CARDIOLOGY

SEPTEMBER 2026

A Member Publication of the
American College of Cardiology

VOL. 55 | NUMBER 7

WHEN DRAMA MIRRORS REALITY: CARDIOLOGY INSIGHTS FROM THE PITT

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TRANSFORM THE FUTURE OF CV CARE AT

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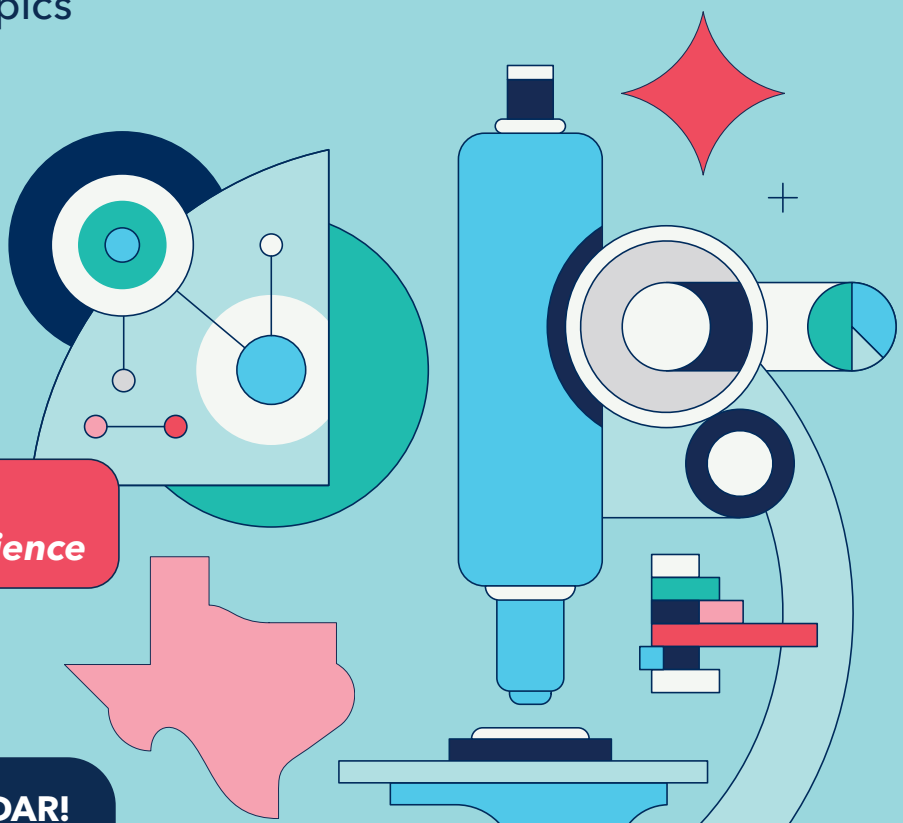
- Abstracts across 60+ topics
- Complex Clinical Cases
- CV Team Abstracts and Cases

Submit by Tuesday, Oct. 6 at 1 p.m. ET!

Learn more at ***ACCScientificSession.org/Science***



MARK YOUR CALENDAR!

Exclusive ACC Member Early Bird Registration
Oct. 14 - Oct. 27

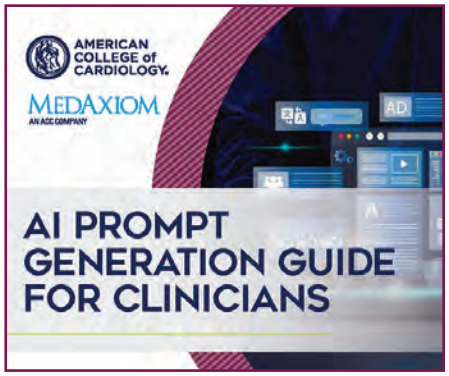
Late-Breaking Clinical Trial Submissions
Oct. 20 - Dec. 1

General Early Bird Registration
Oct. 28 - Dec. 2

AMERICAN COLLEGE of CARDIOLOGY

WORLD HEART FEDERATION

TRANSFORMING CARDIOVASCULAR CARE FOR ALL



TRANSFORM CARE WITH AI PROMPTS

The AI Prompt Guide helps clinicians craft more precise, thoughtful prompts to substantially improve the quality and reliability of AI-generated insights. Designed to help clinicians bridge the gap between clinical expertise and AI capabilities, the guide offers practical strategies to apply AI tools to patient care, workflow optimization and innovative problem-solving.

Scan the QR code to download the AI Prompt Guide, the latest chapter in the ACC and MexAxiom Care Transformation Initiative.

POINT-OF-CARE RESOURCES SUPPORT HCM PATIENT EDUCATION

Affecting at least 1 in 500 adults, hypertrophic cardiomyopathy (HCM) is the most common inherited heart disease in the U.S. ACC's CardioSmart offers free, evidence-based patient education resources to support meaningful clinician-patient conversations about HCM.

Tools including discussion guides, infographics, handouts and more support point-of-care education, improve understanding, encourage timely diagnosis and treatment, and raise awareness of HCM's cardiovascular risks and strong familial link.

Download all HCM resources for free at ***CardioSmart.org/HCM***.

ONLINE COURSE AVAILABLE!

Explore ACC's Pulmonary Artery Pressure Monitoring online course for expert-led insights on integrating this technology into heart failure (HF) care. Through web-based lessons, expert panel discussions, podcasts and a quick-reference infographic, clinicians learn how to identify appropriate patients, understand device functionality and apply evidence-based strategies to improve HF management.

Scan the QR code to learn more and download the infographic.

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The ACC Advantage: Community Powering Cardiology

The practice of cardiovascular medicine is changing at an extraordinary pace. Every day, our members balance the demands of patient care while navigating reimbursement pressures, growing administrative burdens, workforce shortages, rising costs of education and professional development, and the challenge of keeping pace with an ever-expanding body of science and clinical information.

Over the last few months, an ACC crowdsourcing survey provided an important opportunity to listen. The findings reaffirmed that ACC's core value proposition remains centered on delivering trusted education, scientific content, professional development and advocacy. Education, *JACC* Journals, the Annual Scientific Session, networking opportunities and advocacy consistently emerged as the benefits members value most.

Collectively, the results align with other member feedback received over the last several years and suggest that ACC's continued growth and relevance will depend on balancing its traditional strengths in science and education with increased support for workforce challenges, career development, advocacy and professional well-being – themes that come to life in this month's cover story. Using the cultural phenomenon of *The Pitt* as a springboard, we examine the very real workforce, well-being and patient access challenges confronting cardiovascular professionals today and highlight where the ACC is stepping in to ensure its members are equipped to navigate change and continue providing the best, evidence-based care.

This issue of *Cardiology* is dedicated to the power of membership and the unique value of belonging to a professional community united by a shared purpose. Here's to the power of community and the College that brings us together in pursuit of better heart health for every patient, everywhere.

Thank you for all that you do for your patients, each other and the profession. ■

Roxana Mehran, MD, FACC
ACC President

Visit ***ACC.org/ACCPresident*** to watch the latest episode of "On the Rox" where I talk with ACC Board of Governors leaders about the value of membership, recent survey results and how to get involved with Chapters and Sections.

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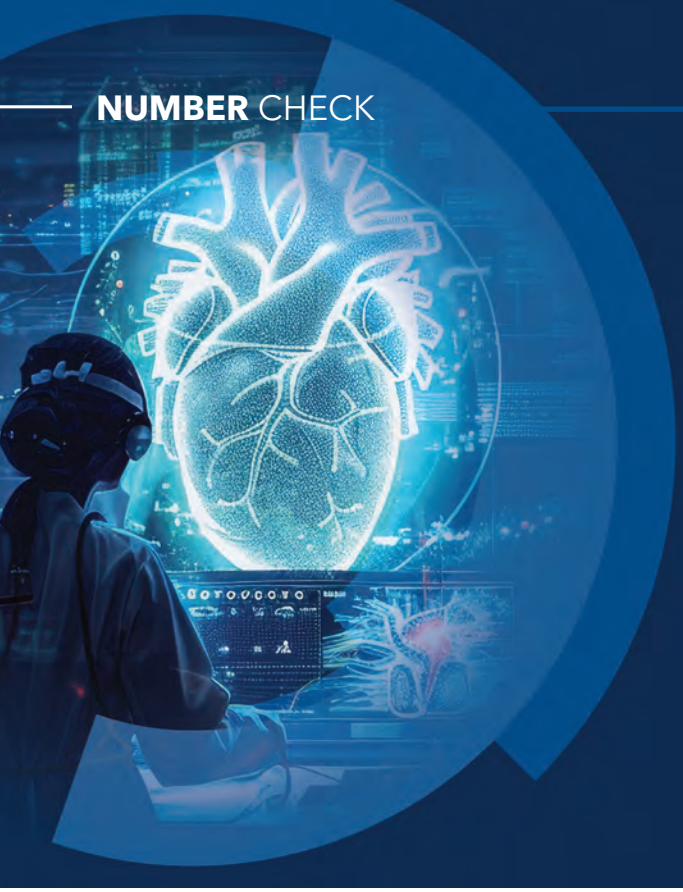


JACC Journals:

Trusted Science. Global Reach.

When information is everywhere, credibility is everything. The latest Clarivate Journal Impact Factors reflect the broad global reach and influence of *JACC* and the entire *JACC* Journals family and underscore the shared commitment across the journals to inform care, accelerate discovery, and advance global heart health and patient outcomes.

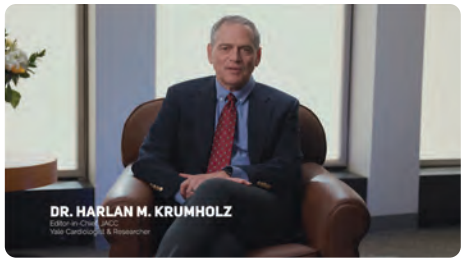
"In an increasingly complex and fast-moving scientific landscape, the value of trusted, high-quality evidence cannot be overstated," says *JACC* Editor-in-Chief **Harlan M. Krumholz, MD, SM, MACC**. "These Impact Factors reflect not only the influence of the science we publish, but the extraordinary commitment of our editors, editorial boards, reviewers and ACC staff. Their professionalism, collaboration and shared dedication continue to elevate the caliber and global impact of *JACC* Journals."

Overall JACC Journal Impact Factor Scores:

22.3 JACC	NEW **5.5** JACC Advances	NEW **6.1** JACC Asia
19 JACC Cardiovascular Imaging	**15.5** JACC CardioOncology	**11.9** JACC Heart Failure
12.7 JACC Cardiovascular Interventions	**7.2** JACC Clinical Electrophysiology	**8.4** JACC Basic to Translational Science

How do you build a journal that stands apart? Through relevance, reach and trust. Two years into his tenure as Editor-in-Chief Krumholz reflects on *JACC's* journey to become a truly global platform for advancing cardiovascular science and speaks to where it's headed next.

Scan the QR code to watch the video.



Explore the latest science and resources at ***JACC.org***. Looking to submit your research? Learn more about publishing your work – your way – in the *JACC* Journals Author Center.

Scan the QR code.

Industry Advisory Forum Highlights Importance of Collaboration

The ACC convened nearly 100 clinicians, ACC leaders, industry partners and staff at Heart House on July 15 for the first Industry Advisory Forum (IAF) of 2026. The day-long event focused on prevention and opportunities to collaborate around scalable solutions that would move the profession from treating cardiovascular diseases to preventing risks.

"The opportunity today is not simply to treat disease better after it occurs, but to identify risk earlier and intervene before disease develops," said ACC President **Roxana Mehran, MD, FACC**, during her presentation on why partnership is key to prevention. "The future of prevention depends on bringing together clinicians, researchers, health systems, industry, policymakers, patients and professional societies around this shared vision."

IAF Chair and ACC Past President **Edward Fry, MD, MACC**, who also co-chairs ACC's Comprehensive CV Prevention Task Force, provided the keynote on why prevention and screening must move upstream and underscored the current global burden of cardiovascular disease in the U.S. and around the world

Expert panels and small group discussions dove further into actionable opportunities, sharing approaches to prevention, screening and earlier treatment within the policy, primary care and outpatient settings. Participants also explored how to enable preventative care at various points along the patient journey, leveraging the strengths of the entire cardiovascular care team, as well as community engagement. ■

ACC ANNOUNCES **2027 OFFICERS AND NEW TRUSTEES**

The ACC Board of Trustees (BOT) has approved the College's next slate of officers and new trustees, who will begin their terms in April 2027 following ACC's Annual Scientific Session in Houston, TX. The incoming officers and two new trustees are:

- **Hani K. Najm, MD, MSc, FACC** (President)
- **Jeffrey T. Kuvin, MD, FACC** (Vice President)
- **Andrew M. Kates, MD, FACC** (Trustee 2027-2031)
- **Laxmi S. Mehta, MD, MBA, FACC** (Trustee 2027-2031)
- **Sanjay Gandhi, MBBS, MBA, FACC** (Treasurer 2027-2030)

"We are pleased to announce the new slate of officers and trustees of the College, starting in 2027," said ACC Past President and Nominating Committee Chair **Christopher M. Kramer, MD, MACC**. "All of the new officers and board members have a terrific track record of service to the College, bring important competencies to the BOT, and all bleed ACC blue. We look forward to their leadership of the College in the years to come."

The ACC's officers and trustees are selected through a rigorous process led by the Nominating Committee and approved by the BOT, using the College's Leadership Competencies as a guide.

Scan the QR code for the current roster of officers and trustees. ■

Upping Their Game

The future of clinical research is strengthened by diverse perspectives. This summer, ACC welcomed the newest Clinical Trial Research (CTR) program cohort to Heart House, where ACC leaders and program alumni shared insights, experiences and inspiration – highlighting how varied professional backgrounds drive innovation, enhance scientific rigor and increase the real-world relevance of clinical research. **Scan the QR code** to learn more about the program. ■

MEMBERS ON THE MOVE

Ami Bhatt, MD, FACC, former ACC Chief Innovation Officer, has been named Chief Medical Officer for WHOOP, the human performance company.

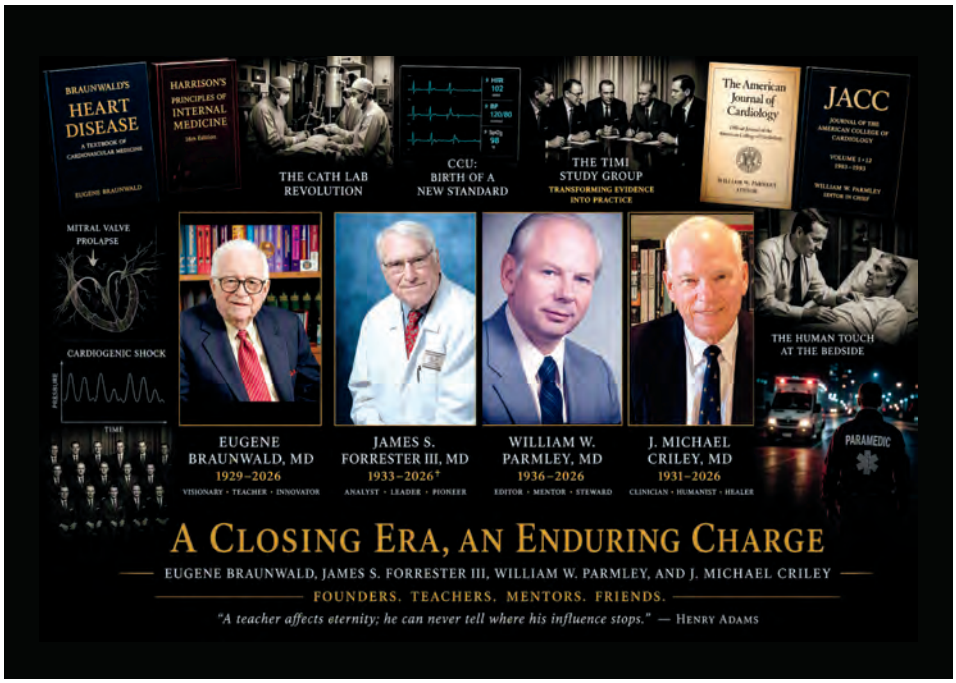
Since joining the ACC in December 2021, Bhatt helped advance and expand its Innovation Program, accelerating efforts to drive the digital transformation of cardiovascular care.

"Thanks to Dr. Bhatt's leadership, energy and vision, the ACC has strengthened strategic collaborations across the health care and technology landscape and made significant strides in empowering clinicians to understand and leverage AI in their work," said ACC CEO **Cathleen C. Gates**.

Scan the QR code to learn more about ACC's Innovation Program. ■

Looking to help grow and sustain programs like CTR? Visit ***ACC.org/Support*** to see how contributions to the ACC Foundation are shaping the future of cardiology.

A Closing Era, An **Enduring Charge**



By John Gordon Harold, MD, MACC

In the span of a single spring, cardiology lost a generation of its founders. **Eugene Braunwald, MD, MACC**, **James S. Forrester, MD**, **William W. Parmley, MD, MACC**, and **J. Michael Criley, MD, FACC**, were not simply distinguished physicians; they were the architects of the discipline we practice today and directly impacted my career. Every catheterization laboratory, every coronary care unit, every clinical trial design and every paramedic responding to a chest pain call carries some trace of their imagination.

We are living through the closing of an era. The giants who taught us how to think about the heart, who named mitral valve prolapse, defined cardiogenic shock, founded the TIMI Study Group, and edited the journals and textbooks that shaped generations, are leaving the stage almost together. Their absence is not only personal; it is structural. The scaffolding of modern cardiovascular medicine was built by their hands, and to lose them in such close succession is to feel the ground shift beneath us.

Yet when mentors of this magnitude pass, the obligation does not pass with them. It transfers. The current generation of cardiology leaders inherits not only their science but also their standards: the intellectual curiosity of Braunwald, the analytic precision of Forrester, the editorial conscience of Parmley, and the bedside humanism of Criley.

The measure of our leadership will be whether we can carry those standards forward with the same generosity of spirit and whether we, in turn, can prepare the next generation as faithfully as they prepared us.

As Henry Adams wrote, "A teacher affects eternity; he can never tell where his influence stops." For Braunwald, Forrester, Parmley and Criley, that influence will travel far beyond any of us: into trainees not yet born, into discoveries not yet imagined, and into a discipline that will forever bear the imprint of their lives. ■

LEADERSHIP LESSONS FROM A LASTING LEGACY

In her recent *JACC* Leadership Page, ACC President **Roxana Mehran, MD, FACC**, reflects on the passing of **Eugene Braunwald, MD, MACC**, and the enduring leadership lessons his career offers the cardiovascular community. Beyond his landmark scientific contributions, Braunwald's influence shaped institutions, advanced patient care, and inspired generations of cardiovascular leaders through mentorship and vision, she writes.

His example underscores that great leadership is rooted in intellectual curiosity, integrity, service and commitment to the future. Mehran notes that as cardiovascular medicine navigates rapid change, the ACC remains dedicated to fostering these values to empower the next generation of leaders and improve heart health for all. **Scan the QR code** to read more. ■

VALENTIN FUSTER CARDIOVASCULAR SYMPOSIUM

DEC. 11 – 13, 2026 | NEW YORK CITY

Join Course Director **Valentin Fuster, MD, PhD, MACC**, alongside internationally renowned faculty, for a one-of-a-kind educational experience.

Designed to bridge the latest research with practical, evidence-based strategies, the symposium will help you translate new science into everyday clinical practice and connect with leaders in the field. Plus, experience the energy of New York City during the festive holiday season.

Register now to secure your spot!
ACC.org/FusterCVSymposium

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JACC Progress Report: Excess CV Mortality Persists in Black Americans

Despite modest improvements from 2023 to 2024, Black Americans continue to experience significantly higher rates of cardiovascular mortality, according to the third annual *JACC* progress report examining disparities compared with White Americans.

Using 2000-2024 mortality data from the U.S. Centers for Disease Control and Prevention, **Adith S. Arun, BS**; **Harlan M. Krumholz, MD, SM, MACC**, et al., calculated excess age-adjusted cardiovascular mortality rates (AAMR) and years of potential life lost (YPLL) for Black and White Americans by sex and cardiovascular disease category.

Results showed a modest improvement in excess AAMR from 2023, by 4.3% among Black men and 0.7% among Black women, although Black women also saw a 5.7% rise in excess heart failure mortality – the only increase seen in the study. The overall trend in improvement represents a partial post pandemic rebound, the authors note.

However, Black Americans continue to experience a substantially higher cardiovascular mortality, with an excess AAMR of 110.4 per 100,000 persons – higher in men (147.2) than women (88.9) and representing >1 million excess YPLL.

Hypertension was the leading contributor to excess mortality, followed by ischemic heart disease and cerebrovascular disease.

"The 2024 data describe a country whose advances in cardiovascular science and care have not yet translated into convergence in cardiovascular survival between Black and White Americans," write Arun, et al. "Closing this gap will require sustained attention to the structural, clinical and policy factors that produce it, and a willingness to treat the absence of progress as itself a finding that demands response." ■

Arun A, Yan B, Lu Y, et al. *JACC*. 2026;June 19: doi:10.1016/j.jacc.2026.05.013.

CV Risk Factor Treatment, Control Rates Low Among Adults With CKM

Treatment of hypertension and hyperlipidemia remains low among U.S. adults with cardiovascular-kidney-metabolic (CKM) syndrome, with less than half achieving blood pressure (BP) or glycemic control, according to research published in *JACC*.

The analysis included 6,384 adults aged ≥20 years with CKM stage 2 or higher (weighted mean age, 44 years; 51% women) using National Health and Nutrition Examination Survey data from 2015-2023.

Overall, only 51% of participants with hypertension and 49% with hyperlipidemia received treatment, with rates declining from 56% to 44% and from 53% to 40%, respectively. By contrast, 84% of participants with diabetes received treatment, increasing from 76% to 88%.

Among treated individuals, BP and glycemic control were achieved in only 45% and 47%, respectively, with little change over time. Cholesterol control was higher, at 68%.

Treatment gaps were most pronounced among younger adults, women and Hispanic adults. Adults aged 20-44 years had the lowest treatment rates for hypertension (28%), diabetes (74%) and hyperlipidemia (20%). Women were less likely than men to receive diabetes and hyperlipidemia treatment, while Hispanic adults were least likely to receive hypertension and hyperlipidemia treatment.

Risk factor control was also poorest among those at highest cardiovascular risk: BP control declined by about 4% with every 5% increase in 10-year cardiovascular disease risk. Glycemic control remained suboptimal across risk strata.

Study investigators **Jingyi Gong, MD**, et al., conclude that improving CKM health will require coordinated strategies to expand awareness and access, advance care-delivery models, and strengthen screening and treatment practices. ■

Gong J, Chiu N, Clinch K, et al. *JACC*. 2026; June 17: doi: 10.1016/j.jacc.2026.04.031.

Scan the QR code for the CKM Focus issue of *JACC*.

Combined LDL-C, Lp(a) and hsCRP Assessment Identifies Long-Term Risk of ASCVD

Combined assessment of LDL-C, Lp(a) and hsCRP identified individuals from varied ethnic backgrounds at higher long-term risk of atherosclerotic cardiovascular disease (ASCVD), according to a HELIUS cohort analysis published in *JACC*.

Maxim E. Annink, MD, MSc, LLM, et al., studied 15,676 participants without prior myocardial infarction or ischemic stroke. They were from African, European and South Asian Surinamese descent, with a mean age of 44 years and two-thirds were women.

Over a median follow-up of 8.9 years, 378 ASCVD events occurred. Comparing top vs. bottom quintiles, hazard ratios were 1.39 for LDL-C, 1.86 for Lp(a) and 1.51 for hsCRP, with no additive or multiplicative interaction.

Risk increased with the number of elevated biomarkers; participants with all three elevated had a 2.44-fold higher risk. Findings were consistent across ethnic groups, with the highest absolute risk among South Asian Surinamese participants.

In an editorial comment, **Anurag Mehta, MD, FACC**, says the findings support "a pathway-oriented approach to prevention that current guidelines already endorse." ■

Scan the QR code for the ACC/AHA Guideline on Dyslipidemia and related resources.

Annink M, Beverloo C, Kraaijenhof J, et al. *JACC*. 2026; June 24: https://doi.org/10.1016/j.jacc.2026.05.006.

Cancer-VTE Bleeding Risk Score Tested

A novel risk score may help clinicians identify patients with cancer-associated venous thromboembolism (VTE) at higher risk for major bleeding while receiving direct oral anticoagulants (DOAC), according to research published in *JACC: CardioOncology*.

The ONCO-DOAC BLEED score was derived from 1,166 patients in Japan's COMMAND VTE Registry-2 and validated in 779 patients from the ONCO DVT and ONCO PE studies. It includes major bleeding history, chronic kidney disease, NSAID use, metastatic or terminal cancer, and upper gastrointestinal, pancreatic or uterine cancer to classify patients as low, intermediate or high risk.

At 163 days, major bleeding occurred in 11% and 7% of the derivation and validation cohorts. The score showed moderate discrimination in both cohorts and performed as well as or better than current scores. ■

Nagai T, Nakanishi N, Yamashita Y, et al. *JACC*. 2026;281-95.

TAVR at 10 Years: What New Data Show

Ten-year results from PARTNER 2A and a propensity-matched PARTNER 2 SAPIEN 3 (P2S3i) analysis, published in a *JACC* focus issue on valvular heart disease, provide new long-term context for TAVR vs. surgery in intermediate-risk patients with severe symptomatic aortic stenosis.

In PARTNER 2A, 974 patients were randomized to TAVR with the second-generation SAPIEN XT valve and 936 to surgery. At 10 years, all-cause mortality was 86% with TAVR and 83% with surgery (HR, 1.13; p=0.02). Mortality was similar for transfemoral TAVR vs. surgery, but higher with transapical/transaortic TAVR. Aortic valve reintervention was also more frequent after TAVR (6% vs. 2%; p<0.001).

Investigators noted that patients requiring nonfemoral access likely represented a sicker phenotype, often with unfavorable vascular anatomy or greater atherosclerotic burden, while transfemoral access now accounts for most U.S. TAVR procedures.

In the P2S3i analysis, investigators matched 783 SAPIEN 3 (third-generation, balloon-expandable) TAVR patients with 783 surgical patients from PARTNER 2A. Mortality was similar (83.4% vs. 82.3%), and reintervention was 2% in both groups. The authors suggested improved valve design, operator experience, patient screening and reduced reliance on nonfemoral access may have contributed to better long-term outcomes with SAPIEN 3. ■

Thourani V, von Stein P, Mack M, et al. *JACC*. 2026;87:3309-21.
Nazif T, Simonato M, Makkar R, et al. *JACC*. 2026;87:3296-3308.

Lifestyle Intervention Lowers Multimorbidity Risk in Prediabetes

An intensive lifestyle intervention may offer lasting protection against multimorbidity in adults with prediabetes, according to a 21-year Diabetes Prevention Program follow-up analysis published in *JAMA*. Metformin was not significantly different from placebo.

The observational cohort analysis included 2021 morbidity data for 1,173 Medicare enrollees from the DPP and DPP Outcomes Study who were randomized to intensive lifestyle intervention, metformin 850 mg twice daily or placebo.

The lifestyle program targeted ≥7% weight loss through diet changes and 150 minutes per week of moderate-intensity physical activity. Median age was 74 years at outcome ascertainment.

At follow-up, multimorbidity – at least two of 15 prespecified conditions – was present in 82% of the lifestyle group, 85% of the metformin group and 87% of the placebo group. Three or more conditions were present in 72%, 81% and 81%, respectively.

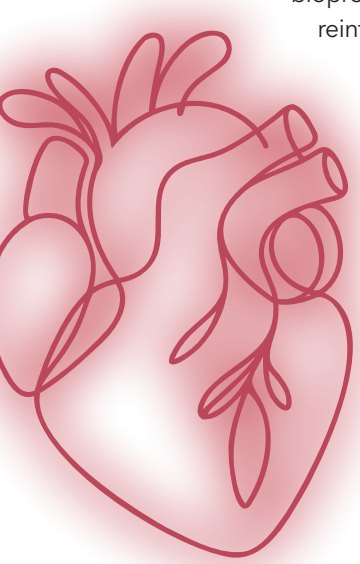
The most prevalent chronic conditions were hyperlipidemia (76%), hypertension (75%) and diabetes (67%).

In adjusted analyses, lifestyle intervention was associated with lower multimorbidity risk vs. placebo (hazard ratio [HR], 0.79) but metformin was not (HR, 0.91). The association was stronger for the highest-cost multimorbidity dyads, including stroke, chronic obstructive pulmonary disease, chronic kidney disease, heart failure and asthma combinations. ■

Salive ME, Tjaden AH, Ames JR, et al. *JAMA*. 2026;June 15: doi:10.1001/jama.2026.8492.

TAVR, Surgery Show Similar Valve Durability at 7 Years

Seven-year data from PARTNER 3 show TAVR offers valve durability comparable with surgery in low-risk patients with symptomatic severe aortic stenosis, with similarly low rates of structural valve deterioration, bioprosthetic valve failure (BVF) and reintervention, based on an ad hoc analysis published in *JAMA Cardiology*.



The analysis included 948 patients who underwent valve implantation: 495 with TAVR using the balloon-expandable SAPIEN 3 valve and 453 with surgery.

Results show the cumulative incidence rates with TAVR and surgery, respectively, were 7% vs. 8% for stage 2 or 3 structural valve deterioration (SVD)-related bioprosthetic valve dysfunction; 7% vs. 8% for all-cause BVF; 4% vs. 5.3% for SVD-related BVF; and 6% in both groups for valve reintervention.

Stage 2 or 3 thrombosis-related bioprosthetic valve dysfunction was more frequent with TAVR than surgery (5% vs. 1%), but most events occurred within three years and few progressed to BVF. Endocarditis-related dysfunction (stage 2 or 3) was similarly low (0.4% vs. 0.5%), and survival free from all-cause BVF did not differ significantly (73% vs. 75%).

"[Seven]-year durability outcomes from PARTNER 3 support SAPIEN 3 TAVR as a strong option for the initial valve intervention when considering lifetime management," the authors write.

In an accompanying editorial, **Patrizio Lancellotti, MD, FACC**, et al., call the findings "reassuring" while noting that durability pathways remain important as TAVR expands to younger patients. ■

Ternacle J, Hahn RT, Silva I, et al. *JAMA Cardiology*. 2026;June 24: doi: 10.1001/jamacardio.2026.2299.

Aficamten Tops Metoprolol For oHCM Exercise Intolerance

Aficamten monotherapy was superior to metoprolol in promoting adaptation to multiple phases of exercise in patients with symptomatic obstructive HCM (oHCM), according to a prespecified analysis of the MAPLE-HCM trial published in *JAMA Cardiology*.

The international trial randomized 175 participants (58 years old, 42% women) with symptomatic oHCM to titrated aficamten 5-20 mg daily or metoprolol 50-200 mg daily for 24 weeks.

Among the 165 participants with core laboratory-validated exercise tests at baseline and 24 weeks, aficamten, vs. metoprolol, significantly improved several measures of exercise capacity: submaximal exercise VE/VCO_2 slope (−2.8), anaerobic threshold (76 mL/min), peak workload (8 watts), time required for VO_2 to recover by 12.5% postexercise (−11 seconds) and circulatory power (819 mm Hg x mL/min per kg).

Patients taking aficamten vs. metoprolol were nearly sevenfold more likely to have a large improvement in peak VO_2 increase of ≥3.0 mL/kg/min (21% vs. 4%). Conversely, patients taking metoprolol vs. aficamten were nearly 11-times more likely to have a large reduction in this metric (20.7% vs. 2.4%).

"Exercise capacity is a critically important therapeutic target in oHCM," where "cardiovascular event rates are infrequent but exercise intolerance is extremely common," write study authors **Gregory D. Lewis, MD**, et al. ■

Lewis GD, Garcia-Pavia P, Masri A, et al. *JAMA Cardiol*. 2026;June 17: doi:10.1001/jamacardio.2026.1730.

Pilot Study Tests GDMT Withdrawal Post AFib Ablation

Stopping guideline-directed medical therapy (GDMT) after catheter ablation may be feasible for some patients with atrial fibrillation (AFib)-mediated cardiomyopathy, but the small pilot study suggests careful follow-up is needed, with heart failure (HF) deterioration occurring in 12% of patients after withdrawal, according to findings from DEFINITION-AF published in *JAMA Network Open*.

Sitong Li, MD, et al., enrolled 50 patients (median age 56 years; 79% male) with suspected AFib-mediated cardiomyopathy at three months post ablation at a single center in China. Participants were randomized to GDMT withdrawal or continuation. The primary endpoint was HF deterioration, defined as LVEF decline of more than 10% to less than 55%, LV end-diastolic diameter increase of more than 10% and beyond normal, NT-proBNP doubling to more than 400 ng/L, or worsening HF signs and symptoms.

Among 47 patients completing six-month follow-up, the primary endpoint occurred in three patients (12%) in the withdrawal group and none in the continuation group (p=0.11). All three recovered LVEF and NT-proBNP after early GDMT reinitiation.

Drug-related complications were more common with GDMT continuation vs. withdrawal (20% vs. 0%; p=0.05), while arrhythmia recurrence was similar between groups (12.5% vs. 12%).

The authors emphasize the findings apply to patients with highly suspected AFib-mediated cardiomyopathy, recovered cardiac structure and function, no HF symptoms, maintained sinus rhythm and low NT-proBNP after ablation. Given the small sample size and heterogeneity of AFib and HF populations, they write the results should be interpreted carefully and not generalized to broader populations. ■

Li S, Sun Y, Lai Y, et al. *JAMA Netw Open*. 2026;9(6):e2620145.

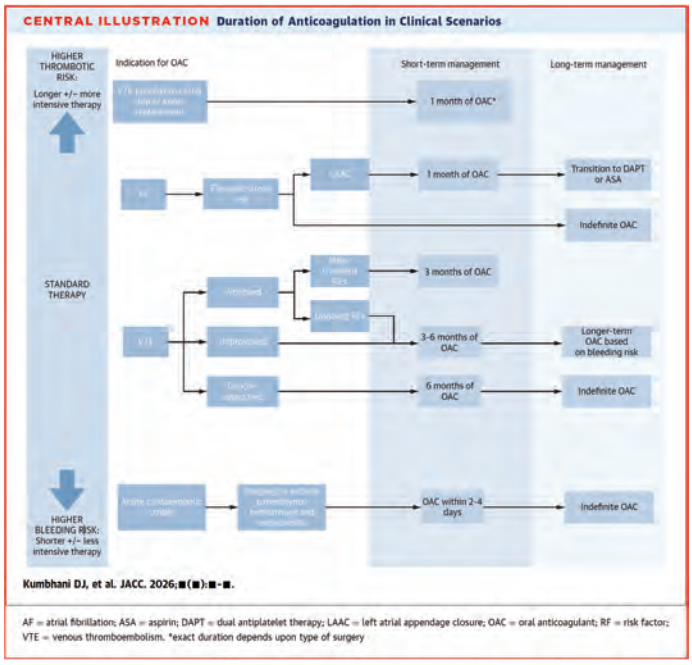
ACC Scientific Statement Guides Antiplatelet Therapy in ASCVD

An ACC Scientific Statement on managing ASCVD aims to help clinicians overcome the perpetual challenge of balancing the risks of ischemia and bleeding when selecting antiplatelet therapy in this population.

Chaired by **Dharam J. Kumbhani, MD, SM, FACC**, and published in *JACC*, the Statement summarizes pivotal clinical trials and compares current ACC/AHA and European Society of Cardiology guidance for acute coronary syndrome (ACS), chronic coronary disease and chronic coronary syndromes.

Consensus recommendations address ischemic vs. bleeding risk in determining antiplatelet strategy, aspirin for primary prevention, perioperative management and patient monitoring, as well as antiplatelet therapy after revascularization and long-term after ASC or myocardial infarction. The document also reviews considerations for peripheral artery disease, stroke/TIA, valve disease and patients requiring anticoagulation.

The authors emphasize medication adherence, suggesting multifaceted strategies such as early post-discharge follow-up, culturally sensitive patient education, attention to social drivers of health and financial burden, monitoring for bleeding, dose adjustment or de-escalation when appropriate, and possible fixed-dose polypill combinations.



Scan the QR code for the full Statement. ■

DOAC Guidance Targets Thrombotic Event Prevention

Despite robust evidence for their efficacy and safety, direct oral anticoagulants (DOACs) remain underused and sometimes inappropriately dosed, particularly in patients at elevated thrombotic risk. An ACC Scientific Statement published in *JACC* provides evidence-based guidance on DOAC use for primary and secondary prevention of thrombotic events.

The Statement reviews key guideline recommendations and established and emerging indications for DOAC therapy. Consensus recommendations address primary prevention of venous thromboembolism (VTE) and stroke; management and secondary prevention of VTE; and secondary prevention after acute stroke, left atrial appendage closure and ablation for atrial fibrillation. It also covers DOAC management in special populations, including patients with chronic kidney disease, liver disease, frailty, obesity, prior bleeding or cancer-associated thrombus.

Practical considerations include drug selection, dosing strategies, duration of therapy, bleeding risk assessment, management of anticoagulant-related bleeding, drug-drug interactions, adherence and cost-related barriers.

The Writing Committee, chaired by **Dharam J. Kumbhani, MD, SM, FACC**, notes the Statement is intended to complement existing guidelines by synthesizing evolving data, clarifying uncertainty and supporting individualized, patient-centered decision-making to improve appropriate and equitable DOAC use. ■

Scan the QR code for the full Statement.

Global HF Definition Updated to Improve Prevention, Diagnosis, Treatment

The AHA/ACC/ESC/WHF Expert Consensus Document: Second Universal Definition of Heart Failure (HF) addresses evolving disease manifestations, diagnostic strategies and pathophysiology, offering one unified definition for clinicians, researchers, health systems and policymakers worldwide.

Published on behalf of the ACC, AHA, European Society of Cardiology and World Heart Federation, in collaboration with the Heart Failure Society of America, ESC Heart Failure Association and the Japanese Heart Failure Society, the document updates the First Universal Definition of Heart Failure released in 2021.

Key changes include a universal classification system for HF causes to standardize reporting across registries and trials, and a shift away from strict LVEF cutoffs that may obscure treatment benefits across HF phenotypes. The definition instead accounts for factors such as age, sex and ethnicity and groups HF into reduced, preserved and improved EF categories to better reflect clinical realities.

The document also emphasizes earlier intervention, mitigation of progression to advanced HF and recognition of HF as a dynamic disease with potential for improvement, remission and recovery. It also underscores the impact of access to care, geography, policy and social drivers of health on HF risk and outcomes.

"HF remains a major challenge that continues to grow globally, and inconsistencies in how it is defined have limited progress in research and treatment," said **Mary Norine Walsh, MD, MACC**, co-chair of the document. "This updated definition provides a clearer, more consistent framework to help clinicians identify risk earlier and guide more personalized treatment approaches that can help improve patient outcomes worldwide."

According to the ACC and AHA, the definition will serve as the foundation for the upcoming Heart Failure Guideline, expected in late 2027.

Scan the QR code for the complete document. ■

TABLE 2 Changes in the 2023 ACC/AHA/Multisociety Guideline for Management of AF

Recommendations for anticoagulation are now made based on yearly thromboembolic event risk using a validated clinical risk score, such as CHA_2DS_2-VASc, but other scores can be used when clinically useful.
Initiation of anticoagulation in patients with an estimated stroke and systemic embolism risk threshold of ≥2% per year (eg, CHA_2DS_2-VASc score of ≥2 in men and ≥3 in women) receives a Class 1 recommendation; those with an estimated risk of 1%-2% receive a Class 2a recommendation.
Patients with AF at intermediate to low (1%-2%) annual risk of ischemic stroke (eg, equivalent to CHA_2DS_2-VASc score of 1 in men or 2 in women) can benefit from consideration of factors that might modify their risk of stroke, such as the type of AF (eg, permanent vs paroxysmal), or the presence of an underlying cardiac substrate perceived to be of greater risk.
In terms of preferred agents, DOACs are recommended over warfarin, except in patients with moderate to severe rheumatic mitral stenosis and those with mechanical heart valves.[17]

AF = atrial fibrillation; DOAC = direct oral anticoagulant.

Kumbhani DJ, et al. JACC. 2026;■(■):■–■.

ENHANCED RADIATION PROTECTION IN CATH LABS

A new expert consensus statement calls for immediate adoption of safer technologies to protect health care professionals. **Scan the QR code** to read the full details from this multisociety document endorsed by the ACC and published in *JACC: Cardiovascular Interventions.*

Empowering Careers at Every Stage: Inside ACC's Leadership Programs

Leadership development is woven into the fabric of ACC's 2024-2028 Strategic Plan, reflecting the College's commitment to cultivating the next generation of leaders and serving as the professional home for cardiovascular clinicians worldwide.

Programs like Emerging Faculty Leadership Academy, the Clinical Trials Research Program, the Leadership Accelerator and the Sandra J. Lewis Mid-Career Women's Leadership Institute are examples of targeted leadership and professional growth opportunities that can lead to measurable outcomes like academic promotions, new program directorships, national leadership roles and successful career transitions.

Below are insights from program leaders and graduates on how these activities are transforming lives, advancing careers, and building local, regional and national leadership networks that will serve generations of ACC members to come.

The Rick Nishimura, MD, MACC & Patrick T. O'Gara, MD, MACC Emerging Faculty Leadership Academy

Thanks to the vision and leadership of ACC Past President **Michael J. Wolk, MD, MACC**, the Emerging Faculty Leadership Academy is celebrating more than 20 years. Dedicated to "educating the educators," **Patrick T. O'Gara, MD, MACC**, ACC past president and long-time education leader, says the program is focused on providing early- to mid-career physicians with deliberate hands-on training around effectively commanding a room, distilling teaching points and articulating what a learner should take away.

For **Eric H. Yang, MD, FACC**, clinical professor of medicine and director of the Cardio-Oncology Program at UCLA, the Emerging Faculty Academy encouraged "ongoing self-reflection and lifelong learning that continues to this day." For **Jennifer Cook, MD, FACC**, medical director of the LVAD Program at Baptist Health in Little Rock, AR, and chair of the ACC Education Standards and Outcomes Committee, the relationships built with colleagues nationwide have enriched her membership in the ACC and provided opportunities to collaborate in leadership."

The Emerging Faculty Leadership Academy cohort at Heart House in 2025.

The current CTR cohort at ACC's Heart House in June.

Clinical Trials Research: Upping Your Game Program

This year-long program gives cardiologists, cardiac surgeons and doctorate-level researchers a behind-the-scenes understanding of running clinical trials alongside nationally recognized trialists, regulatory stakeholders and industry leaders. Two specialized tracks in Structural Heart Disease Research and Electrophysiology Research were added this year.

Janet Wei, MD, FACC, associate professor of cardiology and biomedical sciences at Cedars-Sinai Medical Center in Los Angeles and governor of ACC's California Chapter, says the program was "perfect timing," helping her to identify step-by-step actions required to reach her clinical research career goals."

ACC Past President **Mary Norine Walsh, MD, MACC**, says individuals interested in the program should demonstrate a research track record and documented institutional resources, including protected time, mentorship and infrastructure to carry trials to completion.

Leadership Accelerator

Aimed at early-career physicians and CV Team members, this 10-month program builds skills in leadership identity, executive presence, communication, conflict management and influence.

According to former Board of Governors Chair **Malissa J. Wood, MD, FACC**, the program includes concrete benchmarks of success ranging from advancement into ACC or institutional leadership roles to academic promotion and strategic career moves.

Mahesh K. Vidula, MD, FACC, of the University of Pennsylvania, credits the Accelerator with helping him launch an inflammatory heart disease program and providing an opportunity to meet incredibly talented individuals who he can now reach out to for clinical and professional advice. For **Daniela Crousillat, MD, FACC**, of the University of South Florida, the program strengthened her ability to lead with "confidence, purpose and, most of all, authenticity."

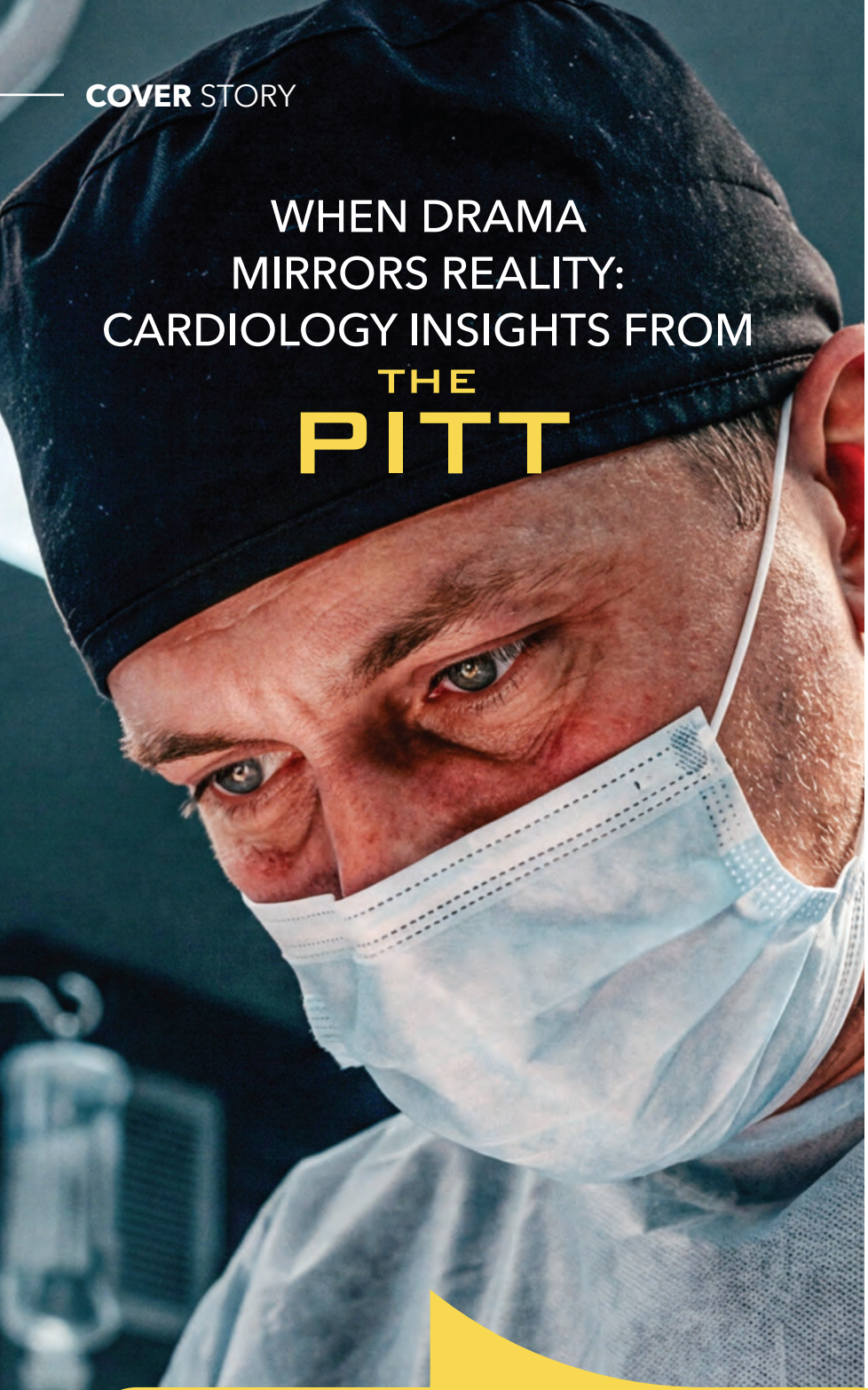
The Sandra J. Lewis Mid-Career Women's Leadership Institute

For women 12 to 21 years past cardiovascular fellowship, this two-year program pairs virtual learning with six in-person sessions at Heart House. Participants reassess personal mission, vision and values; build advanced leadership skill sets; network with experienced leaders; and cultivate lasting mentorship and sponsorship.

For **Sandra J. Lewis, MD, FACC**, the heart of the Institute is its close-knit community of graduates, who equip one another with creativity, courage and confidence to navigate career aspirations and life challenges.

Yamini S. Levitzky, MD, MPH, FACC, says the Institute made her "more intentional about advocating for her work, pursuing new opportunities and building a career that reflects her values." **Carol Ma, MD, FACC**, called the program "life-changing," inspiring her "to reach for my next" alongside a network of women cardiologists ready to make a profound impact. ■

This article was authored by **Jina Chung, MD, FACC**, and **Andrew M. Kates, MD, FACC**. Chung is a graduate of the Sandra J. Lewis Institute and professor of medicine at UCLA, director of Interventional Echo and CMR, and co-director of the Pulmonary Embolism Response Team at Harbor-UCLA Medical Center in Los Angeles, CA. Kates is a graduate of the Emerging Faculty Leadership Academy and professor of medicine and associate chief for education at Washington University School of Medicine in St. Louis, MO. Both co-chaired an ACC.26 session on which this article is based.



WHEN DRAMA MIRRORS REALITY: CARDIOLOGY INSIGHTS FROM THE PITT

Beyond its compelling storylines, the emergency room drama *The Pitt* offers a revealing look at many of the challenges shaping health care today. Burnout, workforce shortages, patient access barriers, workplace violence, and the promise and pitfalls of new technologies are not unique to emergency medicine. They are increasingly familiar realities for cardiovascular professionals navigating a rapidly evolving health care environment.

Perhaps the show's greatest strength is its portrayal of how interconnected these challenges truly are. Clinician well-being, workforce sustainability, patient access and technological innovation cannot be addressed in isolation.

"*The Pitt* gets a lot right. I especially appreciate that throughout the episodes there is a lot of focus on team dynamics and the interconnectivity within medicine – not just relationships with patients, but within the care team, the hospital as a whole and the local community," says **Akshay Khandelwal, MD, FACC**, an ACC Trustee and system chair of cardiovascular medicine at Allegheny Health Network, the setting for *The Pitt*. "It underscores the importance of building a health care system that is resilient, equitable and sustainable and the need for coordinated solutions that support both those receiving care and those providing it."

> [*The Pitt*] underscores the importance of building a health care system that is resilient, equitable and sustainable and the need for coordinated solutions that support both those receiving care and those providing it.
>
> Akshay Khandelwal, MD, FACC

Clinician Mental Health: The Invisible Burden in Cardiology

One of the central themes in *The Pitt* is the emotional toll of clinical practice. The series portrays workplace violence, grief, moral distress and burnout not as isolated events but as recurring realities woven into everyday patient care.

KEY TAKEAWAYS FOR CLINICIANS

1. Burnout is a systems issue, not an individual failing.
2. Mental health support should be part of the professional culture.
3. AI is a tool, not a replacement for clinical judgment.
4. Access remains one of cardiology's greatest challenges.
5. Workforce sustainability is essential for quality care.

For cardiovascular clinicians, these challenges may feel especially familiar. "Caring for patients at critical moments such as acute myocardial infarction, advanced heart failure or sudden cardiac arrest, can carry significant but often underappreciated emotional labor, even when outcomes are positive," says **Garima Sharma, MBBS, FACC**, who has been closely involved in ACC Section and Chapter work, as well as workforce and well-being initiatives.

High patient volumes, demanding call schedules, complex decision-making and administrative burdens can further compound stress. Insurance barriers, resource constraints and situations where recommended therapies do not align with patient goals can heighten moral distress for cardiovascular teams.

The emotional burden also extends beyond clinical complexity. Cardiovascular clinicians often develop long-term relationships with patients and families, creating meaningful connections while increasing the impact of adverse outcomes.

"The patient who dies unexpectedly, the patient or family conversation that stays with you, the complication you replay in your mind long after the procedure – those experiences don't simply disappear," says **Laxmi Mehta, MD, MBA, FACC**, chair of ACC's Membership Committee and a longtime leader of the College's clinician well-being efforts. "While caring for patients is incredibly rewarding, the cumulative weight of carrying that responsibility over years or decades can be substantial."

Addressing these challenges requires more than encouraging individual resilience. When the demands placed on clinicians consistently outpace available resources, the consequences can affect both caregivers and the broader health care system.

"A strong sense of meaning and purpose in clinical work as well as connection to patients and their families are what sustains many clinicians. But purpose and meaning are not enough, we must acknowledge the psychological cost of repeatedly making high-consequence decisions," says Mehta.

A growing body of research links chronic psychological stress to adverse health consequences for clinicians themselves. At the organizational level, burnout can contribute to lower engagement, reduced team effectiveness, poorer patient experience and higher workforce turnover.

Experts emphasize that meaningful progress requires institutional commitment. "Clinicians have a responsibility to patients, but organizations also have a responsibility to build conditions in which excellent care is sustainable," says CardioSmart Editor **Viet Le, DMSc, MPAS, PA-C, FACC**. "Burnout is not a failure of character. It is often a signal that demand, resources,

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autonomy and meaning have moved out of balance."

Sharma advocates for a systems-based approach embedded within organizational culture, including efficient work environments, flexible scheduling, transparent leadership, routine measurement of burnout and stigma-free access to mental health resources.

Mehta also emphasizes the responsibility of leaders to model healthy behaviors and support training environments that prioritize well-being. "Clinician well-being is not a nice-to-have luxury, but a necessary component of every health system and training program," she says. "Creating a culture where clinicians care for themselves and one another is essential not only for workforce sustainability but also for delivering safe, effective, high-quality patient care."

> Burnout is not a failure of character. It is often a signal that demand, resources, autonomy and meaning have moved out of balance.
>
> Viet Le, DMSc, MPAS, PA-C, FACC

AI and Digital Health: Promise vs. Friction

Another recurring theme in *The Pitt* is the growing role of technology in clinical decision-making. The show highlights both the promise of digital tools and the frustration that arises when technology fails to integrate smoothly into care delivery or suddenly becomes unavailable.

Cardiovascular medicine sits at the forefront of this transformation. AI-powered documentation tools, advanced imaging platforms, predictive analytics and remote monitoring technologies are increasingly finding their way into clinical practice. When implemented effectively, these tools can help reduce administrative burden, identify patients at higher risk for complications, and extend care beyond the walls of the clinic or hospital.

Yet, as *The Pitt* illustrates, technology is rarely a simple solution.

Clinicians frequently navigate tension between algorithmic recommendations and clinical judgment. AI tools can uncover patterns that might otherwise be missed, but their performance depends heavily on the data used to develop them. Biases, incomplete information and inaccurate outputs remain important concerns.

At the same time, digital innovation can create new challenges. Remote monitoring programs and connected devices generate large volumes of data that must be reviewed, interpreted and acted upon. Poorly designed workflows can transform tools intended to save time into additional sources of burden.

Equity also remains a critical consideration. Not all patients have reliable internet access, smartphones, wearable devices or the digital literacy needed to engage with emerging technologies. Without careful implementation, new tools risk widening existing disparities in care.

The show also serves as a reminder that health care systems remain vulnerable to technological disruptions, whether from cyberattacks, network failures or power outages. Clinicians must be prepared to continue delivering care when technology is unavailable.

The future of cardiovascular medicine will be shaped not by the adoption of AI alone, but by how thoughtfully it is integrated into patient care. To help clinicians navigate this rapidly evolving landscape, the ACC continues to expand educational resources and strategic partnerships, including the AI-Enabled Clinician Podcast, ongoing collaboration with MedAxiom on AI-driven care transformation tools, the OpenEvidence partnership, and the growing AI Resource Center at *ACC.org/AI*.

"Well-designed technology can reduce duplication, surface risk, simplify communication, and allow clinicians to focus on judgment and relationships," says Le. "The key is to ask whether a new tool removes work or merely moves work onto someone else. Technology should support the human relationship and not become another barrier between patient and clinician."

Patient Access to Cardiology Care and Treatments

Throughout *The Pitt*, patients encounter obstacles that extend far beyond their medical diagnoses. Financial barriers, insurance requirements, treatment delays and

social drivers of health often become as consequential as the conditions being treated.

These challenges are especially visible in cardiovascular care. Despite major advances in prevention, diagnosis and treatment, access remains uneven and continues to influence outcomes.

"Patients do not arrive at our doors with equal time, money, transportation, insurance coverage, health literacy, digital access, family support or trust in the health care system," says Le. "Two people may carry the same diagnosis but have very different chances of benefiting from the same recommendation."

Improving access will require innovation both inside and outside traditional care settings. Telemedicine, community-based screening initiatives, prevention programs and other outreach efforts offer opportunities to expand specialty care and identify cardiovascular disease earlier, particularly in underserved communities.

Within the health care system itself, care coordination remains essential. According to Le, successful transitions of care depend on timely follow-up, accessible patient education, clear communication among members of the care team and attention to social barriers that may affect treatment adherence.

Amy E. Simone, PA-C, FACC, chair of the ACC's Cardiovascular Team Section, emphasizes the importance of education and awareness.

"In many cases, the greatest disparity is not treatment itself, but awareness and access to timely diagnosis," she says. "Patients cannot seek care for symptoms or risk factors they do not recognize. We have to meet patients where they are, raise awareness of cardiovascular disease and create clearer pathways to care before a health crisis occurs."

Advocacy is also essential to advancing programs and policies that support patient access, prevention, community education and workforce capacity. Clinicians often witness firsthand the barriers patients face and can serve as powerful, trusted voices when meeting with lawmakers and other key decision makers.

"I would prioritize policies that remove avoidable barriers between patients and qualified clinicians," says Le. "That includes modernizing PA practice laws, reducing unnecessary administrative requirements, improving payment for prevention and care coordination, supporting telehealth and remote monitoring where appropriate, strengthening rural and community-based access, and improving coverage for evidence-based medications and services."

Continued on the next page

FROM DIALOGUE TO ACTION

The Pitt highlights many of the same challenges confronting cardiology and health care today. **Katie Berlacher, MD, MS, FACC**, a cardiologist at the University of Pittsburgh Medical Center and past chair of ACC's Annual Scientific Session, says it's important for clinicians to stay aware of topics gaining attention in television, podcasts, social media and the news so they can answer patient questions and foster informed conversations.

"The good news is that ACC has been discussing many of these issues with members for years and providing opportunities to share ideas and best practices through meetings, roundtables and online communities," says Berlacher. "As with most challenges, there is unlikely to be a single solution, but rather smaller solutions accompanied by broader changes across the health care system. ACC's role as a convener of members, industry partners, community leaders, and educators remains critical to driving meaningful progress." ■

Continued from previous page

Workforce Pressures: When the System Is Stretched

Few themes in *The Pitt* resonate more strongly with cardiovascular professionals than the reality of working within an overstretched health care system. The series portrays clinicians caring for increasingly complex patients while managing staffing shortages, administrative burdens and limited resources.

Those same pressures are playing out across cardiovascular medicine.

"The workforce challenge in cardiology is showing up at every point in the care continuum," says **Thomas Maddox, MD, MSc, FACC**, who has led ACC workforce strategic efforts in recent years.

Patients are living longer and often require care from multiple specialists, while the teams responsible for coordinating that care are being asked to do more with limited resources. The result can be delayed access to appointments, imaging studies, procedures and follow-up care.

"When teams are overextended, the system naturally drifts toward episodic, reactive care," Maddox says. "That is hard on patients, and it is hard on clinicians."

Workforce shortages are often compounded by administrative complexity and technology-related demands. As teams become stretched, the resulting strain can affect access, continuity and clinician well-being.

"When staffing is inadequate, clinicians carry more cognitive and emotional load," says Le. "When workflows are fragmented, technology can add clicks without adding capacity. When teams are exhausted, access worsens and continuity suffers. Patients then return sicker, which further increases workload."

> The strongest systems empower the entire cardiovascular team to work at the top of their expertise, support patients across the care continuum, and help every patient achieve the best possible outcome.
>
> Amy E. Simone, PA-C, FACC

Many experts see team-based care as one of the most promising solutions. According to Maddox, successful cardiovascular programs increasingly rely on coordinated teams in which physicians, advanced practice providers, nurses, pharmacists, dietitians and care coordinators work together to manage complex patients.

Le agrees, noting that high-functioning multidisciplinary teams depend on "shared goals, clear roles, psychological safety, reliable communication and mutual respect." He emphasizes that every member of the cardiovascular team contributes expertise that expands the reach and effectiveness of care.

For Simone, the future of cardiovascular care depends on fully embracing that collaborative approach.

"No single clinician can meet the growing demands of cardiovascular disease alone," she says. "The strongest systems empower the entire cardiovascular team to work at the top of their expertise, support patients across the care continuum, and help every patient achieve the best possible outcome."

Addressing workforce challenges will require more than filling open positions. It will require rethinking how care is delivered, reducing unnecessary administrative burden, supporting long-term career development and building systems that enable clinicians to thrive – something the ACC remains committed to doing as part of its Strategic Plan.

"One of the lessons highlighted in *The Pitt* is that workforce challenges cannot be separated from the broader health care system," says Khandewal. "The ACC recognizes that reality. Whether through clinician well-being and culture initiatives, health equity efforts, leadership development, team-based care, digital transformation, advocacy, or collaboration with Chapters and partner societies, we are pursuing coordinated solutions that strengthen both the workforce and the care patients receive."

As cardiovascular medicine continues to evolve, the future of care will depend not only on scientific and technological advances, but also on creating environments where clinicians can thrive and patients can access the care they need. *The Pitt* may be fiction, but for many health care professionals, the realities it portrays are all too real. ■

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Building Confidence and Competence: A Structured Educational Pathway For Cardiovascular APPs

As cardiovascular workforce shortages continue to intensify, health systems are increasingly relying on advanced practice providers (APPs) to expand access, improve efficiency and support team-based care delivery. However, the successful integration of APPs requires more than staffing solutions. According to **Nicole Lohr, MD, PhD, FACC**, and **Lisa Findley, DNP, ACNP-BC, CCK, FACC**, both from UAB Medicine in Birmingham, AL, intentional education and competency development are also critical.

Speaking at MedAxiom's CV Transforum in Ponte Vedra Beach, FL, earlier this year, Lohr and Findley noted that while APPs are increasingly recognized as key members of team-based care models, educational pathways for APPs remain highly variable. As a result, APPs entering cardiovascular practice face a knowledge and skills gap that must be addressed through structured postgraduate education, mentorship and competency frameworks.

Lohr and Findley propose a four-part pathway centered around learning, assessment, validation and continued development that would provide a framework for moving APPs from early confidence-building to measurable competency and ongoing professional growth.

Learn

Structured onboarding and mentoring are the focus of the first phase centered around learning. Using MedAxiom's CV Essentials for APPs course as a roadmap during an APP's first year of cardiovascular practice (or first year of practice within a new program) helps APPs build foundational cardiovascular knowledge while giving organizations a standardized, streamlined onboarding experience.

Designed specifically for APPs newly entering cardiology practice, CV Essentials offers up to 50 CME credits and develops competency in cardiovascular diagnosis, clinical decision-making and guideline-directed management. Building these competencies can reduce onboarding variability, accelerate the transition to confident practice, ease the burden on physician mentors and preceptors, and improve consistency across care teams, say Findley and Lohr.

Assess

ACC's ACCSAP is key to the next step involving assessment – helping APPs expand competencies, reinforce broad cardiovascular knowledge, identify gaps and simulate board-style testing experiences before pursuing certification.

Offering up to 185 CME and 185 AAPA credits, the curriculum design can help APPs stay current,

CV Essentials' Four-Part Pathway

1. **Learn (Year 1):** Build foundational cardiovascular knowledge through MedAxiom's Cardiovascular Essentials for APPs course. **Scan the QR code** to learn more.
2. **Assess (Years 1-2):** Expand cardiovascular knowledge and identify competency gaps through ACC's Adult Clinical Cardiology Self-Assessment Program (ACCSAP). **Scan the QR code** to learn more.
3. **Validate (End of Year 2):** Demonstrate broad cardiovascular knowledge through ACC's Certified Cardiovascular Knowledge Examination (CCKE). **Scan the QR code** to learn more.
4. **Continue Developing (Ongoing):** Sustain professional growth through ACC and MedAxiom educational conferences and digital offerings.

enhance their expertise and develop in the areas outlined in ACC's Clinical Competencies for NPs and PAs. Offering in-depth content and board-style questions with rationale and references, ACCSAP's exams are similar with the questions in ACC's Certified Cardiovascular Knowledge Examination (CCKE).

Validate

The final step in the pathway is validation using the ACC's CCKE and ultimately earning the CCK designation. "More than a series of letters behind your name. Passing the exam and earning the CCK is a signal of commitment to a defined standard of care," says Findley.

For individual APPs, the exam validates broad cardiovascular knowledge, demonstrates commitment to evidence-based care and may support leadership opportunities and career advancement. Importantly, passing the exam qualifies individuals seeking to become an AACC and helps with progression toward FACC status. For health systems, hospitals and other organizations, the CCKE provides an objective benchmark to help standardize competency expectations across APP teams.

Based on their experiences at UAB, Lohr and Findley emphasize the importance of program directors clearly communicating both the professional value of the CCKE and its role in strengthening team-wide competency. They also highlight the need for institutions to provide APPs with the support necessary to prepare for the exam, including funding the learning and assessment portions of the pathway.

"If you're going to use the CCKE as a benchmark, you have to provide the runway and the resources," says Findley. "When APPs feel supported, educated and empowered to practice at the top of their license, everyone benefits." ■

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Indiana University Health Arnett Hospital
Indiana University Health Ball Memorial Hospital
Indiana University Health Bloomington
Indiana University Health Fishers Hospital
Indiana University Health Methodist Hospital
Indiana University Health North Hospital
Indiana University Health West Hospital
Inova Alexandria Hospital/Inova Schar Heart and Vascular
Inova Fairfax Medical Campus/ Inova Schar Heart and Vascular
Inova Loudoun Hospital/Inova Schar Heart and Vascular
Inspira Medical Center - Mullica Hill
INTEGRIS Baptist Medical Center
INTEGRIS Southwest Medical Center
Intermountain Health Good Samaritan Hospital
Intermountain Health Lutheran Hospital
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Intermountain Health Saint Joseph Hospital
Intermountain Health St. James Hospital
Intermountain Health St. Mary's Regional Hospital
Intermountain Health St. Vincent Regional Hospital
Jackson Madison County General Hospital
Jamaica Hospital Medical Center
Jersey Shore University Medical Center
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JFK University Medical Center
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LewisGale Medical Center
LewisGale Hospital Montgomery
Lexington Medical Center
Liberty Hospital
Logan Health
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Luminis Health Anne Arundel Medical Center
Lutheran Hospital
Magnolia Regional Health Center
Marshfield Medical Center
Marshfield Medical Center - Weston
Maury Regional Medical Center
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Medical Center Hospital
Medical Center of the Rockies
Medical City Decatur
Memorial Hermann Cypress Hospital
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Memorial Hermann Memorial City Medical Center
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Memorial Hermann Pearland
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Memorial Hospital Shiloh
Mercy Fitzgerald Hospital
Mercy Gilbert Medical Center
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MercyOne Waterloo Medical Center
Merit Health Wesley Medical Center
Methodist Healthcare - Olive Branch Hospital
Methodist Hospital University
Methodist Hospital/Methodist Children's Hospital
Methodist Texsan Hospital
Mississippi Baptist Medical Center
Mon Health Medical Center
Monument Health
MOSAIC Life Care
Moses H. Cone Memorial Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Hospital
MultiCare Tacoma General Hospital
MyMichigan Medical Center - Midland
Naples Comprehensive Health
National Park Medical Center
Nebraska Medicine
NKC Health
North Mississippi Medical Center
NorthBay Medical Center
Northeast Methodist Hospital
Northwest Health - La Porte
Northwest Medical Center - Bentonville
Northwest Medical Center - Springdale
Novant Health Rowan Regional Medical Center
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Sanford Bemidji Medical Center
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Sentara Williamsburg Regional Medical Center
Shannon Medical Center
Southern Ocean Medical Center
Southern Regional Medical Center
Southwest General Health Center
Spartanburg Regional Healthcare System
St. Claire Regional Medical Center
St. Francis Medical Center - LA
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St. Joseph's Hospital - GA
St. Luke's Health - Memorial - Lufkin
St. Luke's Health - The Woodlands Hospital
St. Luke's Hospital
St. Mary's Medical Center - MO
St. Mary's Medical Center - WV
Stormont Vail Health
Summa Health System - Akron Campus
Sutter Memorial Medical Center Modesto
Temecula Valley Hospital
The MetroHealth System
The Mount Sinai Hospital
The University of Kansas Health System
The University of Toledo Medical Center
Trinity Medical Center - Rock Island
Trinity Regional Medical Center
Tucson Medical Center
UCH - Memorial Hospital
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WakeMed Cary Hospital
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UnityPoint Health - Meriter
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AdventHealth Porter
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Antelope Valley Medical Center
Arnot Ogden Medical Center
Arrowhead Regional Medical Center
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St. Mary Medical Center
St. Mary's Health Care Systems
Stony Brook University Hospital
The Finley Hospital
UCHealth Memorial Hospital North
University of Arkansas for Medical Sciences
University of Louisville Health - South Hospital
University of Miami Hospital and Clinics
Vanderbilt Tullahoma-Harton Hospital

Getting to Goals: Applying the 2026 Dyslipidemia Guideline in High-Risk Patients

New evidence-based risk assessment and treatment algorithms were introduced in the 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/ AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia.[1] Some of the biggest changes impact primary prevention, including 1) the addition of chronic kidney disease (CKD) and HIV as groups with statin indications without the need for further risk assessment (joining those with diabetes or LDL-C ≥190 mg/dL); 2) risk assessment for all others without ASCVD based on PREVENT algorithms starting a decade earlier at age 30; 3) new cut-offs for low-, borderline-, intermediate- and high-risk primary prevention; 4) additional personal risk factors that justify consideration of statin initiation in borderline and intermediate

Table 1. Lipid Goals Across Risk Groups

High-Risk Groups	LDL-C Goals	Non-HDL-C Goal	Class of Recommendation
Primary Prevention			
High risk (10-Yr Risk ≥10%)	<70 mg/dL + ≥50% reduction	<100 mg/dL	COR 2a [COR 1 ≥50% reduction]
Diabetes			
Age 40-75, No ASCVD	<100 mg/dL + ≥30% reduction	<130 mg/dL	COR 1
With multiple ASCVD risk factors	<70 mg/dL + ≥50% reduction	<100 mg/dL	COR 2a
Severe Hypercholesterolemia			
LDL-C ≥190 mg/dL No FH, No ASCVD, No risk factors	<100 mg/dL	<130 mg/dL	COR 1
With HeFH, risk factors or subclinical atherosclerosis	<70 mg/dL	<100 mg/dL	COR 1
With clinical ASCVD	<55 mg/dL	<85 mg/dL	COR 1
Subclinical Atherosclerosis			
CAC 1-99, or mild incidental CAC	<100 mg/dL + ≥30% reduction	<130 mg/dL	COR 2a
CAC ≥100-299	<70 mg/dL + ≥50% reduction	<100 mg/dL	COR 1
CAC ≥300-999	<70 mg/dL + ≥50% reduction [<55 mg/dL optional]	<100 mg/dL [<85 mg/dL optional]	COR 1 [COR 2a LDL-C <55 mg/dL]
CAC ≥1,000	<55 mg/dL + ≥50% reduction	<85 mg/dL	COR 1
Clinical ASCVD			
Not very high risk	<70 mg/dL + ≥50% reduction [<55 mg/dL optional]	<100 mg/dL	COR 1 [COR 2a LDL-C <55 mg/dL]
Very high risk	<55 mg/dL + ≥50% reduction	<85 mg/dL	COR 2a

CAC, coronary artery calcium; FH, familial hypercholesterolemia; HeFH, heterozygous familial hypercholesterolemia. Intensity of goal LDL-C reduction increases with darker colors: Yellow <100 mg/dL, Orange <70 mg/dL, Dark Pink <55 mg/dL.

risk groups; and 5) recommendations for expanded coronary artery calcium (CAC) testing and universal Lp(a) screening.

Other guideline changes, however, will have larger impacts in secondary prevention. These include the reestablishment of absolute goals for LDL-C <70 mg/dL and non–HDL-C <100 mg/dL in all with subclinical or clinical ASCVD, and a more ambitious LDL-C goal of <55 mg/dL and non–HDL-C goal of <85 mg/dL in 'very high risk ASCVD.' In addition, there is 1) a reemphasis on achieving at least a 50% reduction in LDL-C in most high-risk groups; 2) an optional Apo-B goal in conditions associated with increased remnant lipoproteins; 3) new medication and lifestyle recommendations for residual hypertriglyceridemia; and 4) a greater emphasis on nonstatin add-on therapies for lipid goal attainment, especially in the high risk.

The return to absolute lipid goals (de-emphasized after the 2013 guideline) is a welcome reset for those with ASCVD. Recent U.S. claims and registry data show that large proportions with established ASCVD continue to remain above previously recommended LDL-C goals even after a myocardial infarction (MI),[2-4] a gap linked to higher event rates and health costs. Although a complex interplay of clinician, patient, health system and policy/regulatory barriers drives 'therapeutic inertia' in lipid management,[5,6] many scalable solutions now exist for overcoming these.

> "We now have lots of tools in the toolbox for achieving target LDL-C levels compared to a decade ago. We have multiple treatment classes to choose from, just like we do for managing blood pressure."
>
> Roger S. Blumenthal, MD, FACC

Table 2. Criteria For Very High-Risk ASCVD

(2 Major Events or 1 Major Event + 2 High-Risk Conditions)

Major ASCVD Events
- Recent ACS (within the past 12 months)
- History of MI (other than the recent ACS event)
- History of ischemic stroke
- Symptomatic PAD (history of claudication with ABI <0.85, or previous revascularization or amputation)

High-Risk Conditions
- Age ≥65 years
- Heterozygous familial hypercholesterolemia
- History of prior CABG or PCI (outside of the major ASCVD event)
- Diabetes
- Hypertension
- CKD (eGFR 15-59 mL/min/1.73 m^2)
- Current smoking
- Persistently elevated LDL-C ≥100 mg/dL despite maximally tolerated statin therapy and ezetimibe
- History of congestive heart failure

ABI, ankle-brachial index; ACS, acute coronary syndrome; CKD, chronic kidney disease; MI, myocardial infarction; PAD, peripheral arterial disease.

Overcoming Clinician Barriers to Lipid Goal Attainment

Gaps in clinician knowledge-training coupled with time constraints and uncertainty about treatment benefits vs. risks have been linked to therapeutic inertia and slow lipid guideline adoption.[5] Lack of lipid testing by clinicians also has been identified in large numbers of patients not achieving LDL-C goals, while the converse, checking and providing follow-up lipid levels, has been found to improve lipid goal attainment.[6]

Clinicians can overcome these barriers by knowing the new guideline's nuanced lipid goals especially across high-risk categories (**Table 1**), disseminating them to colleagues, referring providers and patients, and ordering lipid testing and follow-up. Clinicians should also know the new criteria for 'very high-risk ASCVD' (**Table 2**) and document the need for lowering LDL-C to <55 mg/dL and non–HDL-C to <85 mg/dL in this broad patient group.

Patients who question whether low LDL-C poses health risks will benefit from a discussion of the science that supports the 'lower is better' strategy. Institutional laboratories that still flag LDL-C <70 mg/dL as 'low' can usually be engaged to modify the alert.

Additionally, clinicians should know the criteria for Apo-B testing after LDL-C is at goal, which includes residual hypertriglyceridemia and/or diabetes. They should also test

Visit ***ACC.org/CVDPlus*** to download the new CVD Risk Estimator Plus App, which includes the new PREVENT algorithms.

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for and document elevated Lp(a) levels, and if present recommend family screening and, if ≥125 nmol/L or ≥50 mg/dL, recommend early control of all risk factors including LDL-C to <70 mg/dL. Note, if ASCVD is also present and LDL-C and non–HDL-C are above goals on maximally tolerated statin therapy, a Class I recommendation now exists to add a PCSK9 monoclonal antibody,[1] which also lowers Lp(a) modestly.

Finally, clinicians should know add-on lipid therapies and sequencing strategies (**Box**). Note that patients with suboptimal diets and LDL-C and non–HDL-C levels only slightly above goals are likely to achieve them by dietary measures (reducing saturated fat and increasing fiber-rich plant foods), with referral to a dietitian if needed also a recommendation of the new guideline. In contrast, those practicing healthy diets with high baseline LDL-C and/or very large gaps in goal attainment will need combination therapy.

Roger S. Blumenthal, MD, FACC, preventive cardiologist, director of the Johns Hopkins Ciccarone Center for the Prevention of Cardiovascular Disease and lead guideline author notes, "We now have lots of tools in the toolbox for achieving target LDL-C levels compared to a decade ago. We have multiple treatment classes to choose from, just like we do for managing blood pressure."

Overcoming Patient Barriers to Lipid Goal Attainment

Patient barriers to lipid goal achievement are significant and include perceived or real 'statin attributed muscle symptoms' (SAMS); lack of understanding of the treatment rationale; interacting medications or comorbidities that

ADD-ON LIPID TREATMENTS AND SEQUENCING STRATEGIES

Statins are first-line agents for lipid lowering, except when triglycerides (TGs) are ≥1,000 mg/dL. Treatment intensification with the LDL-C lowering agents below is indicated when LDL-C or non–HDL-C are not at goals on maximally tolerated statin therapy and a healthy diet. Treatment with the TG-lowering agents below is indicated first whenever TGs are ≥1,000 mg/dL, or as add-on agents for residual TG elevation after a maximally-tolerated high-intensity statin and diet intervention, with the caveats below.

Cholesterol Absorption Inhibitor Ezetimibe
Lowers LDL-C by a median of 18% as monotherapy and by 25% combined with a statin. Remains the first add-on agent due to its low cost. "Even when a high-intensity statin is taken only 2-3 times per week, adding ezetimibe can reduce LDL-C by 40-50% from baseline," comments Blumenthal. "The recent EZ-PAVE trial adds to existing evidence that adding ezetimibe to a statin reduces LDL-C and ASCVD events," notes Aspry.

ATP-Citrate Lyase Inhibitor Bempedoic Acid
Lowers LDL-C by a median of 40% when combined with ezetimibe, 21-24% as monotherapy, and 17-18% added to a statin. Also reduces hsCRP. Reductions in MACE were demonstrated in CLEAR OUTCOMES.

PCSK9 Inhibitor Monoclonal Antibodies Alirocumab and Evolocumab
Lowers LDL-C by a median of 45-64%. Self-dosed subcutaneously twice monthly. Reduces MACE as monotherapy or added to a statin. For those with severe hypercholesterolemia or ASCVD with elevated Lp(a), adding a PCSK9 inhibitor to statin therapy as the first step in treatment escalation is reasonable, but drug plans may require addition of ezetimibe first. Oral PCSK9 inhibitor enlicitide could broaden use.

PCSK9 Inhibitor Small-Interfering mRNA Inclisiran
Lowers LDL-C by a median of 48-52%. Dosed subcutaneously in a health center twice yearly after year one. Outcomes data are pending. "May be a reasonable option for patients with Medicare, as coverage is quite good," notes Blumenthal.

Angiopoietin-like Protein 3 Monoclonal Antibody Inhibitor Evinacumab
Lowers LDL-C by a median of 49%. Infused once monthly. Approved for patients with homozygous FH.

Bile Acid Sequestrants Colesevelam and Others
Lowers LDL-C 10-27%. Safe in pregnancy. One pre-statin outcomes trial in men demonstrated reduced MACE.

Fibrates Fenofibrate and Gemfibrozil
Lowers TGs 30-50%. First line option when TG is ≥1,000 mg/dL to reduce pancreatitis risk. MACE reduction data for fenofibrate is limited. Avoid gemfibrozil with statins. Avoid both fibrates in CKD.

Omega-3-Fatty Acids Icosapent Ethyl (EPA only) and Omega-3-Acid Ethyl Esters (EPA and DHA)
Lowers TGs 15-61%. Consider for residual TG elevation after statin and lifestyle changes. EPA-only formulation approved to reduce risk of MACE in ASCVD or T2D with TG 150-499 mg/dL.

Scan the QR code for the ACC/AHA Dyslipidemia Guideline and related resources, including a *JACC* Focus issue on the guideline.

limit the use of high-intensity statins; severe hypercholesterolemia at baseline; lifestyle factors that worsen hyperlipidemias; and socioeconomic factors and cost barriers.

SAMS are pervasive. In the 2012 USAGE study of >10,000 statin users, 12% had stopped statins and 62% reported SAMS or other side effects as the principal reason.[7] However, the prevalence of true SAMs is now estimated to be lower, at around 5%, after the 2021 SAMSON and STATINWISE trials showed no significant differences in myalgia during placebo- vs. statin-treatment.[8,9]

Clinicians can address SAMS by 1) knowing the factors that predict true SAMS;[10] 2) reassuring patients that the likelihood is low that symptoms are truly statin-related; 3) offering to tailor therapy and check muscle enzymes with each lipid test; and 4) using low, nondaily doses of the two statins with the longest half-lives (rosuvastatin and atorvastatin) taken with better hydration. Note that some patients will need to fully trust a clinician before agreeing to be rechallenged.

Low patient understanding of the rationale for statin treatment is also common. In the USAGE study, two of three patients who stopped statins reported being unaware that treatment reduces the risk of MI, and a large proportion had read online stories about statins before stopping them.[7] These data underscore the importance of patient education when prescribing statins. "Conveying that statins can help 'keep arteries open' and 'prevent heart attacks' may resonate more than just saying they lower cholesterol," notes **Karen Aspry, MD, MS, FACC**, a lipid specialist, cardiologist, and director of the Lipid and Prevention Program at Brown University Health Cardiovascular Institute. Evidence exists that coronary calcifications and carotid plaque on imaging improve lipid medication usage.[11,12]

Medication interactions and comorbidities also play roles in statin discontinuation. In the USAGE study, large proportions who discontinued statins had been on medications that had potential statin interactions.[7] However, this risk can be mitigated. "Rosuvastatin, pravastatin, pitavastatin and fluvastatin tend to be better tolerated than others due to their mechanisms of metabolism," notes Blumenthal. Low BMIs, CKD, hepatic dysfunction, increased age and being a genetically 'slow metabolizer' can also lead to statin intolerance and discontinuation but can be mitigated by reduced and/or nondaily dosing. These and other solutions can be found in the 2022 NLA Scientific Statement on statin intolerance.[10]

Overcoming Health System and Policy Barriers to Lipid Goal Attainment

Traditional care models that lack infrastructures for disease management and population health management are poorly equipped to improve lipid goal attainment in large panels of patients. However, integrated health systems (i.e., Kaiser, Geisinger and the Veteran Affairs health systems) and academic institutions transitioning to accountable care organizations have successfully utilized clinical information systems and collaborative care (by pharmacists, nurse specialists and nonlicensed trained health personnel) to achieve and maintain improved lipid outcomes.[13-15]

> Conveying that statins can help 'keep arteries open' and 'prevent heart attacks' may resonate more than just saying they lower cholesterol.
>
> Karen Aspry, MD, MS, FACC

Many others have instituted pharmacist support to improve medication access to the growing number of advanced lipid therapies. Maintaining patients on these medications should get easier for all health systems. "The growing availability of programmable EHRs that can detect high-risk patients not at goals, and the growing use of collaborative care for closing these gaps, should improve lipid goal attainment for all," notes Aspry. "However, policy support will still be needed. Now that we have an LDL-C goal again, we must work towards restoring a national outcomes measure for LDL quality."[16] ■

References available with the online version of this article at ACC.org/Cardiology.

The editors-in-chief thank **Karen Aspry, MD, MS, FACC**, and **Roger S. Blumenthal, MD, FACC**, for their substantial contributions to this article.

Inside the Proposed 2027 Medicare Physician Fee Schedule

The Centers for Medicare and Medicaid Services (CMS) released the **2027 Medicare Physician Fee Schedule (PFS) proposed rule** in July, reducing the PFS conversion factor from $33.5675 to $33.1693 for qualifying alternative payment model (APM) participants and from $33.4009 to $32.8409 for nonqualifying APM participants.

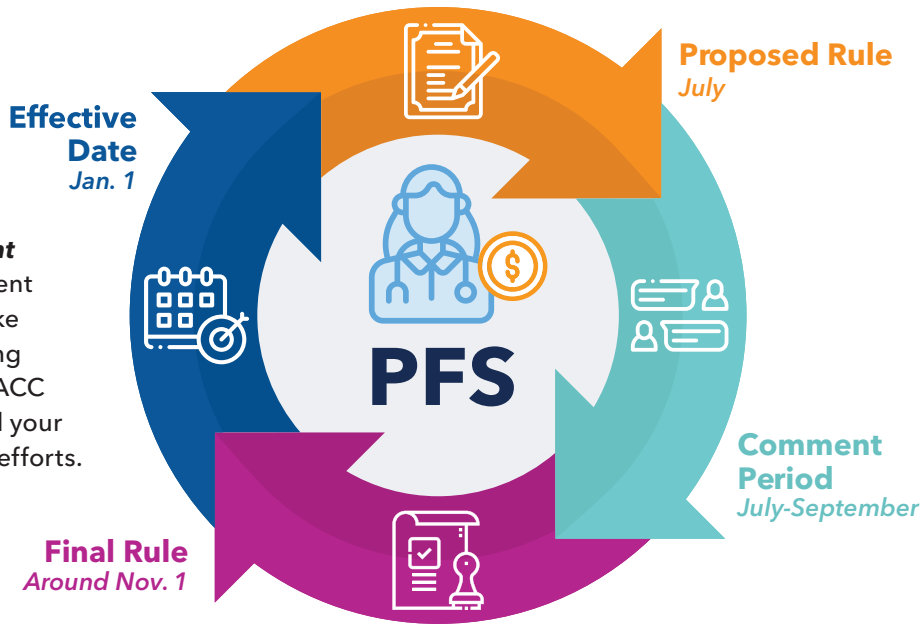
Overall reimbursement for cardiovascular services is projected to increase roughly 1% compared with 2026, including changes to policies and individual service values. Individuals and groups will see different impacts depending on patient populations and services offered. Additional highlights from the proposed rule include:

- Technical refinements and adjustments to the Ambulatory Specialty Model (ASM), including clarifications for ASM participant exceptions due to Taxpayer Identification Number changes or redesignated cardiovascular specialty types.
- Proposed work, practice expense and liability inputs for newly created and revised cardiovascular codes, including cardiac contractility modulation, transcatheter tricuspid edge-to-edge repair, transcatheter tricuspid valve implantation, treatment of incompetent veins, intracoronary drug-coated balloon services, intravascular ultrasound, and left atrial appendage closure.
- A proposal to reduce E/M services billed on same day as a 0-, 10-, or 90-day global period by the same physician or practice by 50%.

For more updates regarding the Quality Payment Program, MIPS Value Pathways, the Medicare Shared Savings Program and Health IT, explore ACC Advocacy's deep dive. ■

Medicare PFS Rulemaking Timeline

Visit ***ACC.org/MedicarePayment*** for the latest on Medicare payment reform, educational resources like ACC's Medicare Payment Building Blocks video series and related ACC Action Alerts where you can add your voice to the College's advocacy efforts.



ACC Submits Feedback on Proposed NCD For TAVR

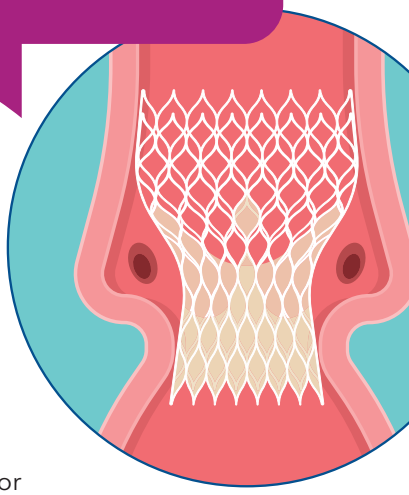
The ACC, along with the Society for Cardiovascular Angiography & Interventions (SCAI) and the Society of Thoracic Surgeons (STS), submitted formal comments to the Centers for Medicare and Medicaid Services (CMS) regarding the proposed decision memo for the National Coverage Determination (NCD) for TAVR.

The letter calls for targeted updates to the proposed policy, supporting patient safety, evidence-based care, nationally consistent quality standards and robust clinical data collection.

Recommendations made by the societies include:

1. **Preserve the multidisciplinary heart team model** by explicitly requiring evaluation of eligible patients with severe aortic stenosis (AS) by both an interventional cardiologist and a cardiac surgeon and maintaining collaborative decision-making as a required component of care.
2. **Maintain a targeted Coverage with Evidence Development (CED) pathway for patient populations where important evidence gaps remain**, including bicuspid AS, valve reintervention, asymptomatic severe AS, aortic regurgitation and moderate AS.
3. **Maintain mandatory participation in a national audited registry**, such as the STS/ACC TVT Registry, and clarify how registry participation may be used to satisfy CED requirements and support quality measurement requirements.
4. **Preserve nationally standardized approaches to quality measurement, benchmarking and continuous quality improvement** through registry participation and externally benchmarked performance assessment.

> TAVR's success has been built on multidisciplinary heart team decision-making, participation in audited national registries like the STS/ACC TVT Registry, and rigorous quality oversight.
>
> Roxana Mehran, MD, FACC



5. **Adopt a programmatic approach to facility and operator requirements** that prioritize institutional performance, multidisciplinary infrastructure and quality outcomes over rigid operator volume thresholds alone.

"TAVR's success has been built on multidisciplinary heart team decision-making, participation in audited national registries like the STS/ACC TVT Registry, and rigorous quality oversight," says ACC President **Roxana Mehran, MD, FACC**. "As CMS considers updates to the TAVR [NCD], the ACC, in collaboration with our partner cardiovascular societies, supports modernizing the policy while preserving these proven safeguards and creating a flexible pathway to evaluate new technologies and indications, ensuring all patients have access to high-quality, evidence-based care." ■

Hospital OPPS and ASC Proposed Rule Highlights

The **2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule** released in July proposes a 2.4% increase to OPPS payment rates that reflects a market basket update of 3.2% reduced by a productivity adjustment of 0.8%.

The proposed rule continues to move services off the inpatient-only list and add services to the ASC covered procedure list, adjusts ambulatory payment classification groupings, updates the ASC and OPPS quality reporting programs, and adds a provision to pay off-campus imaging services at the PFS rate, among other proposals. Read about provisions of note on *ACC.org*. ■

Heart House at 20: A Home For the Future of Cardiovascular Care

This September, the ACC celebrates the 20th anniversary of Heart House, its iconic headquarters at 2400 N Street NW in Washington, DC – a milestone that reflects two decades of growth, influence and service to the global cardiovascular community.

The move to Washington in September 2006 marked a pivotal chapter in the College's history. Having outgrown its long-time headquarters in Bethesda, MD, the ACC recognized the need to be closer to policymakers, regulators and strategic partners shaping the future of health care.

ACC Past President **Michael J. Wolk, MD, MACC**, described the reasons behind the move in a 2005 *JACC* Leadership Page, noting that establishing Heart House in a prominent Washington location would position the ACC as the preeminent cardiovascular professional association, a trusted heart health authority, a key voice with the federal government, and a coalition builder among health care organizations, lawmakers, government agencies and other stakeholders.

These reasons haven't changed. Over the last 20 years, Heart House has served as the hub for advocacy, education and scientific exchange. It has also helped to establish the ACC as a trusted convener, providing a place for ACC members, federal officials, regulators, industry partners and sister societies to exchange ideas, build consensus and advance solutions for transforming cardiovascular care for all.

"Heart House has evolved into far more than a headquarters building. It is a symbol of who we are and where we are going," says ACC CEO **Cathy Gates**. "Not only is Heart House the place for ACC members to come home, it is a catalyst for collaboration and for advancing our vision of a world where science, knowledge and innovation optimize patient care and outcomes worldwide." ■

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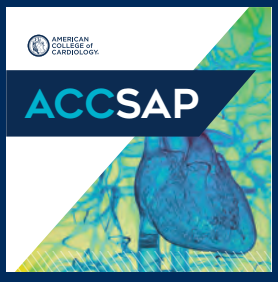

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