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Building an Outstanding Pediatric Heart Program: The Development and Ascent of Rady Children's Hospital Heart Institute

John Moore, MD, MPH & Christopher Davis MD, PhD

The Heart Institute at Rady Children's Hospital San Diego (RCHSD) has a unique story, characterized by its relatively recent formation and a rapid increase in size, quality, and national recognition. This story may hold lessons for other programs undergoing systematic growth and improvement.

US News and World Report (USNWR) has published annual rankings of Pediatric Cardiology and Heart Surgery Programs in the United States since 2008. The scoring system is data- driven and dynamic. Although not without some controversy, the rankings are widely publicized, and there is general consensus that the current scoring system is the best available.[1] Since the inception of rankings in 2008 and until recent years, most of the "Top 10" programs have remained fairly constant and dominated by a group of long-established programs with widely held reputations for excellence. The "Top 10" have generally been hosted by historic, well-known, prestigious medical institutions.

In comparison to most of these institutions, RCHSD is relatively new. The hospital was founded in 1954 as a small community children's hospital and slowly expanded over the decades to grow into the largest children's hospital in California. In parallel, the University of California San Diego (UCSD) was founded in 1960 and has become one of the preeminent research and educational universities in the United States. Cardiovascular programs for pediatrics existed separately in both institutions before an amalgamation between the two was finalized in 2006. At that time, the combined pediatric cardiology program had only six cardiologists and one pediatric heart surgeon. Advantaged with the fundamentals of an expanding children's hospital (**Figure 1**), an evolving world-class university, and an attractive geographic location, the program set about recruiting faculty and building.

In 2008, Rady participated in the first USNWR ranking of pediatric heart programs and was not in the top 30. As years passed, a remarkable ascent of the Program occurred. By 2023, the Program had 35 cardiologists and two surgeons and was ranked #3 in the nation.[2]

Year	Rady's USNWR Heart Program Rank
2008	>30
2012	28
2017	17
2021	11
2023	3

This trajectory was made possible by two factors. First, the USNWR scoring system has evolved to give more weight to clinical outcomes and program quality, and less to "reputation score," the latter tending to calcify rankings over time (rankings inform reputation, which then inform rankings, and so on). Secondly, the RCHSD program grew and evolved based on core principles that allowed for continuing pursuit of excellence. These principles were applied in multiple categories, including Leadership and Institutional Organization, Long-Term Strategy and Culture, Program Infrastructure, and Continuous Quality Improvement.

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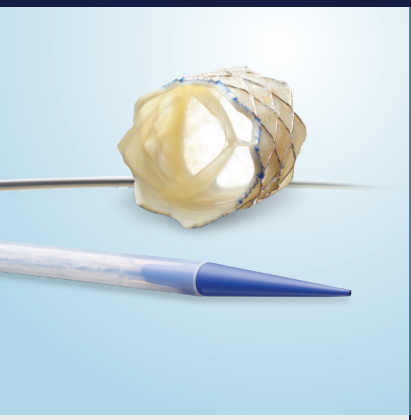

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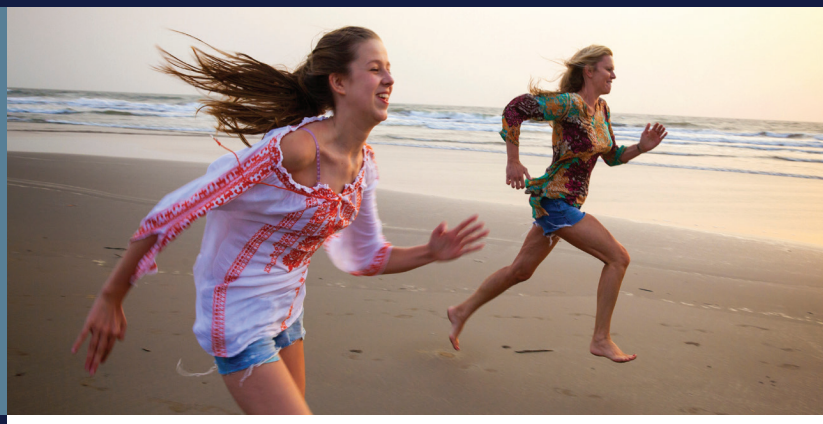

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*The term "stent fracture" refers to the fracturing of the Melody TPV. However, in subjects with multiple stents in the RVOT it is difficult to definitively attribute stent fractures to the Melody frame versus another stent.

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- Venous anatomy unable to accommodate a 22 Fr size introducer sheath
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- Severe RVOT obstruction, which cannot be dilated by balloon
- Obstruction of the central veins
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Rady Children's Hospital in 2023

Leadership and Institutional Organization

In 2005 Rady Children's Hospital recruited physician leadership in cardiac surgery. The following year in 2006, leadership in cardiology was secured. Leaders made long-term commitments to Rady Children's Hospital and to the University of California San Diego and were installed as Director and Co-Director of the Heart Institute. From the outset, a top priority of Heart Institute leadership was to engage the administrations of the hospital and University. An academic and clinical program can thrive only with institutional support that allows for a tripartite mission of clinical excellence, generation of new research to advance the field, and teaching and preparing subsequent generations to build on established excellence. The governance and operations of the Heart Institute is led by an executive committee consisting of the physician directors, other key faculty leaders in cardiology and cardiovascular surgery, the Heart Institute administrative director, and several members of executive hospital leadership. There is a well-defined organizational chart that includes all faculty, staff, and leadership, and multiple venues for communication amongst all members.

Long-Term Strategy and Culture

From the beginning, the goal of physician leadership was to create an outstanding program, competitive with the best in the world. This strategy was codified in the Institute Mission "to provide the best possible and most personalized heart care for infants, children and young adults with congenital heart defects or acquired heart disease."[3]

Additional like-minded physicians and professionals with training and experience in excellent and highly rated programs were recruited to San Diego to lead and staff the Institute. Recruitment of the best and best-fitting personnel is one of the most important tasks of an institution. Leadership sought to create and foster a culture of excellence among physicians, trainees, nursing, and other staff. The mission and culture are endorsed and reinforced continuously and at all levels.

In a field as dynamic as pediatric cardiology and heart surgery, innovation and early adoption of cutting-edge technology are critical to a program's ability to grow and thrive. The Heart Institute places a premium on providing faculty with support to innovate and implement changes that will have lasting impact. Even in well-established and historically successful programs, stasis can sometimes dominate a culture and prevent timely change for the better. A flexible and supportive culture in our program has resulted in being at the forefront of major innovations in the field, including MRI-guided catheterization,[4] PDA stenting[5] and airway stenting.[6]

Program Infrastructure

With growth comes opportunity for specialization, program development, and an increase in breadth and depth of all components needed for a comprehensive cardiovascular center. Programs and sections in every aspect of pediatric and adult congenital cardiovascular medicine were formed during this time, including fundamental program pillars such as cardiothoracic intensive care unit, heart transplant/VAD program, and a fetal program. An advanced adult congenital heart disease program was established in partnership with UCSD adult cardiology. Furthermore, given the complexity of many cardiac patients, strong and formal collaborations were established with other critical pediatric specialties including neonatology, otolaryngology, and pulmonary medicine. These collaborations helped to devise customized and sometimes novel approaches to patient care resulting in important benefits such as reductions in ICU ventilator times and length of stays.

As the number of faculty in every section continued to grow, disease-specific programs for even rare and difficult-to-treat conditions were formed and innovation thrived. Today, over 20 specific programs exist to provide the most comprehensive and specialized care possible. Some are as specific as the pulmonary vein stenosis program, and others such as the neurodevelopmental program are broadly applicable across all patient populations.

The importance of administrative support toward program infrastructure cannot be understated. Administrative leadership and support staff who work in service of clinical excellence, research, and teaching are indispensable parts of the whole.

Continuous Quality Improvement

Well before the comprehensive program infrastructure was completed, leaders of the Heart Institute recognized the need for robust and continuous quality improvement. Part of the strategy involved participation in all relevant national registries. These registries provided important comparative data from multiple programs nationally, and importantly were externally audited and focused on national quality improvement. They provide important vehicles for the assessment of relative strengths and weaknesses in a given center and are a springboard for initiating positive change. Also, internal mechanisms to assess

honestly and comprehensively everything from individual patient outcomes to center-wide practices were emphasized and supported to continually enhance care.

The already large and ever-growing amount of data used for registries and quality improvement requires significant time and effort to adequately track and analyze. A data team was established in our center years ago and has shown a positive return on investment ever since.

More recently, patient experience data generated by questionnaires have been incorporated into quality improvement efforts. The Heart Institute Family Council meets regularly with the administrative director and physician leaders to provide direct feedback and suggestions for improvement from a patient and family perspective.

All data from these and other sources are reviewed in detail throughout the Heart Institute in monthly meetings. A program scorecard was developed by the data group and is available to everyone in the Heart Institute. These data inform nearly every major decision made at the highest levels of the Institute.

Conclusion

Establishing a culture of excellence, promoting open communication, making data-driven decisions, relentless quality improvement efforts, and tight integration with hospital and University leadership have allowed for the substantial growth and rise of Rady Children's Hospital Heart Institute.

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Matters of The Heart and Mind: Interviews

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I have had some very intimidating, entertaining, humiliating and disappointing interviews. In the UK at least, an interview defines the final selection process of applying for a position in the National Health Service at just about any level excepting the most junior position (House Officer) immediately post-graduation. The House Office appointment is largely based on a summary from The Dean of The Medical School of one's career in the five or six years as a student. There used to be a face-to-face interview with The Dean and 10 or 11 senior Medical School Professors, Surgeons, Physicians, Psychiatrists to get into Medical School in the first place. I remember mine very well, not least of all because the letter in 1977 inviting me for interview had gone astray. I owe the personal assistant to the Medical School Registrar a massive thanks for sending a second letter saying: 'We were sorry not to see you for interview today, please could you let us know if you are still interested in studying at St Thomas's Hospital Medical School?' Or words to that effect. I raced to the telephone to tell the story of the undelivered invitation. Thankfully the door was still ajar. Believe me, getting an interview was a big deal. It usually meant you had about a one in six chance of getting a place. These are massively reduced odds from about the one in two hundred which started when you first applied with a headmaster's report, details of exam results and extracurricular achievements and interests. I was excited. For most students this interview was perhaps the only face-to-face exposure to The Dean. The Dean did usually give a pep talk at the commencement but that was to the whole year of 60 students and had overtones of reminding us what an honour it was to be there, how lucky we were and work hard and behave yourselves. The usual.

Cut to my interview for Medical School with the great and the good. An ante room with the lions to the slaughter, interviewees, sizing each other up. Despite my shy retiring nature, I could barely pluck up the courage to chat. It was something like 'Which school do you go to?' and that was it. Only one Etonian but it became apparent I was from further away than anyone, coming from a small town in Yorkshire. In I go to a quiet oak panelled room with arrays of portraits of Deans from hundreds of years ago to the present day. A beautiful rectangular polished oak table. Twelve occupants of the chairs facing me. And me, just me, opposite. To say it was intimidating is an understatement. I do not remember many of the questions. I suspect they were the usual 'Why do you want to be a doctor? Why St. Thomas's? But one did floor me: 'Mr. Wilson, I see you're from Yorkshire, tell me, some people say that a Yorkshireman is similar to a Scotsman but lacking the streak of generosity, what do you think?' Cue: 11 of the 12 suited interviewers burst into raucous laughter... an "in joke." What is going on? I find out subsequently that The Dean was a Yorkshireman, and the question was a good-natured dig at him. My answer? Easy… I was born in Cumberland, not Yorkshire, so I was able to reply stating so, adding 'And as you know Cumbrians are very generous people.' I do not suppose my answer was the reason, but they gave me a place. The rest is history.

I saw a bit more of The Dean than most having been summoned because of a couple of episodes of bad behaviour following rugby matches when I had consumed a little more beer than the average. Well, we were celebrating victories. Thinking back, he was a star, a metaphorical rap on the knuckles for me and letters of apology from me and I was forgiven. There was not a third strike, though I did get close. The night before my pathology finals viva voce exam I had stood in for 'Mangler,' one of the actors in The Christmas Show, who had the most florid periorbital cellulitis you have ever seen and claimed he couldn't perform. His was a small part, most of the words were indecipherable grunts as he was supposed to be a monster type figure. Not many lines to learn. Sure, I could do it. Imagine my surprise as that evening I lurched on stage spitting my words out to the front row only to find myself face to face with The Professor of Pathology. Yes, you guessed, he was my finals examiner at 9:30 the very next morning. The Professor seemed to leave most of the interrogation to his co-examiner who lobbed me some fairly benign questions on kidney disease. I sensed The Professor was desperately trying to remember why he recognised me more acutely than some of the other exam candidates. By the time the penny dropped I was on my way out of the room. Nevertheless, I was relieved to see a PASS next to my name when the results were declared some days later.

So on to senior interviews, how on earth do you choose a fellow position say, when everyone seems to have a reference worthy of instant appointment to the board of the World Health Organisation? As you stagger towards some sort of seniority it does eventually fall to you to make some important decisions as to who you might choose as a fellow, a senior fellow, an attending colleague even. It is almost impossible when 99% of written testimonials read 'It is with the humblest pleasure and respect that I find myself in the privileged position of recommending Dr. Jane Doe / John Doe who is by far the most fantastic, smartest, kindest, talented world beating innovative etc… I have ever had the privilege of working with and recommending for the position of… (insert position).' Saintly individuals, every one of them. Better get on the telephone. Unless the line is bugged, you can get a more useful idea of a candidate's strengths and weaknesses if you did not know them before. Two senior fellow interviewees spring to mind. I will spare their blushes of pride I hope rather than embarrassment, by not revealing their names. Some of you will guess anyway. Dr. 'John Doe' rocks up for interview, his testimonial reads as I described above with the added qualities: 'He is a beast of computer literacy, writes code, and has a wicked sense of humour.' I do not write code, though I am good at shouting 'Help' into the ether when I get stuck (frequently) on the computer. So 'John' comes into my office, every bit the techie. We have barely shaken hands and I have handed him my iPhone which has some ridiculously irritating glitch. In the length of time it has taken to shake hands, I have the cured phone back in my hand. John makes an extremely funny but tactful ironic

comment about my techless-talents which has me laughing. We barely discuss anything else as I have made up my mind that I will offer him the job, though I had better play the game and at least speak to the other interviewees. 'John' has since moved on to an attending position in a city beginning with 'I.' He still has me phoning him two or three times a year to unravel a tech problem and to cheer me up with his rapidly developing Wilsonic humour. One day he will invent something which will ring very loud bells in the interventional treatment of Congenital Heart Disease.

Dr. 'Jane Doe' comes for interview preceded by the usual written testimonial described above. The phone call I have from a World Class Interventional Cardiologist is very positive and supportive. It is winter and her travel plans, arriving from The East Coast in the evening and my work pattern is such that the interview is essentially 'Trial by dinner' in my house. Catering courtesy of Mrs Wilson. We get on well, I am witnessing the same qualities of this doctor described in the phone call I had a few days earlier with her previous boss above. I get up to take a phone call and while I am in the kitchen giving an opinion on a clinical problem in CICU it is taking a bit of time but we had pretty much finished the meal, ending with a Wilson Affogato. I glance back to the table. 'Jane's seat is empty.' I finish the call. I gently ask Mrs. Wilson 'Where's she gone?' 'I'll tell you later,' says Meredith. Dr. 'Jane' comes back to the table. I notice she is carrying quite a large purse, but there you go, what would I know about purse fashion? The evening comes to a natural end, we arrange for her to meet others at the hospital in the morning for a look round and a chat with the categorical fellows who will no doubt give her the real low down. Off she goes in a taxi to the hotel. I retire to the kitchen. I'm very good at cleaning pans. My wife is very good at instructing me such that I do it correctly…

Spontaneously she comes out with… 'Do you realise what was in her handbag'? (Handbag is British talk for purse). 'She had a baby two weeks ago, she's expressing… the baby girl is in New York with Dad.' Momentarily I stop scrubbing. How does the saying go? 'A defining moment.' I challenge anyone to demonstrate a passion for interventional cardiology which could hold a candle to her display of dedication to child and career. I am not even sure I saw 'Jane' the next day but I did hear she had a good look around and had impressed all those she met. It did not matter. I had made my mind up that she had got the job before I had finished the washing up the night before. As you would predict she is already an outstanding opinion in the field of interventional paediatric cardiology. You almost certainly will have heard her speak (quickly, but she's getting better…).

I'd like to tell 'John' and 'Jane' how much I miss their company.

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Pediatric Cardiac Intensive Care Unit Nursing Global Workforce

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Pediatric Heart Disease is a primary cause of morbidity and death in children worldwide, and responsible for 66% of preventable mortality in low- and middle-income countries (LMICs).[1] The prevalence of Congenital Heart Disease (CHD) has been reported to be steadily increasing globally in recent years.[2] A systematic analysis of the global burden of CHD in 2017 found it to be a substantial occurrence, noting 261,247 deaths worldwide, with the majority of deaths in LIMCs, and an overall increasing number (11,998,283 people) living with CHD, accounting for an ~19% increase since 1990[3] in both LMICs and high-income countries (HICs). Despite the increase in CHD, a lack of crucial care needs attributed to inadequate resources and insufficient academic consideration for management requirements globally has been identified.[1]

Optimal care and management of children with cardiac disease requires specialized training and skills. Pediatric cardiac intensive care unit (PCICU) nursing practice is a highly specialized, subspecialty in countries across the world, and includes care of a fragile population of children ranging from neonates to adolescents. Adequately trained nurses are a crucial limiting factor for the provision of safe PCICU care in both LMICs and HICs. The World Health Organization reports nurses as the largest occupational healthcare group worldwide, and an essential force for meeting global strategies on human resources for health goals for the future.[4] Despite the need for skilled nursing care of pediatric cardiac critically-ill patients, there is very limited published data on the current state of formal PCICU nursing education and on-the-job training on a worldwide level. A scoping review of the literature across five geo-regions by Macey, et al.,[8] found a variety of structured and informal education strategies for nurses in critical care settings across the globe; however, comprehensive descriptions for training in low-income (LIC) countries and LMICs were extremely deficient. Furthermore, although resources were extremely variable across settings, LIC and LMICs frequently described them as inadequate.[8] While education level and critical care certification are described in HIC settings,[5-7] specific details of PCICU training are lacking.

Identifying the status of formal PCICU nursing education, certification and on-the-job training globally may help to inform a scientific foundation in this area. Reducing the knowledge gap and informing the nursing science will assist in promoting the development and implementation of nursing initiatives in countries underserved by healthcare resources, and aid in identifying potential barriers and facilitators to obtaining requisite knowledge and skills required to provide optimal PCICU nursing care.

We are looking for PCICU RNs in all settings to complete this survey. Please use the QR code to access the survey. Please feel free to forward this information to others at your organizations.

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Arineta Receives FDA Clearance for its Deep-Learning Image Reconstruction Technology in SpotLight™ Cardiovascular CT Scanners

DLIR Enhances Image Quality with Reduced Noise and Low Dose for Cardiac, Vascular and Thoracic Clinical Procedures

Arineta Cardio Imaging, a leader in point-of-care cardiovascular CT solutions, announced 510(k) clearance from the U.S. Food and Drug Administration (FDA) for its deep-learning image reconstruction (DLIR) technology for use in its SpotLight™ family of cardiovascular CT (CCT) scanners. This next-generation image reconstruction technology, powered by artificial intelligence, allows Arineta to provide enhanced image quality and image noise reduction to its customers.

DLIR utilizes an advanced deep-learning convolutional neural network (CNN) that was trained on more than 3 billion image data points. In comparison to prior technology, DLIR decreases pixel-wise noise magnitude without reducing high-contrast spatial resolution.

DLIR is available on both of Arineta's second generation systems, including the SpotLight dedicated cardiovascular CT and SpotLight Duo cardio-thoracic CT systems. SpotLight CT systems with DLIR are indicated for diagnosis of disease or abnormality and for planning of therapy procedures.

"We have used Arineta cardiac CT systems for several years, and they provide the highest quality cardiac CT clinical images for our practice," said Matthew Budoff MD, a professor at UCLA. "From our FDA 510(k) reader study, Arineta's DLIR technology continues that excellence. Arineta's SpotLight systems make the highest performance cardiac CT available at point-of-care, in an office, mobile, or cath lab setting."

"Today, fewer than 5 percent of US patients that need cardiac CT are getting appropriately scanned due to lack of access at point-of-care," said Arineta CEO Scott Schubert. "This FDA clearance continues Arineta's vision and leadership to make cardiac CT the front-line imaging test for patients with chest pain and suspected cardiovascular disease, as recommended by the ACC & AHA 2021 guidelines."

For more information, visit www.arineta.com.

RICOH 3D for Healthcare Partners with Materialise to Broaden Access to 3D-Printed Patient-Specific Solutions

First-of-its-Kind End-to-End Solution also Enabled Through Ricoh's Expanded Partnership with Merative for Streamlined 3D Print workflow

PRNewswire -- Ricoh USA, Inc. announced at the RSNA Assembly and Annual Meeting, a partnership with Materialise that will provide software solutions to support RICOH 3D for Healthcare – a HIPAA-compliant, ISO 13485 certified 3D medical manufacturing center for the development, design and production of 3D-printed anatomic models – in both their centralized medical device manufacturing facility, as well as in Ricoh's Point of Care facilities. Through the partnership, Ricoh will now be able to drive more personalized healthcare solutions and make it simple to create or expand on-site Point of Care centers.

With an uptick in 3D printing, hospitals are either now seeking to enter the market by establishing Point of Care centers onsite or scaling existing offerings. A main driver of either option is co-located management of facilities and production through partners such as Ricoh, with technologies like those from Materialise. However, it is important for care providers to recognize that when these 3D-printed models and other instruments are used for patient care, they may be considered medical devices, subject to FDA regulation. With RICOH 3D for Healthcare, hospitals can adopt or advance Point of Care manufacturing quickly and affordably without the need to become an FDA-registered medical device manufacturer, implement a complex and costly quality management system, navigate regulatory requirements, or tackle the administrative aspects to support it all with a multidisciplinary team. The partnership reimagines Point of Care 3D printing to democratize enterprise-wide, patient-specific surgical innovation to the rest of the population.

Ricoh is partnering with Materialise to leverage their leading software solutions to bring affordable Point of Care 3D printing services to hospitals across the country. The partnership will allow both parties to expand the use of Materialise software within Ricoh's workflows and continually improve the available toolset to better serve patient care.

"Materialise's software tools will not only help Ricoh provide a better experience for its customers, but also support Ricoh in its goal of democratizing equitable access to impactful tools such as patient-specific anatomic models," said Gary Turner, Managing Director, Additive Manufacturing, North America, Ricoh USA, Inc. "The ecosystem of Ricoh partners, inclusive of Materialise, Merative and Stratasys, has enabled Ricoh to bring world-class software in a first-of-its-kind, end-to-end solution to different healthcare institutions around the country to drive more Point of Care locations and capabilities around the country."

"Outside of large academic medical centers, physician and patient access to 3D printing applications has been limited," said Bryan Crutchfield, Vice President and General Manager of Materialise North America. "This is often due to a lack of resources and technical knowledge to implement and operationalize the technology in the hospital environment. This partnership with Ricoh brings a large managed services infrastructure, which will enable hospital systems to more quickly and affordably implement and scale 3D technology for their physicians and patients. We are excited to partner with Ricoh to bring our end-to-end software platforms to support 3D planning and 3D printing applications at the Point of Care."

Materialise is the latest strategic partnership helping Ricoh continue to lead the way in offering democratized access to patient-specific 3D-printed models in healthcare.

Merge by Merative: Through an expanded partnership with Merge by Merative, a leader in flexible enterprise imaging solutions, Ricoh will make it easier for hospitals and clinicians to access the RICOH 3D for Healthcare Platform via the new PACS Print Gateway. The workflow will be easily initiated via a simple "Send to RICOH 3D" button that can be added to a variety of DICOM viewers. This will initiate the transfer of the appropriate DICOM study to a secure, cloud-based vendor neutral archive. It will also activate the RICOH 3D for Healthcare Case Management Portal to easily manage the case in conjunction with the clinical team. This expansion of Ricoh's partnership with Merge by Merative will accelerate Ricoh's goal of streamlining workflow to more easily democratize access to the program so that more clinicians and therefore more patients can gain access to these patient specific solutions.

Stratasys: RICOH 3D for Healthcare engages in a strategic collaboration with Stratasys to leverage their 3D printing technology to expand access to 3D-printed medical models.

Ricoh's award-winning Managed Services platform and long history of providing highly complex services on-site to customers across the country, will play a crucial role in how Ricoh will provide medical manufacturing services on-site at the Point of Care. RICOH 3D for Healthcare has received 510(k) clearances from the U.S. Food and Drug Administration (FDA) for patient-specific anatomic modeling for diagnostic use, including cardiovascular, neurological, gastrointestinal, genitourinary, and breast applications, as well as craniomaxillofacial (CMF) and orthopedic patient-specific anatomic modeling. The clearances empower Ricoh to support more surgical specialties and patient diagnoses to print diagnostic quality 3D anatomic models of bony and soft tissue using Stratasys 3D printing technology and materials. With the ability to manage 3D print operations at the Point of Care, RICOH 3D for Healthcare provides a streamlined and efficient solution for producing these models.

RICOH 3D for Healthcare is taking a phased approach to integrate Point of Care manufacturing into healthcare systems nationally, thereby creating a nationwide ecosystem for networking and cross-system collaboration. Ricoh currently supports thousands of healthcare organizations with various aspects of their business, including 9 out of 11 of the largest for-profit hospital systems, and 22 out of 32 of the largest nonprofit hospital systems, with about 3,200 facilities under its support – and is also responsible for managing over 1 million pieces of equipment in the United States through more than 2,100 U.S. field technicians across various industries.

To learn more about RICOH 3D for Healthcare, visit Ricoh in booth #8300 at the RSNA Assembly and Annual Meeting. For more information about RICOH 3D for Healthcare, view the RICOH 3D for Healthcare webpage or follow the company's social media channels on Facebook, Instagram, LinkedIn, X (formerly Twitter) or YouTube.

Accarent Health Announced Affiliation with Children's Hospital Los Angeles to Provide Virtual Cardiology, Oncology and Musculoskeletal Second Opinion Services

GLOBE NEWSWIRE -- When your child has a health condition, you want the best possible care. Children's Hospital Los Angeles (CHLA) provides exceptional family-centered care and life-saving treatments delivered by renowned physicians, surgeons, nurses and technicians in a child-friendly environment. CHLA also routinely ranks among the top pediatric hospitals nationwide and is one of the largest in the Western U.S., with the expertise across service lines to provide answers to treat the most complex conditions and diseases.

Recognized by US News & World Report as the #7 pediatric academic medical center nationwide, and by Newsweek as the #4 pediatric hospital in the world, CHLA has agreed to furnish specialists to deliver virtual, peer-to-peer bundled second opinion services in the following pediatric specialties: cardiology & cardiothoracic surgery, oncology, hematology, neurosurgery, vascular anomalies, retinoblastoma, orthopedics, and musculoskeletal disorders. Each bundle includes:

- Review of medical records by a medical specialist in member's diagnosis
- Additional medical record review with surgical or radiation team as needed
- Genetic risk screening
- Clinical trials screening
- Written summary of finding and treatment options sent to the referring physician who will share with the patient
- Virtual consultation to discuss the second opinion report.

CHLA has also developed multiple surgical episodes of care for cardiovascular, musculoskeletal disorders, neurologic conditions and gene replacement therapy to support their second opinion services. All of CHLA's bundled offerings are available through the Accarent network.

Accarent Health connects employers, patients, and plan administrators to a network of top-rated medical centers for superior, cost-effective care. Accarent Health offers transparent, pre-defined bundled pricing, pertinent clinical information, travel and concierge assistance, and case management directly to consumers, making value-based healthcare understandable for the decision-maker with no annual membership fees or volume requirements.

Employers interested in adopting a value-based health care system can learn more about Accarent Health at www.accarenthealth.com.

MAY

02ND-04TH

SCAI 2024
Long Beach, California, USA
https://scai.org/scai-2024-scientific-sessions

10TH-11TH

6th International Conference on Cardiomyopathy in Children
Virtual
https://web.cvent.com/event/260bd0ea-5117-4ce7-9291-0808337a91eb/summary?mc_cid=1f1e6b4461

16TH-19TH

Heart Rhythm 2024
Boston, Massachusetts, USA
https://heartrhythm.com/

JUNE

05TH-08TH

1st World Summit for Pediatric and Congenital Heart Surgery
Bologna, Italy
https://www.worldsummitpchs2024.org/

Program Directory 2023-2024

Published Mid-August

Directory of Congenital & Pediatric Cardiac Care Providers in North America

Contact information at each program for Chief of Pediatric Cardiology & Fellowship Director

Lists each program's Pediatric Cardiologists & Cardiothoracic Surgeons

Lists Pediatric Cardiology Fellowships

Distributed to Division Chiefs by mail

Electronic version available on CCT's website:
CongenitalCardiologyToday.com/Program-Directory

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