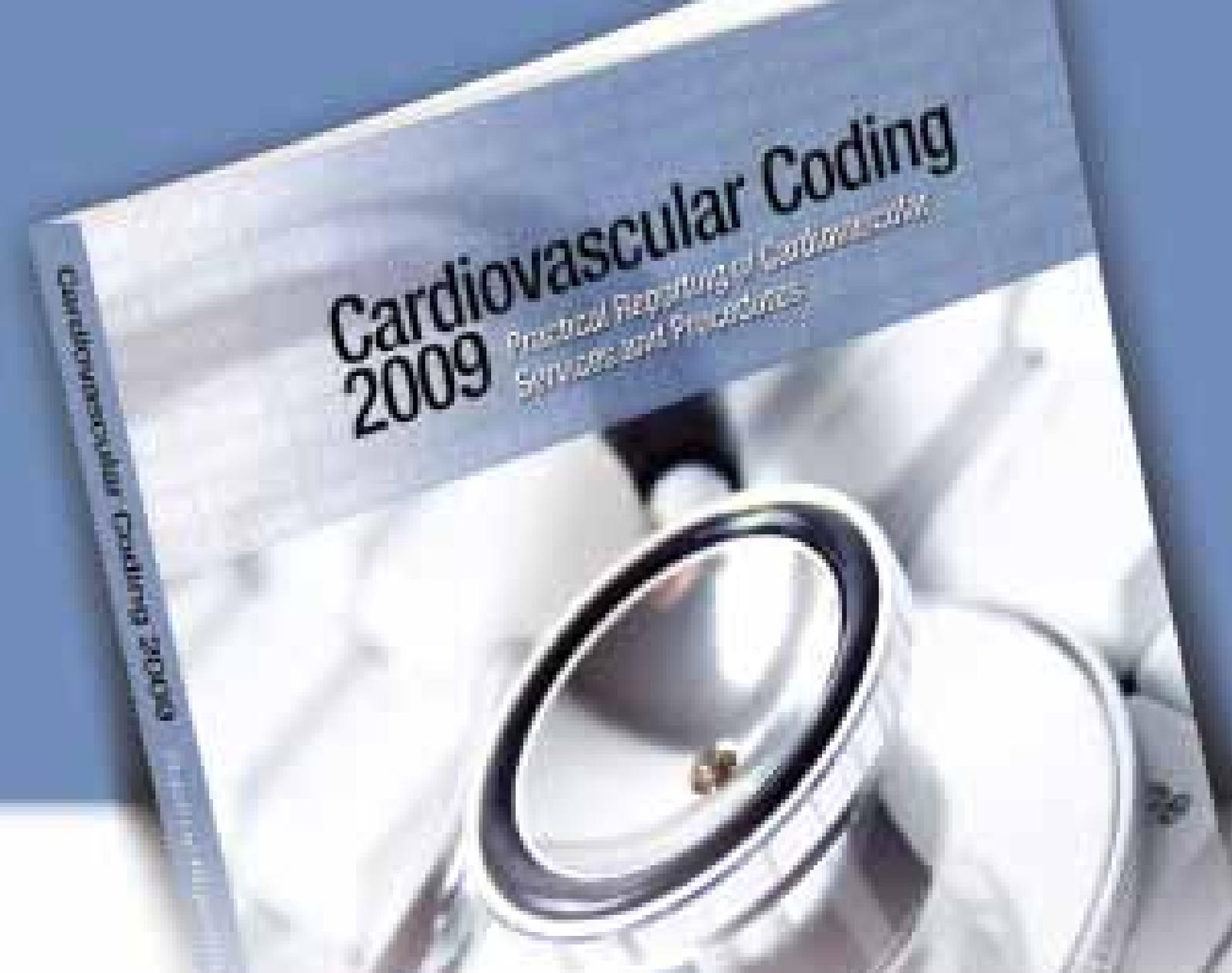
Designed to maintain blood flow, CPR traditionally has consisted of artificial respiration via both chest compressions and lung ventilation. Guidelines called for a compression-to-ventilation ratio of 15:2. Unfortunately, researchers found that bystanders tend to shy away from performing CPR primarily to avoid mouth-to-mouth rescue breathing. Moreover, when chest compressions are stopped for ventilation, blood flow stagnates and organs become starved for oxygen. Finally, mouth-to-mouth resuscitation can complicate the situation by increasing intrathoracic pressure and decreasing venous return.

According to Gordon Ewy, M.D., F.A.C.C., professor and chief of cardiology at the University of Arizona College of Medicine, chest compression alone in a swine model was "dramatically better than doing nothing" until the arrival of trained professionals, plus "to our surprise, was as good as chest compression plus ventilation."

The American Heart Association and the European Resuscitation Council now endorse CPR minus ventilation or "cardiocerebral resuscitation (CCR)." Success with CCR is based on Weisfelt and Becker's three-phase, time-sensitive model of cardiac arrest due to ventricular fibrillation. "If you shock during the first five minutes, survival is very good," Ewy said, "but after five minutes, the fibrillating heart uses up its energy and if you shock it, it goes into asystole or pulseless electrical activity." Continuous compressions reperfuse the heart and brain, greatly improving survival following defibrillation.

Overall, he said, the most critical need is for bystanders to recognize SCD and react accordingly. When emergency personnel arrive within the first five minutes of a cardiac arrest, defibrillation should be administered immediately, but if the patient is 5 to 15 minutes into the episode, the new recommendation suggest 200 chest compressions, a single shock if indicated, followed by another 200 compressions combined with passive oxygen insufflation.

"Cardiocerebral resuscitation is for witnessed primary cardiac arrest; whereas cardiopulmonary resuscitation is for respiratory arrest," Dr. Ewy stressed. "I think we've got to make that distinction and once we do, we will dramatically improve survival."



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CCS.09: Stay Tuned for a Repeat of Last Year's Success

By Michelle Gurvitz, M.D., F.A.C.C.



The time draws near for ACC.09, the American College of Cardiology's 58th Annual Scientific Session, March 29 – 31, in Orlando. As happened at ACC.08, congenital heart disease and pediatric cardiology specialists will find a unique and exciting program planned to help them stay on the leading edge with latest information in their specialty. The program — Congenital Cardiology Solutions 2009, better known as CCS.09 — follows the highly successful and first-ever CCS.08, held at ACC.08, which was attended by more than 400 pediatric cardiologists and congenital heart disease specialists. **James Tweddell, M.D., F.A.C.C.**, of Children's Hospital of Wisconsin in Milwaukee, is chair of the CCS.09 program committee and **John W. Moore, M.D., F.A.C.C.**, is topic coordinator for the CCS Spotlight on Tuesday, March 31.

With an increasing number of children born with congenital heart disease surviving into adulthood, the job is far from over.

The CCS.09 program committee has worked hard to recreate and surpass the success of CCS.08. The first two days of CCS.09, March 29 – 30, will be filled with a variety of sessions including symposia presentations, oral abstracts and smaller, interactive Meet-the-Experts sessions designed to meet the needs of the various attendees. The sessions will cover congenital heart conditions and issues confronting the patient and physician from the fetus to the aging congenital heart patient.

Highlighted main symposia topics include —

- Ebstein's Anomaly: Neonate to Adult
- Fontan Late Outcome and Management of the Failing Circulation
- Complex Transposition of the Great Arteries
- Staging the Patient with Hypoplastic Left Heart Syndrome
- Neurodevelopmental Outcomes of Neonates and Infants Undergoing Cardiac Surgery.

Each symposium will include the input of a breadth of cardiologists and surgeons with expertise in each area to discuss

management options, imaging, outcomes and sequelae of the different conditions. For the first time, we also have a symposium on adult congenital heart disease for the general cardiologist community.

One oral abstract session will highlight the most pertinent abstracts accepted for CCS.09, and other abstracts will be presented in poster formats. The topics include aortic dilation in pregnant women with Marfan syndrome, left ventricular dysfunction in tetralogy of Fallot and outcomes of the neo-aorta after the arterial switch operation.

Five Meet-the-Experts sessions will provide direct interaction with experts on topics such as advances in fetal diagnosis and management, cyanotic congenital heart disease in the adult, pregnancy and contraception, and advances in mechanical cardiopulmonary support.

The CCS Spotlight, Tuesday, March 31, is a full-day session devoted to interventional catheterization techniques and discussion regarding the risks and benefits of different catheter-based procedures. Live interventional cases will be performed at two leading Children's Hospitals — Morgan Stanley Children's Hospital of New York and the Children's Hospital of Philadelphia. Other sessions will also provide updates on the new trials involving percutaneous placement of pulmonary valves and covered stents for coarctation of the aorta.

Last year's CCS.08 was a first in congenital heart disease and pediatric cardiology. The strength of the CCS.09 program is that it is a part of the larger Annual Scientific Session, which encourages greater integration of knowledge among cardiovascular specialties. This program approach addresses the need for a wider understanding among the various specialists and general cardiologists of the needs of our special patients. With an increasing number of children born with congenital heart disease surviving into adulthood, the job is far from over. The greater the participation at CCS.09 of all adult congenital heart disease and pediatric cardiology specialists, the stronger our ability to make a difference for our patients.

Dr. Gurvitz is a member of the CCS.09 program committee and the ACC Adult Congenital and Pediatric Cardiology Section. For additional information about CCS.09 and ACC.09, go to acc09.acc.org.



Gurvitz

FITs Have 'Bootcamps' at ACC.09 and i2.09

In the November 2008 issue of *Cardiology*, FIT Committee member Andrew M. Freeman, M.D., wrote about the many special events taking place at ACC.09 and i2.09 in Orlando. Now that the program browser is posted online for both the ACC.09 Fellows Bootcamp and the i2.09 Interventional Fellows Bootcamp, fellows in training may want to take a closer look and plan their itinerary.

Both Bootcamps take place on Tuesday, March 31, in Orlando. The ACC.09 Fellows Bootcamp focuses extensively on imaging and the morning session covers coronary disease detection with cardiac CT, nuclear imaging, carotid and vascular imaging. Juan Carlos Plana, M.D., F.A.C.C., and Allen Taylor, M.D., F.A.C.C., are the co-chairs and Hector Ventura, M.D., F.A.C.C. is the moderator. The speakers include Tracy Q. Callister, M.D., F.A.C.C., who will speak on CT and coronary artery disease (CAD), and George A. Beller, M.D., M.A.C.C., will address nuclear perfusion imaging to detect CAD. Brian D. Hoit will focus on exercise and dobutamine echocardiography. Stephen Achenbach, M.D., F.A.C.C., will speak on asymptomatic CAD and the role of coronary calcium and intimal medial thickening.

The afternoon presentations feature topics on assessment of left ventricular function and assessment of myocardial viability. Robert Bober, M.D., F.A.C.C., and Mario C. Garcia, M.D., F.A.C.C., are the co-chairs of the left ventricular session, which includes Navin C. Nanda, M.D., F.A.C.C., speaking about echocardiographic analysis of function with two-dimension/three-dimension and Matt C. Budoff, M.D., F.A.C.C., speaking on using cardiac MRI/CT to assess both left ventricular and right ventricular function. Other speakers include Daniel S. Berman, M.D., F.A.C.C., and Subha V. Raman, M.D., F.A.C.C.

The session on myocardial viability is co-chaired by George A. Beller, M.D., M.A.C.C. and Hector Ventura, M.D., F.A.C.C. Marcelo F. Di Carli, M.D., F.A.C.C., will speak about dobutamine stress and nuclear techniques to assess myocardial viability: thallium 201 and PET, and Sangeeta



B. Shah, M.D., F.A.C.C., will speak on cardiac MRI and myocardial viability. James D. Thomas, M.D., F.A.C.C., will wrap up with a presentation on the future and applications of imaging in cardiovascular diseases.

The Bootcamp for Interventional Fellows also takes place on Tuesday. One of the morning sessions focuses on the endovascular track. James B. Hermiller, M.D., F.A.C.C. and Gary S. Roubin, M.D., F.A.C.C. are the chairs. Some of the speakers include Thom W. Rooke, M.D., F.A.C.C., on non-invasive vascular evaluation; John R. Laird, M.D., F.A.C.C., on iliac intervention and Christopher R. Cooper, M.D., F.A.C.C., on renal stenting. The session also includes case reviews. The other morning session is Coronary: Track 1. Matthew R. Wolff, M.D., F.A.C.C., and Raoul Bonan, M.D., F.A.C.C., are the co-chairs. This session also includes case reviews.

At lunchtime, David R. Holmes Jr. will deliver a presentation, "PCI: State of the Art." The afternoon sessions are Coronary: Track II, cochaired by Wolff and Bonan, and valvular and structural heart disease, co-chaired by Bonan and John M. Lasala, M.D., F.A.C.C.

Other not-to-be-missed ACC.09 sessions include the FIT Forum: Stimulating Options 2009, FITs: What You Need to Know in Starting a Cardiology Career, Career Options in Pediatric Cardiology, and Essentials of Cardiovascular Care in Older Adults. For details about all these programs, go to acc09.acc.org and click the Program Planner link near the bottom of the page.

ACC to Participate in Thinktank on National Registry for Safety, AF Ablation

Atrial fibrillation (AF) is a major public health problem and a major risk factor for stroke and heart failure.

New medical devices to image, map and systematically ablate the atria have shown promise for restoration of sinus rhythm; however, the optimal technique, short and long term safety and durability and adjunctive medical therapy, all remain areas of concern.

The question is how to balance support of innovation in device-based therapy with adequate assessment of cardiac safety in patients treated with ablation techniques. A large, collaborative, public domain registry of atrial fibrillation ablation procedures and outcomes might serve an important role toward such ends. The registry could perhaps provide the basis for key aspects of public health, practice guidelines and support new device and drug development evaluations and reimbursement decisions.

The ACC will participate in a thinktank to discuss just such a registry. The “National Registry on Safety & Atrial Fibrillation Ablation: An Incubator Thinktank” takes place April 27 – 28 at the Food and Drug Administration (FDA) White Oak Campus Conference Center, Silver Spring, Md. The thinktank is coordinated by the Cardiac Safety Research Consortium and the Duke Clinical Research Institute in conjunction with the FDA, the ACC, the Heart Rhythm Society, the National Institutes of Health, and Advamed. For more information, go to www.cardiac-safety.org.



Don't Forget 'Heart Matters' on Reach MD XM 160

Be sure to tune into “Heart Matters,” the 13-week radio program being hosted by ACC President **Doug Weaver, M.D., F.A.C.C.**; **Janet Wright, M.D., F.A.C.C.**, ACC’s senior vice president of science and quality; and **Jack Lewin, M.D., ACC’s CEO**.

The program, which started in January, features the latest developments in cardiology from the perspective of the world’s top medical experts. Shows will provide practicing clinicians with important updates on recent trends, promising new technologies and key research findings relevant to practicing cardiology and other related patient care. Listeners can access the *Heart Matters* series Monday through Friday on XM 160 as well as at www.reachmd.com/xmradioseries.aspx?sid=37.



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FACC, Associate Fellow Applications Available Online Now

The new Fellow (FACC) and Associate Fellow online application site is up and running on www.acc.org. To apply online for Fellow (FACC) and Associate Fellow membership, go to www.acc.org/about/join/joinacc_domestic.htm or www.acc.org/about/international/international_membership.htm.

Application Deadlines are May 1st and October 1st. In order to submit the application online, credit card information is required. If paying by another form, you may complete the application, print and mail to Member Services.



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February 3

- Hospital Variation and Characteristics of ICD Implantation in Patients with Heart Failure: Data from the GWTG-HF Registry
- Multislice Computed Tomography in Infective Endocarditis: Comparison with Transesophageal Echocardiography and Intraoperative Findings
- Blood Pressure Response under Chronic Antihypertensive Drug Therapy: the Role of Aortic Stiffness in the REASON Study

February 10

- Aortopathies in Congenital Heart Disease
- The Sudden Demise of Dual RAS Blockade or the Soft Science of the Surrogate Endpoint
- The Alternans Before Cardioverter Defibrillator (ABCD) Trial: Strategies Using T-Wave Alternans to Improve Efficiency of Sudden Cardiac Death Prevention

February 17

- Effect of Physician Volume on the Relationship Between Hospital Volume and Mortality During Primary Angioplasty
- Importance of Venous Congestion for Worsening of Renal Function in Advanced Decompensated Heart Failure
- Persistent Hemodynamic Benefits of Cardiac Resynchronization Therapy with Disease Progression in Advanced Heart Failure

February 24

- Anemia: the Point of Convergence or Divergence for Kidney Disease and Heart Failure?
- Bivalirudin and Clopidogrel with and without Eptifibatide for Elective Stenting: Effects on Platelet Function, Thrombelastographic Indices and Their Relation to Periprocedural Infarction: Results of the CLEAR PLATELETS-2 Study

JACC cardiovascular Imaging

- Cardiac Magnetic Resonance Imaging: Systematic Analysis of Functional and Structural Changes after Coronary Microembolization
- Non-Invasive Measurement of Carotid Extra-Media Thickness: Associations with Cardiovascular Risk Factors and Intima-Media Thickness
- Carotid Imaging: Atherosclerotic Plaque, Adventitia, and Perivascular Fat

JACC cardiovascular Interventions

- Percutaneous Transcatheter Closure of Prosthetic Mitral Paravalvular Leaks: Are We There Yet?
- PROTECT I: A Prospective Feasibility Trial Investigating the Use of the IMPELLA® 2.5 System in Patients Undergoing High Risk PCI. Initial US Experience
- Improvement of Migraine after Patent Foramen Ovale Percutaneous Closure in Patients with Subclinical Brain Lesions: A Case-Control Study

Educational Programs Calendar

2009*	Washington, D.C.
ACCF/SCCT Coronary CTA Practicum *Program Dates available online	CME
February 13 - 15, 2009	Washington, D.C.
The Clinical Practice of Peripheral Arterial Disease: Key Components for Cardiovascular Specialists Michael R. Jaff, D.O., F.A.C.C. Christopher J. White, M.D., F.A.C.C.	CME CE
February 16 - 20, 2009	Big Sky, Montana
31st Annual Cardiology at Big Sky Kim A. Eagle, M.D., F.A.C.C. Sidney Goldstein, M.D., F.A.C.C.	CME
February 27 - 29, 2009	Washington, D.C.
Surgeon-Cardiologist Collaboration: A Patient Centered Approach to Emerging Technologies and Appropriate Use Criteria John G. Byrne, M.D., F.A.C.C. E. Murat Tuzcu, M.D., F.A.C.C.	CME
March 28, 2009	Orlando
Cardiovascular Care 2009: Armed Forces, Public Health Service and Veterans Affairs Combined Cardiology Symposium Jeffrey J. Cavendish, M.D., F.A.C.C.	CME
March 28, 2009	Orlando
Clinical Pharmacology in the Management of Cardiovascular Disease Janet B. Long, M.S.N., A.C.N.P., F.A.H.A.	PHARM CME CE
April 16 - 18, 2009	Philadelphia
The 36th Interpretation and Treatment of Cardiac Arrhythmias: Arrhythmia Management for the Clinician (ACCF Co-Sponsored) Peter R. Kowey, M.D., F.A.C.C.	CME
May 7 - 9, 2009	Washington, D.C.
31st Annual Recent Advances in Clinical Nuclear Cardiology and Cardiac CT Featuring Case Review with the Experts Daniel S. Berman, M.D., F.A.C.C. Guido Germano, Ph.D., M.B.A., F.A.C.C. Jamshid Maddahi, M.D., F.A.C.C.	CME CE
May 29 - 30, 2009	Chicago
Emergency CV Care 2009 Christopher B. Granger, M.D., F.A.C.C. James G. Jollis, M.D., F.A.C.C. Mayme Lou Roettig, R.N., M.S.N.	CME CE
May 29 - 31, 2009	Washington, D.C.
7th Annual Cardiovascular Magnetic Resonance Imaging: State-of-the-Art Updates and Comparisons with Computed Tomography W. Gregory Hundley, M.D., F.A.C.C.	CME
June 19 - 21, 2009	San Francisco
2nd Annual West Coast Cardiovascular Forum Valentin Fuster, M.D., Ph.D., F.A.C.C.	CME CE

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



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