Special Preview Issue

SCIENTIFIC SESSION NEWS

Vol. 21, No. 3 American College of Cardiology 52nd Annual Scientific Session Chicago • March 30–April 2, 2003

Cardiologists Get Ready for HIPAA as Deadline Nears

In an industry ruled by acronyms, one looms larger than all the rest: HIPAA. Across the country, health care institutions are scrambling as the final date for compliance with the Health Insurance Portability and Accountability Act draws near.

Even those who have filed for an extension beyond the April 14 deadline are feeling the heat. It's no wonder: Compliance with HIPAA will require scrutiny of nearly every procedure related to patient care, from the mundane details of filing health insurance claims to the virtual and physical barriers that ensure the confidentiality of personal health information. Not only that, HIPAA has stiff punishment in mind for those who break the rules.

"These are not suggested operational guidelines," said **Andrew M. Keller, MD,** an associate clinical professor of medicine at the College of Physicians and Surgeons of Columbia University in New York City. "You must comply, and ignorance of HIPAA is not a defense."

As coordinator of the ACC 2003 Annual Scientific Session Program Committee on Special Topics, Dr. Keller has organized a half-day symposium on HIPAA and related issues, titled, **"Protecting Patients' Rights in the Electronic Environment: Public Policy, Regulations, and More."** The symposium will introduce cardiologists to the most essential information on HIPAA, particularly regulations governing privacy and confidentiality.

"It's very important for cardiologists to have a clear and concise understanding of what HIPAA regulations are, which rules are finalized, which are still in the works, and how the rules are going to be enforced," Dr. Keller said.

Bijoy K. Khandheria, MBBS, agrees. Many physicians have mistakenly believed that HIPAA wouldn't affect them personally. "It's time to energize people," said Dr. Khandheria, who is co-chair of the ACC 2003 Scientific Session Program Planning Committee and a professor of medicine at Mayo Medical School, Rochester, Minn. "HIPAA impacts everyone."

As sweeping as HIPAA privacy regulations are, they are a far cry from earlier versions. Those proposals had physicians worrying about obtaining written consent before consulting with colleagues, and health care administrators envisioning the need for soundproofing of exam rooms.

Today, Dr. Keller said, most HIPAA privacy regulations are common-sense. Still, they are already changing the health care landscape. Gone are the days when patient medical records could hang on the door outside an exam room, or staff could talk about patients at an open nurses station for all to hear. Publicly visible dry-erase boards with patients' names and diagnoses—gone. Conventional sign-in sheets in doctors' offices—gone. Widespread circulation of surgery schedules to hospital support departments—also gone.

Among other provisions, HIPAA regulations:

1. Establish safeguards to protect privacy, including staff training, procedures to limit access to medical

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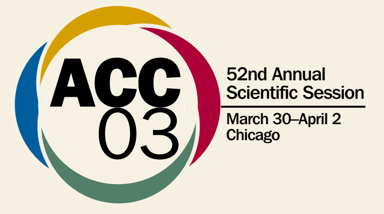

The American College of Cardiology 52nd Annual Scientific Session—or ACC '03—will bring cardiovascular specialists and their nurses, physician assistants, trainees, technicians, and colleagues in related fields to Chicago March 30–April 2, 2003, for the latest research in cardiovascular care.

ACC '03 Welcomes Primary Care Physicians

Some days it seems to **Ellen S. Brull, MD,** that nearly half the patients in her family practice waiting room have cardiovascular disease. Hypertension, high cholesterol, syncope, chest pain—she sees it all.

"In primary care, we deal with cardiology every day," said Brull, who in addition to practicing family medicine in Niles, Ill., is a vice-president of the Illinois Academy of Family Physicians (IAFP).

That's why Dr. Brull was eager to help organize a new **"Cardiology in the Community"** symposium Sunday, March 30 at ACC '03, a joint venture between the American College of Cardiology and IAFP. Dr. Brull sees the all-day symposium as a great opportunity for family physicians and others to learn from the experts about the evaluation and treatment of common cardiovascular conditions.

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ACC '03 Online Registration is available at www.acc.org

Diabetes: A New Definition for Heart Disease

The ACC '03 symposium, "The Role of Diabetes in Cardiac Dysfunction," will explore the important and critical link between diabetes and vascular disease, and delve into the nuances of diagnosis and management.

Ask a person with diabetes what he should do to live a long and healthy life, and he or she will probably talk about blood sugar control. Ask a cardiologist about diabetes, and the list grows much longer.

Slowly, often silently, diabetes ravages the cardiovascular system. A corrosive combination of hyperglycemia, hyperinsulinemia, endothelial dysfunction, and inflammation sets arterial damage in motion. Hypertension, dyslipidemia, and atherosclerosis nearly always follow. In fact, 75 percent to 80 percent of people with diabetes die not of renal failure or gangrene, but of cardiovascular disease.

"All of these things put together increase the risk not only of coronary artery disease but also of myocardial infarction, which may be the initiating event," said **Prakash C. Deedwania, MD,** cardiology chief at UCSF Fresno and the Veterans Affairs Medical Center, Fresno, Calif. "Most patients, and many physicians, are not aware of the important and critical link between diabetes and vascular disease."

A panel of experts will explore that critical link in the ACC 52nd Annual Scientific Session symposium titled, **"The Role of Diabetes in Cardiac Dysfunction."** The program will delve into fundamental concepts, as well as nuances in diagnosis and management. Presentations by **Richard W. Nesto, MD,** Laheley Clinic Medical Center, Burlington, Mass., and **Frank Kennedy, MD,** Mayo Clinic, Rochester, Minn., will focus, respectively, on microvascular and macrovascular disease, and the best approach to controlling blood glucose in diabetic patients with cardiovascular disease. Dr. Deedwania will discuss risk modification beyond glucose control. **Michael E. Farkouh, MD,** will examine the pathophysiology and management of diabetic cardiomyopathy, a condition that may be unrelated to vascular disease but that afflicts perhaps 25 percent of patients with diabetes, often without their being aware of it.

"Diabetic cardiomyopathy independent of vascular disease is a huge public health problem. Many of these patients are undiagnosed, underdiagnosed, and undertreated," said Dr. Farkouh, an assistant professor of medicine at Mount Sinai School of Medicine in New York City.

Vascular Disease

Aggressive risk factor modification is crucial for preventing vascular disease in diabetic patients, as well as for forestalling further damage after a cardiac event. Normalizing blood sugar levels is important, but it's only the beginning. Lowering blood lipid levels is also critical, Dr. Deedwania said. The Heart Protection Study, for example, showed that diabetic patients—even those without vascular disease—benefited significantly from statin therapy to reduce low-density-lipoprotein cholesterol levels.

Today's target for LDL cholesterol in diabetic patients, even those without coronary artery disease, is under 100 mg/dL, a goal as aggressive as that for nondiabetic patients who already have coronary artery disease—and for good reason. "Most of us believe now that by the time patients are diagnosed with diabetes, they already have vascular disease," Dr. Deedwania said. "There is no time to waste."

Keeping blood pressure in check is equally important. The United Kingdom Prospective Diabetes Study (UKPDS) showed that tight blood pressure control was more effective than tight blood glucose control in preventing macrovascular complications such as myocardial infarction. To prevent one cardiovascular event, for example, twice as many patients would need aggressive therapy to control hyperglycemia as would need therapy to control hypertension, Dr. Deedwania said. In addition, several studies have shown that diabetic patients derive greater benefit from blood pressure control than nondiabetic patients.

Current guidelines peg the target blood pressure for diabetic patients at less than 130/80 mmHg—a systolic reading that is 10 points lower and a diastolic reading that is five points lower than targets set for nondiabetic patients with hypertension. Angiotensin-converting-enzyme inhibitors or angiotensin-receptor blockers (ARBs) are the place to start when treating hypertension in diabetic patients, according to both Drs. Deedwania and Farkouh. Diabetic patients will often require two or three medications before the hypertension is brought under control, Dr. Farkouh added.

Diabetic Cardiomyopathy

Besides its role in promoting atherosclerosis, hypertension directly alters the myocardium in deleterious ways. As the heart compensates for an increased cardiac workload, the resulting hypertrophy and impaired relaxation hinder diastolic filling and can eventually lead to heart failure, despite a normal ejection fraction.

Diastolic dysfunction can easily be overlooked in diabetic patients who develop heart failure. Not only do physicians automatically assume that vascular disease is to blame, but heart failure, rather than chest pain, may signal serious ischemia in a diabetic patient and necessitate urgent work-up.

"That's okay. The important thing is to close the loop," Dr. Farkouh said. "You think about ischemia, you look for it, but once you don't find it, you don't stop there. That should be the beginning of looking at the causes of diabetic cardiomyopathy." If ischemia does not appear to be causing the heart failure, an echocardiogram is necessary, to evaluate for diastolic dysfunction and guide therapy, he said.

In addition to tackling hypertension in patients with diabetic cardiomyopathy, it is important to improve blood glucose levels, usually with the addition of an insulin-sensitizing agent, Dr. Farkouh said.

Diastolic dysfunction may coexist with ischemia-related systolic dysfunction. In such cases, treatment of systolic dysfunction takes precedence. Just as in any patient, therapy generally consists of ACE inhibitors, with or without ARBs; beta blockers; and diuretics. ○

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Time is Right for Half-Day Symposium on Atrial Fibrillation

An intensive, multidisciplinary workshop debuting at ACC '03 couldn't come at a better time—just when treatment for atrial fibrillation is at a major crossroads. One of four new point-of-care (POC) symposia, **"Atrial Fibrillation: Bench to Bedside,"** will conduct an up-close examination of this common arrhythmia from myriad perspectives, with an eye to bringing order to uncertainty.

"It offers attendees a way to understand the history, the epidemiology, current practice, and some of the emerging and exciting new therapeutic directions—all rolled into half a day," said session co-chair, **Joseph L. Blackshear, MD,** a professor of medicine at the Mayo Clinic—Jacksonville, in Jacksonville, Fla.

The management of atrial fibrillation is in transition, following publication of the Atrial Fibrillation Follow-up Investigation of Rhythm Management (AFFIRM) Trial in the *New England Journal of Medicine* in December. Arrhythmia specialists had hoped this large, randomized study would provide a scientific basis for choosing between two competing therapeutic strategies. One strategy, so-called rhythm control, aims to eliminate the errant rhythm with cardioversion and antiarrhythmic medications, while the other, rate control, maintains the heart rate within a target range, while allowing the atrial fibrillation to persist. Rate control involves the use of medications to slow the heart rate and anticoagulants to prevent stroke.

The study surprised cardiologists by finding that survival was no better with rhythm control when compared to rate control. Moreover, in both groups, the majority of strokes occurred when warfarin had been stopped, or the intensity of anticoagulation was subtherapeutic. Adverse side effects were more common with rhythm control.

"That sounds like the case is closed: Put everybody on anticoagulation," Dr. Blackshear said. The problem is that most patients with atrial fibrillation are elderly. The arrhythmia occurs in about 2 percent of 70 year olds and 10 percent of 80 year olds. Although elderly patients' stroke risk climbs steadily with age, so does their likelihood of developing gastrointestinal bleeding or some other contraindication to warfarin. Observational studies have shown that fewer than half of patients age 65 and older can take warfarin.

"The AFFIRM study still doesn't tell us how to manage the great bulk of our patients, who are very elderly and often can't take warfarin therapy," Dr. Blackshear said. "We're at the end of a five-year period of intensive study, which we expected would give us an added strategy to use—namely rhythm control—and it didn't do that. We're still confronted with a huge clinical problem."

The atrial fibrillation POC symposium will explore solutions to that problem and chart a course for the future, Dr. Blackshear said. The day will start with the fundamentals, with presentations on epidemiology and the basic mechanisms of atrial fibrillation and atrial remodeling. Next up will be an update on anticoagulation therapy, followed by a review of the latest guidelines on atrial fibrillation management developed by a joint task force of the ACC, American Heart Association, and European Society of Cardiology.

The three-hour symposium will continue with a presentation on the safety and success of electrical cardioversion, including the role of transesophageal echocardiography. Following that will be two reports on catheter-based interventions and surgical procedures aimed at eliminating atrial fibrillation. Filter devices to exclude the left atrial appendage will be the focus of the next presentation. The symposium will conclude with a series of case studies highlighting challenges in atrial fibrillation management.

Dr. Blackshear said he expects attendees to come away with an in depth understanding of how to manage routine cases of atrial fibrillation. As for more complex cases where the answers are less clear, attendees will be primed to watch for new developments in several promising areas of research, as larger studies gauge how as-yet unproven approaches compare to anticoagulation.

"Several are poised to become part of usual practice," he said. "I think people will be very excited to watch these studies emerge." ○

HIPAA (continued from page 1)

records, and the appointment of an individual to monitor and ensure HIPAA compliance;

2. Require health care providers to notify patients of their privacy rights;
3. Enable patients to find out how their personal health information was used;
4. Establish civil and criminal penalties for noncompliance and intentional violations; and
5. Limit release of personal health information to minimal reasonable use.

That last provision has everyone sitting up and paying attention. It's only one example of the "lovely language for lawyering" sprinkled throughout the HIPAA regulations, said attorney **Bradford S. Babbitt, Esq.,** a partner at law firm Robinson and Cole in Hartford, Conn.

HIPAA requires health care institutions to take "reasonable and appropriate" steps to protect the "integrity and confidentiality" of personal health information and safeguard against "reasonably anticipated threats or hazards and unauthorized uses." The problem is, no one has defined those terms, and it may take years of litigation for the courts to come up with some answers.

"It's going to take a while to shake out, and it isn't going to be easy," Babbitt said. "The courts will create the framework and build precedent in the years after HIPAA goes into effect. That precedent will define what constitutes a violation and what doesn't constitute a violation."

In the meantime, the federal government has wide discretion to dole out penalties. They range from fines of $100/violation up to a maximum of $25,000 per calendar year for unintentional lapses, to as much as $250,000 per violation and up to 10 years in prison for intentional noncompliance for personal gain or malicious harm.

HIPAA will also set the stage for patients to file civil lawsuits should personal health information be used improperly. The grounds would likely be negligence, invasion of privacy, or even violation of the Fair Trade Practices Act.

"There are lawyers around the country who are already planning class-action suits based on HIPAA violations—against insurance companies, against providers, and against hospitals," Babbitt said. All of this means that you ought to be adopting an aggressive program to achieve compliance and maintain compliance. This isn't something you can put at the bottom of your To Do list."

One upside: Cardiologists who work in academic medical centers and other large institutions may come to appreciate the leverage HIPAA affords them in keeping some projects from being redlined from the budget. "For physicians, HIPAA is almost a friend," Dr. Keller said. "HIPAA can be used as clear justification for making reasonably needed equipment and facilities changes that might otherwise have been turned down." ○

Primary Care Physicians (continued from page 1)

"Things move very rapidly in cardiovascular medicine, and keeping up is important," she said. "We're on the front lines."

The brainchild of ACC '03 Program Planning Committee co-chairs **Bijoy K. Khandheria, MBBS,** and **David R. Holmes Jr., MD,** the new symposium is a natural extension of the ACC 52nd Annual Scientific Session theme, **"Integration and Quality."**

"As we started to think about integration and quality and teamwork, we realized that family practice physicians play a very important role. They're an integral part of the cardiovascular care team," said Dr. Khandheria, a consultant in cardiovascular disease and internal medicine at the Mayo Clinic, Rochester, Minn.

The symposium is divided into four sessions, each focusing on a common cardiovascular symptom or problem. The morning will start with a session on dizziness, and will blend challenging case studies with presentations on differentiating cardiac and noncardiac causes of dizziness, determining whether a patient should undergo tilt-table and other forms of testing, and evaluating whether a patient requires a pacemaker or can safely drive a car.

Lipid management is next up on the agenda, and will incorporate presentations on the diagnosis and drug therapy of hyperlipidemia. In addition, session Co-chair **Alan S. Brown, MD,** will report on how to set up and run a successful lipid clinic, based on his experience as director of the Midwest Heart Disease Prevention Center in Naperville, Ill. Dr. Brown has shown that a simple system of reminders can triple the percentage of patients who achieve target blood cholesterol levels in a typical medical practice, simply by alerting a physician that a patient is not at goal.

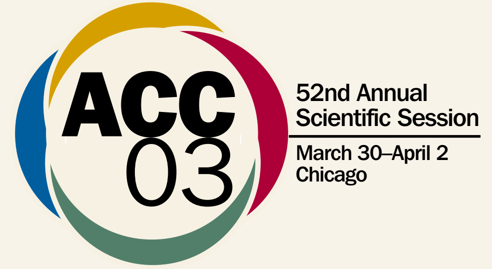
"It comes down to having the information in front of the physician when the patient is in the exam room," he said. "It doesn't have to be an elaborate system."

The afternoon will start off with a session on the evaluation of high-risk patients who are scheduled for noncardiac surgery. Presentations will examine whether a patient should undergo diagnostic testing, the comparison between echocardiographic and nuclear stress testing, and the appropriate action to take once the test results are in.

The closing session of the day will combine presentations on the evaluation of patients with chest pain, including the interpretation of biomarkers and the use of stress testing, with reports on hypertension and hormone replacement therapy.

Beyond its educational value, organizers hope the "Cardiology in the Community" symposium will strengthen the bridge between cardiologists and primary-care physicians. "I'm excited to see us engage our primary-care colleagues," said Dr. Brown, who is also chair-elect of the ACC Board of Governors. "There's a growing collaboration between primary-care physicians and cardiologists, and we can learn a lot from each other." ○

The Most Comprehensive Cardiology Program You Can Find—



- Comprehensive overviews of cardiovascular medicine
- In-depth subspecialty updates
- Cutting-edge research
- Expert speakers
- Networking and more!

Important Dates

March 10, 2003	Deadline for all attendee changes and cancellations in hotel reservations to I.T.S. Group of ExpoExchange
March 10, 2003	Deadline for receipt of written registration cancellations; no refunds issued for cancellations after this date
March 17, 2003	Beginning date to make housing changes and cancellations directly with the hotel (Individual hotel cancellation policies are enforced.)
March 30–April 1, 2003	Exposition open 9 a.m–5 p.m., Sunday through Tuesday
March 30–April 2, 2003	52nd Annual Scientific Session

Fast Facts

- **ACC Central**—opens Saturday, March 29, through April 2, noon–5 p.m.
- **Effective Estate Planning Seminar**—Saturday March 29, 2–5 p.m.
- **Spotlight Sessions**—Sunday, March 30, from 7:30 a.m.–5:30 p.m.
- **Annual Scientific Session**—opens Sunday, March 30, through April 2
- **ACC Computerized Placement Center**—opens Sunday, March 30, through April 2
- **Presidential Plenary Session**—Monday, March 31, 8–9 a.m.
- **52nd Annual Convocation Ceremony**—Tuesday, April 1, 6:30–8 p.m.
- **ACC '03 Meeting Highlights Session**—Wednesday, April 2, 10:30 a.m.–12:30 p.m.
- **On-site registrations** accepted daily from Saturday, March 29, through April 2

Register Today! For more information call 301-897-2694, or toll free 1-800-253-4636, ext. 694, or visit *http://www.acc.org/2003ann_meeting/home/home.htm.*

Revisit ACC '03 Via the Web

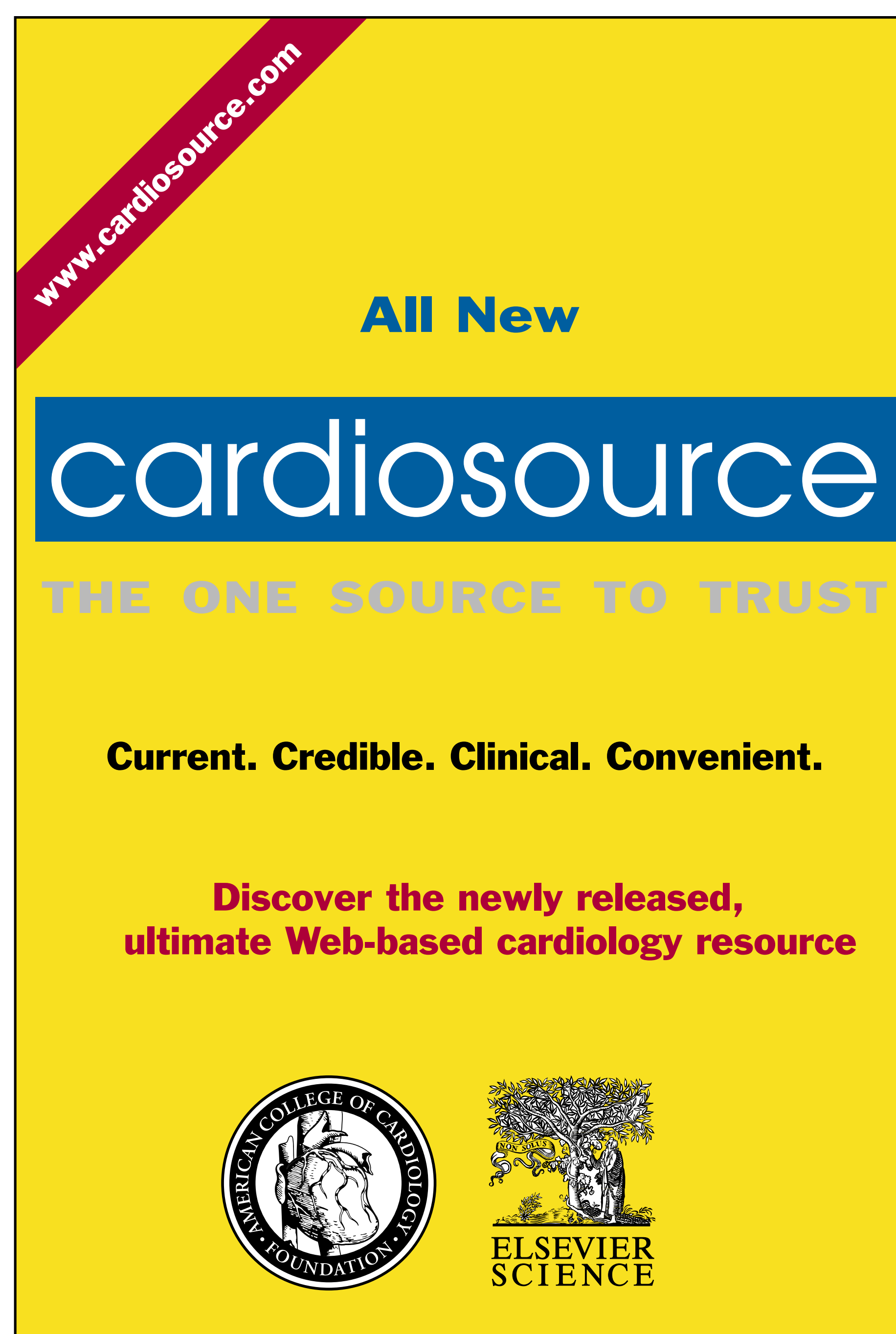
Members who were unable to attend the ACC Scientific Session last year read about the meeting in ACC publications and on the College's Web site. Many also took advantage of ACC '02 Online, a Web-based location for written summaries plus live and delayed broadcasts of meeting coverage.

For the upcoming ACC 52nd Annual Scientific Session, ACC '03 Online will provide comprehensive meeting coverage including:

- Webcasts of important sessions, hand-picked by experts in the field;
- Meeting Highlights sessions;
- Satellite broadcasts;
- Late-breaking clinical trial results; and
- Continuing medical education programs.

If you are unable to attend ACC '03 in Chicago, we invite you to tune in. Members who travel to ACC also are invited to visit ACC '03 Online as a refresher after attending the meeting, to view sessions missed due to schedule conflicts, or to earn CMEs.

To access the meeting electronically, visit *http://www.acc03online.acc.org.*



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