



Table of Contents

- 1 **The Specialty They Built:
Building on the Momentum**
Stephen T. Dalby, MD, FSCAI, FPICS
- 9 **Medical News**
 - Johns Hopkins All Children's Hospital's Hypertrophic Cardiomyopathy Program Named a Center of Excellence
 - America's Best Children's Hospitals 2026 in Pediatric Cardiology & Cardiac Surgery
 - Researchers Identify ADHD and Social Traits in Preschoolers with Heart Defects
- 14 **Meeting Calendar**

The Specialty They Built: Building on the Momentum

Stephen T. Dalby, MD, FSCAI, FPICS

The Specialty We Inherited

Not long ago, the congenital cardiac catheterization laboratory looked very different than it does today. A typical day often consisted of diagnostic hemodynamic assessments, angiography, balloon atrial septostomies in newborns with transposition of the great arteries, balloon valvuloplasty for isolated valve stenosis, and occasional coil embolization or device closure of straightforward lesions. These procedures were transformative for their time, but they largely complemented surgical care rather than redefined it. Most pediatric cardiologists performing catheterization shared a similar procedural skill set, and advanced subspecialty training beyond pediatric cardiology fellowship was uncommon. In many institutions, catheterization was viewed as one component of comprehensive pediatric cardiology practice rather than a distinct procedural discipline.

The compensation and organizational structures that developed during this era reflected that reality. Congenital catheterization was appropriately considered a procedural extension of pediatric cardiology, and physicians performing these procedures were valued accordingly. At the time, there was little reason to think otherwise.

The Specialty They Built

The remarkable evolution of congenital interventional cardiology (CIC) did not occur because new devices simply became available. It occurred because a

generation of congenital interventional cardiologists reimagined what could be accomplished in the catheterization laboratory. As Sergio Bartakian describes in *The Evolution of the Congenital Interventional Cardiologist*, the specialty has continuously adapted to meet increasingly complex clinical challenges, expanding not only the procedures performed but also the expectations placed upon the physicians performing them.¹

Today's congenital interventional cardiologist is no longer defined simply by technical expertise with wires, catheters, and devices. Instead, the specialty has become one of the most multidisciplinary fields within pediatric cardiovascular medicine. Modern intervention requires collaboration with congenital surgeons, cardiac intensivists, advanced imagers, anesthesiologists, electrophysiologists, heart failure specialists, and industry partners to develop therapies that often did not exist only a few years earlier. The interventional cardiologist has become not merely the operator in the catheterization laboratory, but a central architect of patient care.

Perhaps no area of pediatric cardiology has experienced innovation at the pace seen within congenital intervention. Procedures once considered experimental have become standard therapy at experienced centers. Neonatal ductal stenting has fundamentally altered palliation strategies for selected infants with ductal-dependent pulmonary blood flow.² Transcatheter pulmonary valve replacement has transformed the lifetime management of right ventricular outflow



TABLE OF CONTENTS

1 The Specialty They Built: Building on the Momentum

Stephen T. Dalby, MD, FSCAI, FPICS

9 Medical News

- Johns Hopkins All Children's Hospital's Hypertrophic Cardiomyopathy Program Named a Center of Excellence
- America's Best Children's Hospitals 2026 in Pediatric Cardiology & Cardiac Surgery
- Researchers Identify ADHD and Social Traits in Preschoolers with Heart Defects

14 Meeting Calendar

From our hands to hearts around the world



PICS San Diego | August 30 - September 2, 2026 | Booth #416



tract dysfunction, reducing repeat sternotomies and changing expectations for both patients and surgeons. Hybrid procedures have expanded therapeutic options for infants and children who previously had few viable alternatives. Advances in imaging, including three-dimensional rotational angiography, fusion imaging, intracardiac echocardiography, and patient-specific procedural planning, have further expanded what is technically possible.

Importantly, these advances have not simply added new procedures to the congenital interventional toolbox – they have fundamentally shifted treatment paradigms. Increasingly, the question is no longer whether a patient requires intervention, but whether that intervention should occur in the operating room, the catheterization laboratory, or through a hybrid approach that combines the strengths of both. In many centers, congenital interventional cardiologists now participate in these decisions as equal procedural partners with congenital surgeons, helping define treatment strategies rather than simply executing them.

The expertise required to practice congenital intervention has evolved accordingly. Dedicated advanced fellowship training has become the norm, reflecting the reality that mastery of modern congenital intervention extends well beyond what can reasonably be achieved during a standard pediatric cardiology fellowship.³ Operators are expected to possess expertise in structural heart disease across the lifespan, advanced imaging integration, device engineering, radiation safety, vascular access, mechanical circulatory support, and the management of critically ill neonates and adults with Congenital Heart Disease. The learning curve no longer ends with fellowship – it requires continuous adaptation as technologies and techniques continue to evolve.

The expectations placed upon congenital interventional cardiologists have likewise expanded beyond clinical care. Many now lead catheterization laboratories, direct quality improvement initiatives, participate in multicenter clinical trials, collaborate in device development, mentor fellows, and help shape institutional programs. Increasingly, they are called upon to build regional referral networks, develop multidisciplinary structural heart programs, and serve as ambassadors for innovation within their institutions. These responsibilities, while essential to advancing the field, are largely invisible within traditional measures of physician productivity.

This evolution has created a specialty that bears little resemblance to the one that existed a generation ago. The congenital interventional cardiologist of today is no longer simply a pediatric cardiologist who performs catheterizations. Rather, they are a highly specialized proceduralist, an innovator, an educator, a program builder, and an integral partner in the multidisciplinary care of patients with Congenital Heart Disease.

The specialty has matured. The question now is whether the systems used to evaluate, benchmark, and compensate congenital interventional cardiologists have matured with it

The Disconnect Between Innovation and Valuation

While CIC has evolved dramatically, the systems used to recognize, benchmark, and compensate their physicians have remained largely unchanged. This disconnect is not simply a matter of physician compensation – it reflects a broader failure to recognize how profoundly the specialty itself has matured.

The current framework for valuing congenital interventional cardiologists is largely a legacy of an earlier era, when cardiac catheterization was one component of general pediatric cardiology practice. Although the work performed in the catheterization laboratory has fundamentally changed, congenital interventional cardiologists are still frequently benchmarked, evaluated, and compensated within general pediatric cardiology compensation models. In many institutions, productivity expectations, faculty salary surveys, and compensation committees continue to compare congenital interventional cardiologists with physicians whose practices are primarily outpatient and cognitive rather than procedural. This comparison no longer reflects the realities of modern practice.

By virtually every objective measure, CIC now more closely resembles other advanced procedural specialties than general pediatric cardiology. The field requires additional fellowship training, mastery of highly specialized technical skills, management of critically ill patients, sophisticated imaging integration, multidisciplinary procedural planning, and the ability to perform interventions that increasingly substitute for surgical therapy. Similar characteristics define pediatric surgical subspecialties, structural heart intervention, and interventional radiology, yet CIC is rarely valued alongside these disciplines.

The mismatch becomes even more apparent when physician work is measured through traditional productivity metrics. Relative value units (RVUs) were designed to estimate physician effort based on time, technical skill, mental effort, and procedural risk. In practice, however, RVU-based compensation often rewards procedural throughput more effectively than procedural complexity. Congenital interventions frequently require hours of meticulous planning and execution, individualized device selection, multidisciplinary coordination, and prolonged intraprocedural decision-making. Two procedures with similar RVU assignments may differ dramatically in technical complexity, physiologic risk, and cognitive demand. As congenital intervention has advanced, this disconnect has become increasingly apparent.

This challenge has been recognized by leaders within our own specialty. In the recent Society for Cardiovascular Angiography and Interventions (SCAI) Policy Statement on Economic Barriers to Interventional Cardiology Care for Adults and Children With Congenital Heart Disease, Box and colleagues describe a reimbursement environment that frequently undervalues congenital intervention because existing payment systems inadequately account for procedural complexity, infrastructure requirements, and the multidisciplinary resources necessary to care for patients with Congenital Heart Disease.⁴ The authors



note that many congenital catheterization programs depend on institutional support despite providing highly specialized regional referral services that cannot be easily replicated. They also highlight the ongoing challenges associated with procedural coding, valuation, and reimbursement that continue to limit the financial sustainability of congenital interventional programs.

Importantly, these observations should not be interpreted as criticism of current reimbursement systems alone. Rather, they illustrate that valuation frameworks have simply failed to evolve at the same pace as the specialty they are intended to measure. Innovation in congenital intervention has accelerated over the past two decades, while systems used to define physician value have remained comparatively static. The result is an increasing gap between the complexity of modern congenital intervention and the mechanisms used to recognize it.

The consequences extend well beyond physician compensation. When procedural complexity is undervalued, institutions may underestimate the resources required to support congenital interventional programs. Recruitment of additional faculty becomes more difficult. Protected time for research, education, device development, and program building becomes increasingly difficult to justify. Smaller programs struggle to recruit and retain highly trained interventionalists, placing additional strain on existing physicians and potentially limiting patient access to advanced therapies. As highlighted by both the SCAI Policy Statement and recent workforce projections, these pressures raise important questions about the long-term sustainability of CIC if current valuation models remain unchanged.⁴⁻⁶

Perhaps the most important question is not whether congenital interventional cardiologists should be paid more. It is whether the specialty is being measured appropriately in the first place.

If modern congenital intervention truly functions as a highly specialized procedural discipline – one that increasingly replaces surgery, demands advanced technical expertise, requires

additional years of dedicated training, and serves as a regional resource for complex Congenital Heart Disease – then it should be evaluated through that lens. Continuing to define CIC primarily as a procedural subset of general pediatric cardiology no longer reflects the specialty that has emerged.

Recognizing that distinction is not merely semantic. It is the essential first step toward developing valuation systems, compensation models, and institutional expectations that accurately reflect the work congenital interventional cardiologists perform today.

Building on the Momentum

Fortunately, CIC is not beginning this conversation from scratch. Over the past decade, leaders within our specialty have increasingly recognized that the rapid evolution of congenital intervention has not been matched by corresponding changes in reimbursement, physician valuation, or workforce planning. Through organizations such as SCAI, the American College of Cardiology, and other professional societies, congenital interventional cardiologists have invested countless hours improving procedural coding, advocating for more accurate valuation of physician work, and developing policies that support sustainable access to specialized care. Much of this work occurs behind the scenes, but it has established an essential foundation for future progress.

The recent SCAI Policy Statement by Box and colleagues represents an important milestone in these efforts. Beyond outlining reimbursement challenges, the document recognizes CIC as a unique procedural discipline and offers a thoughtful framework for addressing many of the structural barriers facing the specialty. By highlighting limitations in current valuation systems, the need for congenital-specific coding expertise, and the financial realities confronting congenital catheterization programs, the statement shifts the conversation beyond physician compensation to one centered on patient access, workforce sustainability, and the long-term health of congenital

heart programs. This editorial is intended to build upon that momentum.

Meaningful progress, however, cannot depend solely on the efforts of professional societies or a small group of physicians serving on coding committees, Relative Value Scale Update Committee (RUC) advisory panels, or national leadership positions. Lasting change will require broader engagement from the congenital interventional community. Just as innovation in the catheterization laboratory has depended upon collaboration across institutions, continued progress in physician valuation will require collective participation from physicians throughout the specialty.

That participation can take many forms. Some physicians will contribute through leadership within SCAI, the ACC, or other professional organizations. Others will participate in multicenter registries, outcomes research, device development, coding initiatives, or health policy efforts. Many will advocate closer to home by educating hospital administrators, compensation committees, and health system leaders about the complexity and value of congenital interventional programs. Fellowship directors can also prepare the next generation of congenital interventional cardiologists not only to become exceptional proceduralists, but also to understand the administrative, economic, and policy forces that increasingly shape modern practice.

At the same time, there are several practical opportunities to move the specialty forward.

First, we must consistently define CIC as the highly specialized procedural subspecialty it has become. Language shapes perception, and perception ultimately influences valuation. Whether discussing recruitment, faculty appointments, compensation, or institutional planning, congenital interventional cardiologists should no longer be viewed simply as pediatric cardiologists who perform catheterizations. They are advanced procedural specialists whose practices increasingly parallel those of pediatric surgical subspecialists, structural heart interventionists, and interventional



radiologists in technical complexity, procedural responsibility, and multidisciplinary leadership.

Second, we must continue generating evidence that demonstrates not only procedural success, but also the broader value of congenital intervention. As a specialty, we have excelled at measuring technical outcomes. We should now place equal emphasis on demonstrating reductions in repeat surgery, hospital length of stay, healthcare utilization, quality of life, and lifetime resource use. These data will become increasingly important when engaging hospital leadership, payers, and policymakers responsible for supporting congenital heart programs.

Third, institutions should critically examine how congenital interventional cardiologists are evaluated and compensated. Productivity models designed primarily for outpatient cognitive specialties are poorly suited for physicians whose practices center on lengthy, technically demanding procedures, regional referral care, multidisciplinary program development, and innovation. While procedural volume remains important, institutional expectations should also recognize procedural complexity, program leadership, research, education, quality improvement, and the unique role congenital interventional cardiologists play in building comprehensive congenital heart programs.

Perhaps most importantly, the specialty must continue to tell its own story. Congenital interventional cardiologists have traditionally allowed their work to speak for itself. That humility has served patients well, but it has also contributed to persistent misconceptions regarding what modern congenital intervention actually entails. Many administrators, policymakers, and even colleagues outside the field still associate congenital catheterization with the procedures of two decades ago rather than the highly specialized, multidisciplinary practice it has become. If we do not clearly communicate how our specialty has evolved, we should not be surprised when outdated perceptions continue to shape outdated valuation models.

This is not a call for CIC to separate itself from pediatric cardiology. Quite the opposite. Every major advance in Congenital Heart Disease has resulted from close collaboration among cardiologists, surgeons, intensivists, imagers, anesthesiologists, nurses, technologists, and industry partners. The same collaborative spirit that transformed patient care must now be applied to ensuring that congenital intervention is appropriately recognized, supported, and sustained.

The history of CIC has been defined by physicians willing to challenge assumptions, embrace innovation, and redefine what was possible for patients with Congenital Heart Disease. The next challenge is different, but it demands the same mindset. As our specialty continues to evolve, we must ensure that the systems responsible for measuring its value evolve alongside it.

The Next Generation

Every generation of congenital interventional cardiologists has inherited a field defined by the vision and perseverance of those who came before. The pioneers of congenital catheterization demonstrated that many lesions once thought to require surgery could be treated through catheter-based techniques. The next generation expanded those boundaries through device innovation, transcatheter valve therapies, hybrid procedures, and increasingly sophisticated interventions that have fundamentally changed the care of patients with Congenital Heart Disease.

Today's trainees are inheriting a specialty unlike any that existed even a decade ago. They are entering catheterization laboratories equipped with advanced imaging technologies, novel devices, multidisciplinary heart teams, and procedural capabilities that continue to expand at an extraordinary pace. They are learning procedures that were once considered experimental and are now becoming standard practice. More importantly, they are entering a field that continues to redefine what is possible for children and adults with Congenital Heart Disease.

Yet they are also entering a specialty facing important challenges.

The pathway to becoming a congenital interventional cardiologist has never been longer. Additional fellowship training has become the norm, reflecting the technical and cognitive demands of contemporary practice. Procedural complexity continues to increase, as does responsibility for program development, quality improvement, research, education, and regional referral care. Expectations have expanded in nearly every dimension of practice.

For many trainees, these realities are accompanied by an important question: Is this career sustainable?

That question encompasses more than compensation. It includes mentorship, professional fulfillment, opportunities for innovation, work-life integration, institutional support, and the ability to build a long and rewarding career. However, valuation remains an important part of that equation. A specialty that requires additional years of training, assumes increasing procedural risk, and delivers extraordinary value to patients should also provide a professional environment that reflects those demands.

Our responsibility extends beyond ensuring fair recognition for today's congenital interventional cardiologists. It includes creating a specialty that continues to attract talented physicians who are inspired by its mission and confident in its future. If we fail to align the specialty's valuation with its evolution, we risk making an already demanding career path less attractive to the very individuals who will define its next chapter.

Conversely, if we successfully build a professional environment that recognizes the true value of congenital intervention, we strengthen not only recruitment but also innovation, collaboration, and patient care. Every advancement that has transformed Congenital Heart Disease – from the first balloon valvuloplasty to contemporary transcatheter valve replacement – has depended upon gifted physicians choosing to devote their careers to this field. Ensuring that future



generations continue to make that choice is one of our greatest responsibilities.

Ultimately, the future of CIC will be determined not only by the procedures we invent, but by the people we inspire.

Conclusions

Congenital interventional cardiology has become one of the most innovative and technically sophisticated procedural specialties in pediatric cardiovascular medicine. Through decades of collaboration, creativity, and perseverance, congenital interventional cardiologists have transformed the care of children and adults with Congenital Heart Disease, expanding therapeutic possibilities in ways that were scarcely imaginable a generation ago.

The specialty has evolved. Our systems for recognizing and valuing it must evolve as well.

Achieving that goal will require continued innovation - not only in the catheterization laboratory, but also in how we define physician work, measure value, support programs, and prepare the next generation of interventional cardiologists. Professional societies, institutions, and individual physicians each have an important role to play. Some will advance procedural innovation, others will contribute through research, advocacy, education, leadership, or workforce development. Together, these efforts will shape the future of the specialty.

Perhaps the defining characteristic of CIC has always been its willingness to challenge conventional thinking in pursuit of better care for patients. That same spirit must now be applied to the systems that define our profession. Ensuring that valuation reflects expertise, complexity, and the true scope of modern congenital intervention is not simply a matter of physician recognition – it is an investment in the long-term sustainability of the programs and people upon whom our patients depend.

For the past three decades, congenital interventional cardiologists have redefined what is possible for patients with Congenital Heart Disease.

Now it is time to ensure that the systems responsible for measuring our value finally catch up.

References

1. Bartakian S. The evolution of the congenital interventional cardiologist. *Congenital Cardiology Today*. 2025;23(6):1-4.

2. Bentham JR, Zava NK, Harrison WJ, et al (2018). Duct stenting versus modified Blalock-Taussig shunt in neonates with duct-dependent pulmonary blood flow: associations with clinical outcomes in a multicenter national study. *Circulation*. 137(6):581-588. <https://doi.org/10.1161/CIRCULATIONAHA.117.030124>
3. Armsby LB, Vincent RN, Foerster SR, et al (2015). Task Force 3: Pediatric Cardiology Fellowship Training in Cardiac Catheterization. *J Am Coll Cardiol*. 66(6):699-705. doi:10.1016/j.jacc.2015.03.012
4. Box, L. C., Hoyer, M. H., Bartakian, S., Batlivala, S. P., Blankenship, J. C., Cigarroa, J. E., Hiremath, G., Lakshminrusimha, S., Ringewald, J. M., Rooney, C., Sutton, N. J., Wright, M., & Ing, F. F. (2025). Economic Barriers to Interventional Cardiology Care for Adults and Children With Congenital Heart Disease and Potential Policy Solutions: A SCAI Policy Statement. *Journal of the Society for Cardiovascular Angiography & Interventions*, 4(10Part A), 103873. <https://doi.org/10.1016/j.jscai.2025.103873>
5. National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Health and Medicine Division; Board on Children, Youth, and Families; Board on Health Care Services; Committee on the Pediatric Subspecialty Workforce and Its Impact on Child Health and Well-Being. (2023). *The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents*. National Academies Press (US). <https://doi.org/10.17226/27207>
6. Frank LH, Glickstein J, Brown DW, Ross RD (2024). Child health needs and the pediatric cardiology workforce: 2020-2040. *Pediatrics*, 153(Supplement 2), S227-S237. <https://doi.org/10.1542/peds.2023-063678J>



STEPHEN T. DALBY, MD, FSCAI, FPICS
Assistant Professor of Pediatrics
 Pediatric Cardiology, Congenital
 Interventional Cardiology
 Arkansas Children's Hospital
 University of Arkansas for Medical
 Sciences
 Little Rock, AR, USA
SDalby2@uams.edu



PICS Society

Pediatric and Congenital Interventional Cardiovascular Society



PICS Fellows & Early Career Course
 August 27-29, 2026

MARRIOTT MARQUIS SAN DIEGO MARINA



PICS Society



SAVE THE DATE **SAN DIEGO**

MARRIOTT MARQUIS – SAN DIEGO MARINA

AUG.30–SEPT.2,2026

Program Directory

2026-2027

Published Mid-August

**Directory of Congenital & Pediatric Cardiac Care Providers
in North America**

Electronically available on CCT's website
CongenitalCardiologyToday.com/Program-Directory

Stop by our booth at PICS #116 for a printed copy

**Each program's contact information for
Chief of Pediatric Cardiology & Fellowship Director**

**Lists each program's
Pediatric Cardiologists & Cardiothoracic Surgeons**

Lists Pediatric Cardiology Fellowships

Need to update your listing? Contact Kate Baldwin
kate.f.baldwin@gmail.com



Johns Hopkins All Children's Hospital's Hypertrophic Cardiomyopathy Program Named a Center of Excellence

Johns Hopkins All Children's Hospital has been recognized as a Center of Excellence by the Hypertrophic Cardiomyopathy Association (HCMA), making it one of only two pediatric centers in Florida and the only one on the West Coast of Florida to achieve this distinction.

"This prestigious designation is a great honor and demonstrates Johns Hopkins All Children's commitment to providing expert care for this very specific patient population," says pediatric cardiologist Alfred Asante-Korang, M.D., F.A.C.C., who has cared for heart transplant patients for more than 20 years. "As the #39 ranked children's hospital in cardiology and heart surgery by the 2025-2026 U.S. News & World Report Best Children's Hospitals, this is yet another distinction that ensures families know we are providing them exemplary, extraordinary care—the very best."

Earning this achievement means the program has been evaluated by HCMA and proven to provide high-quality care to patients with hypertrophic cardiomyopathy consistent with guidelines and are dedicated to HCM treatment and research. Areas of evaluation include:

- Expertise
- Volume of care
- Quality of research
- Patient communication and responsiveness
- Patient and Medical Education
- Facilities

"The Johns Hopkins All Children's Heart Failure/ Cardiomyopathy Program is a well-established referral center for heart transplantation, heart failure and mechanical support, providing hope for children with heart failure through the most advanced treatments," says pediatric cardiologist Jessica Laks, M.D., MSc, who specializes in heart failure, cardiomyopathy and transplantation. "I am honored to lead our HCM clinic and treat our patients who deserve—and will receive—incredible, compassionate care."

Patients receive high-quality care and specialized disease management that is comprehensive, multidisciplinary and all-inclusive. The clinic treats through a team approach with a variety of treatments including medical therapy, heart-failure management and education. A multi-specialty team of cardiologists, cardiac intensive care specialists, cardiac anesthesiologists and cardiac surgeons provide clinical and technical support for the program.

The program also offers a dedicated inpatient service as well as a dedicated HCM clinic. The clinic includes a genetic counselor, social worker and exercise physiologist. The team utilizes data-driven evidence-based protocols to manage this fragile cohort of patients. Comprehensive services offered include:

- Advanced Imaging & Diagnostics: state-of-the-art echocardiography and cardiac MRI for precise evaluation.
- Genetic Counseling & Testing: helping families understand hereditary risks and treatment options.
- Patient and Family Care Coordination: the program's division of patient and family care coordination assists patients and families in many ways. The program has a social worker, case manager, dietitian, pharmacist, financial counselor and child life specialist.
- Research and Support Services: the success of pediatric HCM program requires a collaborative effort by a team of healthcare providers and supporting staff. Support members also include medical and allied medical personnel and scientists devoted to research in HCM.

For more information about Johns Hopkins All Children's Hospital's HCM Program, visit t.jh.edu/ACHHCM or call 727.767.3333.



CHIP NETWORK
CONGENITAL HEART INTERNATIONAL PROFESSIONALS



America's Best Children's Hospitals 2026 in Pediatric Cardiology & Cardiac Surgery

Newsweek

Walking into a children's hospital reveals a space devoted not only to advanced medical care, but also to comfort, imagination and hope. These institutions treat thousands of children each year across a wide

range of specialties while supporting the broader health of their communities. This evaluation highlights leading pediatric hospitals nationwide, recognizing those that deliver high-quality, specialized care

and strong outcomes across multiple fields of children's medicine.



Rank	Hospital	City	State
1	Ann & Robert H. Lurie Children's Hospital of Chicago	Chicago	Illinois
2	Boston Children's Hospital	Boston	Massachusetts
3	Lucile Packard Children's Hospital at Stanford	Palo Alto	California
4	Children's Hospital of Philadelphia	Philadelphia	Pennsylvania
5	Cleveland Clinic Children's	Cleveland	Ohio
6	Cincinnati Children's Hospital Medical Center	Cincinnati	Ohio
7	Duke Children's Hospital & Health Center	Durham	North Carolina
8	Nationwide Children's Hospital	Columbus	Ohio
9	Johns Hopkins Children's Center	Baltimore	Maryland
10	Mayo Clinic Children's Center	Rochester	Minnesota
11	UCSF Benioff Children's Hospitals, San Francisco and Oakland	San Francisco	California
12	Texas Children's Hospital	Houston	Texas
13	UCLA Mattel Children's Hospital	Los Angeles	California
14	NewYork-Presbyterian Morgan Stanley Children's Hospital	New York City	New York
15	Rady Children's Hospital - San Diego	San Diego	California
16	UPMC Children's Hospital of Pittsburgh	Pittsburgh	Pennsylvania
17	Monroe Carell Jr. Children's Hospital at Vanderbilt	Nashville	Tennessee
18	Children's Hospital Colorado Anschutz Medical Campus, Aurora	Aurora	Colorado
19	Children's National Hospital	Washington	D.C.
20	Mass General Brigham for Children	Boston	Massachusetts
21	University of Michigan Health C.S. Mott Children's Hospital	Ann Arbor	Michigan
22	Hassenfeld Children's Hospital at NYU Langone	New York City	New York
23	American Family Children's Hospital	Madison	Wisconsin
24	Children's Hospital of Alabama	Birmingham	Alabama
25	Children's Hospital Los Angeles	Los Angeles	California
26	Children's Hospital of Orange County	Orange	California
27	University of Chicago - Comer Children's Hospital	Chicago	Illinois
28	UNC Children's Hospitals	Chapel Hill	North Carolina
29	Ochsner Children's Hospital	New Orleans	Louisiana
30	Loma Linda University Children's Hospital	Loma Linda	California
31	Cedars-Sinai Guerin Children's	Los Angeles	California
32	MUSC Shawn Jenkins Children's Hospital	Charleston	South Carolina
33	Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center	Hackensack	New Jersey
34	University of Virginia Children's Hospital	Charlottesville	Virginia
35	Orlando Health Arnold Palmer Hospital for Children	Orlando	Florida
36	Children's Memorial Hermann Hospital	Houston	Texas
37	Oklahoma Children's OU Health	Oklahoma City	Oklahoma
38	Children's Wisconsin	Milwaukee	Wisconsin



Rank	Hospital	City	State
39	UC Irvine Medical Center	Orange	California
40	Johns Hopkins All Children's Hospital	St. Petersburg	Florida
41	Inova L.J. Murphy Children's Hospital	Falls Church	Virginia
42	Children's Mercy Kansas City Hospital	Kansas City	Missouri
43	Yale New Haven Children's Hospital	New Haven	Connecticut
44	Valley Children's Hospital	Madera	California
45	Rush University Children's Hospital	Chicago	Illinois
46	Children's Hospital of Richmond at VCU	Richmond	Virginia
47	Mount Sinai Kravis Children's Hospital	New York City	New York
48	St. Louis Children's Hospital - Washington University	St. Louis	Missouri
49	Children's Hospital of New Jersey at Newark Beth Israel Medical Center	Newark	New Jersey
50	Our Lady of the Lake Children's Hospital	Baton Rouge	Louisiana



Publish

- Written by fellows, doctors and their team
- Case studies, articles, research findings, reviews and human interest
- No publication fees
- Print and electronic
- Published within 3-6 months of submission
- Fellows: turn PowerPoint decks into articles



CONGENITAL
CARDIOLOGY
TODAY



Subscribe Electronically
Free on Home Page

www.CongenitalCardiologyToday.com



Researchers Identify ADHD and Social Traits in Preschoolers with Heart Defects

Frontiers

Congenital Heart Disease (CHD) which is a problem with how the heart forms before birth -- occurs in approximately 1 % of newborns.

It has previously been shown that school-age children, adolescents, and young adults with CHD are more likely to display traits of autism. Now, a team of researchers in the UK has shown that preschool children with CHD are also at risk of developing behavioral problems. They published their results in *Frontiers in Pediatrics*.

"Here we show that, although children with congenital heart disease show higher levels of attention difficulties and poor peer relationships compared to healthy children during the preschool years, greater cognitive stimulation within the home environment may reduce the risk of developing such difficulties," said corresponding author Chiara Nosarti, Professor of Neurodevelopment and Mental Health at King's College London.

Nosarti and colleagues focused on 56 children between four and six years of age with CHD and enrolled between 2014 and 2020 in the Congenital Heart Imaging Project, led by Prof Serena Counsell, King's College London. These children either had critical CHD, for example, transposition of the great arteries, or serious CHD, including any noncritical heart lesion that had required catheterization or surgery before one year of age.

The researchers compared these children with a cohort of 215 healthy control children enrolled in an unrelated program, the UK's Developing Human Connectome Project.

Measuring Problematic Behavior

The authors invited all parents to fill out five tried-and-tested questionnaires to measure their child's comprehensive behavioral profile, such as the Children's Behavior Questionnaire, the Social Communication Questionnaire, and the Empathy Questionnaire. Higher scores on these questionnaires indicate more severe behavioral difficulties.

The researchers used the Index of Multiple Deprivation, based on postal code, as a proxy for the parents' socio-economic status. And to measure how much the children's environment stimulated their cognitive development, parents were asked to complete the 28-item Cognitively Stimulating Parenting Scale. This rates the degree of verbal interaction and educational activities at home, as well as the availability of materials like child-size tables and chairs, storybooks, coloring books, and musical instruments.

The analyses showed that after correction for the effects of sex, gestational age at birth, and neighborhood deprivation, children with CHD had higher odds of ADHD and peer relationship problems than their healthy peers.

Close to Home

Importantly, the results also showed that a highly stimulating home can protect against developing these problematic behavioral outcomes.

"It remains unclear whether cognitively stimulating environments influence child behaviors, or whether child behavior, in turn, affects the degree of cognitive stimulation provided by caregivers," wrote the authors.

The study did not look at the mechanisms which might cause the observed differences. However, they noted in their study that peer relationship problems may be driven by a lower capacity of children with CHD to recognize facial emotion expressions and identify false beliefs, which has previously been shown in school-age children.

"Alongside cardiac care, environmental factors such as fostering a stimulating home learning environment should be taken into account when designing support plans for children with CHD," concluded Nosarti.



Recruitment Advertising

- ✓ In print and electronic monthly issue
- ✓ On our website
- ✓ In monthly Email Blast
- ✓ No cost for CCT to create the ad
- ✓ Multiple sizes available



Subscribe Electronically
Free on Home Page

www.CongenitalCardiologyToday.com



Click the position title to view the full job description

Assist / Assoc Professor of Clinical Pediatrics & Child Health

Phoenix Children's
Phoenix, Arizona



Pediatric Cardiologists

Kaiser Permanente - Southern
CA Permanente Medical Group
Riverside & San Bernardino
County, California



Pediatric Cardiologist

Loma Linda University
Children's Hospital
Loma Linda, California



Pediatric Cardiology Opportunities

Ochsner Children's Hospital
New Orleans, Louisiana



Pediatric Cardiologist Advanced Imaging with Cross-Sectional Focus

MaineHealth Maine
Medical Center
Portland, Maine



Regional Pediatric Cardiologists

Ochsner Children's Hospital
Baton Rouge, Lafayette,
Monroe, Louisiana
Gulfport, Mississippi



Pediatric Cardiologist Preventative Cardiology

Children's Mercy Hospital
Kansas City, Missouri



Pediatric Cardiologists

The University of Nebraska
Medical Center
Children's Nebraska
Lincoln & Omaha, Nebraska



Pediatric Cardiologist

The University of Utah
Primary Children's Hospital
Las Vegas, Nevada



Pediatric Cardiologist

Akron Children's Hospital
Akron, Ohio



Pediatric Cardiologist Director of Cardiac Imaging

Akron Children's Hospital
Akron, Ohio



CONGENITAL CARDIOLOGY TODAY

Recruitment Advertising

- ☒ In print and electronic monthly issue
- ☒ On our website
- ☒ In monthly Email Blast
- ☒ No cost for CCT to create the ad
- ☒ Multiple sizes available



CONGENITAL
CARDIOLOGY
TODAY

Program Directory 2026-2027*

– Directory of Congenital & Pediatric
Cardiac Care Providers in North America

* Currently Updating, Published Mid-August

Electronic Version:

[CongenitalCardiologyToday.com/
Program-Directory](https://CongenitalCardiologyToday.com/Program-Directory)



AUGUST

14TH - 17TH

**2026 Pediatric and Adult Congenital Cardiology
Review Course (Mayo Clinic)**

Los Angeles, California, USA

<http://ce.mayo.edu/>

30TH - SEPT 2ND

PICS Symposium 2026

San Diego, California, USA

<https://www.picsymposium.com/home.html>

SEPTEMBER

18TH - 19TH

5th CME Cardiologists Conference

Athens, Greece

<https://cardiologists.plenareno.com/>

OCTOBER

19TH - 20TH

**V Euro HeartCare & Cardiovascular Medicine
Conference**

Berlin, Germany

<https://heart.plenareno.com/>

Publish

- Written by fellows, doctors and their team
- Case studies, articles, research findings, reviews and human interest
- No publication fees
- Print and electronic
- Published within 3-6 months of submission
- Fellows: turn PowerPoint decks into articles



CONGENITAL
CARDIOLOGY
TODAY



Subscribe Electronically
Free on Home Page

www.CongenitalCardiologyToday.com



CORPORATE TEAM

**PUBLISHER &
EDITOR-IN-CHIEF**
Kate Baldwin
kate.f.baldwin@gmail.com

**CO-FOUNDER &
MEDICAL EDITOR**
John W. Moore, MD, MPH
jwmmoore1950@gmail.com

**FOUNDER &
SENIOR EDITOR**
Tony Carlson
tcarlsonmd@gmail.com

**STAFF EDITOR &
WRITER**
Virginia Dematatis

**SOCIAL MEDIA
CONTENT MANAGER**
Jason Williams, MD
jason.williams@duke.edu

STAFF EDITOR
Loraine Watts

**EDITOR-IN-CHIEF
EMERITUS**
Richard Koulbanis

EDITORIAL BOARD

Aimee K. Armstrong, MD
Jacek Bialkowski, MD
Anthony C. Chang, MD, MBA
Howaida El-Said, MD, PhD
Ziyad M. Hijazi, MD, MPH
John Lamberti, MD
Tarek S. Momenah, MBBS, DCH

John W. Moore, MD, MPH
Sir Shakeel A. Qureshi, MD
P. Syamasundar Rao, MD
Carlos E. Ruiz, MD, PhD
Hideshi Tomita, MD
Sara M. Trucco, MD
Gil Wernovsky, MD

OFFICIAL NEWS & INFORMATION PARTNER OF



PICS Society

Pediatric and Congenital Interventional Cardiovascular Society