SCAI News & Highlights
The Society for Cardiovascular Angiography and Interventions

SCAI Responds to Controversy: New and Ongoing Quality Initiatives Set to Roll in 2011

SCAI is starting the new year with a fresh approach to continuous quality improvement (CQI). Continuing a long history of setting standards for care with practice guidelines and appropriate use criteria, among other documents, and helping interventionalists achieve quality through the Society's Cath Lab Survey Program, SCAI is poised to release new tools that will help interventional cardiologists reach the highest professional standards: safe, effective, and appropriate care for their patients.

The new resources will include a set of position papers on quality assessment and improvement, a new program for independent accreditation of cath labs, and a quality improvement toolkit aimed at helping hospitals tailor quality programs to their own needs. All are due to be launched over the next several months.

These initiatives come at a time when healthcare institutions are preparing to adopt "pay for performance" models and

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SCAI 2011: Where Cutting Edge Meets Everyday Practice

Featuring a unique combination of one-to-one learning and a wide range of topics, the SCAI 2011 Scientific Sessions is specially designed to let attendees "program" the meeting to meet their educational needs.

"The overall goal for SCAI 2011 will be less emphasis on didactic sessions and more emphasis on smaller group learning," says SCAI President-Elect and Program Committee Chair Christopher J. White, M.D., FSCAI. "In these smaller groups, attendees will be able to steer the discussion in the direction they want it to go."

Now in its 34th year, the SCAI Scientific Sessions will be held May 4–7 at the Hilton Baltimore in Maryland, in walking distance of the city's Inner Harbor, with the world-renowned National Aquarium and Maryland Science Center as well as Camden Yards and the Spirit Cruise Lines. Dr. White is co-chairing the meeting with James B. Hermiller, M.D., FSCAI, Frank F. Ing, M.D., FSCAI, and Daniel S. Levi, M.D. FSCAI.

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SCAI Brings Full Quality Resources to Maryland

With a combination of expert advice, advocacy, media relations, and an array of quality tools, SCAI is taking the lead in addressing mounting concerns about the use of coronary stenting in Maryland. Allegations of overuse, raised against a very small number of interventional cardiologists, have prompted state regulators to examine stenting volume at hospitals throughout the state and have spurred full-fledged investigations by both state and federal agencies.

Although SCAI leaders have not commented on the merits of specific cases, they are proactively addressing the larger quality concerns it raises by reaching out to policymakers, journalists, and the public.

"SCAI is very actively engaged in this process," said SCAI President Larry S. Dean, M.D., FSCAI. "We want to be sure we address these issues properly, so that the regulations and legislation that are put in place have a meaningful impact on patient outcomes and are considered to be legitimate by both interventional cardiologists and the public."

Over the last year, a task force made up of SCAI members and representatives from the Maryland Chapter of ACC, with support from national ACC, have been meeting with Maryland lawmakers and regulators. Local interventionalist Mark A. Turco, M.D., FSCAI, has led discussions focused on such topics as the nuances of data analysis; the standards, guidelines, and quality tools available from SCAI and ACC to guide cath lab quality; the role of peer review in preventing and identifying problems in the quality of patient care; and the value of external oversight.

SCAI and ACC have proposed that Maryland legislators mandate external oversight of cath labs by the Accreditation for Cardiovascular Excellence (ACE) program, an independent accrediting body jointly formed by SCAI and ACC. In turn, the ACE program requires participation in National Cardiovascular Data Registry (NCDR®) or a similar registry that generates high-quality, risk-adjusted outcomes data, and will provide regulators and payers with a better alternative to administrative claims data for assessing the quality of cardiovascular care.

At the request of Maryland officials, SCAI and ACC have drafted comprehensive legislation, the Maryland Cardiovascular Patient Safety Act of 2011, which would mandate cath lab accreditation for all Maryland hospitals performing PCI, along with other quality assurance measures. The bill now has sponsors in both the Maryland House and Senate.

SCAI and ACC leaders have also been reaching out to reassure the public, communicating with journalists, including *The New York Times* and *Baltimore Sun*, among others, and serving as resources for media queries. For example, SCAI arranged for Dr. Turco to be interviewed by a number of media outlets, including an hour-long interview on the local NPR affiliate (listen at www.SCAI.org).

Among the worst consequences of the attention given to the Maryland case would be a loss of patient trust in interventional cardiologists or in the therapeutic value of PCI, Dr. Dean said. "Most of the public believes the vast, vast majority of interventional cardiologists are doing what's right for them," Dr. Dean said. "We would never want to lose that." ■

Quality Initiatives (cont'd from pg 1)

cardiologists are responding to allegations about the possible overuse of coronary stents. Together these trends make it increasingly clear that delivering the best possible care to patients—and proving it to healthcare regulators and payers—depends on more than skill in the cath lab. What's needed, SCAI believes, is an in-depth, comprehensive, and systematic approach to CQI.

Larry S. Dean, M.D., FSCAI

"We all want to give the best quality care to our patients," says SCAI President Larry S. Dean, M.D., FSCAI, director of the UW Medicine Regional Heart Center and professor of Medicine and Surgery at the UW School of Medicine in Seattle. "But as a profession, we have to step up and show that we're serious about policing ourselves. We have to take ownership, because we're the ones who understand the nuances of what's appropriate and what's not."

Charles Chambers, M.D., FSCAI

The problem with many quality improvement programs is they rely on outcomes tracking, and go no further, says Charles Chambers, M.D., FSCAI, who heads SCAI's Public Relations Committee and is a professor of medicine and radiology at Penn State in Hershey, PA. "Outcomes are important and benchmarking is essential to a quality improvement program, but CQI is so much more," he says. "Peer review, random case selection, looking at overall laboratory performance, working with appropriateness criteria, assessing guidelines, having protocols in place. That's what CQI is. It's the big picture."

The importance of a robust CQI program became obvious recently when allegations arose in Maryland over the possible overuse of coronary stents at one hospital, and then spread to other institutions as regulators used claims, or billing, data to raise questions about procedure volumes. Both SCAI and the American College of Cardiology are working closely with the State of Maryland to help regulators develop processes that ensure both the quality and appropriateness of cardiovascular interventions without imposing onerous oversight by those unfamiliar with the nuances of interventional cardiology.

For example, Dr. Dean and other SCAI representatives have been pointing out how an analysis can go awry when gauging the appropriateness of utilization using billing data alone. They are also introducing regulators to SCAI's longstanding quality resources—including clinical guidelines, appropriateness criteria, and the Cath Lab Survey Program—as well as the Society's new, soon-to-be-released CQI initiatives.

Among the new resources is a two-part SCAI position paper on quality assessment and improvement in interventional cardiology. Part I is slated for publication this winter in *Catheterization and Cardiovascular Interventions*. It describes the steps involved in initiating a CQI program that evaluates not just outcomes, but also the structure of the health system and the processes used to evaluate and improve clinical results. It defines both core and optional measures to use in assessing quality, as well as a systematic approach to data collection, data analysis, program intervention, and reassessment.

Lloyd W. Klein, M.D., FSCAI

"This is a call to cath lab directors that there is a right way of doing quality improvement and you need to do it the right way if you want to uncover problems," says Lloyd W. Klein, M.D., FSCAI, primary author on the position paper and professor of medicine at Rush Medical College in Chicago. "The key is to capture all of the relevant data, not just some of it. I'm hoping that this will be a foundation for the way each cath lab evaluates itself."

The Accreditation for Cardiovascular Excellence (ACE) program is another new resource for demonstrating quality in cardiovascular and endovascular procedures. An independent accrediting agency founded by SCAI and now also sponsored by ACC, ACE originally focused on review and oversight of facilities performing carotid artery stenting, in response to a mandate for accreditation from the Centers for Medicare and Medicaid Services (CMS). ACE standards encompass five areas: facility, personnel, quality assurance, patient indications, and patient outcomes.

Now that the application process for carotid stenting has been successfully launched, ACE has turned its attention to developing an accreditation program for facilities that perform other cardiovascular procedures, including cardiac catheterization, angiography, structural heart disease intervention, PCI, and non-carotid endovascular procedures. The PCI accreditation program is expected to launch in early 2011.

Christopher J. White, M.D., FSCAI

Sunil V. Rao, M.D., FSCAI

Also in the works is a QI toolkit being developed under the direction of Christopher J. White, M.D., FSCAI, SCAI's president-elect and chair for cardiovascular diseases at The John Ochsner Heart & Vascular Institute in New Orleans, and Sunil V. Rao, M.D., FSCAI, associate professor of medicine at Duke University Medical

Center, and director of the cath labs at Durham VA Medical Center in Durham, N.C.

Though it is in the early stages of development, Dr. White sees the toolkit as offering many options that cath labs can use in tailoring a quality program for their particular circumstances.

"People need suggestions and guidance, but quality programs also need to be grassroots," says Dr. White. "What I would like to do with this toolkit is empower 50 or 100 trainers who would teach quality to local hospitals in their region. Community hospitals would then be empowered to think about and draw up their own quality programs. They would understand how to do QI themselves."

Elements of the toolkit are likely to include a wide variety of tools, including but not limited to requirements for board certification, recommendations for appropriate industry relationships, guidance on how to interpret and use quality metrics in improving processes and outcomes, checklists for avoiding errors, and tools for facilitating random case review, cath lab conferences, community education, and continuing medical education events for physicians.

"The QI toolkit will range from personal aspects of yourself as a physician to what your role is in the community and the region," says Dr. White.

Some aspects of the new CQI initiatives may be controversial. For example, some interventional cardiologists may resist SCAI's call for enhanced internal peer review In essence, this recommendation would require cath labs to systematically pull random cases for each operator and arrange for peer review of outcomes and appropriateness, taking into account the patient's clinical circumstances.

"This is not a cath lab conference where you sit around and look at interesting cases," says Dr. Dean. "This is where you review random cases and actually look at the procedures in a meaningful way."

Peer review can be politically challenging, but quality experts consider it essential because it is one of the few ways to detect inappropriate utilization, as has been alleged in the Maryland case. Outcomes tracking and risk-adjusted benchmarking do a good job in identifying programs or operators that may be lagging in PCI proficiency, but they aren't designed to raise red flags about stents that shouldn't have been implanted in the first place.

"High-volume operators who stent borderline or non-occlusive lesions are likely to have tremendous outcomes, because the chances of complications are pretty low under these circumstances," says Dr. Chambers. "An outcomes-related QI program will not identify potential overuse. Random peer review is necessary."

No one is insisting, however, that peer review must be performed by an external party. As long as it is done properly and is not tainted by competitive motives, internal peer review can be effective.

What SCAI does insist, however, is that CQI programs, including peer review, must be done in a positive way. Catching problems early and correcting them is the goal, not public rebuke.

"If you put a quality program together that is negative, it breeds negativity, and you don't move forward with that," says Dr. White. "This is supposed to be a supportive, rehabilitative, restorative process. You're building toward doing things better, doing things with more facility and more safety."

Interventional cardiologists can learn more at SCAI's Annual Scientific Sessions in May, where an entire session will be devoted to quality improvement. This publication and SCAI's website, www.SCAI.org, will highlight SCAI's CQI activities and how members can participate, make suggestions, and ask questions. ■

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NCDR Responds to Need for Data on CHD Patients With New Registry

Congenital heart disease (CHD) occurs in approximately one of every 120 births, making it the most common birth defect in the United States. Thanks to medical and surgical advances, many children born with CHD live well into adulthood. However, until now, no resource for sufficiently collecting and analyzing quality improvement data related to these efforts has been available.

Now, facilities treating CHD patients can enroll in the new **IMPACT Registry™**, collect CHD data, and receive benchmark reports that will allow them to measure performance-related CHD interventions and identify ways to improve outcomes. Created through the ongoing commitment of the American College of Cardiology Foundation, SCAI, and the American Academy of Pediatrics, the IMPACT Registry will help clinicians assess the prevalence, demographics, management, and in-hospital outcomes of CHD patients who undergo diagnostic catheterization and catheter-based interventions.

The IMPACT Registry (IMproving Pediatric and Adult Congenital Treatment) is the sixth national clinical data registry of the National Cardiovascular Data Registry's (NCDR). It was successfully piloted this year, with 16 sites submitting data. Paving the way for new site enrollment, the pilot sites tested the usefulness of data elements collected and the feasibility for all centers to collect the information.

For more information or to enroll, contact the IMPACT Registry team at 800-257-4737 or ncdr@acc.org. ■

SCAI 2011

SCAI 2011 (cont'd from pg 1)

New Focus on Interactivity

The meeting will still feature old favorites, such as the Founders' Lecture, Hildner Lecture, and Mullins Lecture (see pages 6–7) and, of course, some large didactic sessions showcasing late-breaking clinical trials and case presentations, but **interactivity** will be the theme of the entire meeting. For example, the program will feature brown-bag lunch gatherings during the complex case review sessions.

"People who have come to this meeting in the past won't have seen the type of educational environment we will be offering at the brown bags and round table sessions," Dr. White explains. Instead of five faculty members speaking over a 90-minute period in one big room with seats for 200 people, there will be elements where we will move those faculty into smaller rooms with 10 to 15 seats.

"There will be more individualized programming," says Dr. White. "The teaching will be more one-on-one so that people can feel more comfortable about asking their questions as opposed to sitting in a big room and getting what everybody gets and maybe being too intimidated to ask their question."

Forever Favorite: Cased-Based Education

Based on past attendee feedback, which has consistently given high marks to case-based sessions, the Program Committee has asked faculty to feature cases as much as possible.

"We know that a case-based approach helps participants apply what they've learned to their own cases," says Dr. Hermiller. "Those have consistently been the best-attended sessions, from the pediatric/congenital 'I Blew It' session to the C3 Summit, where graduating interventionalists-in-training dissect their cases. Everybody loves those sessions."

"Talking about how a randomized clinical trial found that X was better than Y is important, but physicians learn in the process of conducting a case and treating a patient," says Dr. White. "The case-based approach allows individuals to make whatever the topic is more personalized, so it's about you and your problems."

"What I have always appreciated about the SCAI annual meeting has been the focus on cases, so we've loaded the pediatric/congenital program with case-based sessions," said Dr. Levi. "No matter your specialty or where you are in your career, you'll be able to learn from the Brain Scratchers and I Blew It sessions."

Hot Topics and Sizzling Controversies

There will also be some new emphases in the topics covered. One topic that will receive major attention is continuous quality improvement.

"Quality has always been, and will always be, integral to SCAI's mission and, therefore, an important part of the annual meeting," says Dr. White, "but it's taking center stage this year, amidst new concerns about appropriate and necessary care."

As reported on page 1, SCAI's response to worries arising from allegations against individual physicians have focused on quality, and specifically on efforts to standardize internal peer review processes as well as support external oversight through entities such as the Accreditation for

Cardiovascular Excellence (ACE) program. SCAI 2011 will feature a symposium on quality improvement.

"Our goal is to be able to offer a toolbox of methodologies for individuals to take home to their cath labs and use to put in place quality improvement projects," says Dr. White. "Every cardiologist can improve their work. Quality improvement doesn't imply that you're doing anything wrong; it simply says that we can all do things a little better."

This year's meeting will also offer more detail on cutting-edge topics than was possible at last year's event, says Dr. Hermiller. "Everyone wants more education on percutaneous aortic valves, percutaneous mitral valve repair, and structural heart disease with left atrial appendage closure. SCAI 2011 will provide that and more."

As in past years, sessions will examine the most practice-relevant clinical trials of the previous 12 months, giving attendees an opportunity to discuss with faculty how trials such as PARTNER, GRAVITAS, HORIZONS-AMI, and ZILVER-PTX should be altering their patient care. New to the pediatric/congenital is a new session titled "Late Great Pediatric Trials," featuring COAST.

Also new to the pediatric/congenital program is a brand-new session titled "Cardiovascular Thrombosis in the Pediatric Patient: Diagnosis and Treatment," which will feature information relevant to everyone who attends the program, stressed Dr. Levi. "This is a session I've never seen offered at another program, and it's necessary because so many of the complications we see in pediatric patients are secondary to clots," he said. "In fact, I think adult cardiologists should attend this session, too, because many are now seeing adults with congenital heart disease, and this session will feature issues they'll need to address."

The meeting's live cases will echo that emphasis on innovation. One highlight will be live and taped cases, showcasing new techniques, including some that haven't even come to the United States yet.

The Program Committee has also revamped some sessions. The Early Career Interventionalist Symposium, for example, will feature additional faculty and a longer time period. And the Mini-Symposium on Transradial Interventions may be outgrowing its name, says Dr. Hermiller. "It was a huge hit last year," he says, "so we're giving it a bigger room."

For more information or to register, visit www.SCAI.org/SCAI2011. ■

Award-Winning Reporter and Heart Attack Survivor Bruce Johnson to Discuss Communicating Through Media at SCAI 2011

Longtime journalist C. Bruce Johnson will deliver a presentation at SCAI 2011 that will foray into territory that may be new for many interventional cardiologists: how physicians can use media to communicate with the public. Mr. Johnson stands in a unique position to convey his message; he is both a journalist and a heart attack survivor, saved by angioplasty.

"I had a massive heart attack July 2, 1992, while working as a reporter in a tough neighborhood in Washington, DC," said Mr. Johnson, an Emmy Award–winning reporter and anchor for over 30 years with WUSA-TV9, the CBS affiliate in Washington, DC. "I went to Greater Southeast Hospital and then the Washington Hospital Center where they performed angioplasty."

That brush with death followed by the encouragement of a friend who lost her husband to a heart attack was the start of a personal mission for Mr. Johnson to tell the story of heart attack survivors and how physicians and patients can best work together for heart health. His book, *Heart to Heart: 12 People Discover Better Lives After Their Heart Attacks*, tells his story and those of 11 other survivors, digging into the roles of patient habits and the patient–physician relationship in heart disease treatment.

Journalist and patient Bruce Johnson will speak at SCAI 2011 on how physicians can get their messages to the public.

"One of the main things we try to communicate in this book is that patients need to be their own number one advocate and take more responsibility for their good health," said Mr. Johnson. "Too many times we show up at the doorstep of the emergency room or the doctor's office and say, 'Well, I've done my part to make myself sick and near

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Bruce Johnson (cont'd from pg 5)

death; you can fix me and save me.' We maintain in this book that we need to take just the opposite approach."

On the other hand, physicians have also responded to the book by saying it illuminated things about heart patients that they had not been aware of.

"Some of the biggest response we've gotten has been from doctors who said they didn't know; they've never had this kind of time to spend with their patients," he said.

To get the word out about his book *Heart to Heart*, Mr. Johnson has used the tools of the journalism trade, including newer social networking tools available to everyone, including physicians. He sees social networking as an exciting avenue physicians can use to communicate information to the public.

"Social media and the Web is the best thing that ever happened to people like doctors," he said, pointing to cutbacks in traditional media outlets such as television stations, which often have limited resources and may no longer have a dedicated medical reporter. Through the use of websites, physicians can post writing and stream video and audio of interviews. Use of social media can eventually lead to stories being picked up by television, radio, and newspapers.

"Don't wait on the media to come to you, and don't waste your time calling media that will never have time to get to you," said Mr. Johnson. "If you put it out there on the social network, and it's a good story—and trust me, if it's built around a patient, it's a good story, and get a good patient who can help you tell his or her story—once it's out there the media will come and find you."

Centering stories around the patient is a point that Mr. Johnson finds he cannot stress enough. As part of professional responsibilities, physicians hone the craft of speaking to and writing for one another. Finding a way to translate ideas meaningfully for a lay audience can sometimes present challenges. Whether physicians are communicating about good health practices, research, treatment advances, or legislation, to get the attention of the broader news media outside of professional publications, the lens through which stories must be presented is the patient.

"We know the doctors are the ones with the skills doing great work, but you are going to get a lot more attention, you are going to keep people coming back to your message and to your new messages, if you can just drive home the point that it's about the patient," he said.

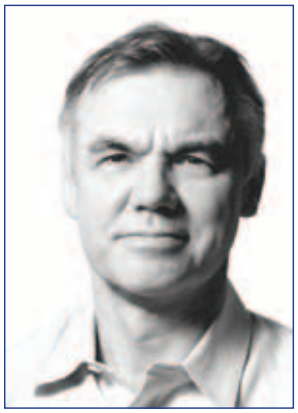
When using social networking to communicate a message, Mr. Johnson starts with some by now well-known tools: Facebook and YouTube. The website for his book contains links to a Facebook page dedicated to the book and to Mr. Johnson's individual Twitter account. He makes strong use of streaming video from YouTube and links to other organizations, such as audio streaming of an NPR interview he participated in.

In his talk in May at SCAI 2011 in Baltimore, Mr. Johnson will give suggestions for how physicians can use the same tools to inexpensively and effectively communicate with the public.

"The lines have changed in terms of the borders. Because of social networking, you're no longer just a doctor in Washington, DC, or Canton, Ohio, he said. "You are a doctor for the world. You can get out there with social media, and everybody can reach you, and you can reach everybody."

For more information or to register for SCAI 2011, log on to www.SCAI.org/SCAI2011. ■

Founders' Lecture to Explore Transcatheter Valve Therapies



John Webb, M.D., FSCAI

John Webb, M.D., FSCAI, has traveled the globe teaching fellow physicians how to repair or replace faulty heart valves using minimally invasive techniques. In May, he will deliver the Founders' Lecture at the SCAI 2011 Scientific Sessions, recounting the challenges that arose in the development of transcatheter valve therapies and previewing upcoming advances.

Dr. Webb, who has performed or proctored more than a thousand transcatheter aortic valve replacements in 20 countries, said that refining the technique was an arduous journey in itself.

"When we started, we could successfully implant the valves, but it was difficult to reproduce and not reliable," said Dr. Webb, the McCleod Professor of Heart Valve Intervention at the University of British Columbia in Vancouver. "With time, as each new problem was identified, we were able to take a careful look at it and analyze it and come up with a way of managing these patients so that these complications would be less likely. It was really a story of incremental improvements in the technique and patient selection and the device."

The first aortic balloon valvuloplasties were being done just as Dr. Webb was beginning his training in interventional cardiology. He became interested in how to improve the technique by doing more than just stretching the calcified aortic valve with a balloon. But skeptics dismissed the idea of an implantable valve as too far-fetched.

"We thought it was very possible that a transcatheter valve procedure could be developed and could be reproducible, but with no experience, nobody really knew

for sure," Dr. Webb said. "Certainly none of us had any idea that this would become as successful as it has been."

It was not until about 2006 that Dr. Webb became convinced that transcatheter aortic valve implantation would become a common procedure. Though practical obstacles still exist, he is confident they can be overcome. He continues to welcome a steady stream of cardiovascular teams to the University of British Columbia for intensive training.

"Over the long term, regulatory limitations will be resolved and funding limitations will be dealt with," he said. "The rate of transcatheter valve implantation will continue to rise, and in time it will be the dominant method of replacing aortic valves."

In his Founders' Lecture, Dr. Webb will also explore the development of transcatheter pulmonary valve procedures, mitral valve repair, and implantation of replacement valves inside failed surgical valves.

For more information or to register for SCAI 2011, log on to www.SCAI.org/SCAI2011. ■

Hildner Lecture: History of Coronary Stent Offers Inspiration for Today

Richard Schatz, M.D

Richard Schatz, M.D., can tell a story or two about how stenting has revolutionized cardiology. In May, he'll do just that when he delivers the Hildner lecture at the SCAI 2011 Scientific Sessions.

In his keynote address, Dr. Schatz will glance back at history, from the days when the treatment of myocardial infarction was so hands-off even nitroglycerin was frowned upon, to the first balloon angioplasty procedure by Andreas Gruentzig in 1977, to the implantation of the first coronary stent in the late 1980s.

"The forefathers who developed these devices worked really hard and leaped all sorts of barriers—too many to count," said Dr. Schatz, research director for cardiovascular interventions at the Heart, Lung and Vascular Center at Scripps Clinic in La Jolla, CA. "It's important to realize how easy life is now thanks to guys like Gruentzig and Palmaz. Without the stent, our lives would be miserable."

A collaboration between Dr. Schatz and radiologist Dr. Julio Palmaz, the ground-breaking Palmaz-Schatz coronary stent became commercially available in the United States in 1994, after years of development and clinical trials. Dr. Schatz's challenge was to take a peripheral stent developed by Dr. Palmaz and figure out how to make it better, smaller, and more flexible, so that it was suitable for the coronaries.

The Palmaz-Schatz coronary stent hit the market just in time to secure interventional cardiology's future. Some of the initial enthusiasm for angioplasty was starting to wane, as high restenosis rates cast doubt on its long-term effectiveness. Stenting changed all that and has continued to improve clinical outcomes with each innovation.

The history of the coronary stent provides a model for interventional cardiologists today, Dr. Schatz said.

"I would encourage them to always be innovative, to not be satisfied with the way things are in the cath lab," he said. "Every time somebody hands you a device, you should look at it and say, 'How can I make this better?'"

For more information or to register for SCAI 2011, visit www.SCAI.org/SCAI2011. ■

Just Announced: Dr. John Cheatham to Deliver Mullins Lecture

Don't miss the next issue of *SCAI News & Highlights*, featuring a sneak preview of SCAI 2011's Mullins Lecture. John Cheatham, M.D., FSCAI, will present "The Past, Present, and Future of Hybrid Procedures." Dr. Cheatham is the George H. Dunlap Endowed Chair in Interventional Cardiology, director of Cardiac Catheterization and Interventional Therapy, and co-director of The Heart Center at Nationwide Children's Hospital in Columbus, OH.

John Cheatham, M.D., FSCAI

SCAI's First Global Interventional Summit Reflects Worldwide Collaboration and Commitment to Improving Patient Care

Cardiologists came from five continents and dozens of countries to attend the inaugural Global Interventional Summit.

More than 30 cardiology societies from around the world came together in Istanbul Oct. 22–24 for SCAI's first Global Interventional Summit (GIS).

Sponsored by SCAI in collaboration with the Turkish Society of Cardiology, the GIS was a unique opportunity to share new ideas and perspectives, promote equal partnership and collaboration among interventional cardiologists from around the world, and ultimately improve patient care worldwide. About 350 cardiologists from North America, Europe, Asia, South America, and Africa participated.

"We all face the same fundamental challenges," said SCAI Past President Ziyad M. Hijazi, M.D., MPH, FSCAI, of Rush University Medical Center in Chicago. "A growing number of SCAI members are based outside the United States. Only through collaboration and communication can we find solutions to challenges. And SCAI, which is a society dedicated purely to interventional cardiology, can help make that happen."

Dr. Hijazi and SCAI Past President Ted Feldman, M.D., FSCAI, of Northshore University HealthSystem in Chicago, directed the program in collaboration with Oktay Ergene, M.D., FSCASI, FESC, president of the Turkish Society of Cardiology, and Levent Saltik, M.D., FSCAI, of Istanbul University Cerrahpasa Medical School.

"We saw cooperating with SCAI in organizing a Global Interventional Summit as a good opportunity to establish a unique and prestigious international scientific meeting in this field," said Dr. Ergene. "Both SCAI and the Turkish Society of Cardiology considered this cooperation not as a one-time trial but as the successful initiation of a joint project."

A New Kind of Meeting

The various international cardiology societies didn't just attend the summit as participants. Instead, they also helped lead it.

"Instead of identifying faculty ahead of time, we reached out to all the societies to create the faculty for the meeting," explained Dr. Feldman. "Each society sponsored two faculty members. This is a totally new way of putting a meeting together."

Attendees could participate in either or both of the GIS's two educational tracks. One track, directed by Dr. Feldman, focused on adult coronary, carotid, and peripheral interventions and featured case-based scenarios. The other, directed by Dr. Hijazi, focused on pediatric and adult congenital and structural interventions. Topics covered included aortic valve disease, mitral valve disease, and hypoplastic left heart syndrome.

Both tracks featured live cases, ranging from simple procedures to complex percutaneous valve implantation, transmitted via satellite to attendees at the summit. "The live cases were more or less thematic with the lecture and case presentation material in each session," said Dr.

Feldman. "It's one thing to talk at the podium, but when you can see real procedures, it brings out a discussion of the reality of practice."

The live cases were performed by guest interventionalists from around the world, with facilitation by local Turkish cardiologists. "The live cases offered a great opportunity for cardiologists from around the world to learn from one another," added Dr. Feldman. "When you go to a large western European or American meeting, you see a very homogenous approach to interventional procedures. The demands on the operator to be creative in using the equipment available are much greater in other parts of the world."

Faculty recommended by regional and national medical societies moderated sessions in two tracks: pediatric and adult congenital and structural interventions, as shown here, and adult coronary, carotid, and peripheral interventions.

Another highlight of the summit was the Global Roundtable Discussion Series. Organized and led by representatives of the various interventional societies, these small group discussions promoted dialogue on issues faced by interventionalists both in and out of the cath lab. "We all got to hear first-hand from different societies from around the globe about the issues in their countries," said Dr. Hijazi. "The discussion was lively and informal."

Some roundtables focused on clinical issues, such as the transradial approach; valve therapies; off-label use of devices for pediatric and congenital patients; contrast agents; radiation in the cath lab; and left main, drug-eluting, and bifurcation stenting. "The Roundtables demonstrate that you can do catheterization in so many ways," said Dr. Hijazi. "What we do in the United States is good, but there are other ways to approach problems."

Other roundtable discussions focused on nonclinical issues, such as training of early-career interventionalists, quality standards in the cath lab, and the development of registries.

"There was a lot of interest in training program requirements, accreditation of cath labs, and physician operator credentialing," noted Dr. Feldman. "In the world outside the United States, there are very few standards, and people are really struggling with ways to manage these challenges. Of course, the Society has a decades-long history of addressing these issues."

Looking to the Future

The meeting was a big hit with participants, said Dr. Hijazi. "They gave very positive feedback, and many participants became new members of SCAI at the summit. Most were saying that the meeting was so excellent they would like to see it happen every year."

It's too early to say whether that will happen, says Dr. Hijazi, adding that the summit may become an every-other-year event. And SCAI would love to return to Turkey, which Dr. Hijazi described as "the bridge between east and west."

The Turkish Society of Cardiology would welcome SCAI back, said Dr. Ergene. "We are glad to select SCAI as our partner to establish such an important international event that will hopefully become a tradition in the calendar of cardiovascular meetings in future years," said Dr. Ergene.

For more information about the Global Interventional Summit, visit www.SCAI.org/GIS. ■

Thank You From SCAI

SCAI gratefully acknowledges the following generous supporters of the Global Interventional Summit:

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SCAI Announces New Editor-in-Chief for *CCI*

On Jan. 1, 2011, SCAI Immediate Past President Steven R. Bailey, M.D., FSCAI, became the new Editor-in-Chief of the Society's official journal, *Catheterization and Cardiovascular Interventions (CCI)*. Dr. Bailey steps into the role filled for the last 10 years by Christopher J. White, M.D., FSCAI, and for two decades before that by the *Journal*'s founding editor, Frank Hildner, M.D., FSCAI.

"It is an honor to follow two such accomplished Editors-in-Chief," says Dr. Bailey. "Under their leadership and vision, *CCI* has flourished and grown to be the preeminent journal for our profession."

Editors Through the Decades: SCAI's official journal, *Catheterization and Cardiovascular Interventions*, has evolved with the field of Interventional Cardiology. The *Journal* was established and nurtured by Dr. Frank Hildner (right) when the profession was in its infancy. Over the past 10 years, Dr. Chris White (left) grew the *Journal's* readership, scope, and quality during a period marked by stiff competition and the move to electronic publishing. And now, on the cusp of a new decade, Dr. Steve Bailey (center) has plans to build on the accomplishments of his predecessors while launching innovations all his own.

Dr. Bailey intends to continue the tradition of ongoing improvement and development of new readership. He has assembled a team of Section Editors to join the Editorial Board (see sidebar) and to grow the *Journal*'s content in new and evolving areas, including treatment of valvular heart disease. "I value the support of these experts and am looking forward to working with them," says Dr. Bailey.

A Smooth Transition

The editorial transition actually began several months ago, with Dr. White gradually transferring *CCI's* reins to Dr. Bailey and his team in San Antonio, TX. "Dr. Hildner was there for me when I took over," says Dr. White. "And Steve and I have known each other forever, so it was an easy process."

Both men served in the Army, working as interns together and later embarking on similar paths in cardiovascular medicine. "We've been competitive with each other since Army days, but it's been a respectful competition that forged a great friendship," says Dr. White.

"I know Steve will do a great job," he adds. "He has good ideas and will be committed to the *Journal*."

Dr. White's advice to Dr. Bailey: "Energize *CCI* by making it your own. The *Journal* is a direct reflection of you."

Taking the Lead

Dr. Bailey's plan is to build on the successes achieved by his predecessors while implementing new ideas. "As one example, we want to continue the tradition of improving the *Journal*'s impact factor – a marker of quality used in the publishing world – while still publishing the case reports that are so valuable to us as interventional cardiologists," says Dr. Bailey.

He also plans to reenergize the *Journal*'s sections on cath lab basics, hemodynamics, and pharmacology. "These were signature features launched by Dr. Hildner," says Dr. Bailey. "I'm pleased to honor Frank in this way while providing a means for all of us to refresh our knowledge of these important topics."

In addition, says Dr. Bailey, "we plan to enhance *CCI's* scientific content by adding statistical reviews of submitted manuscripts. This important and often-overlooked perspective will ultimately improve the *Journal's* quality."

CCI's New Section Editors

Joining *CCI*'s Editorial Board as Section Editor are the following SCAI Fellows:

Theodore Bass, M.D., FSCAI
Helen Hazuda, Ph.D., FSCAI, Statistical Consultant
Ziyad M. Hijazi, M.D., MPH, FSCAI
Morton Kern, M.D., FSCAI
Valerie A. Lawrence, M.D., FSCAI
Roxana Mehran, M.D., FSCAI
John Webb, M.D., FSCAI

Dr. Bailey is also eager to implement new initiatives, many of which build on rapidly evolving communications tools. For starters, he intends to link the *Journal*'s web content to video, especially for case reports.

"It will add value for all of our readers to read cases and then watch them," he says. "We will also add SmartTags to link content to the e-table of contents and other content in the *Journal*."

Dr. Bailey is also already working closely with both *CCI*'s publisher, John Wiley & Sons, Inc., to streamline access to the *Journal* and submission of manuscripts. One example of how Dr. Bailey is fast-tracking the manuscript review is with an expedited process for manuscripts that have been submitted but not accepted to other journals. As long as authors submit the comments from the reviewers at the other journal and have made appropriate changes to the manuscript, SCAI's review process will be shortened considerably. He is also coordinating with SCAI to publish documents essential for the growth of the profession.

"One of *CCI*'s important roles is as the official journal of SCAI," he says. "I expect the *Journal* to play an increasing role in the dissemination of information from the Society, including the practice guidelines, appropriate use criteria, consensus documents, and position papers that will help our specialty and our Society."

SCAI President Larry S. Dean, M.D., FSCAI, is excited to see where Dr. Bailey will take *CCI* over the next five years. "Steve is in a great place to take *CCI* to the next level," says Dr. Dean. "His experience on many SCAI committees and as president give him unique insights into the *Journal*'s role in improving cardiovascular care and what SCAI members throughout the world need from their *Journal*." ■

Dr. White Recalls Ten Years as *CCI* Editor-in-Chief

"It has been an unbelievable ride," says Christopher J. White, M.D., FSCAI, of his 10-year tenure as *CCI*'s Editor-in-Chief. "It has been a daily challenge but also a fulfilling one, and I'm proud of the results. The *Journal* has become essential reading for interventional cardiologists."

For the past 10 years, Dr. White has logged no less than 15–20 hours per week focused on *CCI*. Although he enjoyed the job, he was ready to hand the *Journal* over to his successor and long-time friend Steven R. Bailey, M.D., FSCAI.

"I'm proud to hand Steve a different beast," says Dr. White. "I put my own stamp on the *Journal*, just as he will."

Challenges Along the Road

During his decade-long "ride" as *CCI* Editor, Dr. White faced a series of challenges, including new competitors and the need to supply readers not just with a quality print experience but also an electronic medium that keeps up with the profession and developments in communications.

In the early days, he says, "my goal was to broaden the *Journal*'s audience without changing *CCI*'s unique quality. By that I mean, the 'tips and tricks' so loved by interventional cardiologists. I knew even in the beginning that was what kept readers coming back for more."

To achieve this balance, Dr. White grew the *Journal*'s credibility – calculated with a publishing metric known as "the impact factor" – while preserving its focus on case reports. He explains: "Advertisers measure *CCI*'s value by its impact factor, but our readers evaluate its value based on the cases."

In fact, *CCI* now has the highest impact factor of all journals focused on invasive/interventional therapies.

"I'm really proud of that," he says. "Publishing case reports actually handicaps your impact factor, but we knew they were essential to *CCI*'s identity and educational value for readers, so we kept them."

The case reports are also part of what makes the *Journal* fun to read, says Dr. White. They, along with the online comments written by the Editorial Board, give the *Journal* energy. "They make the *Journal* come alive for readers. We turn them around in two weeks. I think we're the only journal that does that."

CCI's quality also grew over time. Today, fewer than one in four submitted manuscripts is accepted, up from one in two a decade ago.

"We've improved the quality of the *Journal*, raised our profile, and managed to keep up with competition," says Dr. White.

A Strong Finish

Dr. White's last responsibility to *CCI* was to make the transition to his successor smooth, and to be a resource for Dr. Bailey. "Steve will do a great job. I'm excited to see what he'll do with the *Journal*. He has good ideas, and *CCI* will continue to grow with him."

"On behalf of SCAI, I sincerely thank Chris for his dedication to *CCI* and to the Society. We are all better caregivers thanks to his stewardship and vision," says SCAI President Larry S. Dean, M.D., FSCAI.

SCAI's Know What Counts Public Education Program Sparks Debate About Health Reform

Then gubernatorial candidate Dan Onorato told attendees he would need their help to solve the healthcare challenges facing Pennsylvania.

"Health reform will bring challenges to quality," stressed Program Director Dr. Tony Farah. "We have to be ready to face these challenges so patients continue to receive quality care."

This fall, SCAI brought together in Pittsburgh, PA, approximately 200 patients and their families, physicians, nurses, hospital administrators, payers, and journalists to examine the potential impact of health reform on the various stakeholders in health care. Cosponsored by the Preventive Cardiovascular Nurses Association (PCNA) and WomenHeart: The National Coalition for Women with Heart Disease, the latest offering in SCAI's Know What Counts regional public education program featured a lively debate between attendees and keynote speaker Allegheny County Chief Executive and then gubernatorial candidate Dan Onorato (D).

"Health care involves everyone, so it's important to involve everyone in the discussion about reform, from policymakers to payers and providers to patients themselves," said SCAI Trustee and Know What Counts Committee Chair Tony G. Farah, M.D., FSCAI. "I wanted to put everyone in the same room and have a healthy dialogue about the issues."

The timing couldn't have been better, added Dr. Farah. "It was less than two weeks before the November elections, and Pennsylvania's governor's race was very close. Both voters and media were very interested in hearing what Mr. Onorato had to say and in getting some perspective on the hot topic of reform. The only thing that would have made it better is if the Republican candidate had come, too."

In fact, SCAI had invited Mr. Tom Corbett, who went on to win the election by a small margin, but his absence didn't quell interest. In fact, all three of the area's major newspapers covered the event, focusing largely on the questions attendees threw at Mr. Onorato, such as where the candidate stood on malpractice reform and how he planned to help the Commonwealth rein in costs.

Cost and quality were the two topics that came up repeatedly in the four-hour program, especially when Deborah L. Rice, executive vice president of Health Services at Highmark, Inc., the area's largest insurance provider, described issues the insurance industry will face with implementation of the Patient Protection and Affordable Care Act.

"It's not really healthcare reform. … It's really insurance reform," she said, "and it will affect all constituents – providers, hospitals, and payers. I do believe that, as an industry, the insurers are part of the problem, but I think we all are. We need to ask how we can use healthcare reform as a burning platform to launch from. We have an opportunity to work in

Complementary Continuing Education Program Focuses on Personalized Medicine

The Know What Counts program in Pittsburgh also featured a program where healthcare providers could earn continuing education credits while learning about another topic likely to impact how cardiovascular disease is diagnosed and treated in the future. "Are You Ready for Personalized Medicine? Implications for Your Patients, Your Practice, and Your Health Care System" helped attendees understand how advances in biomarkers research, genetic testing, and gene therapy may reshape risk stratification and cardiovascular care.

a much more collaborative way to address some very real challenges."

Among those challenges, said Ms. Rice, is the fact that healthcare costs now comprise 17 percent of the gross domestic product. "And it's growing at a rate faster than can be managed," she said. "It's a problem we need to figure out."

She pointed to the impacts of both underuse and overuse: Because preventive and early detection services are often underused, costs are driven up, even as inefficiencies in the healthcare systems can lead to overuse, such as when tests are repeated because the patient changes providers.

Ms. Rice predicts significant changes in the payer industry, including high regulation of insurance products and much more consumer-driven purchasing. "It's going to be complicated," she said. "There are a lot of components that will drive us all to work differently together."

"The health reform law is 2,700 pages long and contains over 1,000 amendments. It is one of the most complex pieces of legislation ever passed, and it will affect everyone in this country," said Dr. Farah. "It's incumbent on all of us to understand its provisions."

Hospitals and providers will need to adapt in major ways, predicted both Dr. Farah and Christopher T. Olivia, M.D., who is president and CEO of the West Penn Allegheny Health System. Because the health reform law will be funded through a combination of taxes and fees as well as Medicare and Medicaid cuts, said Dr. Farah, healthcare providers will see changes as reimbursement models move away from fee for service and toward bundled payments. Meanwhile, the country's 131 academic medical centers will face a host of new challenges.

"These hospitals are often the last resort for many patients," said Dr. Farah. "They take care of many of the country's uninsured and are where many of the scientific breakthroughs happen. And, of course, they are where we train the next generation of doctors."

"In times like these, it can be difficult to remember that it's not about us—the providers—or politics. It's about patient care and individual patients. We have to keep that focus," stressed Dr. Farah as he talked about how innovations in the treatment of heart attack impacted one patient in particular, Art Thompson, a three-time heart attack survivor who spoke at the program. Mr. Thompson told the audience about his experience as a patient and his concerns about how he and his wife of 30 years would access specialty care in the future.

"I worked as long as I could, for 39 years, to make sure I had health coverage," said Mr. Thompson. "What I want to know now is what will happen to my wife and myself as cuts keep coming. Will we still have access to [specialist] doctors when we need them?"

"Patients will have to be more proactive about their care," said Barbara Johnston Fletcher, R.N., MSN, who serves on PCNA's Board of Directors and who co-directed the Know What Counts program. "Health reform is helping health professionals realize we can't do it alone. It's going to take a team approach."

In her talk titled, "Self-Care and Your Health," Ms. Fletcher described two scenarios where patients, under the guidance of their health professionals, might be active in identifying and monitoring their symptoms and, addressing them appropriately.

"Patients respond very positively to the self-care management model, and there are research data to show it does make a difference," said Ms. Fletcher. "For example, we see reduced emergency room visits and shorter hospitalizations as well as improvements in physiological and psychological measurements. All of these things can translate to improved outcomes and reduced healthcare costs."

"Almost every day two or three patients ask me how health reform will affect them," said Dr. Farah. "It's a topic on everyone's mind. One attendee even suggested the program should be broadcast on public television."

In the age of social media (see p. 5), the Internet may trump TV for program dissemination. Check out video footage from this Know What Counts program and others at www.SCAI.org and www.SecondsCount.org.

Know What Counts Committee Seeks Volunteers

Dr. Farah is hopeful SCAI members will volunteer to host Know What Counts programs in their own cities. The Know What Counts Committee is working hard to make it easy for members to take on the task. "This is the fourth of these programs, and we've nearly arrived at a template so they can be to a certain extent portable," he said. "We want to minimize the work each Know What Counts 'champion' has to invest while at the same time create an excellent experience for attendees."

To volunteer to host a Know What Counts program or to join the Know What Counts Committee, contact Kathy Boyd David at kbdavid@SCAI.org. ■

SCAI Thanks …

SCAI has undertaken the Know What Counts public educational initiative with its own resources as well as commercial support. The programs in Pittsburgh were supported in part by Abbott Vascular and Medtronic CardioVascular. The Society gratefully acknowledges this support while taking sole responsibility for all content developed and disseminated through the effort.

Fall Fellows Program Sets Stage for Successful Careers

The SCAI Fall Fellows Courses celebrated its fifth anniversary in December 2010 by welcoming a record number of interventional cardiology fellows-in-training for a week of learning and networking. More than 275 fellows from around the world joined an international faculty in Las Vegas, NV, for five days of didactic education, hands-on learning, and a chance to meet their colleagues who represent the future of the field.

Arriving from six continents, 31 countries, and 37 states, fellows-in-training were exposed to a range of topics in interventional cardiology. Attendees were able to pre-register for one of two programs: the Adult Cardiology Course or the Congenital/Structural Heart Disease Course as well as a number of hands-on training opportunities conducted before the official program kick-off.

Attendees enjoyed the small-group sessions that allowed them to work closely with thought-leaders in interventional cardiology. They gave high marks to case presentations and simulator-based training to enhance the knowledge gained from the educational sessions. Beginning with basic science and focusing on techniques and new technologies, the course concluded with advice from the experts on strategies for success and how to begin a successful career.

In addition to the structured programs, pre-program workshops provided by the Canadian Society of Interventional Cardiology and evening satellite symposia were in high demand. Rounding out the enrichment opportunities provided on site were complimentary enrollment for SCAI membership benefits; free registration for the Interventional Fellows Institute online program; and access to the SCAI Career Center, which features interventional cardiology positions available throughout the United States.

The Adult Cardiology track was directed by Michael J. Cowley, M.D., FSCAI; Bonnie Weiner, M.D., MSEC, MBA, FSCAI; and Christopher U. Cates, M.D., FSCAI. The Pediatric/Congenital track was directed by Ziyad M. Hijazi, M.D., MPH, FSCAI. The program directors were joined by more than 30 faculty who were widely available throughout the course for one-to-one discussions with the fellows-in-training. Fellows made good use of the availability of the faculty and enjoyed the unique opportunity to seek advice and discuss their careers with many of the field's most well-known experts.

The SCAI Fall Fellows Courses are held annually in December for fourth-year interventional cardiology fellows-in-training and third-year pediatric fellows-in-training; spots are available for fellows-in-training from outside of the United States and Canada. For more information about the Fall Fellows course, including information about 2011 course dates and registration, visit www.SCAI.org/Fellows. ■

Acknowledgments

SCAI expresses deep appreciation for generous support from the following companies in making the SCAI 2010 Interventional Cardiology Fellows Course a success.

Gold
- Abbott Vascular
- Boston Scientific

Silver
- Cordis Cardiac & Vascular Institute
- Daiichi Sankyo Lilly
- Edwards Lifesciences
- Medtronic
- Merck
- The Medicines Company
- W. L. Gore and Associates, Inc.

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- NuMed, Inc.
- St. Jude Medical

SCAI appreciates the in-kind support of educational simulators from:
- Abbott Vascular
- Cordis Cardiac & Vascular Institute
- Mentice
- Terumo Medical Corporation

For in-kind support of vascular access models, SCAI thanks:
- Cook Medical

For in-kind support of FFR and OCT, SCAI thanks:
- St. Jude Medical

SCAI Enhances IFI and ICI Assessment Questions

The Interventional Fellows Institute (IFI) and the Interventional Cardiologists Institute (ICI) now offer an expanded selection of assessment questions to ensure fellows-in-training and practicing physicians can maximize their usage of these valuable resources. With more than 2,000 interventional cardiologists from around the world now registered, the IFI and ICI programs continue to be a mainstay in SCAI's growing list of educational offerings.

The IFI and ICI programs are complimentary benefits for SCAI members. The IFI site is provided as a resource for fellows-in-training and program directors to supplement interventional cardiology training programs, while the ICI website offers the same curriculum to practicing physicians in need of Board preparation or general review.

> "Whether the course is used for board review or just as a refresher on a specific topic or technique, physicans will find the extra practice opportunities to be a great addition to the curriculum."
> –Dr. Parikh

Increased Assessment Opportunities

Current program users are familiar with the IFI and ICI curriculum, which features 14 courses containing more than 70 units on a wide range of interventional cardiology topics. While assessment exams that test knowledge on the broad range of subjects covered within each course have been available since the program's release in 2006, regular users have been asking for more.


Manish Parikh, M.D., FSCAI

"The IFI and ICI courses cover a significant amount of material, and until now there hasn't been a sufficient way to really test a physician's comprehension of the subjects," explained IFI and ICI Program Director Manish Parikh, M.D., FSCAI. "While the course-level exams are important for general understanding, the unit-level exams allow a physician or a fellow-in-training to delve deeper into what they are taking away from each presentation. With more training programs and more physicians looking for education than ever before, these assessment tests greatly enhance the online program's value for all of our users."

IFI and ICI's most recent update introduces more than 1,000 new practice exam questions to the overall program. The newly released unit tests feature 5–10 questions available in conjunction with each of the presentations within the program. Users will be able to take the unit tests either before or after they review the curriculum, which allows the unit exams to serve as both a pre- and post-test. Unlike the existing course-level tests, which are scored and available only one time per user, the unit-level tests are designed to be taken multiple times to allow physicians and fellows-in-training to use them for review and to enhance their understanding of the material.

New Questions Beneficial for All Users

An integral part of the IFI program are the course-level exams, where fellows-in-training complete a test covering up to eight units to test their understanding of a range of topics. Exam results are instantly scored and passed along to program directors for review, and a fellow receives his or her score by meeting with the program director to review the questions scored right and wrong. These exams, available only once per user, are entered into the fellow's transcript. While course-level exams continue to be an important part of IFI's structure, the fellows were looking for additional opportunities for practice.

"Fellows-in-training have requested more practice test questions that can be taken multiple times," Dr. Parikh said. "These practice exams allow fellows to really master each of the topics covered within a course before they tackle the larger course exam. More practice allows fellows to feel more confident with the material, and they are able to demonstrate a larger body of knowledge when they complete the course-level exams."

Practicing physicians also benefit from additional test questions. "With many SCAI members turning to ICI as a useful tool for review and certification preparation, the new questions offer physicians a significant amount of practice," Dr. Parikh explained. "Whether the course is used for board review or just as a refresher on a specific topic or technique, physicians will find the extra practice opportunities to be a great addition to the curriculum."

Getting Started

Registration for the program is complimentary. To register and learn more, visit www.interventionalcardiologistsinstitute.com or contact SCAI's Online Education Manager Stephanie Mathias at smathias@scai.org or 800-922-7224.

Sponsorship

The IFI and ICI courses are supported by an educational grant provided by the Cordis Cardiac and Vascular Institute. ■

SCAI Makes Important Updates to CME Procedures

To strengthen compliance with the Accreditation Council for Continuing Medical Education's (ACCME) latest criteria for CME providers, SCAI is making several modifications to its existing CME policies and procedures. They are necessary in order to comply with ACCME's current requirements.

As has always been SCAI's policy, and in accordance with ACCME requirements, all Society committee members and faculty presenters are required to complete a conflict of interest disclosure form, indicating their existing financial relationships with commercial interests. Those who decline to provide this information to SCAI are absented from participation in SCAI activities.

Newly required by SCAI, and also to comply with ACCME requirements, is the addition of a conflict of interest resolution attestation form, to be completed only by those faculty presenters who have relationships with commercial interests to disclose. Those faculty members will be asked to resolve potential conflicts by having a peer review the content of their assigned presentation(s), or by providing their presentation to the program committee for review. In either instance, the review will need to be completed at least one week before the start of the program. If conflicts are identified, the presenter will be asked to resolve those conflicts based on the recommendation of the reviewer and/or program committee. Those who do not complete this conflict resolution activity will be absented from participation in the program in question.


Timothy Sanborn, M.D., FSCAI

"SCAI believes that these changes will bring the Society into stronger compliance with the ACCME's requirements," said SCAI Education Committee Chair Timothy Sanborn, M.D., FSCAI. "SCAI also recognizes that as today's CME environment becomes increasingly scrutinized, these changes are necessary in order to remain completely transparent in our activities."

To comment, or for any questions related to these changes, contact SCAI's CME Department at cme@scai.org or 800-992-7224, ext. 703. ■

CME CALENDAR FROM SCAI AND PARTNERS

SCAI program | Program jointly sponsored with SCAI | Program cosponsored by SCAI

FEBRUARY 2011

– 2011 SCOTTSDALE INTERVENTIONAL FORUM (SIF)

Date: Feb. 17–19, 2011
Sponsor: Scottsdale Heart Group at Scottsdale Healthcare Hospitals
Location: Scottsdale, AZ
Directors: David Rizik, M.D., FACC, FSCAI, Mark Reisman, M.D., FSCAI, and James B. Hermiller, M.D., FSCAI
For more info: www.SCAI.org/Education/CosponsoredEvents.aspx

APRIL 2011

– 2011 CONCEPTS IN CONTEMPORARY CARDIOVASCULAR MEDICINE

Date: April 28–30, 2011
Sponsors: Memorial Hermann Heart & Vascular Institute, Texas heart Institute at St. Luke's Episcopal Hospital, and UT Health Science Center at San Antonio
Location: Houston, TX
Directors: Richard W. Smalling, M.D., Ph.D., FSCAI, Zvonimir Krajcer, M.D., Steven R. Bailey, M.D., FSCAI, Christopher J. White, M.D., FSCAI, and Colin Barker, M.D.
For more info: www.cardiovascularconcepts.org/Home Page.html

MAY 2011

– SCAI 2011 ANNUAL SCIENTIFIC SESSIONS

Date: May 4–7, 2011
Location: Baltimore, MD
Directors: James B. Hermiller, M.D., FSCAI, Christopher J. White, M.D., FSCAI, Frank F. Ing, M.D., FSCAI, and Daniel S. Levi, M.D., FSCAI
For more info: www.SCAI.org/SCAI2011 or kcurtis@scai.org or call 800-992-7224

– C3 SUMMIT FOR INTERVENTIONAL FELLOWS

Date: May 6, 2011
Location: Baltimore, MD
Director: Jeffrey J. Popma, M.D., FSCAI
For more info: www.SCAI.org/C3 or kcurtis@scai.org or call 800-992-7224

SEPTEMBER 2011

– THE VEINS CHICAGO 2011: NATIONAL VENOUS INTERVENTIONAL SUMMIT

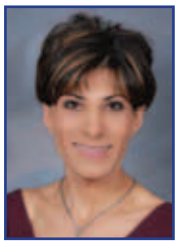
Date: Sept. 23–25, 2011
Sponsor: Prairie Education and Research Cooperative (PERC)
Location: Chicago, IL
Directors: Gregory Mishkel, M.D., FSCAI, and Raghu Kolluri, M.D.
For more info: www.SCAI.org/Education/CosponsoredEvents.aspx

SCAI WIN and Abbott Vascular Launch Patient Screening Pilot

SCAI Women in Innovations (WIN) is partnering with Abbott Vascular's Women's Heart Health Initiative to pilot a national patient screening effort designed to improve the quality of care provided to all female patients. Launched to address the referral gap between obstetrician/gynecologists (ObGyns) and cardiologists, the new project recognizes first that many women see their ObGyn as their primary care physician and, second, that not all ObGyns are trained to recognize the symptoms of cardiovascular disease, the leading cause of death for women in the United States. Through this project, SCAI WIN and Abbott Vascular aim to increase the chances of early detection of heart disease in women.

SCAI WIN has worked with Abbott Vascular to design a screening tool for ObGyns and their staff to use for the duration of the project. Abbott Vascular is also sponsoring educational forums at project pilot sites and has prepared materials for such forums, so that the volunteer sites can easily educate their clinical teams. The goal is to screen 3,000 patients, and for SCAI WIN to use the resulting data to launch future projects related to the care of female patients with heart disease.


Sudhir Mungee, M.D., FSCAI


Michelle Couri, M.D

Seven sites are participating in the pilot, with more expected to sign up. Among the pilot sites is Heartcare Midwest in Peoria, IL, where the project is led by physician champions Sudhir Mungee, M.D., FSCAI, and local ObGyn Michelle Couri, M.D. At press time, they expected to screen at least 500 patients by the start 2011.

"The concept of empowering women with knowledge regarding their cardiovascular risk was appealing and could translate into future favorable outcomes," said Dr. Mungee, who noted that the key to success at Heartcare Midwest was a strong working relationship with the local ObGyn community.

"Signing up for this project was an easy decision because our office already practices integrative medicine," said Dr. Couri. "Integrative medicine requires treating the whole patient rather than just the symptoms immediately relevant to their gynecological health. After getting screened, my patients are thanking me for caring about them so much."

Also emphasizing the importance of establishing buy-in from the ObGyn Department was David Dobies, M.D., FSCAI, who is director of the Genesys Heart Institute at Genesys Regional Medical Center in Grand Blanc, MI. "Following the support of leading Genesys obstetrician Dr. Joseph Kingsbury, we were able to make the initiative a priority amongst the entire staff," explained Dr. Dobies, whose site had screened almost 200 patients at press time.

> "The concept of empowering women with knowledge regarding their cardiovascular risk was appealing and could translate into future favorable outcomes."
> –Dr. Mungee


David Dobies, M.D., FSCAI

"With heart disease taking the lives of more women than any other disease, Abbott is focused on actively supporting public health initiatives that can have a positive impact on women's lives," said Robert Hance, Abbott's senior vice president, vascular. "Abbott's Women's Heart Health Initiative is an innovative program that partners with the ObGyn community to increase the screening and diagnosis of cardiovascular disease in women. Through this initiative, our goal is to promote the early detection of heart disease, with the hope of improving survival rates for women across the country."


Roxana Mehran, M.D., FSCAI

WIN Chair Roxana Mehran, M.D., FSCAI, is also enthusiastic about the partnership and its potential for improving patient outcomes. "SCAI WIN is honored to work with Abbott Vascular on this project," she said, "and we are excited to see its advancement in hopes of gathering data to support future projects related to improving the state of women's heart health."

For more information on how to enroll your site in the project, contact Abbott Vascular's Women's Heart Health Initiative Director, Jerri Anne Johnson at jerri.johnson@av.abbott.com.

For more information on SCAI Women in Innovations, visit www.scai-win.org. ■

The Importance of Focus in the Early Interventional Career

By Emmanouil S. Brilakis, M.D., Ph.D., FSCAI


Emmanouil S. Brilakis, M.D., Ph.D., FSCAI

I distinctly remember the day in my last year of fellowship when a young faculty member reviewed my CV. He commented on the lack of focus of my research efforts and wondered why I had done projects all over the map: electrophysiology, acute coronary syndromes, interventional techniques, and biomarkers, among others. He was genuinely perplexed. Initially, I did not take these comments well. I thought I had done a pretty good job getting involved in research and being productive, and that the comments were unfair. After some time, however, I started realizing that he was more right than I wanted to admit.

Why is focus important, especially early in an interventional career?

- Because **time is limited,** especially in the current era of rapid developments. Learning to do everything well is not feasible.
- Because focus provides for **development of true mastery of a topic,** and better appreciation of what is known and what is not known in an area. Understanding what is not known allows for meaningful research.
- Because focus enables (gradual) **development of expertise** in an area. This is how you grow into someone whom people think of when questions arise on the topic. You become the expert who is asked to review manuscripts and grants, and give presentations on this topic. This can lead to a geometric growth, as you get exposed to cutting-edge facets of the topic and interact with other leaders in the field.

What should you focus on?

Some of the best advice on where to focus is given in the book *Designing Clinical Research,* by Hulley and Cummins, who summarize the selection of a research project (which is I believe is similar to selecting a research or clinical focus area, or any project) by the acronym FINER:

F, for **feasible**, is the beginning point. Choosing an area in which you have access to several patients is important. If you see only a handful of hypertrophic cardiomyopathy patients each year, then it would not be wise to try to develop it as your area of focus.
I, for **interesting:** If there is no excitement about the topic, momentum is unlikely to build and the inevitable obstacles along the way may not be overcome.
N, for **novel**. Cardiac auscultation was at the forefront several decades ago, but is unlikely to sustain a research or practice focus today.
E is for **ethical,** and
R stands for **relevant**, as in of interest to others.

Interventional cardiology offers unique opportunities for focus, such as:

- Many **novel areas to choose from,** including (but not limited to) percutaneous valve interventions, left atrial appendage occlusion, chronic total occlusion angioplasty, peripheral interventions, and novel imaging techniques, such as computed tomography, near-infrared spectroscopy, and optical coherence tomography.
- **Opportunities to match clinical and research interests,** a very powerful combination.
- Numerous **options to seek funding for research and clinical work,** through industry, the NIH, and foundations.
- A **large potential audience** of interventionalists motivated to learn how to improve their practice and skills.

Words of caution:

1. A career in interventional cardiology resembles a marathon more than a sprint. Focus is important but will not provide immediate results. It takes time to "pay your dues" and master an area. How much time? 10,000 hours, says Malcolm Gladwell in his book *Outliers*. This is equivalent to 3 hours per day for 10 years. Progress can, however, be geometric after an initial "lag" in preparation time.
2. Focusing on a novel procedural area will invariably result in times of stress and disappointment. Continued preparation can improve judgment on when to push the limits and when not to. It can also improve the technical skills for "bailing out" if complications occur.
3. Deciding what to focus on is not a decision to be taken lightly or expeditiously. It is best based on the junction of what is available and your personal goals and interests. Talk to as many people as possible, read, attend conferences, and take time to think. Much like selecting a spouse, choosing your area of focus will determine your actions and progress for many years to come.

Focus is extremely important during the early stages of an interventional career – at the end of fellowship and at the beginning of your own practice. This is a time of steep learning clinically, procedurally, and in research. Focus forms the foundation for what will subsequently develop. For me, the encouragement to focus was one of the best pieces of advice I received.

Dr. Brilakis is an associate professor of Medicine at the University of Texas Southwestern Medical School and director of the cardiac catheterization laboratory at VA North Texas Healthcare System. He is a member of SCAI's Interventional Career Development Committee and the Staged PCI Clinical Document Writing Committee. ■

Do You Understand the New Diagnostic Cardiac Codes?

Driven by pressure from the Centers for Medicare and Medicaid Services (CMS) and the AMA RUC, the CPT Editorial Panel created new "bundled" non-congenital cardiac catheterization codes that must be used to report these services, effective Jan. 1, 2011. The new "bundled" diagnostic cardiac catheterization codes are fairly simple, with most cases now reported using a single code. However, such a drastic departure from traditional coding conventions has sparked requests for clarification regarding the use of these new codes. Some of the more common questions are presented below.

If you or your coding staff have additional questions regarding the correct use of these new codes, submit inquiries to dhopkins@scai.org.

Q: The cross-references in the 70000 series angiography section are confusing. For example, 75605 appears to direct the additional reporting of 93567 [injection procedure during cardiac catheterization including image supervision, interpretation and report for supravalvular aortography]. Is the book directing me to additionally report the new code?

A: Code 93567 is only reportable in conjunction with cardiac catheterization. CPT merely updated old existing cross-references within CPT. The intent for the use of the new code supersedes these cross-references, which are merely a guide to make billers aware that these new codes exist.

Q: It's not at all uncommon to have a non-selective renal at the time of a cath. For Medicare, we would use the G0275 [renal angiography, non-selective, one or both kidneys, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of any catheter in the abdominal aorta at or near the origins (ostia) of the renal arteries, injection of dye, flush aortogram, production of permanent images, and radiologic supervision and interpretation], but for patients covered by any insurance carriers that do not recognize Medicare G-codes, is 75625 [Aortography, abdominal, by serialography, radiological supervision and interpretation] the appropriate code?

A: In order for the 75625 to be applicable, one cannot examine just the renal arteries; discussion of the aorta would need to be included in the report. Whereas non-selective renal artery(ies) studies are included in abdominal aortography, a non-selective study of the renal arteries alone would not be sufficient to report 75625. If only a non-selective renal angio is performed without study of the aorta for commercial carriers, consider 75625-52.

Q: Can 75774 [angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation] be reported for each additional bypass graft selected?

A: No. Doing so would ignore the "(s)" in the descriptors for the graft codes (93455, 93457, 93459, 93461), would be inappropriate, and might be considered as abusive coding. ■

SCAI urges all members to get educated on how to use the newly created bundled codes for diagnostic catheterization. To help members prepare to implement the new coding, SCAI and ACC created and hosted a special coding webinar in December. SCAI members can access it in their MySCAI box at **www.SCAI.org.**

SCAI Helps Clear Up Confusion About Stents

In an episode of the *Dr. Oz Show* that aired Nov. 9, 2010, entertainer and cardiothoracic surgeon Dr. Mehmet Oz took aim at stents and their role in the treatment of cardiovascular disease. To help clear up confusion that may have resulted from sensational promotions suggesting stents are unnecessary and dangerous, SCAI filmed and disseminated via social media and SecondsCount.org a short video showcasing the work interventional cardiologists do and the role of PCI in cardiovascular care. The video features SCAI leaders and a number of patients who were successfully treated with PCI. The video can be accessed at www.SCAI.org and on www.SecondsCount.org. SCAI is also making the videos available on DVD for members who want to show it in their waiting rooms and for patient groups.

The SecondsCount.org Editorial Board, under the leadership of Editor-in-Chief Mark A. Turco, M.D., FSCAI, developed and posted a guide to help patients with four questions Dr. Oz recommended every prospective patient ask his or her doctor before receiving a coronary stent. The information on www.SecondsCount.org will help patients and their families better understand how interventional cardiologists decide if they will benefit from a stent.

"Use the information here to assist you in having a conversation with your doctor about stents," the site suggests. "Angioplasty and stents can save lives if you are having a heart attack and can relieve pain and improve your quality of life if you have a blockage in your heart artery, but like any medical treatment, they are not for everyone. A conversation with your treating physician is the best way to determine if a stent is right for you."

SCAI is urging members to direct patients to SecondsCount.org for this and other information about invasive/interventional therapies. ■