



Wisconsin
Chapter
American
College of
Cardiology

WC-ACC

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Thomas J. Lewandowski,
M.D., F.A.C.C.
WC-ACC Governor

I hope this message finds you all enjoying the beautiful Wisconsin Summer. Soon, we will all wonder where the warm temperatures and long days have gone. As the temperature has increased, so has our Chapter activity. Our CCA representative, Judy Nichols, MSN, NP-C, has been working hard in creating a CCA council to help coordinate activities for our CCA members within the state. Not to be outdone, our FITs completed their first activity with a talk from Patrick White from ACC/MedAxiom at Miller Park, which was followed by the game between the Brewers and St. Louis Cardinals on June 10th. They are now organizing activities for the 2011/2012 Academic year. One of our Pediatric members, John S. Hokanson, M.D., F.A.C.C., has been busy working on an initiative with Mended Little Hearts (MLH) regarding pulse oximetry screening. If we have enough interest, I would love to see this become a Chapter focus for our Pediatric colleagues.

Since my last message, our Wisconsin project has been given a name. It is now called, "SMARTCare Deliver." Believe me, that is a lot easier to remember than, "Smarter Management And Resource Use For Today's Complex Care Delivery." You will all be receiving a description of the project in a separate correspondence later this month. Those of you who may be interested in helping out will have ample opportunities to get involved. Each regional Councilor will be collecting feedback, so after reading about the project, feel free to pass on your comments or concerns.

Finally, Silja Majahalme, M.D., F.A.C.C. is working hard on this year's Annual Meeting. This year's meeting will take place on Saturday, October 22nd in Madison. The focus of this year's meeting centers on quality and what that entails within each subspecialty of cardiology. Please save the date and plan to join us!

As always, feel free to contact me if you have any concerns or just want to discuss how the Brewers are doing this year.

Thomas J. Lewandowski, M.D., F.A.C.C.
Governor, Wisconsin Chapter ACC

Wisconsin ACC Chapter Member Profile

Executive Summary

There are 562 active ACC members in Wisconsin, 38 of which are emeritus. They are broken down and compared to national as follows:

Membership Profiles

	ACC Membership	Wisconsin Chapter
AA	9.4%	9.7%
AF	0.8%	.6%
CCA	13.0%	19.7%
Practice Administrator	1.3%	1.1%
FF	64.1%	58.0%
FIT	11.3%	10.7%
MA	0.1%	.2%

SAVE THE DATE

Wisconsin Chapter ACC Annual Meeting

Saturday, October 22, 2011
Madison, Wisconsin



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CCA Update

by Judy Nichols MSN, NP-C



The Cardiac Care Associates welcome Dr. Thomas Lewandowski and the officers and Councilors of the Wisconsin Chapter of the ACC. We look forward to an exciting year under your leadership. As our Wisconsin Chapter continues to grow, I would like to extend an invitation to all of the CCAs to take an active part

in shaping our chapter. In the weeks ahead we plan to convene a special CCA sub group that will discuss chapter goals, and work closely with the Liaison and the Governor to enhance the CCA experience in our state. This sub group will meet approximately 4 times a year via telephone conference, and may include one dinner meeting as well. Networking will primarily be done through email, and the time commitment will be nominal. Our state is rich in cardiovascular knowledge, and we seek to create bonds and communication to all regions. If you are interested in becoming part of this sub-group please contact me and we will welcome you to our group.

Mark your calendars for October 22, 2011 and consider joining us at the annual Wisconsin Chapter meeting. I hope to see you all there!

Judy Nichols MSN, NP-C

nichols.judy@marshfieldclinic.org
Office: (715) 387-4069
Cell: (715) 897-5277

ACC - PAC

The ACC Political Action Committee (ACCPAC) strives to amplify the voice and political power of members of the College.

It is a voluntary, non-profit, unincorporated association, not affiliated with any political party or candidate. ACCPAC exists to provide our members a seat at the table with members of Congress who understand the importance of cardiovascular care. ACCPAC is empowered by its contributors to support both federal candidates and political committees.

For the first time in its history, ACCPAC, during the 2009-2010 election cycle, surpassed \$1 million in voluntary contributions from ACC members around the nation. Reaching this milestone places ACCPAC among the elite physician specialty PACs. One-hundred percent of your personal contributions are used to support the campaigns of members of Congress who will listen to our message aimed at improving health care for patients with cardiovascular disease, facilitating the delivery of cardiovascular services by practicing physicians, and funding cardiovascular research and prevention.

In the last cycle, the WC-ACC raised \$8,255.00
So far in the 2011 cycle, the Chapter has raised \$3,000.00
The WC-ACC aims to exceed the 2010 numbers.

Please contribute to the ACCPAC at www.accpacweb.org



IMPORTANT!

Cuts for Not
E-Prescribing
Coming Soon!

Avoid the 2012 e-prescribing penalty! The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized a new incentive program for eligible professionals who are successful electronic prescribers (e-Prescribers). Practitioners who participated in 2009 and 2010 received bonus payments of 2 percent. Those who participate in 2011 will receive a 1 percent bonus payment. The 2011 reporting period goes from Jan. 1 to Dec. 31, 2011.

Beginning in 2012, physicians will be penalized if they do not successfully participate in the e-prescribing program. However, it is very important to note that CMS will use e-prescribing data from Jan. 1 to June 30, 2011 to determine whose payments are reduced in 2012. In short, this means that anyone not reporting by the end of June 2012 will see all of their 2012 Medicare payments reduced by 1 percent. The ACC has prepared great resources to help you navigate the requirements and not be caught with a penalty come January 2012.

For the latest important information about this reduction, please visit www.cardiosource.org/healthit. There you will see:

- Program details
- FAQs
- A slide set
- Links to an on-demand PINNACLE webinar recorded in mid-March
- Recommendations on e-prescribing systems

Please direct any of your questions on the Medicare e-prescribing program and its requirements to Lisa Goldstein at the ACC office. In the event that she is not available, Rebecca Kelly and Brian Whitman will be able to assist. All members of the Advocacy Division are aware of this pending situation and should be able to help triage, as well.

Any questions on e-prescribing systems and implementation should be directed to ACC's Health IT team.

The ACC office can be reached at (800) 253-4636.

It's Easy to Contribute

1. Visit www.accpacweb.org
2. Click on "Join the PAC"
3. Follow the three simple steps on the screen:
 - Verify your contact information
 - Make your contribution
 - Finalize with electronic signature
4. Then...you're done!

Please join us in making Wisconsin a more powerful presence in the federal legislature through the ACCPAC.



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ACCPAC Join ACCPAC Today!

Committee
for Quality
Cardiovascular
Care

ACC PAC * 2400 N Street, NW, Washington, DC 20037
www.accpacweb.org * 202.375.6397 * 202.375.6847 (Fax)

Please indicate the amount you would like to contribute to ACCPAC:

\$5,000 \$2,500 \$1,000 \$500 \$250 Other _____

NOTE: These amounts are suggestions only. Federal law allows individuals to contribute up to \$5,000 annually to PACs.

Please select preferred contribution method:

My PERSONAL Check Enclosed (Please make checks payable to ACC PAC)

Charge my PERSONAL Visa MasterCard Discover American Express

Monthly deduction amount: _____

Card # _____ Expiration Date: _____

The information below is required to process your contribution:

Name: _____

Home Address: _____

Employer: _____

City: _____ State: _____ Zip: _____

Phone: _____

Check box if you do not want your name publicized in ACC-related materials.

Signature: _____ Date: _____

Contributions to the ACCPAC are strictly voluntary. Federal law requires political committees to report the name, mailing address, occupation and name of employer for each individual whose contributions aggregate in excess of \$200 in a calendar year. I am an American citizen or have been admitted to permanent U.S. residence and this contribution is made in my name. I understand that contributions to ACCPAC are not deductible as a charitable contribution on Federal Income Tax returns.



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Physician Signatures

by *Ellen Berra WPS Medicare*

For medical review purposes, Medicare requires that the author authenticate services provided/ordered. Medicare denies many claims due to the lack of an appropriate signature. Here are some things to keep in mind on signature requirements:

1. The signature must be that of the provider of service. This means the person providing the service whether that is the physician or a non-physician practitioner (NPP). No one else can sign for the physician; this includes another physician in a group, the senior nurse, etc.
2. The signature must be hand-written or electronic. Medicare does not accept stamped signatures.
3. The Centers for Medicare & Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines (DG) for Evaluation and Management (E/M) services require that the provider's signature be legible. If your signature is not legible, please provide a signature log or authentication statement verifying the information. We want to remind providers to keep their signature cards or logs up-to-date. A provider's signature may change over time. We recently saw a denial from the Comprehensive Error Rate Testing (CERT) program when the signature on the card no longer matched the signature on the documentation.
4. The signature of the transcriptionist is not the same as the physician signature. While your office may need or require this information, Medicare does not.
5. If you are using electronic medical records, please verify your system and software products protect against modification. Providers using electronic systems should recognize the potential for misuse or abuse with alternate signature methods.

6. If you are splitting or sharing services between yourself and a NPP, then both parties must sign their portion of the service. The NPP cannot sign for the physician.
7. Physician offices should have a protocol in place to have physicians sign their records within a reasonable time, generally 48 to 72 hours after the encounter, but certainly prior to submitting the claim to Medicare.
8. You cannot add a signature to a record later (this does not include the brief time to transcribe the record), instead use an attestation statement.

Lack of provider signatures causes numerous denials through the Comprehensive Error Rate Testing program (CERT) and medical review process. You can find more information on the signature requirements through the following resources:

WPS Medicare Website: <http://www.wpsmedicare.com>

We have information specific to E/M billing and a video presentation on E/M services.

http://www.wpsmedicare.com/part_b/resources/provider_types/evalmngmnt.shtml

CMS IOM Publication 100-08, Chapter 3, Section 3.4.1.1.D

<http://www.cms.gov/manuals/downloads/pim83c03.pdf>

CMS Fact Sheet: Comprehensive Error Rate Testing (CERT) Signature Requirements

http://www.cms.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Volunteer Today! – We Need You!

As a member of the Wisconsin Chapter ACC you have the unique opportunity to be a voice for your membership section. This year we are forming Committees for the Fellows-in-Training (FIT), Cardiac Care Associates (CCA) and Practice Administrator (PA) members. We hope that you take advantage of this opportunity to meet and work with your fellow cardiology professionals to build a strong bond across Wisconsin to better the cardiology industry as a whole. It is the goal of our incoming Governor, Dr. Thomas J. Lewandowski, M.D., F.A.C.C., that the entire cardiology team be represented.

Each of these Committees will be led by a Liaison to the Board of Directors who will report on the ideas and recommendations from the Committee. Committees will meet for an initial face-to-face meeting to get to know one another and develop the goals for each Committee, then convene primarily by teleconference every two to three months. The primary focus for each will be on expanding the membership base in their category, identifying relevant information to incorporate into the Annual Meeting, and creation of a "landing page" on the web site with content specific to their members needs.

Please consider volunteering your time in 2011.

YES! I am interested in serving on a committee.

- Fellow-in-Training (FIT)
- Cardiac Care Associate (CCA)
- Practice Administrator (PA)

Full name: _____

Practice/Institution: _____

Direct phone: _____

E-mail: _____

Please alert the office of your interest by:

E-mail: info@wcacc.org

Phone: 414-755-6295

Fax: 414-276-7704



Case Study – Sub acute stent thrombosis

Background

64 yo white, married, gentleman with known history of coronary artery disease. He has had coronary artery bypass graft surgery on two occasions. He is status post drug-eluting stent (Endeavor) placement to the LAD and Diagonal artery in October of 2010. He has a history of dyslipidemia, diabetes mellitus, GERD, peripheral vascular disease, hypertension, ongoing tobacco-abuse, obesity with BMI of 36.2, COPD, and has recently been diagnosed with renal cell carcinoma.

Case

In March 2011 the patient was evaluated for gross hematuria and right flank pain. His urinalysis revealed moderate red cells without evidence of bacteria. A KUB was ordered and no renal calculi were appreciated. Spiral CT scan ensued and identified a large right distal ureteral mass. He underwent cystoscopy and was found to have a tumor in the distal urethra and bladder.

The patient called the cardiology office requesting permission to 'go off Plavix' in preparation for elective nephrectomy to treat his carcinoma. Nursing staff reiterated the importance of one year of uninterrupted clopidogrel therapy post drug-eluting placement (last DES was placed 5 months prior). An appointment was offered to the patient to speak with the cardiologist regarding specific recommendations; however the patient declined the appointment.

The patient stopped taking his dual antiplatelet therapy about 2 weeks before his proposed surgery.

In April 2011 the patient underwent right radical nephroureterectomy with excision of bladder cuff, and right pelvic lymph node dissection due to a large right distal ureteral tumor; associated with essentially nonfunctioning right kidney related to obstruction. Later that evening Cardiology was consulted to evaluate the patient who complained of chest pain with elevation of cardiac markers. The patient had epidural anesthesia placed and it was recommended not to restart anticoagulation until about 12 hours after epidural removal.

Data

VS BP 112/63, pulse of 88 regular.
TNI was 68.9 on initial draw and 62.4 subsequently.
Electrocardiogram shows right bundle branch block with old inferior infarct.
Echocardiogram shows inferior wall hypokinesis.

Cath Report

Cardiac catheterization took place the following day. Hemodynamic Data: Left ventricular systolic pressure was 132 mmHg with LVEDP of about 30mmHg. Aortic pressure on pullback was 124/69 mmHg. Left Ventriculogram: Not performed due to renal insufficiency.

Coronary angiography:

Right dominant coronary system.
Left main arises from the left sinus of Valsalva and reveals 10% to 20% stenosis.
Left circumflex coronary artery is occluded proximally with faint bridging collaterals noted.
Right coronary artery is known to be occluded.
Left anterior descending artery is occluded in the distal segment. In the proximal segment, there is a stent in the left anterior descending artery, as well as ostial and proximal segment of diagonal artery. These stented segments have a significant amount of haziness and about 75% stenosis at the bifurcation.
Saphenous venous graft to distal segment of right coronary artery is patent.
LIMA to LAD is known to be atretic from prior angiogram and was not evaluated.
Saphenous vein graft to obtuse marginal branch known to be occluded.

Intervention

Based on angiographic findings, decision was made to proceed with percutaneous intervention of the LAD-diagonal system due to significant amount of haziness, felt likely to be related to subacute stent thrombosis. Kissing balloon angioplasty was performed simultaneously and alternating balloon angioplasties were performed as well. Follow-up angiogram revealed significantly improved stenosis at both sites. Dual antiplatelet therapy was re-started.

Summary

This 64 male underwent drug-eluting stent placement with an Endeavor stent in late October of 2010 and maintained dual antiplatelet therapy until mid April 2011 (approx 5.5 month duration). He suffered a post-operative Non ST segment myocardial infarction due to suspected sub acute stent thrombosis. Although length of antiplatelet therapy status post PCI with drug-eluting stents has been debated, the American Heart Association Science Advisory committee has made recommendations for one year of uninterrupted dual antiplatelet therapy, and deferral of elective surgical procedures during this time frame, in those individuals who have had drug coated stents placed in the coronary arteries.

Conclusion

Subacute stent thrombosis is an infrequent, however very real, complication of treatment with drug eluting stents, especially in patients who require surgery during the year in

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which PCI was performed. Dual antiplatelet therapy is vital in the post drug-eluting stent placement period and many cardiologists screen their patients by asking them about the need for any upcoming medical procedures. However, sometimes unpredicted circumstances will arise that require cessation of dual antiplatelet therapy. Patients who discontinue aspirin and Plavix within 3 – 6 months after drug-eluting stent placement present major treatment challenges. The consequences of subacute stent thrombosis include increased risk of acute myocardial injury and death. Holmes et al. (2007) suggest, “In cases where surgery is required, the surgeon should be consulted to determine the absolute necessity for discontinuing dual antiplatelet therapy.

If at all possible, temporary interruption of clopidogrel therapy (stop 5 days before and restart < 48 h after surgery) perioperatively without discontinuation of daily aspirin therapy (81mg) should be attempted” (p. 116). This particular patient opted to discontinue his dual antiplatelet therapy without consulting with his cardiologist. In retrospect, he described that the fear of cancer and his desire to have it removed from his body fueled his choice to stop

the medications prematurely.

Had the patient or his surgeon consulted with cardiology prior to the event, perhaps a more timely discontinuation of the therapy (5 days instead of 2 weeks) may have lead to a more favorable outcome.

Cardiology groups need to be proactive in describing the potential risks related to abrupt cessation of dual antiplatelet therapy to patients and other medical professionals. Open lines of communication must be established between patients, primary care providers and surgeons in the year following drug-eluting stent placement. We continue to look to the future for advances in stent platforms and medications that may increase the long-term safety of drug eluting stents.

Holmes, D., Kereiakes, D., Laskey, W. Colombo, A., Ellis, S., Henry, T., Popma, J., Serruys, P., Kimura, T., Williams, D., Windecker, S., Krucoff, M. (2007). Thrombosis and drug-eluting stents. Journal of American College of Cardiology, 50, 109-118.

Invitation to Participate:

Cardiologist-for-a-Day Program in Wisconsin

Every day Cardiology professionals are faced with new advances in medicine that are drastically changing the landscape of patient care. However, there are other new challenges such as important policy decisions that have a direct and significant impact on the ability of cardiologists to provide quality care while still operating an effective and efficient practice. One way that you can help policy makers understand the environment we work in is a program called Cardiologist-for-a-Day.

- Witness procedures such as the implantation of a defibrillator or the placement of a stent to open up a blocked artery.
- Learn about new advances in the treatment of heart disease and what it means for patients in their community.
- Get a behind-the scenes look at how a medical practice operates—from what it takes to get reimbursed for treating a patient to the infrastructure needed to address regulatory requirements.

The Cardiologist-for-a-Day program is intended to give policy makers a rare chance to experience how policy decisions affect medicine and patient care in a way they may not have seen before. During the program, participants are given the opportunity to:

The Wisconsin Chapter is planning to coordinate Cardiologist-for-a-Day programs in 2011. We are seeking volunteers who would be willing to participate in hosting legislators to their practice or academic institution. If you have any interest in this program and want to learn more, please fill out the form below and remit to the WC-ACC office. A planning committee will be organized to identify dates, locations and other logistics this Spring.

Yes! *I am interested in more information regarding participation in a Cardiologist-for-a-Day event in 2011.*

Name: _____

Practice/Institution: _____

Location (city): _____ Region of State: _____

Contact phone: _____

Direct e-mail: _____



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Wisconsin Chapter Members Currently Serving on ACC Committees:

AACVPR/ACC/AHA Cardiac Rehabilitation Performance Measures Writing Committee

Member: Neil B. Oldridge, M.D., University of Wisconsin School of Medicine and Public Health

CHDPC- Quality in Pediatric Cardiology WG - Performance Indicators

Member: James S. Tweddell, M.D., F.A.C.C., Children's Hospital of Wisconsin

ACC/AHA Task Force on Clinical Data Standards - Writing Committee to Develop Clinical Data Standards on Heart Failure

Member: Michael P. Cinquegrani, M.D., F.A.C.C., Medical College of Wisconsin

Clinical Electrophysiology and Electrocardiography Committee

Chair: Richard L. Page, M.D., F.A.C.C., University of WI Schl of Mdcn & Public Hlth

Member: Cesar Alberte-Lista, M.D., F.A.C.C., University of Wisconsin Hospital

ACC/AHA Task Force on Practice Guidelines - ACC/AHA/ESC Writing Committee to Update Guidelines for the Management of Patients With Atrial Fibrillation

Chair: L. Samuel Wann, M.D., M.A.C.C., University of Wisconsin, Madison and Medical College of Wisconsin, Milwaukee

HRS Representative: Richard L. Page, M.D., F.A.C.C., University of WI Schl of Mdcn & Public Hlth

Member: Craig T. January, M.D., Ph.D, F.A.C.C., University of Wisconsin Hosp and Clinic

Council on Clinical Practice

Member: L. Samuel Wann, M.D., M.A.C.C., University of Wisconsin, Madison and Medical College of Wisconsin, Milwaukee

Health Policy Statement on Structured Reporting for Cardiovascular Imaging

RSNA Representative: Charles E. Kahn, Jr., Medical College of Wisconsin

Informatics Committee

Member: Bijoy K. Khandheria, M.B.B.S., F.A.C.C., Aurora Medical Center

ACCF/AHA Heart Failure Guideline Writing Committee

Representative: Maryl R. Johnson, M.D., F.A.C.C., University of Wisconsin Madison

AAFP Representative: Patrick Edward McBride, M.D., M.P.H., F.A.C.C.

JACC: Cardiovascular Imaging

Editorial Consultant: A. Jamil Tajik, M.D., F.A.C.C., Aurora Cardiovascular Services

Senior Consulting Editor: Bijoy K. Khandheria, M.B.B.S., F.A.C.C., Aurora Medical Center

ACCF/AHA/ACR/PCPI/NCQA Cardiac Imaging Performance Measures Work Group

Member: Azita G. Hamedani, M.D., M.P.H., University of Wisconsin Hospital & Clinics

Masters of the American College of Cardiology

Member: L. Samuel Wann, M.D., M.A.C.C., University of Wisconsin, Madison and Medical College of Wisconsin, Milwaukee

ACCF/AHA/SCAI/PCPI/NCQA PCI Performance Measures Group

Member: Kevin McCabe, M.D., SC Johnson & Son

NCDR ICD Registry Subcommittee - Research and Publications

Member: Humberto J. Vidaillet, Jr., M.D., F.A.C.C., Marshfield Clinic

Adult Congenital and Pediatric Cardiology Council

Member: James S. Tweddell, M.D., F.A.C.C., Children's Hospital of Wisconsin

Patient-Centered Care Strategic Business Partnerships Subcommittee

Member: L. Samuel Wann, M.D., M.A.C.C., University of Wisconsin, Madison and Medical College of Wisconsin, Milwaukee

Board of Governors

Member: Thomas J. Lewandowski, M.D., F.A.C.C., Appleton Cardiology Associates

Cardiovascular Team Section Advocacy Working Group

Member: Mia P. Stone, RN, Aurora St. Lukes Medical Center

Perioperative Cardiovascular Evaluation for Noncardiac Surgery

Member: Judy R. Kersten, M.D., F.A.C.C., Medical College of Wisconsin

Cardiovascular Team Section Practice Outcomes & Research Working Group

Member: Mia P. Stone, RN, Aurora St. Lukes Medical Center

Peripheral Vascular Disease Committee

Cardiac Care Associate Member: Mia P. Stone, RN, Aurora St. Lukes Medical Center

Cardiovascular Team Section Working Group For Registered Nurses

Chair: Angie Schlemm, RN, BSN, Aurora St. Lukes Medical Center

Representative to the American Medical Association House of Delegates

Member: L. Samuel Wann, M.D., M.A.C.C., University of Wisconsin, Madison and Medical College of Wisconsin, Milwaukee

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WI Chapter Members Attend Annual Summit

Wisconsin Chapter members recently attended the ACC.11/i2 Summit Annual Scientific Sessions in New Orleans. You can read all the media coverage about the event at www.cardiosource.org/acc11coverage

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Thomas Lewandowski, M.D., F.A.C.C., Peter Smith, M.D., F.A.C.C., and Peter Rahko, M.D., F.A.C.C.



ACC Board of Governors



Wisconsin Chapter members make time to network at the All Chapter Reception

Contemporary Issues In Cardiac Pacing

by *Peter N. Smith, M.D., F.A.C.C.*
Marshfield Clinic

Peter N. Smith, M.D., F.A.C.C., Wisconsin Chapter Councilor recently wrote an article titled "Contemporary Issues In Cardiac Pacing." The article addresses current pacing practices and issues. Pacing, sensing, sensing amplifiers, and pacing leads are discussed. Cardiac resynchronization is reviewed. Issues of ventricular pacing avoidance, pacemaker lead infections, ionizing radiation effects on pacing and pacing issues after deterioration and expiration of the patient are considered.

To view this article in full length visit the WC-ACC Web site: <http://wcacc.org/members/newsletters.htm> and click on "Contemporary Issues In Cardiac Pacing" under the News Articles section.

Arrhythmias in the Real World 2011

September 8-10, 2011

Heart House

Washington, D. C.

Please consider attending Arrhythmias in the Real World 2011. Wisconsin's own Peter N. Smith, M.D., F.A.C.C., F.H.R.S. serves as Program Director.

Over two million Americans are affected by atrial fibrillation, which is the most common arrhythmia seen in clinical practice. Ventricular arrhythmias and other rhythm disorders can also increase the risk of disabling symptoms and mortality.

Cardiovascular specialists need to be aware of the latest research, clinical applications and device therapies available in diagnosing and detecting arrhythmias. Arrhythmias in the Real World 2011 is a stimulating and interactive course that will provide practicing clinicians with an educational experience that will enhance their knowledge and clinical skills in diagnosing and managing patients experiencing arrhythmias. In this two-and-one-half-day course, attendees will interact with leading experts through exciting case-and evidence-based presentations, focused breakout sessions and networking opportunities.

For More Information Visit: <http://www.cardiosource.org/Certified-Education/Courses-and-Conferences/2011/September-2011/ARW-2011.aspx>



ACC Upcoming Events

For more details on these events visit: www.cardiosource.org/Certified-Education/Courses-and-Conferences/All-Courses-and-Conferences.aspx

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AUGUST

August 13, 2011
Mind the Gap: AFIB and the Evolving Strategies in Anticoagulation
Sheraton Chicago Hotel & Towers
Chicago

August 18, 2011
ACCF Study Session for ABIM Maintenance of Certification: Interventional Cardiology Updates 2010 and 2011
The Ritz-Carlton
Dallas

August 19-21, 2011
ACCF/SCAI Premier Interventional Cardiology Overview and Board Preparatory Course
The Ritz-Carlton
Dallas

SEPTEMBER

September 6-10, 2011
The ACCF Cardiovascular Board Review
Fairmont Hotel
Chicago

September 8-10, 2011
Arrhythmias in the Real World 2011
Heart House
Washington, D.C.

September 10, 2011
ACCF Interactive Study Session for Maintenance of Certification
Cardiovascular Disease Updates 2010 and 2011
Fairmont Hotel
Chicago

OCTOBER

October 13-16, 2011
2011 Foundations for Practice Excellence: Core Curriculum for the Cardiovascular Clinician
Heart House
Washington D.C.

October 13-15, 2011
2011 Heart Valve Summit: Medical, Surgical and Interventional Decision Making
JW Marriott Chicago
Chicago

October 19-22, 2011
2011 Cardiometabolic Health Congress
Co-sponsored by: American College of Cardiology Foundation
Sheraton Hotel
Boston

October 22, 2011
Wisconsin Chapter Annual Meeting
Madison

DECEMBER

December 2-3, 2011
How to Become a Cardiovascular Investigator
Heart House
Washington D.C.

December 9-11, 2011
44th Annual New York Cardiovascular Symposium: Major Topics in Cardiology Today
Hilton New York
New York City

JANUARY 2012

January 9-13, 2012
43rd Annual Cardiovascular Conference at Snowmass
Snowmass Resort
Snowmass, Colo.

If you know of any CME/CE opportunities in Wisconsin, please send them to info@wcacc.org. They will be posted in future issues of our newsletter and on www.wcacc.org.

Wisconsin
CHAPTER

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