Wisconsin
CHAPTER

2009
Spring Issue

Wisconsin Chapter American College of Cardiology

WC-ACC

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ACC's 60th Anniversary Celebration & Chapter Reception

The ACC celebrates its 60th Anniversary with a celebration in appreciation of ACC members, chapters and partners.

Join us this weekend at the
Peabody Hotel, International Ballroom
Sunday, March 29
6:30-10:00 p.m.

for entertainment including a live band, NBA Orlando Magic Dancers and magicians, food, drinks and fun as we mark our 60th Anniversary!

Don't miss your opportunity to network with your
ACC Member Communities from 6:30 – 7:30 p.m.:

ACC Chapters
Adult Congenital and Pediatric Cardiology Section
Cardiac Care Associate Members
Fellows in Training Members
International Guests
Interventional Scientific Section
Women in Cardiology Section

Congratulations to the Wisconsin Chapter

The ACC has developed foundation objectives for Chapters as well as additional broadening goals to attain. The Chapter Executives and the Governors are challenged to achieve certain objectives annually.

The Third Annual ACC Chapter Recognition Program was held in early 2008, and during the January Leadership Forum in Washington DC, the Wisconsin Chapter was awarded recognition from among the nineteen others in the Grande membership category.

The ACC specifically recognized that the chapter developed its' very active FIT and CCA Committees in 2008 which resulted in a high level of participation at the Annual Meeting.

Govenor, Dr. Matthew R. Wolff, M.D., F.A.C.C. and Chapter Executive Jennifer Rzepka accept the 2008 Chapter Award on behalf of the Wisconsin Chapter.

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Improving the STEMI System of Care

The American Heart Association has launched Mission: Lifeline, its national community-based initiative aimed at quickly activating the appropriate chain of events critical to opening a blocked artery to the heart that is causing a heart attack.

"Mission: Lifeline is our newest tool in fighting disability and death caused by heart attack and stroke," said Raymond J. Gibbons, M.D., American Heart Association president, at the launch of Mission: Lifeline.

"To improve their outcomes from a heart attack, patients need to recognize heart attack symptoms and immediately call 9-1-1 for emergency assistance. From that starting point, this critical chain of events must move quickly and appropriately so that we can open the blocked artery to their heart and restore blood flow to the heart muscle. This initiative will seek to improve quality and speed in many steps of this sequence of care for heart attack patients."

The American College of Cardiology enthusiastically supports the goals and implementation of Mission: Lifeline and the American College of Cardiology Wisconsin Chapter is committed to working with Mission: Lifeline – Wisconsin on our common goal of improving STEMI systems of care in Wisconsin. Both the ACC and AHA believe our common goal can not be practically realized without the participation of our ACC Wisconsin Chapter and its leadership.

Here in Wisconsin activities are underway marking the first year of Mission: Lifeline – Wisconsin. In the fall 2008 the AHA EMS STEMI Assessment survey was fielded across the country and in Wisconsin achieved an 80% rate of return from Wisconsin EMS agencies. In February 2009 the AHA released preliminary national findings of one of the nation's largest national surveys of EMS systems. "We were encouraged that more EMS systems than anticipated had vehicles equipped with 12 lead ECGs, devices that diagnose STEMI and other heart attacks," said Robert E. O'Connor, M.D., chair of the American Heart Association's Mission: Lifeline Emergency Cardiovascular Care task force. "However, we found the need for better systems to allow EMS to transmit data from ECGs and activate the cath lab on the way to the hospital and for policies allowing them to take patients to the facility able to provide appropriate care, whether it's the closest facility or not."

In May 2009 the initial Mission: Lifeline – Wisconsin stakeholder meeting will be held and with input from task force members actions for the Wisconsin plan will be identified. ACC Wisconsin Chapter Governor, Dr. Matt Wolff, will chair the Mission: Lifeline – Wisconsin task force. Dr. John Phelan, Chair, Dean & St. Mary's Cardiac Center, Dr. Tim Henry, Mission: Lifeline National Task Force, and Brian Litza, Section Chief, Office of EMS, Wisconsin Department of Health will be presenting at the May meeting.

Our Wisconsin STEMI systems of care are encouraged to complete a survey and register their system with Mission: Lifeline at http://www.americanheart.org/missionlifeline.

Mission: Lifeline is based on the findings of a group of key experts and stakeholders the association convened in March 2006 to develop a plan for improving care for ST-elevation myocardial infarction (STEMI), the type of heart attack caused by the sudden, total blockage of a coronary artery. The findings and recommendations of this workgroup were published in May 2007 and appear online in Circulation: Journal of the American Heart Association.

continued on next page

New Health IT Resources Available

The Centers for Medicare and Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ) recently released new tools to assist medical practitioners in adopting health information technology (HIT) and to participate in the new CMS e-prescribing incentive program.

CMS released "**Medicare's Practical Guide to the E-Prescribing Incentive Program**," which provides an overview of the program and how to participate. CMS also released the **technical specifications for e-prescribing systems** that must be present to qualify for the program. Under new Medicare law, beginning on Jan. 1, 2009, physicians who successfully e-prescribe will receive incentive payments of 2 percent of Medicare-allowed charges. The size of the payment will decrease to 1 percent in 2011-2012 and 0.5 percent in 2013. Those who have not adopted e-prescribing by 2012 will be penalized by 1 percent of Medicare-allowed charges, with the penalties size growing in 2013 and beyond.

For a copy of either document listed in bold, please refer to the attachments, or contact the WC-ACC Office: info@wcacc.org / 414-755-6295

Meanwhile, AHRQ's "Health IT Adoption Toolbox," which is in a question-and-answer format, includes information on planning, executing and evaluating the implementation of HIT. More information, direct links, and tools to assist physicians participate in this program are available on ACC Web site at: http://www.acc.org/HealthIT.

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Improving the STEMI System Continued

while most of the 865,000 heart attacks that occur each year are non-ST elevation heart attacks that are not easy to recognize early, ST elevation heart attacks can be quickly recognized and treated to reduce heart damage. A STEMI heart attack carries a substantial risk of death and disability and calls for a quick response on many fronts. Although Mission: Lifeline is focusing on improving the system of care for the nearly 400,000 people who suffer from a STEMI heart attack, improving that system will ultimately improve care for all heart attack patients.

The opportunity for improvement in STEMI care delivery is great, as evidenced by these facts:

- Close to 400,000 people suffer from a STEMI heart attack (ST-elevation myocardial infarction), which carries a substantial risk of death and disability.
- 30 percent of STEMI patients fail to receive percutaneous coronary intervention (PCI) or clot-busting drugs.
- Of those who receive clot-busting drugs, fewer than half are treated with a door-to-needle time of 30 minutes or less.
- 70 percent of the STEMI patients who are not eligible for clot-busting therapy fail to receive PCI, the only other reperfusion option.
- Of those who receive PCI, only 40 percent are treated with door-to-balloon times within 90 minutes, as recommended by the American College of Cardiology and the American Heart Association.
- In 2004, the median time to PCI was 293 minutes, according to The Joint Commission (TJC).
- Of the nearly 5,000 acute care hospitals in the United States, about 2,200 have heart catheterization laboratories and only 1,200 of those are capable of performing PCI, according to the summary of last year's STEMI systems of care conference proceedings. This means that 75% of the nations hospitals are not capable of performing life-saving PCI for STEMI patients. *Reference: Rosamond W, Flegal K, Friday G, et al. Heart disease and stroke statistics–2007 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Circulation. 2007;115:e69-171.*

The challenges to delivering timely, appropriate STEMI care are multiple and complex, involving patients, physicians, emergency medical services systems, hospitals and the community at large. By bringing together healthcare resources into an efficient, synergistic system, improvements in the overall quality of care will occur. The needs of heart attack patients will be met throughout the continuum of care – from the time patients experience symptoms and enter the STEMI system, throughout each aspect of the system, and after returning to the local community and to their physician for rehabilitative care.

For more information please contact: Victoria O'Brien, Director, State Health Alliances - Wisconsin, American Heart Association, at Victoria.obrien@heart.org or 414-227-1407 or Anne Simaytis, Communications Director, American Heart Association, at anne.simaytis@heart.org or 414-227-1448.

FIT Update

by Thomas Lewandwoski, M.D., F.A.C.C.

After a slow start and a little start up grant from the National ACC, the Wisconsin Fellow's Society started making strides. This coming year, we hope to keep the momentum going and expand participation. With that in mind, we are still looking for a representative from the Children's Hospital to act as the liaison for the Pediatric Fellows. Fellow participation at the annual conference was lower than expected, so our first goal for the year will be to actually get our Fellows registered for the Wisconsin Chapter meeting. Watch for registration information in the next newsletter and online soon.

Before jumping into what else we look to accomplish this year, I would like to take some time to thank and congratulate all of the FITs who participated in our poster/abstract competition and our vignette competition. Your excitement and energy were wonderful. Specifically, we would like to congratulate Dr. Miguel Leal, winner of the vignette competition.

For the coming year, our additional goals include:

- Build relationships with FIT program Directors and fellows to foster positive and consistent contact between training programs
- Increase FIT participation in the annual state meeting
  - Specific to this we will expand our vignette competition to local competitions at each program with two submissions from each program going to the annual conference.
  - Continuation of our Poster/Abstract competitions and assist with submission of the abstracts to the appropriate annual national meeting and medical journals
- Increase visibility of our Society
  - Additional web page located on our state's web page: www.wcacc.org
  - Increase FIT networking through coordination of social events
  - Wisconsin FIT Facebook page.
- Develop a Spring Standalone FIT program tailored specifically to FITs

We have a lot of goals, but look forward to seeing what we can accomplish together.

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ACC.09

Join the American College of Cardiology this weekend for its 58th Annual Scientific Session in Orlando on March 29 – 31, 2009. The ACC's Innovation in Intervention: i2 Summit 2009 in partnership with Cardiovascular Research Foundation will be taking place on March 28 – 31, 2009.

ACC.09 and i2.09 feature the latest and most innovative findings in cardiovascular science, as well as the most clinically relevant practical applications. Join us for a two-for-one special: the knowledge of two meetings in one place, for a Full Access discounted price. This meeting is not only an opportunity to see more, learn more, and do more with the most innovative information in the world of clinical cardiology but also offers busy cardiovascular professionals the chance to participate in two meetings that now offer synchronized timing, making it easier than ever to move from session to session within each meeting and between each meeting, so you can access all the education.

Whatever your specialty may be, this joint conference provides all cardiovascular professionals the opportunity to interact with experts from around the world and discuss diverse approaches to similar clinical problems. Oral presentations and state-of-the-art lectures will encourage a tradition of lifelong learning for cardiovascular teams who desire to increase their knowledge on all areas of cardiology and intervention. Plus, see the latest breakthroughs in science in the Late-Breaking Clinical Trial and live case sessions.

Get your Full Access pass to all the education and networking you need. Explore our site for all the information you need on the Education, Exposition, Call for Science, Registration & Housing and more!

Visit www.acc09.acc.org for more details now.

WiCORE Debuts to Rehab Clinicians

by Fred Petillo, Wisconsin Heart Disease and Stroke Prevention Program

How do you do healthcare quality improvement if you don't have a reliable source of data that supports decision making? Fortunately, Wisconsin's cardiac rehabilitation programs don't have to answer that question. Not at least since July 1, 2008. On that date, a new patient registry became available statewide. WiCORE – The Wisconsin Cardiac Rehabilitation Outcomes Registry – is now a reality through the joint cooperation of the Wisconsin Society for Cardiovascular and Pulmonary Health and Rehabilitation (WISCPHR), the Wisconsin Heart Disease and Stroke Prevention Program (HDSP), and the University of Wisconsin Division of Information Technology (DoIT). It was developed through a generous grant from the Centers for Disease Control and Prevention (CDC).

WiCORE is a web-based, HIPAA-compliant, de-identified, patient-level registry that allows cardiac rehab programs to record, trend, and analyze their patient treatments and outcomes. The system even allows a rehab program to compare its results to those of other programs in the State. The system balances flexibility with ease of use, and WiCORE's highly intuitive interface and navigation means that users need very little help learning how to use the system.

The goal of WiCORE is to significantly improve patient outcomes by giving cardiac rehab programs the information technology tools they need to implement continuous quality improvement. WiCORE does this by acquiring more than 250 items of health information about each patient submitted to the registry, and then presenting numerical and graphical summaries of these outcomes. Cardiologists will find WiCORE reports to be a substantial new aid in understanding both individual and group outcomes, and it is our hope that these data will create a new and deeper level of collaboration between cardiologists and cardiac rehab staff. With its extensive demographic data, WiCORE should also find applications in reducing disparities in outcomes among subpopulations.

In the first six months of use, WiCORE attracted 77 subscribing programs out of the 125 in the State. Even better, those programs entered more than 5,000 patient records, and the pace of data entry seems to be increasing. It is safe to say that WiCORE is on track to be one of the most prolific state registries for chronic disease treatment. WiCORE is so successful that it is attracting interest from other states; it currently captures data from programs in Minnesota and as far away as Florida! Although other states have attempted a registry, none have produced a product that is as comprehensive as WiCORE. Wisconsin is even ahead of a national effort to produce a registry, so much so that the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) is looking very closely at the system Wisconsin produced.

For more information, go to https://wicore.wisc.edu and click on "Preview WiCORE" or call Mark Vitcenda at 608-263-6290.

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CAC Committee Report

by Thomas Lewandwoski, M.D., F.A.C.C.

On November 24, 2006, CMS issued the final rule that would implement certain related provisions of the Medicare Modernization Act, including a portion of the Medicare Contracting Reform provision. As part of this, CMS started a transition from Medicare intermediary and carrier contracting authorities which were separate entities for Parts A and B of medicare. The new entities or Medicare Administrative Contractors or MACs would administer both Parts A and B within a jurisdiction or region. Over the last two years contractors were chosen in a pre-determined order.

On September 5, 2007, CMS announced that it had awarded the J5 A/B MAC (Iowa, Nebraska, Missouri,and Kansas) contract to Wisconsin Physicians Services Health Insurance Corporation (WPS). Subsequently, WPS began a process of reviewing all Local Carrier Decision (LCD) coverage policies to assure consistency of coverage between J6 (Illinois, Wisconsin, and Minnesota). Most of the cardiology LCDs were re-reviewed over the last two CAC meetings with essentially no change in the policies. WPS was applying for coverage of J6, however, CMS recently awarded Noridian Administrative Services, LLC (NAS) the contract for the combined administration of Part A/Part B Medicare claims payment in Jurisdiction 6 comprised of Illinois, Minnesota and Wisconsin. NAS will also process home health and hospice claims from providers in Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, U.S. Virgin Islands, Wisconsin and Washington.

Between now and 2010, coverage will be moved from WPS to NAS. Subsequently, several LCDs may again come up for review to maintain consistency across regions. Up till now, the National ACC has not stated what role the CACs will play in the future under the MAC system. A meeting will occur on February 20, 2009 to discuss this and other issue among CAC representatives.

So presently, things are a little up in the air, however, we should know more soon.

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New PHS Clinical Practice Guidelines Offer Tobacco Treatment Roadmap
UW Offers Tobacco Cessation Outpatient Clinic

The U.S. Public Health Service released an update to the Treating Tobacco Use and Dependence Clinical Practice Guideline, providing the most current evidence-based tools to help patients stop tobacco use. More information is available at http://www.ctri.wisc.edu/Researchers/researchers_CPGupdate2008.htm

CCA Update

by Robert Strelka, PA-C

Spring 2009 is upon us and if you feel anything like I do, I can't wait! I realize our economy is turned upside down, but in Wisconsin, it always seems that increased temperatures make the daily grind go a lot easier. Nonetheless, it is a pleasure writing to you again and hope everyone is having a good beginning of the new year.

Now, a few updates regarding Cardiac Care Associates in Wisconsin and from Matt Wolff MD - president of the Wisconsin chapter of the ACC. Dr. Wolff is again pushing for the increased presence of CCA's in Wisconsin. When comparing Wisconsin to other states of similar size, we continue to be among the leaders in CCA memberships.

Regardless, Dr. Wolff is encouraging CCA growth both in memberships as well as participation in the Wisconsin ACC Annual Meeting. Last years meeting was a huge success, but we would like to see an increase in CCA registration and poster abstracts.

The opportunities are endless and the rewards are great, so start thinking now how you could be involved. The CCA committee will also have a conference call soon to identify specific goals for 2009 including the annual meeting.

As mentioned in a previous newsletter, let's make one of our goals in 2009 to recruit a minimum of one new CCA member.

Please remind them of the benefits including:

1. Free access to CardioSource.com
2. Registration discounts for ACC.09 and all ACC Live Programs
3. Reduced prices on ACC products
4. Leadership opportunities
5. CE / CME for most educational programs and
6. Free CARDIOLOGY journal subscription.

Have a great spring and summer and I look forward to seeing you at the fall annual meeting.

Robert Strelka PA-C
CCA Liaison to the WC-ACC Board
robertstrelka@yahoo.com

Wisconsin ACC Chapter Member Profile

There are 438 active ACC members in Wisconsin 33 of which are emeritus, broken down and compared to national as follows:

Member Type		
	ACC Membership	**Wisconsin Chapter**
AA	8.9%	9.2%
AF	0.9%	0.6%
CCA	13.3%	21.4%
FF	65.2%	57.5%
FIT	11.5%	11.1%
MA	0.2%	0.2%

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Medicare Enrollment is Now Available Online in Wisconsin

On December 1st, the Centers for Medicare & Medicaid Services (CMS) announced that Internet-based Provider Enrollment, Chain and Ownership System (PECOS) is available to physician and non-physician practitioners in 15 states and the District of Columbia.

PECOS will allow physicians and non-physician practitioners to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare and check on the status of a Medicare enrollment application via the Internet. CMS will expand access to PECOS over the next two months, and hopes to have the system available nationally by late 2009.

The ACC continues to work with CMS to reduce the administrative burden and cost of the Medicare enrollment process.

For more information, visit the PECOS Web site.
https://pecos.cms.hhs.gov/pecos/login.do

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CCA Spotlight

Case Study

Background
Based on the ED documentation: 52-year-old female who had a strong family history for coronary disease presented to the ED at 0005. She had some intermittent chest pain over the last few months. She was pain free in the ED. EKG was nonischemic. Her chest pain was substernal, with an achy sharp pain that also involved the jaw as well as the left arm. She had no DVT or PE risk factors, and had no pleuritic component to her discomfort. She had a very low suspicion for pulmonary embolus. Her doctor practiced in the East Troy area and did not have privileges at this facility. Was admitted to the chest pain service for further evaluation.

Overview of our Program:
We have had a Rapid Rule out program at our facility for years but in May 2008 – we implemented a new Chest Pain Service where our Cardiology fellows evaluate these patients and patients are directly admitted to our Cardiologists as Observation patients. The goal is help empty out our ED while still rapidly "ruling these patients out" for Cardiac disease or ischemia.

The average length of stay for these patients in the ED is about 4 hours. During this time, initial blood work, EKG & assessment is done. We then implement our Chest Pain order set which facilitates getting the required sets of Cardiac enzymes along with Stress testing. This patient spent 2.5 hours in the ED before transferring up to a bed for further observation & testing.

Blood Work:

Time of Lab	CK-MB	Troponin
01:12 (POC)	< 0.10	1.2
4:45	<0.05	1.6
10:20	<0.05	0.9

EKG:
Normal Sinus Rhythm; Normal EKG with no previous EKG to compare. Follow up EKGs were performed without any acute changes.

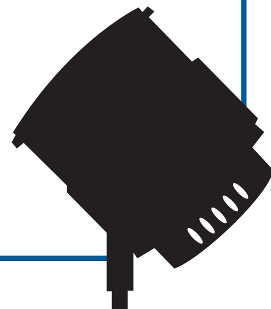
Stress Testing: Stress ECHO
The patient had a baseline EKG, which showed normal sinus rhythm and no other abnormality. The patient exercised for 9.04 minutes on the standard Bruce protocol and target heart rate was achieved. Baseline heart rate was 88 beats per minute. Peak heart rate was 177 beats per minute, which was 102% of maximum predicted heart rate for age. Baseline blood pressure was 120/66 mmHg. Maximum blood pressure was 146/80 mmHg. Maximum workload achieved was 10.10 METS. At peak stress, there were no EKG changes suggestive of ischemia. The patient had a transthoracic echocardiogram, which revealed normal LV cavity size, normal wall motion and normal LVEF. There was evidence of trace tricuspid regurgitation. At peak stress, there was improvement in contractility of all the walls of the LV, decrease in LV cavity size and improvement in LVEF. There were no significant tachycardia or bradyarrhythmias noted.

Conclusions
1. Exercise stress echocardiogram is negative for ischemia by EKG and echocardiogram criteria
2. The patient had good functional capacity.

Discharge criteria were met with follow up instructions provided. Patient was discharged at 1300 from nursing unit for a LOS of 13 hours.

Summary:
By implementing a Chest Pain Service, we have been able to streamline the care of patients who do not have a Cardiologist yet need basic diagnostic testing to rule out CAD. Also, by using standardized Chest Pain order sets, we can ensure that all required testing is done to facilitate the care of the patient. With this process in place, if Stress ECHO testing is performed, our total average LOS is 20.8 hours. This process has allowed us to free up patient beds in the ED, assist with potential diversions of ED cases along with rapidly ruling out cases for CAD.

Angie Schlemm RN, BSN
Aurora St. Luke's Medical Center
Cardiac Systems Analyst
Milwaukee, WI.



ACC Upcoming Events

APRIL

April 1-2, 2009 (ACC Co-sponsored)
First International Cardiovascular Conference:
Focus on the Middle East
Location: Indianapolis, Indiana
Directed by: Douglas Zipes, MD, MACC
Sponsored by: Indiana University School of Medicine

April 16-18, 2009 (ACC Co-sponsored)
The 36th Interpretation and Treatment
of Cardiac Arrhythmias.
Arrhythmia Management for the
Clinician: A Practical Approach
Program #: 1640
Location: Philadelphia, Pennsylvania
Directed by: Peter R. Kowey, MD, FACC
Sponsored by: Main Line Health Heart
Center Lankenau Hospital

April 24-25, 2009 (ACC Co-sponsored)
6th Annual Ponte Vedra Cardiovascular Symposium
Program #: 1946
Location: Ponte Vedra Beach, Florida
Directed by: Michael Koren, MD, FACC;
Daniel Yip, MD, FACC
Sponsored by: Florida Cardiovascular Education Foundation

April 29-May 1, 2009 (ACC Co-Sponsored)
11th Annual Echocardiography Conference: State-of-the-Art 2009
Program #: 1957
Location: New York, New York
Directed by: Rebecca Hahn, MD
Sponsored by: The College of Physicians and Surgeons of Columbia University

MAY

May 7-9, 2009
31st Annual Recent Advances in Clinical Nuclear Cardiology and Cardiac CT Featuring
Case Review with the Experts
Program #: 1853
Location: Washington, DC
Directed by: Daniel S. Berman, MD, FACC; Guido Germano, PhD, MBA, FACC; Jamshid Maddahi, MD, FACC

May 29-30, 2009
Emergency Cardiovascular Care 2009
Building STEMI Systems of Care
Program #: 1697
Location: Chicago, Illinois
Directed by: Christopher B. Granger, MD, FACC; James G. Jollis, MD, FACC; Mayme Lou Roettig, RN, MSN

May 29-31, 2009
7th Annual Cardiovascular Magnetic Resonance Imaging: Updates and Comparisons with Computed Tomography
Program #: 1650
Location: Washington, DC
Directed by: W. Gregory Hundley, MD, FACC

JUNE

June 18-20, 2009
2009 ACCF/SCCT Coronary CTA Practicum
Program #: 1923
Location: Washington, DC
Directed by: Michael Ridner, MD, FACC

June 19-21, 2009
The West Coast Cardiovascular Forum:
Current Insights and Future Directions
Program #: 1683
Location: San Francisco, California
Directed by: Valentin Fuster, MD, PhD, FACC

AUGUST

August 13-15, 2009
2009 ACCF/SCCT Coronary CTA Practicum
Program #: 1906
Location: Washington, DC
Directed by: Allen J. Taylor, MD, FACC, FAHA

August 20, 2009
ABIM Maintenance of Certification Interventional Cardiology Updates 2007 and 2008
Program #: 1896
Location: Dallas, Texas
Directed by: Joseph D. Babb, MD, FSCAI, FACC; James E. Tcheng, MD, FACC, FSCAI, FESC

August 21-23, 2009
Interventional Cardiology Overview and Board Preparatory Course
Program #: 1603
Location: Dallas, Texas
Directed by: Joseph D. Babb, MD, FSCAI, FACC;
James E. Tcheng, MD, FACC, FSCAI, FESC

SEPTEMBER

September 8-13, 2009
The ACCF Cardiovascular Board Review for Certification and Recertification
Program #: 1602
Location: Lake Las Vegas, Nevada
Directed by: Kim A. Eagle, MD, FACC; Patrick T. O'Gara, MD, FACC

September 10-12, 2009
2009 ACCF/SCCT Coronary CTA Practicum
Program #: 1938
Location: Washington, DC
Directed by: Jason H. Cole, MD, MS, FACC

September 10-12, 2009
Arrhythmias in the Real World 2009
Program #: 1693
Location: Washington, DC
Directed by: Peter N. Smith, MD, FACC; Arthur J. Moss, MD, FACC;
Kelley P. Anderson, MD, FACC

September 10 -12, 2009
Heart Valve Summit: Medical, Surgical
and Interventional Decision Making
Program #: 1690
Location: Chicago, Illinois
Directed by: David H. Adams, MD, FACC;
Steven Bolling, MD, FACC; Robert O. Bonow, MD, MACC; Howard Herrmann, MD, FACC

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