July 13, 2009

Dear Colleagues,

Between 1968 and 2000, mortality from heart disease dropped 40%–50% in the United States. Subsequently, from 1999 to 2007, age-adjusted death rates from coronary artery disease fell 25.8%. As a result of better identification of risk factors, prevention strategies, early diagnosis, and prompt, effective treatments, patients are significantly less likely to die from myocardial infarction than they were just decades ago. In addition, the majority of patients who suffer an MI and receive swift treatment now return to active, productive lives.

The Centers for Medicare and Medicaid Services (CMS) has proposed a fee schedule for 2010 that undervalues — and therefore discourages access to — the very strategies that have reduced cardiovascular mortality and enabled patients to live well despite heart disease. I find it extremely worrisome that CMS is proposing to cut fees for services that are the bedrock of prevention and early diagnosis; specifically, consultations would no longer be reimbursed at a higher level than typical physician visits, and fees for diagnostic angiograms would be reduced by 13%. Furthermore, CMS has also proposed to cut fees for interventional cardiology procedures by an average of 14% and to slash fees for cardiovascular imaging services by as much as 40%.

In addition to these and other practice expense cuts aimed at cardiovascular specialists, all physicians face the possibility of 21.5% fee reductions based on the continued application of the flawed sustainable growth rate (SGR) formula. Taken together, the combined impact of the SGR and practice expense cuts means individual cardiovascular practices could suffer reductions of between 25% and 50% for the treatment of Medicare patients. This is an outrageous scenario that suggests CMS either does not fully understand the costs associated with running a medical practice or does not recognize the important role of specialty care in reducing death and disability from cardiovascular disease.

Our task is to try to understand the agency’s goals, ask the right questions, and help develop solutions that best serve our patients.

What Is CMS Thinking? CMS is basing its proposed practice expense cuts on data collected from a survey fielded by the American Medical Association (AMA) to ascertain how much it costs to run a medical practice. Unfortunately, the survey’s response rate was very small, with only 55 responses remaining after many were deemed incomplete or unacceptable. SCAI and other cardiovascular organizations conducted a similar survey five years ago to analyze the costs associated with employing nurses, technicians, and other support personnel; maintaining secure information technology and other infrastructure; purchasing and upgrading equipment; and so forth. While we found that the average per-cardiologist, indirect practice expenses totaled $131 per hour based on the 2003 survey, the AMA survey yielded an indirect practice expense figure

(continued on page II)
of only $88 per hour. This suggests that the cost of running a practice has dropped 33% in five years. We all are aware that the costs of running a medical practice are increasing, not decreasing, just as we know that our practices cannot take such deep hits without it impacting patient care.

Another issue to consider is that the proposed fee schedule moves funds from CMS's finite pool of resources away from specialty care and toward primary care. This reflects the new paradigm that is taking hold in Washington – the belief that the key to healthcare reform is to expand the role of primary care specialists over that of physician specialists. CMS must be unaware that, for many patients, interventional cardiologists deliver both the diagnostic and interventional procedures they need AND the guidance of primary care providers. In my practice, we are not just performing PCI. Among other things, we also check lipids and blood pressure and even offer vaccinations. I'm sure many of you offer this same comprehensive care.

What Can We Do? Our task is to convince CMS to re-evaluate the data from the AMA survey and to reconsider the ramifications of reducing patients' access to cardiovascular services, including consultations with specialists and diagnostic procedures. THERE IS VERY LITTLE TIME TO MAKE A DIFFERENCE. CMS must receive our comments by 5 p.m. Eastern Time on Monday, August 31, 2009.

I recommend the following action plan, which includes a role for everyone:

**Action Plan for SCAI and YOU:**

- **SCAI is working** independently and as part of the House of Cardiology to avert the proposed practice expense cuts. We are engaged in dialogue with CMS and are asking important questions about the data guiding CMS toward such drastic practice expense cuts. For starters, we have asked CMS and AMA to share the raw survey data and an explanation of their analysis.

  The Society is also developing a detailed analysis of the proposed rule and will submit it to CMS soon. This response will point out that the cost of providing cardiovascular care has not declined since 2003, when we provided CMS with far more robust survey data. Our response will outline accurate data on the costs of running a medical practice.

- **YOU can help** by writing to CMS. Please go to the inside back cover of this publication or www.SCAI.org, where you’ll find talking points and a sample letter that you can complete and send to CMS. Details on where to send your letters are included as well. Please be sure that your letter will be received by CMS no later than Monday, August 31, 2009, at 5 p.m. Eastern Time.

  Keep in mind the goal of our personal letters to CMS is to clarify misperceptions about the costs of running a cardiovascular medical practice that delivers high-quality, evidence-based care to Medicare and other patients. Please send your letter to CMS as soon as possible and, if possible, email a copy to SCAI: dhopkins@scai.org

  - **YOU can help** by reaching out to Congress about both the proposed practice expense and SGR fee cuts, too. An excellent tool for reaching your Congressional representatives is via the toll-free grassroots hotline offered by the American College of Cardiology. Call 800-200-7193 or log on to www.acc.org/can

  - **SCAI is working** with the House of Medicine to battle the SGR-based fee cuts aimed at all physicians. There is good reason to believe that Congress will over-ride these cuts, as it has done in all but one of the last 10 years. However, we are not taking this for granted. We are actively engaged with Congressional representatives on this issue as well as general healthcare reform.

  - **YOU can help** by weighing in with Congress on the broader issue of healthcare reform. Contact your elected representatives via the AMA's legislative outreach website: http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/health-system-reform-action-kit.shtml

  - **SCAI is working** to mobilize patients so that their voices are not overlooked in decision making that ultimately impacts them. We are reaching out to patient advocacy groups to encourage them to join in this fight and help CMS understand how much they value the care their cardiologists provide.

  - **YOU can help** by talking to your patients, making them aware of the proposed cuts and the impact these cuts could have on their access to care. Please invite your patients to contact CMS and their elected representatives, too. SCAI has developed an easy-to-use template that patients can use to write to CMS. You can download the template from www.SCAI.org.

  In addition to all of these important efforts, SCAI representatives will visit Capitol Hill this month with messages about the value of cardiovascular care and our concerns about the impact the proposed cuts could have on our patients and our practices. We are laying the groundwork for Congressional opposition to the proposed cuts. Please check www.SCAI.org in about a week for new information on how you can get involved in this effort specifically.

  Finally, please know that I view this action by CMS as an assault on cardiovascular medicine. I am deeply concerned about the impact that the new fee schedule could have on our patients' ability to access care with the potential to save lives and restore quality-of-life. In my roles as both practicing cardiologist and SCAI president, I will be personally and vigorously engaged in this battle all the way. I hope you will join me.

Sincerely,

Steven R. Bailey, M.D., FSCAI
President, SCAI
president@scai.org
Announcing SCAI’s 2010 Annual Scientific Sessions in San Diego

It may seem that SCAI’s 2009 Annual Scientific Sessions just ended, but some members are already looking ahead to next year: They’re the ones who are planning the event.

The 2010 meeting will take place May 5–8 at the Hilton San Diego Bayfront in California. “It’s a terrific location—one that’s fun to be at once the meeting’s over,” says Program Co-chair James B. Hermiller, M.D., FSCAI, of the Care Group at St. Vincent Heart Center of Indiana in Indianapolis. “It’s a terrific location that combines a superb destination spot with outstanding meeting facilities.”

Attendees Give SCAI 2009 Annual Scientific Sessions Highest Ratings Ever

Attending SCAI’s annual meeting in May was clearly the best bet in Las Vegas. The meeting achieved terrific attendance, breaking previous records, and attendees also gave the sessions the highest mean ratings ever.

“I am delighted that we had such excellent attendance,” said Ted Feldman, M.D., FSCAI, who has served as the meeting’s program director for the past four years. “This year there were many new program elements, but the overall philosophy of providing a comprehensive, balanced update on Interventional Cardiology in a collegial, interactive environment is what I think makes the meeting strong.”

The two highest rated sessions were the meeting’s traditional keynote addresses, the Hildner and Founders’ Lectures, which focused this year on professionalism in medicine and appropriate use of PCI. Other top-rated sessions reflected the diverse content offered at the meeting and included a dialogue session between SCAI and the Accreditation Council for Graduate Medical Education in the Interventional Training Directors’ Symposium, the
Announcing 2010 Annual Scientific Sessions (cont’d from pg 1)

And while it's too early in the planning process to share too many details, Dr. Hermiller knows what his goal is: “a meeting where interventional cardiologists can efficiently tap into the newest, most important, and most relevant information, presented in a way that makes it easy for them to implement in their practices when they go back home.”

New Offerings

Along with old favorites will come some new sessions, says Program Co-chair Christopher J. White, M.D., FSCAI, of Ochsner Health System in New Orleans. “The thing that makes SCAI’s meetings valuable is that we focus on the cutting edge,” he says. And the 2010 meeting will reflect that with a new emphasis on noncoronary work.

“We’ve always had sessions on peripheral arterial disease at our meetings, but next year we want to make sure it gets the full attention it merits,” explains Dr. White.

The time is right for such a session, he says, noting that the number of physicians trained in the area is now large enough to create a demand for this kind of educational session. Polling shows that more than half of physicians in catheterization laboratories are already tackling vascular disease, he says.

“This new emphasis reflects the evolution of our practice from being heart-based to being cardiovascular-based, really from the top of the head to the tip of the toes,” says Dr. White.

The program will also reflect what Dr. White calls another “frontier of intervention”: an emphasis on structural heart disease and new developments in percutaneous valvular repair.

About a dozen U.S. sites are already experimenting with this emerging technology, says Dr. White, who predicts that the field will see much more of it by next year. “It’s going to be a significant part of our practice,” he says.

Even the standard sessions on coronary disease will offer plenty of fresh content, Dr. White emphasizes. “The coronary sessions are constantly being reinvented,” he explains. “We always have new data and new information on how to treat arteries. After all, that really is the core of our specialty.”

While the Annual Scientific Sessions primarily target interventional cardiologists, adds Dr. Hermiller, it also offers special programming for fellows, pediatric interventional cardiologists, and catheterization laboratory nurses and technicians.

An increased focus on cardiovascular disease will attract a broader audience than ever before, says Dr. White. And, he adds, that emphasis will help SCAI live up to its name. “We used to be the Society for Cardiac Angiography and Interventions,” he says. “In recent years, we’ve adopted the word ‘Cardiovascular.’ Next year’s meeting will highlight that new focus on total body cardiovascular care.”

To register or get up-to-date information about the 2010 annual meeting, visit www.SCAI.org.
inaugural Congenital Heart Disease keynote address, three sessions in the RCIS Review Course, and the live case focused on peripheral interventions.

Impact on Clinical Practice
SCAI views as a fundamental indicator of the meeting's value whether attendees learn something new that will improve their clinical practices. For the great majority of attendees who participated, the answer was a definitive yes. Frequently mentioned changes focused on anti-coagulation and anti-thrombotic regimes, approaches to bifurcation lesions and triple-vessel disease, stent deployment, and use of the SYNTAX scoring methodology.

Meeting Experience
Especially Valued
The 2009 Annual Scientific Sessions marked SCAI’s return to its traditional format of relatively small, interactive sessions offering opportunities for presenters and audience members to engage in lively exchange. Extensive research among the attendees identified a strong consensus that SCAI’s traditional annual meeting format is highly valued by its educational constituencies.

Quality and Cost–Benefit
Rated Highly
SCAI examined trend data from six uniform questions asked of attendees annually since 2001. These questions focus on the overall quality of the meeting and whether attendees believe they got their money’s worth in learning value.

“We use the same questions annually to allow comparisons from year to year,” explained Dr. Feldman. “The results reinforce the conclusion that the Society’s return to its traditional meeting format was a decision that paid off.”

Diverse Attendance
The Society welcomes general cardiologists and other healthcare professionals to its CME programs, including the Annual Scientific Sessions. The 2009 annual meeting also included programming relevant to nurses and technicians/technologists, such as the Cardiac Cath Handbook and RCIS Review Course. In the many surveys and interviews completed by these allied health professionals, feedback was enthusiastically and almost unanimously very positive.

Industry Presence: Right Where It Belonged
The annual meeting offers attendees the opportunity to meet with vendors in the Exhibit Hall and learn about the latest advances in the development of devices and medications, as well as information about services provided by other healthcare organizations. Interviews with exhibitors showed that while the number of people who stopped by their booths met or exceeded their expectations, they were especially pleased with the discussions held and the two-way knowledge exchange that took place. “The meeting went very well,” said one exhibitor, voicing a comment expressed by many of his colleagues. “This was the best audience for what we do because there were lots of decision-makers here.”

Data-Based Planning Underway for 2010
SCAI’s Program Committee is already busy planning next year’s meeting (see page 1). The results of evaluations from the 2009 annual meeting will inform many of their decisions.

“We’ll look at the ratings given to specific panel topics, such as structural and congenital heart disease, types of sessions (e.g., live cases, posters), as well as the themed sets of sessions, like the C3 (Complex Coronary Complications) Summit directed to interventional fellows,” said James B. Hermiller, M.D., FSCAI, who will direct the 2010 program along with Christopher J. White, M.D., FSCAI. “We’ll also use the results of a new evaluation question that sought to identify where gaps exist in routine clinical practices. If we can fill these gaps, we can have a direct impact in the form of improved patient outcomes.”

SCAI’s 2010 Annual Scientific Sessions will be held May 5–8 in beautiful San Diego, CA. To register or get more information about the meeting, visit www.SCAI.org today!
SCAI Honors Interventionalist-in-Training With First Award in Memory of Dr. Gregory Braden

The first SCAI Gregory Braden Memorial Fellow of the Year Award was presented to interventionalist-in-training Sripal Bangalore, M.D., MHA, during the Society's 32nd Annual Scientific Sessions in Las Vegas, NV. A committee of physicians selected Dr. Bangalore based on his dedication to cardiovascular investigation and pursuit of academic excellence, both reminiscent of the legacy of Dr. Braden.

"My husband enjoyed teaching and training fellows," Mrs. Marion Braden said of her husband before presenting the award to Dr. Bangalore. "At the yearly fellows meeting, he would spend hours with a fellow and would not leave his or her side until every question was completely answered. Greg's dedication to the fellows led his family to want to contribute and encourage fellows-in-training to find a cure for coronary disease."

"SCAI established this award to honor Greg's memory and to continue his legacy as a renowned interventional cardiologist, teacher, and researcher," said SCAI President Steven R. Bailey, M.D., FSCAI. "Greg is greatly missed, but we believe he would have appreciated this award and the role it will play in helping young physicians to develop the skills and attributes that Greg personified."

Candidates for the Gregory Braden Memorial Fellow of the Year Award are evaluated based on their interventional skills in multiple modalities, personal contribution to cardiovascular research, authorship in cardiovascular research journals, promise for making contributions to cardiovascular research, and dedication to patient care and well-being.

When nominating Dr. Bangalore, his mentors wrote enthusiastically of his skill, potential, and dedication to his patients. Dr. Bangalore graduated from medical school with a 4.0 grade average and then attended Western Kentucky University, where he received his Masters in Health Administration. He participated in postdoctoral cardiac MRI research at The Johns Hopkins School of Medicine. He completed his internship, residency, and cardiology fellowship at St. Luke's Roosevelt Hospital. During his time at St. Luke's, Dr. Bangalore also completed a research rotation at Brigham and Women's Hospital Angiographic Core Laboratory. He is expected to complete his interventional cardiology fellowship this summer.

Dr. Bangalore has already published nearly 70 manuscripts and editorials, including many in top cardiovascular journals, including the American Heart Journal, Journal of the American College of Cardiology, and The Lancet.

Mrs. Braden presented Dr. Bangalore with a crystal plaque, a $5,000 grant, and a complimentary membership in SCAI for one year.

Dr. Bangalore is the first of five recipients who will be named Gregory Braden Fellows. For more information on eligibility and how to apply, visit www.SCAI.org.
SCAI/Cordis Research Grants Awarded at 2009 SCAI Annual Meeting

SCAI and the CORDIS® CARDIAC & VASCULAR INSTITUTESM awarded $25,000 research grants to two interventional fellows-in-training, Jon George, M.D., Temple University, and Amardeep Singh, M.D., University of Southern California, during the SCAI Annual Scientific Sessions. Both projects are “perfect examples of the type of work the Cordis–SCAI program is designed to encourage,” said Committee Chair William G. Kussmaul, M.D., FSCAI.

The SCAI/Cordis Fellowship Program for Interventional Cardiology selects two research proposals each year based on their potential to explore promising advances in cardiovascular invasive/interventional techniques that will have a positive impact on patient care. The proposals submitted by Drs. George and Singh were chosen because they “exemplify the entire spectrum of bench-to-bedside research, all of which is vital to advancing human heart health,” said Dr. Kussmaul.

Dr. George received the SCAI/Cordis research grant for his project, “Endomyocardial Injection of Human Cardiac Stem Cells into Diffusely Damaged Myocardium: To Termination or Regeneration?” Although stem-cell therapies are unproven in the treatment of heart disease, Dr. George's project will “address a critical step,” said Dr. Kussmaul, “whether delivered stem cells survive and engraft, or not.”

Dr. Singh’s research, “Assessment of Myocardial Perfusion by a Quantitative Automated Method at Cardiac Catheterization in Comparison to Cardiac Magnetic Resonance Imaging,” offers promise of an automated method to quantify myocardial perfusion in the cardiac cath lab, said Dr. Kussmaul.

Dr. Kussmaul also recognized and applauded the commitment shown by Cordis Corporation in providing these unrestricted funds. “Each year these grants encourage and support the best cardiology fellow projects.”

“The Cordis Cardiac & Vascular Institute is dedicated to advancing potential treatments for those who suffer from cardiovascular disease, and we are proud to support research grants like these that may lead to a positive impact on patient care,” said Mike Madden, executive director of the Cordis Cardiac & Vascular Institute, Cordis Corporation.

For more information about next year’s research fellowship awards programs, visit www.SCAI.org.
SCAI ’09: Clinical Highlights at a Glance

Media coverage of SCAI’s 2009 Annual Scientific Sessions was unprecedented for the Society. There isn’t sufficient room to highlight all the clinical news, but here’s a glance at some of the news-makers:

Late-Breaking Clinical Trials

The Clopidogrel Medco Outcomes Study, an observational study of 16,690 patients, suggested that proton pump inhibitors (PPIs) may attenuate the effects of clopidogrel, raising the risk of acute myocardial infarction (MI), stroke, and other major cardiovascular events by about 50% during the 12 months after stenting. By comparison, the overall risk of hospitalization for upper gastrointestinal bleeding was less than 1%. Investigators concluded that PPIs should be used only when clearly indicated in patients prescribed clopidogrel after coronary stenting. These data shed light on a controversial subject and provide important guidance for daily practice.

At a press conference held on site at the annual meeting, SCAI issued a statement on the Clopidogrel Medco Outcomes Study, urging health care providers who are treating post-stenting patients on dual-antiplatelet therapy to consider prescribing a histaminergic (H2) blocker (such as Zantac or Tagamet) or antacids instead of a PPI considering the high risk for adverse events shown in this study. “H2 blockers are not metabolized by the CYP enzyme system that is responsible for activating the pro-drug, clopidogrel, into the active metabolite of clopidogrel that has antiplatelet actions. Therefore, there is no inhibition of the antiplatelet effect of clopidogrel by H2 blockers,” SCAI noted. “In cases in which the patient needs medication to treat gastrointestinal conditions unrelated to their cardiac disease or its treatment with a stent, the interventional cardiologist is advised to contact the patient’s primary care provider or gastroenterologist to discuss treatment alternatives to PPIs.”

The AMADEUS study found that the CARILLON percutaneous mitral annuloplasty device offers a new treatment option for patients with functional mitral regurgitation. Echocardiographic measures of mitral regurgitation significantly improved 1 and 6 months after implantation of the investigational device. Rate of major adverse events were low, and patients experienced improvement in exercise tolerance and quality of life. This study represents some of the first clinical trial results with this new class of catheter-based, nonsurgical therapy for mitral valve disease.

The FlatStent EF, a new device designed for treatment of patent foramen ovale (PFO), was found to be safe and effective at 90-day follow-up. The FlatStent EF is unique because it is implanted within the PFO tunnel, leaving minimal exposure to the circulation. Immediately following implantation, some 71% of patients had complete PFO closure. After 90 days, 89% had complete or clinical closure. The FlatStent EF device is one of the first “minimalist” implant approaches to shunt closure.

Coronary and Peripheral Arterial Disease

Transradial catheter access was found to be feasible and effective in a study of primary percutaneous coronary intervention (PCI) for acute MI, even in high-risk patients. The average door-to-balloon time in this study was 95 minutes, and the average procedure time was 41 minutes. The overall procedural success rate was 93%.
A program in Canada that transfers patients with acute MI to a major medical center for primary PCI—and immediately returns those who are stable to the community hospital for recovery—is proving safe and efficient. Overall, there was no significant difference in hospital mortality between transfer patients and those who came directly to the treating hospital. Some 81% of transfer patients were stable enough for “repatriation” after PCI.

According to the 6-year follow-up results of the SIRIUS study, rates of target lesion and target vessel revascularization remained significantly lower among patients treated with the sirolimus-eluting CYPHER stent, when compared to the Bx VELOCITY bare metal stent. Furthermore, rates of stent thrombosis by definite/probable ARC criteria were 1.2% with CYPHER and 2.1% with the bare metal stent (p = 0.3042).

Patients treated with the Zilver PTX Drug-Eluting Peripheral Stent maintained clinical improvement after two years, according to interim data from a registry study. Event-free survival rates at 6, 12 and 24 months were 95%, 87% and 78%, and freedom from target lesion revascularization rates were 96%, 89% and 82%.

Rates of bypass surgery have fallen by more than one-third since their peak in 1997, according to data from a large inpatient
Researchers found that the age-adjusted rates of bypass surgery gradually increased from 79.29 per 100,000 in 1988, to 131.31 per 100,000 at their peak in 1997 (p<0.01). Then, rates declined rapidly to 83.01 per 100,000 in 2004 (p<0.01).

For the first time in the United States, researchers have demonstrated the feasibility and safety of transendocardial injection of allogeneic mesenchymal precursor cells for the treatment of patients with heart failure. In the study, an entire group of patients was treated with stem cells from a single healthy donor, without any procedural complications or evidence of an immune response against the foreign material. Cardiac function also improved significantly during 3-month follow-up.

SCAI issued a statement on the Clopidogrel Medco Outcomes Study, urging health care providers who are treating post-stenting patients on dual-antiplatelet therapy to consider prescribing a histaminergic (H2) blocker (such as Zantac or Tagamet) or antacids instead of a PPI considering the high risk for adverse events ...

Structural Heart Disease

A multicenter study found that stenting was a technically feasible alternative to open-chest surgery or balloon angioplasty in children with coarctation of the aorta. Stenting resulted in significant improvement in the average diameter of the aorta at the site of coarctation and markedly reduced the average pressure gradient between the upper and lower body (31.6 mmHg vs. 2.7 mmHg). Resting blood pressure was also significantly better.

Cryoballoon angioplasty appeared to be as safe and effective as other transcatheter therapies for pulmonary vein stenosis in children. After the procedure angiographic pulmonary vein diameter increased from a mean of 2.4 mm to 4.1 mm (p<0.001). The pressure gradient decreased from a mean of 12.3 mmHg to 3.6 mmHg (p=0.001). Late restenosis remained a problem, however.

In patients with regurgitant/stenotic pulmonary valve conduits, transcatheter insertion of the Edwards Sapien THV into the pulmonic position appeared to be both safe and effective. Implantation was successful in 7 out of 8 patients using an antegrade technique. The pressure gradient across the valve dropped from an average of 37.5 mmHg before the procedure to an average of 16.4 mmHg after the procedure. At 30 days, valve regurgitation was not evident in most patients.

A long-term follow-up study confirmed the lasting benefits of balloon valvuloplasty for treating children with pulmonary valve stenosis. After a follow-up averaging 13.7 years, all patients were free of symptoms. Pressure gradients remained low, and in 66% of patients, valve regurgitation was rated as absent, trivial or mild. Similarly, 85% of patients had no more than mild right ventricular enlargement.

In a study of adults with atrial septal defect (ASD), both surgery and use of the Amplatzer ASD closure device were successful treatment options. However, in surgical patients pre-existing atrial arrhythmias were more likely to persist, the incidence of new atrial arrhythmias was higher, paradoxical septal motion of the left ventricle was far more common, and left ventricular ejection fraction was lower.

Left atrial function is nearly always abnormal in patients with untreated patent foramen ovale, according to an echocardiographic study. The abnormal “atrial fibrillation-like” physiology of the left atrium may help explain why patients with PFO are at increased risk for stroke, and may prompt earlier treatment, according to investigators.
Demographic Studies

- Three studies explored the role of angioplasty and stenting in the elderly. One study involving 120,595 patients found that PCI is reasonably safe in the elderly, although complications such as need for transfusion, contrast-induced nephropathy, and stroke are significantly more common than in younger patients.

- A separate study involving 3,960 patients found that long-term survival after stenting is significantly lower in those over the age of 80, but this disadvantage can be minimized through use of drug-eluting stents.

- A third study of 790 elderly patients who underwent primary PCI for ST-elevation myocardial infarction (STEMI) found that elderly patients were about twice as likely to experience a major adverse cardiac event (MACE) as were younger patients. One explanation may be a higher incidence of co-existing medical conditions; however, door-to-balloon times were significantly longer in elderly patients, 82 minutes on average vs. 66 minutes (p=0.0377).

- Two studies were among the first to document outcomes in female patients treated with primary PCI for STEMI. One found that simply being female increased the odds of procedural failure by a factor of 2.04.

- The second study confirmed that women undergoing primary PCI are often older than men, more likely to have co-existing medical conditions, and more likely to experience delays in treatment due to delayed recognition of symptoms. In addition, TIMI scores were significantly lower in women (2.8 on average vs. 2.9 in men, p=0.048). In-hospital death rates in women were significantly higher, 12.8% vs. 5.4% in men, p=0.003.

- A study from one of the largest public health systems in the country found that African American patients experienced significantly worse outcomes after PCI than patients of other races. After a follow-up averaging 1.7 years, investigators found that MACE-free survival was significantly lower in African Americans (78.8% vs. 85.9%, p<0.001). One likely explanation is that African American patients appeared to wait longer before seeking treatment and, therefore, had more advanced coronary disease. These findings may signal a need for better outreach and education, investigators concluded.

For more in-depth summaries of these and other clinical studies presented at the SCAI annual meeting, visit http://scaiscientificsessions.org/2009pressroom.html.
Interventionalist-in-Training Receives SCAI/GE Healthcare Research Grant

SCAI and GE Healthcare awarded the Research in Cardiovascular Angiography and Diagnostic Imaging grant to Ramy Badawi, M.D., of the Ochsner Clinic Foundation in New Orleans, at this year’s SCAI Annual Scientific Sessions. Each year, the SCAI/GE Healthcare (Medical Diagnostics) grant program for interventional fellows awards at least one grant of $30,000 to support the work of invasive/interventional cardiologists-in-training who have made outstanding contributions to the field of angiography and diagnostic imaging research.

“The SCAI/GE Healthcare fellowship award is a unique opportunity for funding of original research by cardiology fellows,” said Committee Chair Tyrone Collins, M.D., FSCAI. “This grant program encourages young investigators to design and complete novel projects related to imaging modalities. In this era of reduced funding by industry we are fortunate to have the continued support of GE Healthcare.”

This year, Dr. Badawi received the grant for his proposal, “Surveillance Angiography after Left Main Stem (LMS) Percutaneous Coronary Intervention (PCI): A Comparison of 64-Slice Multidetector Computed Tomography (MDCT) Against Invasive Angiography,” which evaluates the post-PCI surveillance capabilities of MDCT.

“It is important as new modalities become available, that we assess their usefulness and identify best where they fit in,” said Kimberly A. Skelding, M.D., FSCAI, co-chair of the SCAI/GE Healthcare Fellowship Awards Committee.

“GE Healthcare is dedicated to Early Health and this research grant is an opportunity for earlier diagnosis and better patient care to be a reality,” said Elizabeth A. Gottshall, vascular brand manager at GE Healthcare-Medical Diagnostics. “Since 2004, GE Healthcare and the Visipaque team have been proud to sponsor this Fellows Program.”

Dr. Badawi’s research “has the potential to change our practice for surveillance following left main stenting,” continued Dr. Skelding. “The ability to perform a noninvasive test in follow up rather than a repeat catheterization would remove the risk of a repeat procedure for the patient, not only improving safety, but also patient comfort following a higher-risk intervention.”

SCAI and GE Healthcare congratulate Dr. Badawi, whose work is indicative of the ground-breaking research in this field. “Interventional cardiologists have a history of pushing the envelope and embracing new technology to improve patient outcomes and patient safety,” said Dr. Skelding. “Dr. Badawi’s project is a fine example of this concept.”

For more information about next year’s research fellowship awards programs, visit www.SCAI.org.
The Society for Cardiovascular Angiography and Interventions expresses deep appreciation for the generous support from the following companies for the 2009 Annual Scientific Sessions:

**PLATINUM**
- Boston Scientific Corporation
- Cordis Cardiac & Vascular Institute
- Schering-Plough Corporation

**GOLD**
- Abbott Vascular
- Bristol-Myers Squibb/Sanofi Pharmaceuticals Partnership
- Medtronic
- The Medicines Company

**SILVER**
- Daiichi Sankyo, Inc. and Eli Lilly and Company

**BRONZE**
- GE Healthcare
- St. Jude Medical

**Appreciation is also expressed to:**
- Coherex Medical
- Radi Medical Systems, Inc.

**SCAI also appreciates the in-kind support of educational simulators from:**
- Medical Simulation Corporation

**SCAI Thanks:**
- Coherex Medical for supporting the program notepads and pens
- Medtronic for supporting the memory sticks
- Radi Medical Systems, Inc. for supporting the lanyards

**SCAI ALSO THANKS:**
- Cordis Cardiac & Vascular Institute for its generous educational grant to support the 6th Annual Interventional Fellows Complex Coronary Complications (C3) Summit
- GE Healthcare for its support of the 2009 SCAI/GE Healthcare Fellows Grant Program for Research in Angiography and Diagnostic Imaging
- Cordis Cardiac & Vascular Institute for its support of the 2009 SCAI/Cordis Fellowship Program for Interventional Cardiology
Gratitude for a year of service.

New President Dr. Steven R. Bailey (right) thanked his predecessor, Dr. Ziyad M. Hijazi, for a year of visionary leadership. Among many initiatives, Dr. Hijazi established SCAI’s Structural Heart Disease Council to help this emerging field flourish.

Appreciation of pioneers. SCAI awarded its highest honor, the F. Mason Sones, Jr., M.D., FSCAI, Distinguished Service Award, to one of the Society’s founders Dr. John H.K. Vogel (left) and Past President Dr. Michael Cowley (right) in recognition of their tireless efforts to promote optimal care. Check out the next newsletter for tributes to these two pioneers in Interventional Cardiology.
Hildner Lecture makes headlines. Annual Scientific Sessions Program Chair Dr. Ted Feldman (left) thanked Dr. Christopher J. White for a lecture that had attendees talking for days. Dr. White discussed professionalism in medicine and what it really takes to be a good doctor, attributes he calls “the four C’s.” Portions of his lecture appeared on The Healthcare Blog, which has a readership of 80,000. To listen to Dr. White’s lecture, visit SCAI TV at www.clinicaltrialresults.org

“Everyone in medicine needs to hear this speech!” remarked one attendee. He was referencing Dr. Paul Teirstein’s Founders’ Lecture on the underuse of PCI following trials like COURAGE, whose findings many apply to patients whose angina symptoms might best be addressed by PCI. You can listen to Dr. Teirstein’s lecture on SCAI TV at www.clinicaltrialresults.org

SCAI Past President Dr. Gregory J. Dehmer

Dr. Timothy Sanborn (left) checked out the newly launched www.CardioVascularForumCS.org, which was showcased at SCAI’s booth in the exhibit hall.
SCAI members are working to convince a Washington State health care technology review panel not to limit coverage of drug-eluting stents (DES) for thousands of patients whose health care is covered by Medicaid or public employee health plans.

The Health Technology Assessment (HTA) program has been exploring the safety, effectiveness, and cost of DES for the past year, most recently holding a day’s worth of hearings and announcing preliminary recommendations that would limit reimbursement of DES to patients with diabetes, lesions longer than 15 millimeters, or coronary arteries narrowed to 3 millimeters or less. This recommendation may be adopted by other members of a 12-state consortium.

SCAI Trustee Robert Bersin, M.D., FSCAI, and Senior Director for Advocacy and Guidelines Wayne Powell testified at a May 8 hearing convened by the HTA’s 11-member clinical committee. They were joined by many others who also stressed the safety, efficacy, and cost-effectiveness of the devices for many patients with coronary artery disease.

“We presented the peer-reviewed literature, which clearly demonstrates the effectiveness of DES for patients, and shows how DES, by reducing restenosis, saves costs in the long run. We also presented newer data from Duke University researchers who analyzed the outcomes of more than 240,000 patients in the Cath PCI registry. The study showed significantly better outcomes for patients treated with DES vs. bare metal stents (BMS),” said Dr. Bersin, Director, Endovascular Services and Clinical Research at Seattle Cardiology and The Cardiovascular Consultants of Washington.

SCAI expressed disappointment with the HTA’s recommendations to limit coverage, noting that the HTA’s recommended coverage policy would mean that, under this policy, many patients will not have access to the same optimal cardiovascular care as other citizens of Washington State.

The Washington State HTA decision will not be finalized until August of this year, said Mr. Powell. “In the interim, SCAI continues to provide any new published data to the HTA and encourage its members to reconsider their recommendation.”

As of press time, the HTA had not published its recommendation in writing. “As soon as the decision is published, SCAI will work to improve the recommendations,” stressed Mr. Powell.

After 18 months, the group will review the decision, taking into account new studies of DES that could change the outcome.

**The Long Debate**

The HTA program was founded in 2007 to act like a Consumer Reports for medical technologies, according to Director Leah Hole-Curry, “sorting through the hype, and summarizing the scientific evidence about whether these procedures are safe, work as claimed, and are worth the cost.” Since then, the program has opened reviews of 17 different medical technologies, and used the results to deny coverage of procedures like virtual colonoscopies.

HTA panelists said they decided to review stents because of concern over rapid growth in off-label use over the last five years. In March, the program released a draft report and invited comments from SCAI, the stent industry, and cardiologists to incorporate into the final report.

After reviewing dozens of studies comparing DES with BMS, the program released a report in April concluding that DES were no more effective at preventing overall mortality, cardiac mortality and myocardial infarction, though it found that DES did a better job preventing target vessel revascularization. It also found no significant difference in safety between the two types of devices.

SCAI responded immediately with 14 pages of formal comments coauthored by the American College of Cardiology. The Society’s response criticized the HTA report for unwarranted negativity toward off-label use of DES and for failing to include studies that would have undercut the conclusions. The response pointed out that the Food and Drug Administration does not have a role in determining clinical uses for devices after the agency approves them.

“Suggesting that ‘off label’ means ‘inappropriate’ or unstudied is not accurate,” the report stressed.

SCAI President-Elect Larry S. Dean, M.D., FSCAI, took a lead role in crafting the Society response. He was particularly disappointed that the report’s author — Spectrum Research — did not include the results of Duke investigators, which is the most comprehensive study to date comparing DES with BMS.

“The study found that DES were more effective than BMS — and equally safe,” said Dr. Dean. “That should have put this debate to rest, but it didn’t.”

The Duke University study was released in late March — after the draft report was published, but before the HTA issued its final report. Spectrum Research said
the study was released too late to be included in the final analysis, although the study was discussed during the May hearings.

The report’s authors made a handful of changes based on SCAI’s formal response, but the objections did not appear to have changed the report’s overall conclusions.

Steven L. Goldberg, M.D., FSCAI, director of the Cardiac Catheterization Laboratory at the University of Washington Medical Center, called the review “unbalanced.” In a formal response to the draft report, Dr. Goldberg wrote, “It seems to exist primarily to cast a dismissive perspective on the current standard of practice of interventional cardiology.”

Dr. Dean said he was concerned that the HTA committee has no particular expertise in interventional cardiology. The panel includes an anesthesiologist, a naturopathic physician, a heart surgeon, a chiropractor, an epidemiologist, a family nurse practitioner, an oncologist, two family physicians, a radiologist, and a prosthetic orthotist. Michael Ring, M.D., FSCAI, served as a technical consultant to the panel, but his role was limited to answering specific questions from panel members.

“These aren’t doctors who see interventional patients day to day, so they don’t see the impact that optimal treatment with DES has on patient’s lives,” said Dr. Dean. “That’s part of the challenge ahead, to demonstrate the dramatic impact that the devices have on individual patients and how improving quality of life leads to greater productivity among our citizens.”

For more information on SCAI’s efforts in Washington or how you can get involved in SCAI’s advocacy activities, visit www.SCAI.org or email Wayne Powell at wpowell@scai.org.

Steven L. Goldberg, M.D., FSCAI
SCAI, working with the Society of Interventional Radiology (SIR), has successfully alerted and enlisted support from local physician representatives to work within their state Carrier Advisory Committees (CACs) process to support coverage for off-label use of stents for peripheral procedures in accordance with the American Medical Association’s (MAC) policy for off-label use. The Local Coverage Determinations (LCDs) for the Palmetto GBA, BCBS Arkansas, and WPS Medicare Administrative Contractors (MACs) all now support coverage for off-label use of stents for peripheral stent services.

Over the past few years, throughout the United States, Medicare claims processing has been transitioning from generally small, state-based carriers to larger, multi-state MACs. With this consolidation there has been increased activity in updating and revising LCDs to ensure consistency for all states covered by the new MACs.

During this process, several MACs proposed LCDs disallowing off-label use of stents for peripheral stent procedures. With the support of SCAI and SIR, physician representatives have revised the draft MAC LCDs to allow for off-label use when it is supported by the medical literature, which is consistent with the AMA policy, “Patient Access to Treatments Prescribed by Their Physicians.”

If you become aware of any carrier trying to push forward a coverage policy that attempts to restrict physicians from using FDA-approved devices in an acceptable off-label manner, contact SCAI headquarters at dhopkins@scai.org.

American Medical Association (H-120.988)
Patient Access to Treatments Prescribed by Their Physicians

The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate “off-label” uses of drugs on their formulary… (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07) www.ama-assn.org/ama1/pub/upload/mm/471/114.doc
SCAI members are redefining the scope and activities of the Society’s Interventional Career Development Committee to do more to address the needs of interventional fellows-in-training and interventional cardiologists new to practice. The Interventional Career Development Committee’s plan is to develop a platform for peer-to-peer interaction, combined with professional and educational opportunities specifically designed for early-career interventionalists.

“We hope to breathe new life into the Interventional Career Development Committee so that it attracts and involves new members, especially early-career interventionalists, to work with and learn from SCAI’s more seasoned members,” says Immad Sadiq, M.D. “At all stages, but especially the early-career stage, interventional cardiologists benefit greatly from the mentorship of peers.”

Committee members will encourage these relationships by establishing a mentorship program with a variety of offerings—everything from career advice to publication collaboration and review. “As the spectrum of cardiovascular pathology treated by interventional cardiologists continues to evolve and expand at an unprecedented rate, the need for career development activities grows in parallel,” notes Committee Co-chair Kimberly A. Skelding, M.D., FSCAI. The Committee will provide members with access to tools for finding and selecting the right job, setting practice priorities, and keeping up with a rapidly expanding and developing specialty.

The Interventional Career Development Committee will also help young cardiologists gain skills and expertise to complement the brief, 12-month curriculum of most fellowship programs. “Coronary, valvular and structural heart disease, carotid stenting, and acute stroke therapy all are increasingly falling within the realm of today’s interventional cardiologist, placing greater demands on interventionalists-in-training and those who have recently completed their training,” says Paul McMullan, Jr., M.D.

“The Committee is dedicated to providing more guidance and education in these areas,” adds Dr. Sadiq. “It’s a great way to attract new members and foster the continued excellence of SCAI as the home for interventional cardiologists.”

The Interventional Career Development Committee is an open forum that convenes each year at the SCAI and ACC annual meetings, and continues its work year-round via conference calls and email.

Below is a list of the current Interventional Career Development Committee members and their specific areas of interest. If you are interested in becoming part of the SCAI Interventional Career Development Committee, or are interested in becoming part of the mentorship program as either mentee or mentor, contact Laura Brown at lbrown@scai.org.

<table>
<thead>
<tr>
<th>Name</th>
<th>Practice</th>
<th>Specialty</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Bartholomew, M.D.</td>
<td>Daytona Heart Group</td>
<td>Interventional Cardiology, Nuclear Cardiology</td>
<td>Cardiac CT</td>
</tr>
<tr>
<td>Jeremy Buckley, M.D.</td>
<td>Geisinger Medical Center</td>
<td>Interventional Cardiology</td>
<td>STEMI systems of care, health services and outcomes research</td>
</tr>
<tr>
<td>James DeVries, M.D.</td>
<td>Dartmouth-Hitchcock Medical Center and Dartmouth Medical School</td>
<td>Interventional Cardiology, Peripheral Vascular Disease/Endovascular Intervention</td>
<td>Acute stroke intervention and peripheral vascular intervention</td>
</tr>
<tr>
<td>Arun Kalyanasundaram, M.D.</td>
<td>Cleveland Clinic</td>
<td>Interventional Cardiology</td>
<td>Coronary interventions, structural heart disease, peripheral interventions, newer imaging modalities, cardiovascular outcomes and clinical trials</td>
</tr>
<tr>
<td>Priya Velappan Kumar, M.D.</td>
<td>Piedmont Cardiology Associates</td>
<td>Interventional Cardiology</td>
<td>Acute coronary syndromes, coronary physiology, and heart disease in women</td>
</tr>
<tr>
<td>Paul McMullan, Jr., M.D.</td>
<td>Ochsner Medical Center</td>
<td>Interventional Cardiology, Peripheral Vascular Intervention</td>
<td>Hypothermic therapy, acute stroke intervention</td>
</tr>
<tr>
<td>Immad Sadiq, M.D., FSCAI</td>
<td>Miriam Hospital, a Brown University Affiliate</td>
<td>Interventional Cardiology, Vascular Medicine, Endovascular Medicine</td>
<td>Peripheral arterial disease, aortic aneurysmal disease with EVAR and TEVAR, carotid stenting and acute stroke management</td>
</tr>
<tr>
<td>Kimberly Skelding, M.D., FSCAI (co-chair)</td>
<td>Geisinger Medical Center</td>
<td>Coronary Interventions, Structural Heart Disease</td>
<td>Coordinating a clinical and genomics database, running a women’s heart program, and doing clinical research</td>
</tr>
<tr>
<td>Paul Sorajja, M.D. (co-chair)</td>
<td>Mayo Clinic</td>
<td>Interventional Cardiology</td>
<td>Hemodynamics and structural heart disease</td>
</tr>
</tbody>
</table>
Ten years ago the American Board of Internal Medicine (ABIM) approved certification in interventional cardiology. To date, more than 5,800 interventionalists are now “I-Card” diplomates – having met the standards necessary to become certified in this subspecialty of cardiovascular disease. Now the first class of diplomates who achieved certification in 1999 is completing the requirements for Maintenance of Certification (MOC). Unlike initial certification, MOC requires physicians to not only maintain their certification in cardiovascular disease and pass an interventional cardiology examination, but also to meet requirements for self-assessment in medical knowledge and practice performance.

Many SCAI members may be familiar with the medical knowledge self-assessment, but practice performance and quality improvement may be new, although they are equally important. Through its Self-Evaluation of Practice Performance requirement, ABIM’s MOC program provides interventional cardiologists an opportunity to follow a methodology to assess practice quality and establish an essential foundation of practice improvement, something few physicians do.

Interventional cardiologists will need to earn a minimum of 20 (out of a total of 100) self-evaluation points in this category. ABIM provides some meaningful options, including the Practice Improvement Module (PIM), an online tool that is ordered from ABIM. Completing PIMs involves three steps: Data Collection, Plan for Improvement, and a Test of Change. PIMs reference national guidelines for care, use measures developed by other national organizations, and use links to educational resources.

Because many SCAI members already collect data or are involved in quality improvement activities, ABIM’s Self-Directed PIM may be a meaningful option. Many interventional cardiologists have used the National Cardiovascular Data Registry® (ACC-NCDR) to inform quality improvement projects at their institutions, and completed the Self-Directed PIM to report on and receive MOC credit for those projects. The Self-Directed PIM may be used both for new quality improvement projects and to report the results of a recently completed project.

Interventionalists can also earn practice performance credit through ABIM’s Approved Continuous Quality Improvement (ACQI) program. For example, more than 1,100 hospitals nationwide are participating in one such program, the Door to Balloon initiative (D2B). Physicians who have served, or are serving, as members of a team that worked on D2B in their hospital can attest to participation for MOC credit. A list of ABIM-approved CQI programs is at www.abim.org/acqi.

SCAI offers content on its website and programming at its meetings that prepares interventional cardiologists to take the recertification exam and facilitates fulfillment of ABIM’s requirements for self-assessment in medical knowledge and practice performance. This year at the Annual Scientific Sessions in Las Vegas, participants in the fully booked simulation sessions and the many attendees at the learning sessions earned self-evaluation points toward maintenance of certification (MOC). “I will have completed 60 of the 100 points here,” said one attendee.

Ted Feldman, M.D., FSCAI, chair of this year’s annual meeting, and Timothy A. Sanborn, M.D., FSCAI, a member of SCAI’s Education Committee, were instrumental in offering the MOC programming, which also included Practice Improvement Module (PIM) tutorial sessions. “It’s good what they’ve done at this meeting,” said one attendee. Another agreed, “Yes, the requirements are confusing, but once the process is explained, it’s straightforward.”

Look to SCAI’s Guidewire to MOC program, at http://www.scai.org/MOC, for step-by-step explanation of the MOC process and examples for completing ABIM MOC requirements.

(continued on page 18)
“As a hospital-based interventional cardiologist, I found working with the ACC-NCDR database and our D2B initiative a simple yet rewarding practice improvement experience,” said Timothy A. Sanborn, M.D., Head of the Division of Cardiology at NorthShore University HealthSystem and member of SCAI’s Education Committee. “Predominantly office-based interventionalists may find the ABIM PIMs for Preventive Cardiology, Hypertension, and Communication with Patients or Referring Physicians more worthwhile for their practice.”

If you have not enrolled in MOC, visit the ABIM website at www.abim.org to do so. You can access your password-protected home page using the “Physician Login” to enroll, complete your practice characteristics profile, and order modules. If your certification expires in 2009 and you have not yet scheduled your exam, please note that the deadline for registration for the fall 2009 exam is August 1.

Reconstructing the Clinical Experience Virtually, One Case at a Time

Complex, unusual, and sometimes controversial cardiovascular cases are seen in the hospital or practice setting every day. Following a successful case, interventionalists and surgeons may want to share information with colleagues, or when they encounter complications, they may seek guidance from expert colleagues. Sharing information or seeking advice from colleagues at the same institution or practice is mere steps away; doing so with colleagues around the globe can be challenging. Until now.

CardioVascularCS.org to the Rescue

In May, SCAI and EndovascularForum.org (EVF), an IC Sciences Company, collaborated to launch CardioVascularCS.org, an interactive website for interventional cardiologists to share knowledge, experience, and perspective on challenging cases with colleagues worldwide. CardioVascularCS.org, also known as Cardiovascular Forum, is an extension of EndovascularForum.org, the first interactive online forum dedicated to endovascular and cardiovascular specialists. Co-founded in 1996 by Barry Katzen, M.D., FACP, FACC, founder and Medical Director of Baptist Cardiac and Vascular Institute, and Jim Benenati, M.D., Medical Director, Peripheral Vascular Laboratory, Baptist Cardiac and Vascular Institute, in Miami, FL, EVF members collaborate to share, discuss, and debate clinical observations, findings, and cases to accelerate awareness and adoption of the most innovative and occasionally controversial procedures among physicians. The EVF, and now CardioVascular Forum, reconstructs the clinical experience virtually by presenting an interesting or difficult case, complete with interactive challenge questions, and inviting community members to participate in discussion about the case.

“The CardioVascular Forum is founded on the premise of shared discovery,” said John Heinen, chief technology officer and executive vice president of IC Sciences. “All clinical submissions come from a multispecialty, intra-disciplinary, and global physician membership. The physicians themselves create an international community of learners, all of whom share the same goal — delivering optimal care to their patients.”

EVF and CardioVascular Forum represent a growing online community with over 10,500 registrants from more than 135 countries. The goal of this partnership is to have every SCAI member become an actively contributing member of CardioVascular Forum. In addition to CardioVascular Forum’s partnership with SCAI, EVF partners with other leading endovascular and cardiovascular societies and symposia.

CardiovascularCS.org, a free online forum, gives physicians and other clinicians access to myriad learning options. CardioVascular Forum features Interactive Case Forums, where physicians post cases and registrants respond to interactive challenge questions and discuss the case; the innovative “Clinical Images,” in which physicians post images from unusual cases and registrants discuss the image; and video cases and slide decks from EVF’s and CardioVascular Forum’s family of participating partners. New cases post every week; registrants post new images at any time. Registrants are invited to submit cases through the interactive case study proposal tool. Physicians whose cases are published receive a $1,500 honorarium.

The forum also supports fast, informal case review or topic discussion through the interactive forum feature. Registrants can start or participate in discussions in topics such as coronary interventions, stroke, and vascular access. With simple clicks of the mouse, registrants can upload interesting cases and encourage discussion or debate; add links to and discuss recent journal articles; and seek feedback about a challenging case.
Inaugural Cardiovascular Forum Case Sparks Debate
CardioVascular Forum hit the ground running. Bonnie Weiner, M.D., FSCAI, past president of SCAI and professor and director of Interventional Cardiology Research, St. Vincent Hospital at Worcester Medical Center, Worcester, MA, posted the inaugural case entitled To Discharge or Not to Discharge?: How Soon Can Stable PCI Patients Go Home? This case discussed how soon a patient should be discharged following elective PCI and preceded by days SCAI’s publication of the consensus document, “Defining the Length of Stay Following Percutaneous Coronary Intervention.”

Almost immediately, Dr. Weiner’s case elicited an unprecedented burst of forum responses that led to ongoing discussion and debate. Physicians from around the world offered insight and opinions on how they would proceed. “Such debate and sharing of experience is precisely the type of learning we hope to foster on the Cardiovascular Forum,” said Dr. Weiner. “It’s like having a virtual annual meeting at your fingertips 24 hours a day, 7 days a week.”

A second case, Paradoxical Coronary Embolism, submitted by Jeffrey Cavendish, M.D., FSCAI, features six video clips showing the patient angiograms from the procedure.

For more information or to join Cardiovascular Forum, visit www.cardiovascularcs.org.

CME FROM SCAI AND PARTNERS

SCAI-SPONSORED PROGRAMS
To register for any of these programs, contact Rebecca Teichgraeber at rebeccat@scai.org or 800-992-7224.

2009 SCAI ADULT AND PEDIATRIC FALL FELLOWS COURSES
Date: December 7–11, 2009
Location: Las Vegas, NV
Directors: Michael J. Cowley, M.D., FSCAI, Bonnie Weiner, M.D., MBA, MSEC, FSCAI, Christopher U. Cates, M.D., FSCAI, and Ziyad M. Hijazi, M.D., MPH, FSCAI

ACCF/SCAI PREMIER INTERVENTATIONAL CARDIOLOGY OVERVIEW AND BOARD PREPARATORY COURSE
Date: Aug. 21–23, 2009
Sponsor: American College of Cardiology Foundation
Location: Dallas, TX
Directors: Joseph D. Babb, M.D., FSCAI, FACC, and James E. Tcheng, M.D., FACC, FSCAI
For more info: www.acc.org/ivboard

AATS HEART VALVE SUMMIT
Date: Sept. 10–12, 2009
Sponsor: American Association of Thoracic Surgery
Location: Chicago, IL
Directors: David H. Adams, M.D., FACC, Steven F. Bolling, M.D., FACC, Robert Bonow, M.D., MACC, and Howard C. Herrmann, M.D., FACC
For more info: www.aats.org/

THE CARDIAC CATH HANDBOOK LIVE V
Date: Sept. 11–12, 2009
Sponsor: Cooper University Hospital, Robert Wood Johnson Medical School
Location: Philadelphia, PA
Directors: Zoltan G. Turi, M.D., FSCAI, Ted Feldman, M.D., FSCAI, and Morton J. Kern, M.D., FSCAI
For more info: http://scai.org/drt1.aspx?PAGEID=5876

WOMEN IN INTERVENTIONS
Date: Oct. 15–16, 2009
Sponsor: Medtronic CardioVascular
Location: Chicago, IL
Directors: Kimberly A. Skelding, M.D., FSCAI, and Patricia Best, M.D.
For more info: http://scai.org/drt1.aspx?PAGE_ID=5876

INNOVATIONS IN CARDIOVASCULAR INTERVENTIONS
Date: Dec. 7–9, 2009
Sponsor: Dan Knassim, Ltd. Program
Location: Tel Aviv, Israel
Directors: Rafi Beyar, M.D., and Professor Chaim Lotan
For more info: http://www.congress.co.il/ici2008/home.html
1. TELL US YOUR NAME AND CONTACT INFORMATION. (PLEASE PRINT)

Name (Last, First, MI): __________________________________________________________
Gender: □ Male □ Female
Email: ____________________________________________________________
Degree: □ MD □ PhD □ DO □ MBBS □ Other
Address (This is where your journal will be mailed—check one): □ Business □ Home
____________________________________________________________________________
City: ___________________________ State: ______ Zip: __________ Country: __________
Phone: (_____)__________________ Mobile: (_____)__________________ Fax: (_____)________

2. CHOOSE THE MEMBERSHIP TYPE THAT IS RIGHT FOR YOU.

US AND CANADA APPLICANTS (CHECK ONE)

☐ Intervventional Affiliate (online journal only): … FREE
   □ Currently in an interventional training program
     Start Date: __________ End Date: __________
   
☐ Fellow (FSCAI): …………………………….. $475
   □ Board certified in interventional cardiology, or
   □ 5 years in practice & 1,000+ procedures
     (375+ for pediatric) □ Two sponsorship letters required
   
☐ Member: ……………………………………… $475
   □ Significant percent of time performing catheterization/interventions
   but not eligible for/desiring fellowship
   
☐ Advancement to Fellowship ………………………… $100
   (current member only):
   A CV is required for Fellowship.

INTERNATIONAL APPLICANTS (CHECK ONE)

☐ International Fellow (FSCAI): ………………… $335
   □ 5 years in practice & 1,000+ procedures (375+ for pediatric)
   □ Two sponsorship letters required
   
☐ International Associate (online journal only): … $100
   □ Current member of a non-U.S. interventional society
   List Society: ____________________________

*Sponsorship letters required as follows: 1st letter from an SCAI fellow, 2nd letter from other sponsor (e.g., colleague, cath lab director)

3. PROVIDE US WITH YOUR PAYMENT INFORMATION.

Payment Method: Check # _______________ □ Mastercard □ Am. Exp. □ Visa Amount $ __________
Credit Card # ____________________________________ CCV # __________ Exp. Date __________
Billing Address ________________________________________________________________
City: ___________________________ State: ______ Zip: __________ Country: __________

I hereby consent to the release by any hospital, educational institution, governmental agency, physician, professional society, or other person possessing or requiring the same whether or not listed above, of any and all information in any way pertaining to my personal character, training, experience, or professional competence.

I hereby release from any liability any and all individuals and organizations or their authorized representatives who provide this information in good faith and without malice subject to this consent.

I hereby release from all liability The Society for Cardiovascular Angiography and Interventions and any and all individuals for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications.

I hereby certify that all information recorded on this application and any attached documents is accurate and supports my qualifications for membership in The Society for Cardiovascular Angiography and Interventions for which I now apply. I hereby agree that The Society for Cardiovascular Angiography and Interventions may verify any of the above data. If approved for membership, I agree to conform to the Constitution and Bylaws of the Society (available upon request).

I __________________________________________________________________________ Date __________

SCAI staff will follow up with you for missing documentation.

THREE EASY WAYS TO SUBMIT!

MAIL
SCAI
2400 N Street, NW Suite 500
Washington, DC 20037-1153

FAX
(202) 689-7224

ON-LINE
www.scai.org

Questions?
Call (800) 992-SCAI
**Instructions for Sending Comments to CMS on the 2010 Proposed Physician Fee Schedule**

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below no later than 5 p.m. (Eastern Time) on Monday, August 31, 2009.

**ADDRESSES:** In commenting, please refer to file code CMS–1413–P. CMS does not accept comments by facsimile. You may submit comments in one of three ways:

1. Electronically: You may submit electronic comments on this regulation to http://www.regulations.gov/search/index.jsp. Follow the instructions under the “More Search Options” tab.
2. By regular mail: You may mail written comments to the following address ONLY:
   
   Centers for Medicare & Medicaid Services,
   Department of Health and Human Services,
   Attention: CMS–1413–P,
   P.O. Box 8013,
   Baltimore, MD 21244–8013

   **Please allow sufficient time for mailed comments to be received before the close of the comment period, which is 5 p.m. (Eastern Time) on Monday, August 31, 2009.**

3. By express or overnight mail: You may send written comments to the following address ONLY:
   
   Centers for Medicare & Medicaid Services,
   Department of Health and Human Services,
   Attention: CMS–1413–P,
   Mail Stop C4–26–05,
   7500 Security Boulevard,
   Baltimore, MD 21244–1850

**Talking Points and Form Letters**

We are asking ALL SCAI MEMBERS to write to CMS, urging the agency to stop these reductions. We strongly suggest that you send a letter in your own words and provide detail on your practice expenses in that letter. In your correspondence, please include the following:

- Introduce yourself as an interventional cardiologist and provide the location of the practice where you work.
- Tell CMS that Medicare payments for invasive and interventional cardiology procedures have already been reduced significantly.
- Stress that, despite what the AMA survey suggested, your practice expenses have not declined by 33% since 2003 (assuming this is the case) and provide examples from your own practice.
- Ask why almost half of the AMA survey responses were thrown out and why 55 responses is being considered a valid representation of all of cardiology.
- Point out that the survey data currently used to derive rates have passed stringent statistical tests regarding reliability and representativeness.
- Emphasize that the proposed cuts for 2010 will directly affect the quality of care you can render to Medicare beneficiaries because the cuts will require reduced staff sizes, limit your ability to maintain and upgrade equipment, and otherwise negatively impact your practice.

While a form letter is preferred, personalizing and sending the following form letter would be helpful.

---

**Form Letter from a Physician:**

As an interventional cardiologist and a member of the Society for Cardiovascular Angiography and Interventions, I am committed to providing high-quality, evidence-based patient care. However, the payment reductions included in the proposed 2010 Medicare Physician Fee Schedule (CMS–1413–P) will make that difficult.

I am especially concerned that the proposed fee schedule reduces reimbursement for services fundamental to prevention and early diagnosis. Specifically, in 2010, the fee schedule would no longer reimburse consultations at a higher level than typical physician visits, and fees for diagnostic angiograms would be reduced by 13%. These and other cardiovascular services have resulted in 40%-50% reduced mortality from heart disease from 1968 to 2000 and contributed to 25.8% reductions in age-adjusted death rates from coronary artery disease between 1999 and 2007. We have made tremendous strides in the fight against cardiovascular disease. This is not the time to reduce our efforts!

This proposal inflicts on average 14% reductions in payments for interventional cardiology based entirely on the results of a practice expense survey completed by only 55 cardiologists. Virtually no information is available to the public regarding these 55 respondents. It is unknown what types of practices the respondents have or whether they are representative of the average cardiovascular practice. By contrast, the survey data currently used to derive rates passed stringent statistical tests regarding reliability and representativeness.

The idea that cardiologists’ practice expenses dropped by 33% over the past several years is ludicrous!

Most important, I am very concerned that these changes will impact patients’ ability to access optimal cardiovascular care. Please do not implement these changes in 2010.

Sincerely,

[your signature]
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