

We challenge you to
save women's lives.



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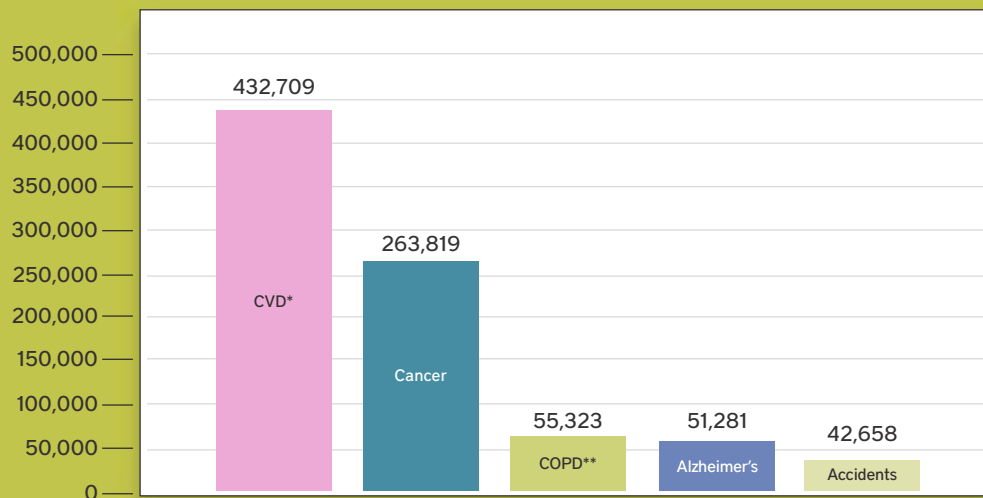
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ASSOCIATION OF WOMEN'S HEART PROGRAMS

A Call for Continued Action

Cardiovascular disease kills more women each year than the next four causes of death combined.



Causes of Death¹

Source: AHA 2010 Statistics Update

* Cardiovascular Disease

** Chronic Obstructive Pulmonary Disease

Since 1984, more women than men have died of heart disease each year and yet much of the medical community still largely considers it a “men’s disease.”

About This Report

HEART DISEASE IS THE NUMBER ONE KILLER OF WOMEN, a fact that all too often goes unacknowledged. In late 2005, several cardiology specialists established the Association of Women's Heart Programs (AWHP) to help remedy this problem.

The mission of the organization was clear: to promote the highest-quality cardiovascular care for women with an emphasis on gender differences and to ensure that both healthcare providers and women are aware of and understand the unique aspects of cardiovascular prevention and treatment.

Through partnership with the broadest array of medical care providers, AWHP's vision was to create a world where women receive heart healthcare equal to that received by men and where heart disease is no longer the leading cause of death for women.

Although we had to close our doors in response to the current economic climate, those of us who have been involved with AWHP will continue to advocate for this issue and for urgently needed solutions. We feel confident that our message and mission can live on. Our hope is that this report will challenge the medical community, heart health organizations and elected officials to continue where we left off.

This report summarizes issues and concerns surrounding women's cardiovascular disease and includes highlights of three AWHP initiatives launched to collect data necessary to inform the organization's endeavors.

Voices for Change



ELIZABETH G. NABEL, MD
President, Brigham and Women's Hospital
Formerly, Director, National Heart, Lung, and Blood Institute
from the Keynote Address at AWHP's Thought Leaders' Conference

In the medical profession, we are taught that there is a certain set of classic symptoms for heart disease and they are important symptoms. But they're symptoms that men often experience. Women's symptoms are often different and have been termed atypical. Well, they are not so atypical. They are very typical for women and so we still have a number of cultural pieces that we have to work through.

Women's symptoms are
not so atypical

GEORGIA'S STORY²
from WomenHeart

I am 53 and had my first heart attack at 47. Three and a half years later, I began having lots of angina, but was told over and over again that it was "reflux." Three days later, I had another heart attack. How do we get the doctors to believe us when we say we are sick? How many of us have been put on tranquilizers, antidepressants, sent to therapy, had upper GI series, or told we were hysterical? I have already made my sister promise that the following words will be chiseled into my headstone: "I TOLD YOU IT WASN'T REFLUX!"

How do we get doctors to
believe us?



SALVATORE TRAZZERA, MD, FACC, FACP, FCCP
Farmingdale Heart and Vascular

Women used to be called "hysterical." How far have we come when women complain about their symptoms and a physician doesn't hear the possibility of heart disease, but instead assumes anxiety, panic or stress? In medical school we were taught our patients often tell us what is wrong if only we listen. Well, for whatever reason, we are not hearing what women are trying to tell us. That's really unacceptable and can have dire consequences. We've heard endless stories from women who were misdiagnosed and then went on to have a heart attack.

We are not hearing
what women are trying to tell us

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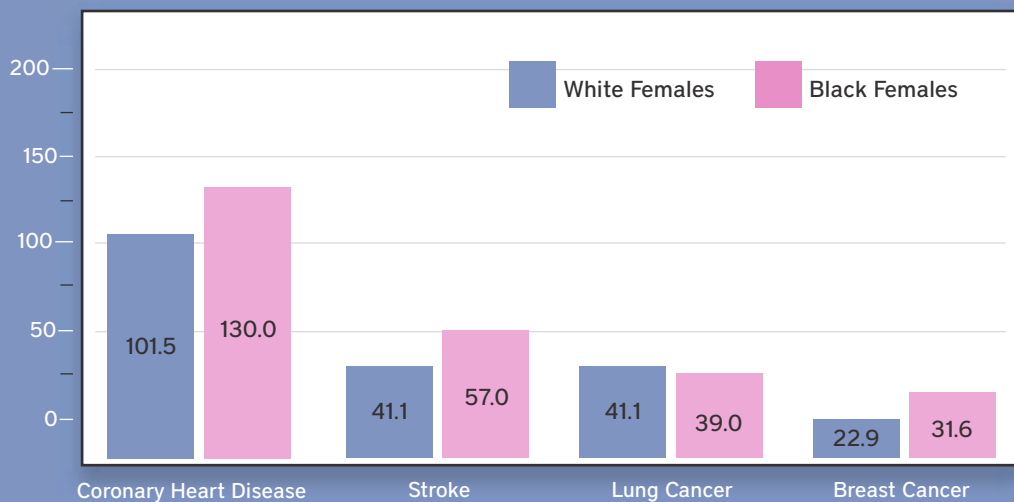
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Emory University Medical Center

*While I believe we should measure awareness again, one issue we must be clear
about is what providers actually do with information they get. What they know is one thing;
how they change or don't change behavior is something else.*

— ATHENA POPPAS, MD, *Director, Echocardiography Laboratory at Rhode Island Hospital*

More than 1 in 4 women will die of cardiovascular disease while 1 in 30 will die of breast cancer.



Death Rates for White and Black Females³

Source: AHA 2010

Women of color are less aware of the risk of heart disease than Caucasians despite their higher morbidity.

The Problem

ALTHOUGH DEATH RATES FROM CARDIOVASCULAR DISEASE (CVD) have declined overall, there is less improvement in survival among women compared to men, according to the American Heart Association's 2010 Statistical Update Report. The reasons for this include:

- **LACK OF PROFESSIONAL AWARENESS AND PREVENTIVE FOCUS.** Because a majority of the medical community lacks information about women's heart health, women are less likely than men to receive recommendations from their physicians about preventive heart disease therapies.
- **LACK OF VALIDATED DIAGNOSTIC TESTS.** Women at risk of heart disease are less often referred for the right tests. Also, current approaches to and guidelines for diagnostic testing need to be revised for the female patient.
- **LACK OF RECOGNITION OF GENDER DIFFERENCES.** Clinicians and other healthcare providers often attribute chest pain in women to non-cardiac causes, such as anxiety, panic or stress. Additionally, women have a greater tendency toward "atypical" symptoms, including upper back pain, difficulty breathing, nausea and unexplained fatigue. Currently there is little gender-specific data to provide to the medical community.
- **LACK OF EDUCATION AND AWARENESS AMONG WOMEN.** Though nearly 60% of women now recognize heart disease as the leading cause of death among women, the statistics are racially and ethnically skewed: 62% of white women are aware of this versus 38% of black women and 34% of Hispanic women.⁴



According to the 2010 American Heart Association Update,⁵ the most recent data (2006) show that Hispanic women were more likely than white women to report that there is nothing they can do to keep themselves from getting CVD. The majority of respondents reported they were confused about basic CVD prevention strategies. This not only impacts the medical care women seek but also the lifestyle behaviors they adopt.

These disparities in heart disease between men and women underscore the need for more fully integrated, multidisciplinary women's heart programs that can deliver gender-specific and comprehensive cardiovascular care to the tens of millions of women who are at risk and those already afflicted.

Improving women's heart healthcare, solving that problem, in and of itself is not necessarily difficult. It is a matter of recognizing symptoms and knowing when to refer patients to heart specialists. The challenge is reaching medical care providers and alerting them to what women need from them.

— SUSAN BENNETT, MD, FACC
President, Association of Women's Heart Programs

Why...
has the decline of heart disease in
women not kept pace with that of men?

Why...
have women not benefited
as much as men from recent advances
in cardiovascular care?

What...
obstacles prevent providers from
understanding women's heart symptoms
and taking appropriate action?

Why...
are so many women with
cardiovascular issues misdiagnosed?



A Brief History of the Women's Heart Disease Movement

PRIOR TO 1999 THERE WAS NOTHING that could be defined as a movement to improve cardiovascular care in women. This was primarily due to 1) the belief that heart disease is largely a “man’s disease,” and 2) a lack of recognition that women are different when it comes to preventing, diagnosing and treating heart disease. Such lack of awareness meant that many women went undiagnosed and were not treated as quickly and effectively as men with the same condition, and as a result, they were dying in great numbers.

However, this lack of understanding took a turn after three women— Nancy Loving, Jackie Markham and Judy Mingram — survived heart attacks and in 1999 founded WomenHeart: The National Coalition for Women with Heart Disease. Recognizing how little heart disease information was available to women, they pushed to raise awareness among women and the general public about women’s heart disease, an issue that was all but invisible within the women’s healthcare community.

Three years later, in 2002, the National Heart, Lung, and Blood Institute launched *The Heart Truth*® campaign to give women a personal and urgent wakeup call about their risk of heart disease. The centerpiece of *The Heart Truth* is the Red Dress, which was introduced as the national symbol of women and heart disease awareness at the same time.

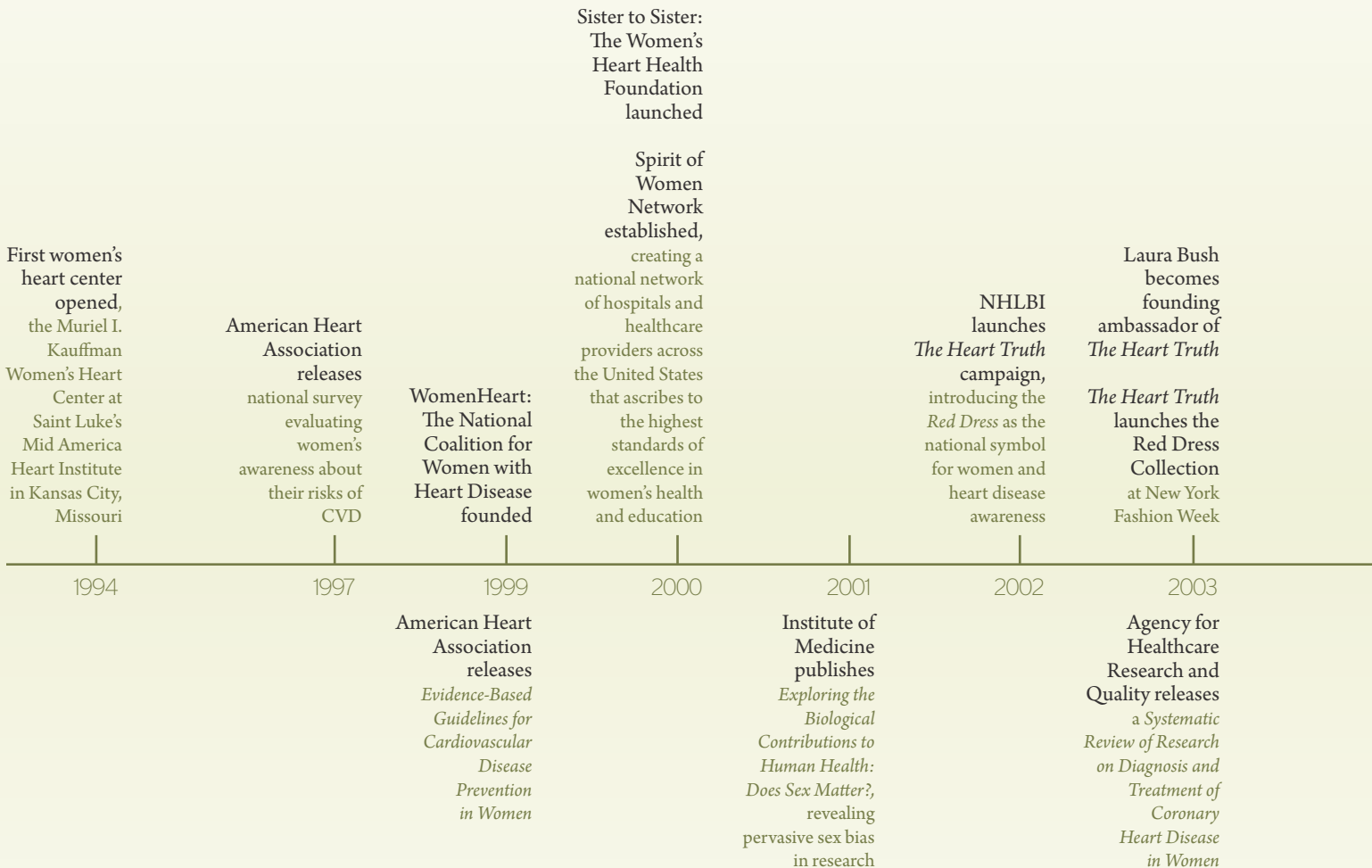
A number of other organizations, including the American Heart Association with its “Go Red for Women” campaign, emerged to help tackle this problem, as did Sister to Sister and Events of the Heart. Hospitals also began to develop their own women’s heart programs.

As a result of these efforts, women’s awareness of heart disease as the number one killer has nearly doubled — 34% in 2000 to nearly 60% now. In contrast, an astonishingly few healthcare providers knew that CVD kills more women than men — 8% of primary care physicians, 9% of ObGyns, and 17% of cardiologists, according to the 2005 Mosca study on physician awareness.⁶

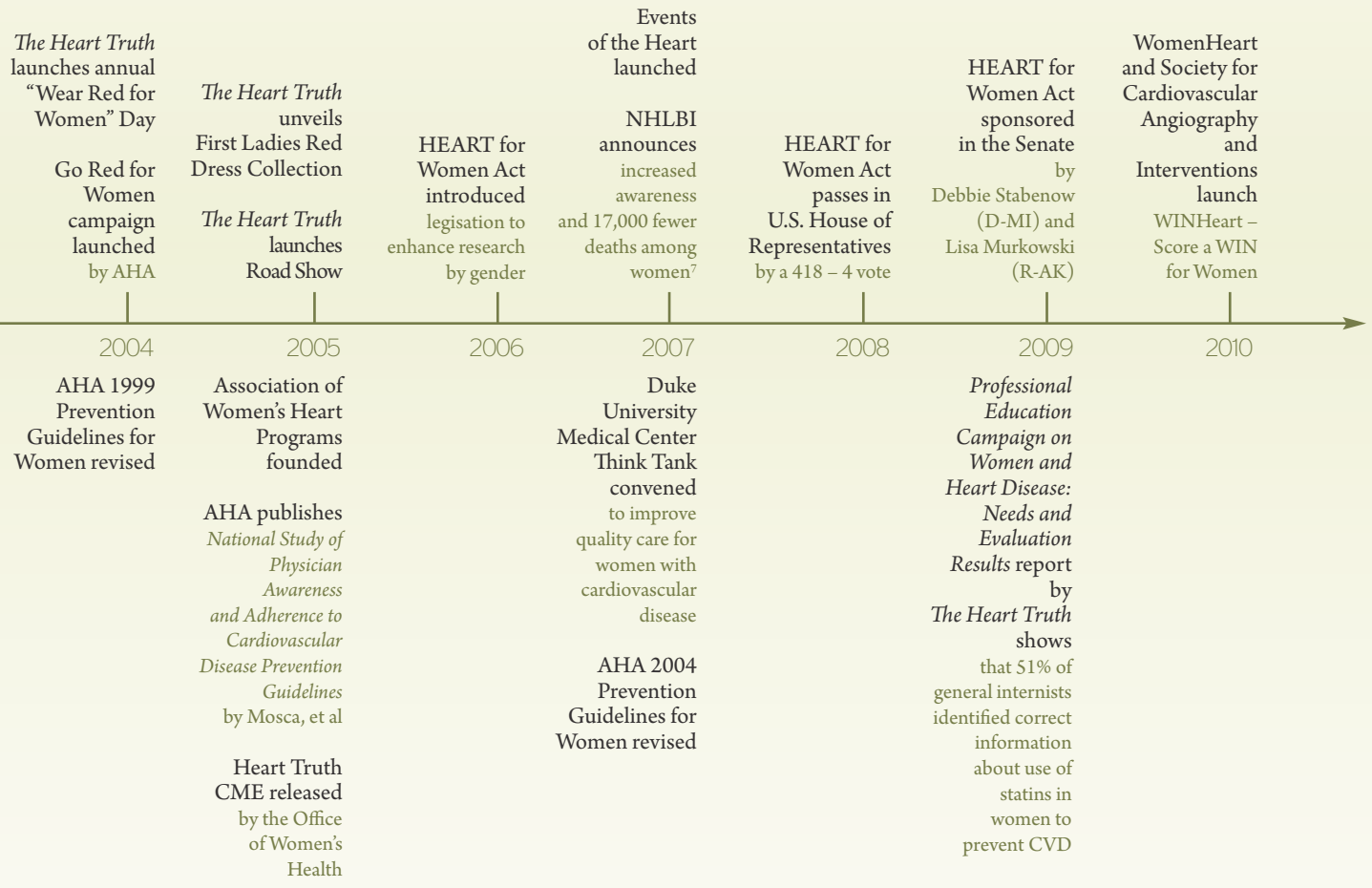
It’s not enough for women
to hear the slogan “talk to your doctor”
when many doctors lack information.

The Women's Heart Movement

Patient-Targeted Initiatives



Medical Care Provider-Targeted Initiatives





Birth of the Association of Women's Heart Programs (AWHP)

BUILDING ON THE MOMENTUM AND SUCCESS of heart health campaigns aimed at women and recognizing the lack of awareness among doctors, a group of concerned cardiology specialists sought to replicate this educational movement among the medical care community. Thus was born the idea for the Association of Women's Heart Programs (AWHP). Its founders include Dr. Susan Bennett, Dr. Pamela Marcovitz, Dr. Salvatore Trazzera, Dr. Tracy Stevens and Marcia McCoy, RN, MSN.

The founders summarized AWHP's goals this way: We would like to see healthcare providers recognize the problem, understand how women are different from men and diagnose their symptoms accurately.

After reaching out to and involving leaders and experts in the field of cardiology and with the support of founding sponsors Bristol-Myers Squibb, AstraZeneca, Medtronic and Novartis, the work of the new organization began.

In mid-2006, AWHP explored the idea of establishing a credentialing and accreditation program for women's heart health programs. It became clear, however, that this was a larger task than this nascent organization could undertake, made more difficult by the lack of data that women's heart programs provided measurably better care over existing approaches.

Instead, AWHP decided a more effective and immediate strategy would be to provide the medical care community with education and knowledge that emphasizes gender differences to save women from suffering and dying of heart disease.

To inform this effort AWHP undertook three initiatives to bridge the gap between what was known and what was lacking about women's cardiovascular disease: 1) an Attitude and Perception Audit, 2) a National Public Opinion Survey and 3) a Thought Leaders' Conference. Highlights follow.

This urgent issue is going to become more significant as women become more aware of their risk for CVD. They are already looking to their primary care physicians and ObGyns to be knowledgeable about these issues and answer their questions.

— MARCIA I. MCCOY, RN, MSN

Director, Muriel I. Kauffman Women's Heart Center, Saint Luke's Mid America Heart Institute

Association of Women's Heart Programs Unique and Informative Initiatives

AWHP carried out three listening initiatives to collect data:

- ▶ An Attitude and Perception Audit
- ▶ A National Public Opinion Survey
- ▶ A Thought Leaders' Conference

Findings from these initiatives informed AWHP's perspective and its strategic plan for moving forward.

Attitude and Perception Audit

AWHP COMMISSIONED a national qualitative attitude and perception audit to gather information from highly regarded experts in various fields of medicine and leaders of health provider organizations. Participants were selected based on their experience and expertise and their ability to speak on behalf of their peers and members of their organizations, thus providing AWHP with important perspectives from within and outside of the cardiology field.

The audit was chosen as the most effective way to gain an overview and insight into key audiences' perceptions about the issue of women's heart disease and what can be done. The one-on-one interview process allowed the researchers to probe the attitudes of these experts and encouraged them to reflect opinions beyond their own.

Audits are often used to reveal what future research and steps ought to be taken to move an organization forward. A complete list of participants can be found in Appendix 2.



*We go to women's heart events and we see the converted, all the people we know.
The ones who are already doing something. But we can't seem to reach beyond that.
Why aren't cardiologists taking the lead? Where is ACC's leadership?
ACOG's, primary care physicians and others?*

— PERCEPTION AUDIT PARTICIPANT

*A key element of success is to have the doctors and health professionals fully on board.
For The Heart Truth® campaign to have maximum impact, doctors need to know what their patients
know. There is likely increased awareness because women are being prompted to talk to their doctors,
but we have not yet seen a real sea change in provider awareness.*

— SARAH TEMPLE, Chief, Client Affairs/Social Marketing,
Ogilvy Public Relations Worldwide, NHLBI's The Heart Truth® campaign agency since 2001

The audit was designed to

- assess the medical community's perspective on the need to improve cardiovascular care for women and the priority this problem has compared to other health issues
- understand obstacles to reaching medical care providers so AWHP can design targeted programs
- provide reliable information and insight to inform AWHP's organizational development and communications



Women with heart disease are worried about hitting another glass ceiling in the workplace if it's known they have heart disease. Men no longer have that problem. We have to break that perception for women! At conferences, women come to me in private to ask personal questions, but they won't ask them in front of their peers.

— PERCEPTION AUDIT PARTICIPANT

Women need to own this disease in the same way they own breast cancer.

— PERCEPTION AUDIT PARTICIPANT

What experts said about medical care providers' attitudes and beliefs

GUIDELINES. Yes, there are guidelines, but doctors don't follow guidelines.

GENDER DIFFERENCES. Male doctors don't seem to believe there are gender differences and no amount of science will convince them.

WAIT AND SEE ATTITUDE. It may well take a generation of doctors to change the thinking about women's heart disease and be put into practice; we'll just have to wait.

PCPs and ObGyns are a woman's first line of defense against heart disease. But I talk to women all over the country who say, "I know I'm at risk. Both parents had heart disease and I felt like a walking time bomb. But none of my doctors would pay attention to that until I actually had a heart attack."

— PERCEPTION AUDIT PARTICIPANT

What experts said about obstacles to reaching providers

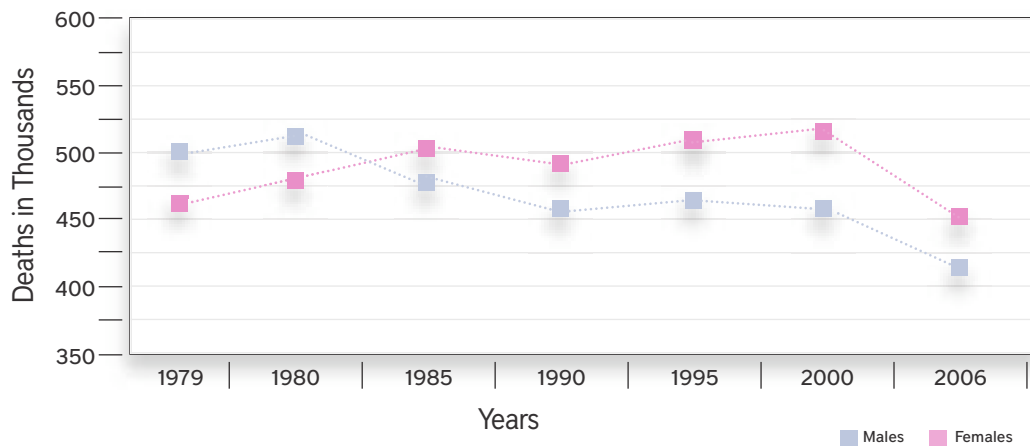
PHYSICIANS ARE FLOODED WITH INFORMATION. Each year there are about 30,000 articles doctors have to read just to keep up with their specialties. That's 100 per day! How can we ask them to read dozens more articles in other areas of medicine?

SMALL PRACTICES ARE UNDER SIEGE. Figuring out how to support private practitioners — primary care physicians, ObGyns, etc. — is paramount. Many are swimming upstream and can't get the resources they need on subjects like this.

THE LACK OF CARDIAC GENDER-SPECIFIC DATA IS ASTONISHING. It's a crapshoot for doctors sometimes because they don't know the data about how the meds and procedures are going to work with women. This is a systemic issue.

More is being done to prevent and treat heart disease in men because providers often fail to recognize the symptoms in women.

Gender differences in symptoms, prevention and treatment of heart disease go largely unrecognized and thus contribute to a high number of fatalities in women.



Trends in Deaths from Cardiovascular Disease for Males and Females⁸

(United States: 1979-2006)

Source: NCHS and National Heart, Lung, and Blood Institute

FRAN'S STORY⁹

from WomenHeart

Age 37

I have been experiencing chest pain on and off for the past year, often accompanied by pain in my upper right back, nausea and lightheadedness. My two primary care doctors keep telling me I am not a heart attack candidate, but neither can explain the chest pain. One of them said if I was having a heart attack it would feel like a rope tied around my chest was continually tightening and that I would have shortness of breath. Both my parents have severe heart disease. No one seems to be listening to me.

no one
seems to be listening to me

What the Audit Revealed as Issues of Concern

ISSUE 1: Changing provider behavior regarding women and heart disease

- Concern about attitude, accompanied by resignation, that not much can be done
- Recognition that changing physician behavior is an enormous challenge
- Wide spectrum of answers on how to change behavior
 1. Educate new field of doctors and “wait for change to occur”
 2. Develop strategic and concerted efforts to disseminate information through professional organizations, Web newsletters, CMEs and other methods
 3. Mandate regulations and use enforcement tools like public reporting of outcome and quality measures and even litigation



The best place to update information is at the beginning — in the curriculum at medical schools. But that also is a long process — both implementing curriculum changes and waiting until a new field of doctors and providers emerge with new knowledge.

— PERCEPTION AUDIT PARTICIPANT

ISSUE 2: Difficulties associated with reaching providers

- Medical care providers are besieged with information and dozens of competing women’s health issues vie for their time and attention
- Need exists for someone to translate scientific research into practical suggestions, tools and even recommendations for systematic change

ISSUE 3: Complexity of the women’s heart health field

- No single respected “voice” of women’s heart health listened to by providers
- Many general public campaigns and initiatives to raise awareness, but none aimed specifically at the medical community
- Growing array of women’s heart health programs in hospitals throughout the country, but many are viewed as marketing efforts

BRENDA'S STORY¹⁰

from WomenHeart

I am now 50 years old and in the past 18 months have been in the hospital 16 times with heart problems. I have had a heart attack, several smaller attacks, open-heart surgery, eight heart caths and several stents. When I had my first heart attack, I waited two hours in the ER while people with feet problems went ahead of me. The reason for that is the triage nurse was sure I was not having a heart attack; that it was only esophagus problems. Had I been a 75-year-old male with chest pains, I would have gotten immediate attention. This is a real problem ... I want to be a voice crying in the gender-biased wilderness: to change the preception that heart disease is for men only.

Had I been a 75-year-old male, I would
have gotten attention

AWHP's Conclusions from the Audit



CONCLUSION 1:

It is generally understood that saving women's lives will mean educating medical care providers about women and cardiovascular disease, informing them about their important role and motivating them to take action by changing their behavior.

CONCLUSION 2:

While cardiologists are more aware than other medical providers that cardiovascular disease is the number one cause of death and morbidity among women, there is no specific focus on the part of cardiologists to raise their colleagues' awareness or that of other providers.

CONCLUSION 3:

The greatest opportunity to save lives and reduce heart disease in women will be to partner with primary care and family physicians, obstetrician-gynecologists, nurses, emergency room personnel and other providers.

National Public Opinion Survey

AWHP PARTNERED WITH the California Pistachio Commission to conduct a national opinion survey of 1,000 adult US men and women to discover their level of awareness of heart disease in women and the role they believe non-cardiologists play in women's heart health. This was the first survey that has polled men about women and CVD.

The survey was conducted by Pulse Opinion Research. The results, released in February 2007 as part of American Heart Month, were dramatic. The survey illustrated that a conflict clearly exists between what people believe and the reality of the situation when it comes to the issue of women's heart health. Most people trust that their doctors are aware of women and heart disease and yet a 2005 American Heart Association study showed that an overwhelming number of doctors do not know even basic facts about women and heart disease.

Key Survey Findings

- Well more than half (59%) of women and almost half of men (44%) know that heart disease is the leading cause of death among women.
- 27% of women in the survey felt protected against heart disease because they see their doctors regularly.
- A vast majority of people polled (82%) trust their doctors to know the critical facts about heart disease in women.
- 40% of women said they were at risk for heart disease, yet only 44% of those women had ever initiated a discussion about their heart health during doctor visits.
- About 70% of Americans turn to their family doctor, primary care physician, or internal medicine doctor when concerned about heart problems and only 20% seek help from a cardiologist.
- 48% of respondents said their doctor had not initiated a conversation of their cardiovascular health in the previous five years.
- When examining the survey results by age groups, the data was equally startling: In the 30-39 age group, 63% said their doctor had never initiated a conversation about heart disease. In the 50-64 age group, 42% reported no doctor-initiated discussion.



People believe that doctors know the critical facts about heart disease in women, but the evidence is to the contrary. A conflict clearly exists between what people think and the reality of the situation.

In response to the survey findings

SUSAN BENNETT, MD, FACC

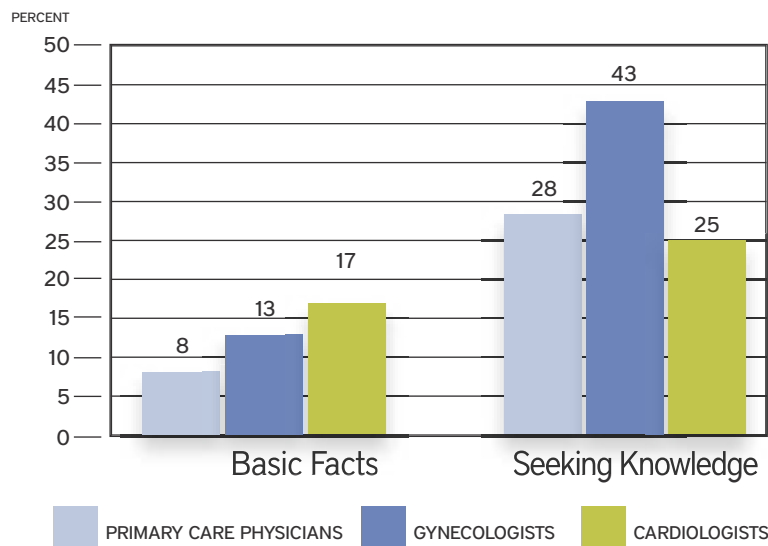
President, Association of Women's Heart Programs

The good news is that national awareness campaigns like The Heart Truth and its Red Dress symbol are reaching and empowering more and more women with the message that cardiovascular disease is the single greatest health threat to women.

The problem is that millions of at-risk patients are relying on their doctors to know all the facts about women's heart disease. In our minds, we see thousands of educated and empowered women — and the men who care about them — crossing a bridge in search of cardiovascular disease prevention, women-focused diagnosis and care that is specific to women's hearts, their bodies and their needs.

We are concerned that the medical care providers themselves are not prepared to meet the women on the bridge with knowledge and approaches to care, to give them what they both need and seek. Our mission is to close this gap to provide better quality heart healthcare to women and to reduce the number of women who are dying from heart disease.

Our mission is to reduce
the number of women dying
from heart disease



Physician Awareness that More Women
than Men Die of Heart Disease¹¹

Physician Population by Specialty

Thought Leaders' Conference

IN MID-2007, AWHP CONVENED A GROUP of carefully chosen leaders, representing a broad spectrum of medical care providers and related government agencies and public institutions. They gathered for a Thought Leaders' Conference, a day of intense and candid discussion about women's cardiovascular health and about the care and treatment of women with cardiovascular disease.

This unprecedented meeting included ObGyns, primary care and family physicians, emergency room physicians, nurses and nurse practitioners, the AWHP board and other cardiologists, all dedicated to women's health.

The panel included:

- **Mary Ettari**, MPH, PA-C, Chair, American Academy of Physician Assistants
- **Judd E. Hollander**, MD, President, Society for Academic Emergency Medicine
- **Lynne Kirk**, MD, FACP, Immediate Past President, American College of Physicians
- **Jack Lewin**, MD, Chief Executive Officer, American College of Cardiology
- **Mary Mitchell**, Director of Professionalism and Gynecological Practice, American College of Obstetricians and Gynecologists
- **Mary Ellen Roberts**, RN, APNC, MSN, Past President, American Academy of Nurse Practitioners
- **Stanley Zinberg**, MD, MS, FACOG, Dept. EVP & Vice President, Practice Activities, American College of Obstetricians and Gynecologists



To Close the Gender Gap

After a lengthy panel discussion, participants identified four categories necessary to close the gender gap in heart healthcare within the medical community:

MOTIVATION: effecting behavior change in medical care providers

EDUCATION: translating information into practical tools for providers on the front line

STANDARDS OF CARE: creating basic guidelines for providers to care for women with heart disease

SYSTEMS CHANGE: influencing the underlying systems that drive provider care for women

Primary care physicians
infrequently discuss heart health with their
patients during annual physicals.

Our “Door-to-Balloon” campaign measures the time in emergency rooms from entrance to intervention. More than a thousand hospitals are participating. Most start out by saying, “We can do it under one hour,” but on closer inspection they find out it took longer, considerably so with women. Now we have to correct that.

— JACK LEWIN, MD,
Chief Executive Officer, American College of Cardiology



SUSAN'S STORY¹²

from WomenHeart

I called 911 when I had severe heartburn and back pain, sweating and short of breath. The ER doc discharged me, but said to stop and buy a bottle of Mylanta on my way home. Twelve hours later my mother found me on the floor, nearly unconscious after having had a full-blown heart attack. It's amazing I'm still alive.

It's amazing I'm still alive

Going into the Thought Leaders' Conference

We...
recognized the urgency of the problem.

We...
recognized the steep
barriers to reaching providers.

We...
recognized the complexities and
difficulties of practicing medicine
in the 21st century.

And we...
knew that only a collective
response by the medical community
would make a difference.

TO GET A SENSE OF THE RANGE OF QUESTIONS and responses from these medical leaders, we offer the following excerpts from a lengthy panel discussion. The answers were diverse and often poignant, some more specific than others.

Question & Answer

Q: In your field is there a sense of urgency about the fact that cardiovascular disease is the number one killer and that women are dying needlessly?

ETTARI: Among physician assistants there is a sense of urgency, but it's overshadowed by the urgency we feel around obesity and diabetes. Even so, we are quite aware that heart disease is the number one killer and the different ways that disease presents in men versus women.

ROBERTS: Nurse practitioners feel an urgency, though some believe they need to get the word out, while others feel it's more important to talk about the risk factors than about heart disease itself.

LEWIN: Cardiovascular physicians sense the urgency and are undertaking a major effort to partner with others to educate women and the public about this. We see the challenge as related to the need for multi-specialty and multidisciplinary action.

Boomers are going to need a huge amount of care and problems like obesity and diabetes will contribute greatly to the need for CVD care and we won't have enough practitioners available. So we know we are going to have to practice in teams... we will be working in partnership with internal medicine, family practice, ObGyn, emergency medicine and other specialties.

MITCHELL: ObGyns recognize heart disease as a priority, but as one of many priorities.

I do think it is very important to focus on the available science and figure out how we can use it to reduce the barriers, whether it is payment, education, knowledge, behavior, et cetera and then how we generate the future new science that we need to most effectively deal with this problem. But the potential to get things done with all of the organizations, all of the professionals working together, is really tremendous.

— LYNNE KIRK, MD, FACP
Tim and Toni Hartman Professorship in Medicine, UT Southwestern Medical Center

Q: Are your colleagues feeling increased pressure from their female patients about their cardiovascular disease care and about their risk of heart disease? In other words, do the women who are patients know more than the doctors right now?

In response to this question, four out of six answered, “yes and no.” In other words, they agreed that there are many well-educated consumers/patients and that doctors are certainly getting a lot more questions, but whether their knowledge is greater than the doctor’s is another issue.

Q: What is the greatest challenge as we begin to focus on prevention and more accurate diagnosis of cardiovascular disease in women?

ROBERTS: The biggest factor is that we don’t get reimbursed for primary prevention. And when you have that “15-minute-turned-into-5 minute” office visit, it’s really hard to educate.

Another reason physicians may not perceive an urgency is because the literature that deals with cardiovascular disease in women is not familiar to our providers. I sit on pharmaceutical advisory boards and they say, “Well, okay. This was approved. How come the ER docs aren’t using it?” And my answer is, “Well, you did the study with an inpatient setting and you published it in the Cardiology journal and you want to know why an ER doc doesn’t know it exists?”

— JUDD HOLLANDER, MD, Professor and Clinical Research Director,
Department of Emergency Medicine, University of Pennsylvania

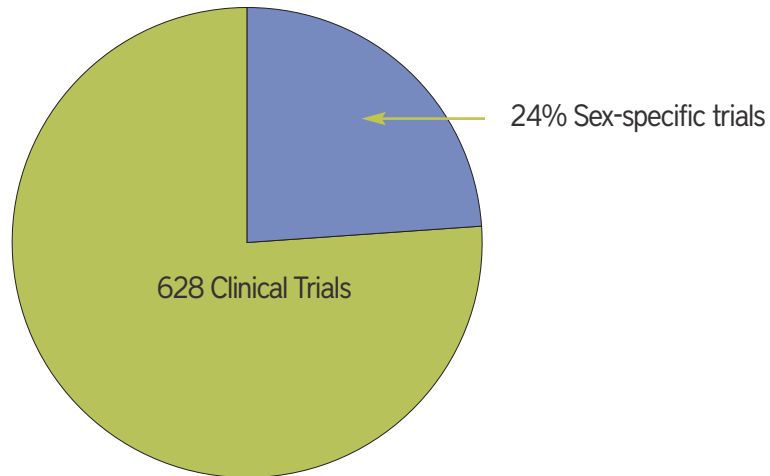
I believe most of us see the urgency of this problem, but the solution will require a collaborative effort. So how can we harness the power of the full spectrum of the medical care field? If we don’t, incremental changes will have very little impact and simply take too long.

— PAM MARCOVITZ, MD, FACC
William Beaumont Hospital

Q: Women often say they consider their ObGyn their primary care physician. How prevalent is it that ObGyns include information during regular visits about heart disease prevention?

MITCHELL: Preventive counseling and health education are integral parts of ObGyn practice. They measure blood pressure and counsel on risk factors. Some are doing lipid assessments. We (American College of ObGyns) have been happy to work with ACC and AHA on three editions of the cardio guidelines for women and we have active local chapters and districts involved with these types of partnerships.

How much gender-specific data do we have?
Not much.



Low Rate of Gender-Specific Results Reporting in Cardiovascular Trials¹³

Source: Mayo Clinic Proceedings, Feb. 2007

How much gender-specific data do we have? Not much. Of 628 landmark clinical trials, we found that fewer than 25% reported gender results. This impedes the ability to provide evidence based information to physicians, which is essential to building credibility within the medical community about the fact that a gender gap exists.

— TRACY STEVENS, MD, FACC
Medical Director, Muriel I. Kauffman Women's Heart Center,
Saint Luke's Mid America Heart Institute

Q: Do your members (American College of Physicians) believe that there are meaningful gender differences in cardiovascular disease and are your members aware of and using these guidelines?

KIRK: I think guidelines are available in a wide variety of places. To be useful guidelines must be available to the provider at the time of patient care and must be integrated into the care for the patient. We have an online education databank called PIER, Physician Information and Education Resource. It addresses the 400 most common things internists see, and includes a module on women and heart disease.

PIER modules are evidence-based and regularly updated. So you can see the guideline as you are seeing the patient, but you can also drill down to the primary information, including articles that support that guideline. About 25-30% use this resource regularly in their day-to-day patient care.

Q: I've heard lots of people say by the time a woman gets to a cardiologist it's often too late. How can cardiologists increase the urgency for other physicians to give referrals and to help educate women?

LEWIN: We (doctors) need to take responsibility ourselves now that we have the tools to use data and to become self-regulating and move toward optimal performance.

How does that happen? The National Cardiovascular Data registry that is in 2,000 hospitals is a start. Perhaps this should become the National Clinical Data registry and maybe it should be extended — starting with cardiovascular-related care — for use broadly, by internal medicine doctors, ER personnel, ObGyns obviously, nurses and physician assistants, so that we are all together looking at how we are doing. That is something we could talk about, but we need to decide to do this together. It is not really beyond our reach in cardiology. Other specialties are not quite as financially able to put this kind of material out.

One of the best ways to assure that we are doing the right job is to get consensus around guidelines. We certainly have the consensus within cardiovascular medicine, but we need to make sure those guidelines are available at the point of care, in a way that is readily usable. We need to turbo-charge the guidelines over the next few years and that has to be in partnership with everybody at this table, plus others.

— JACK LEWIN, MD
Chief Executive Officer, American College of Cardiology

Q: Many of you have said that female patients are not asking questions about their heart health, but it has also been said that patients aren't always getting accurate detection or diagnosis. Can more knowledgeable patients who speak up impact the care that they get?

KIRK: Yes. When we developed our diabetes materials we did focus groups of patients from various backgrounds – socio-economic, gender and ethnicity – and learned remarkable things. The patient voice is extremely important. Letting patients as groups help us to help them is extremely important.

ROBERTS: I want to add that empowering patients is probably one of the best things we can do, because they are going to come and ask. Here is an example. A woman asked at a baby shower whether she should be getting an EKG at her annual physical. She was 60 and I encouraged her to go back and ask the doctor to do one, because at her age that should be part of her regular physical. So empowering our patients is a key component in getting better care.

ETTARI: That is a perfect example where there is a disconnect between what we would like to do and what insurance will pay for. Just because a patient wants an EKG, doesn't mean they can just get one. They require an appropriate diagnosis or symptom, or in many instances they will have to pay for it.

We are caught in that conundrum daily. We are using creative diagnostic codes to be able to justify procedures and the next article we see in the professional journal is about ethics and medicine asking: are you manipulating your diagnoses in order to take care of a patient's wishes or to do good care?

LEWIN: We are watching the demise of primary care in general, because of its under-reimbursement. That exacerbates problems and delays diagnosis and we need to address that reality. We are losing primary care infrastructure because insurance companies and Medicare don't value those services or pay for them.

*The outcome literature, especially on CME, is abysmal.
Sitting in a darkened room and listening to people talk doesn't really change behavior.
Integrating guidelines into electronic medical records would make it easy to have the right
conversation with the patient. We would say, 'This is indicated for you.
This is why I'm recommending it. Let's get this done.'
That's something that's very exciting and could come about quite quickly.*

— LYNNE KIRK, MD, FACP
Tim and Toni Hartman Professorship in Medicine, UT Southwestern Medical Center

Q: A lot seems to be going on in the various associations and societies that have been discussed today, so why are women still dying from heart disease at the rate they are?

KIRK: I think access is still a tremendous problem for a lot of women. Certainly, the most obvious are the uninsured. Until they develop acute symptoms and have to go to the ER many women have no idea that they are suffering from hypertension, hypercholesterolemia, or diabetes. And then sometimes it's too late.

ZINBERG: Public information campaigns could go a long way toward addressing the issue.

LEWIN: We need to look at reimbursement for primary care, because that is critically important — it goes along with expansion of access — and then we need to coordinate care better. It is multidisciplinary. Coordination of care costs money too and it needs to be valued. That is what the “medical home” issue is about, because people often have multiple co-morbidities and healthcare issues and we need to put that all together.

ETTARI: If we could get as excited about women's cardiovascular disease as the Women's Health Initiative did about breast cancer, it would make my life easier. When WHI first came out my women patients were coming and wanted to immediately be taken off of any hormones while they were still smoking a pack of cigarettes a day.

Thought Leaders' Conference Summary

Sense of Urgency

It is a priority, but one of many

It is urgent, but overshadowed by issues like breast cancer, obesity and diabetes

It will require a multi-disciplinary team effort, but that takes time to build

Greatest Challenge

Lack of reimbursement for primary prevention

The “15-minute-turned-into-5 minute” office visit

Overwhelming amount of new information providers must learn

Disconnect between what providers would like to do and insurance provisions

Guidelines and Gender Differences

Guidelines are available but not always seen or used

Would be more useful if available at time of patient care

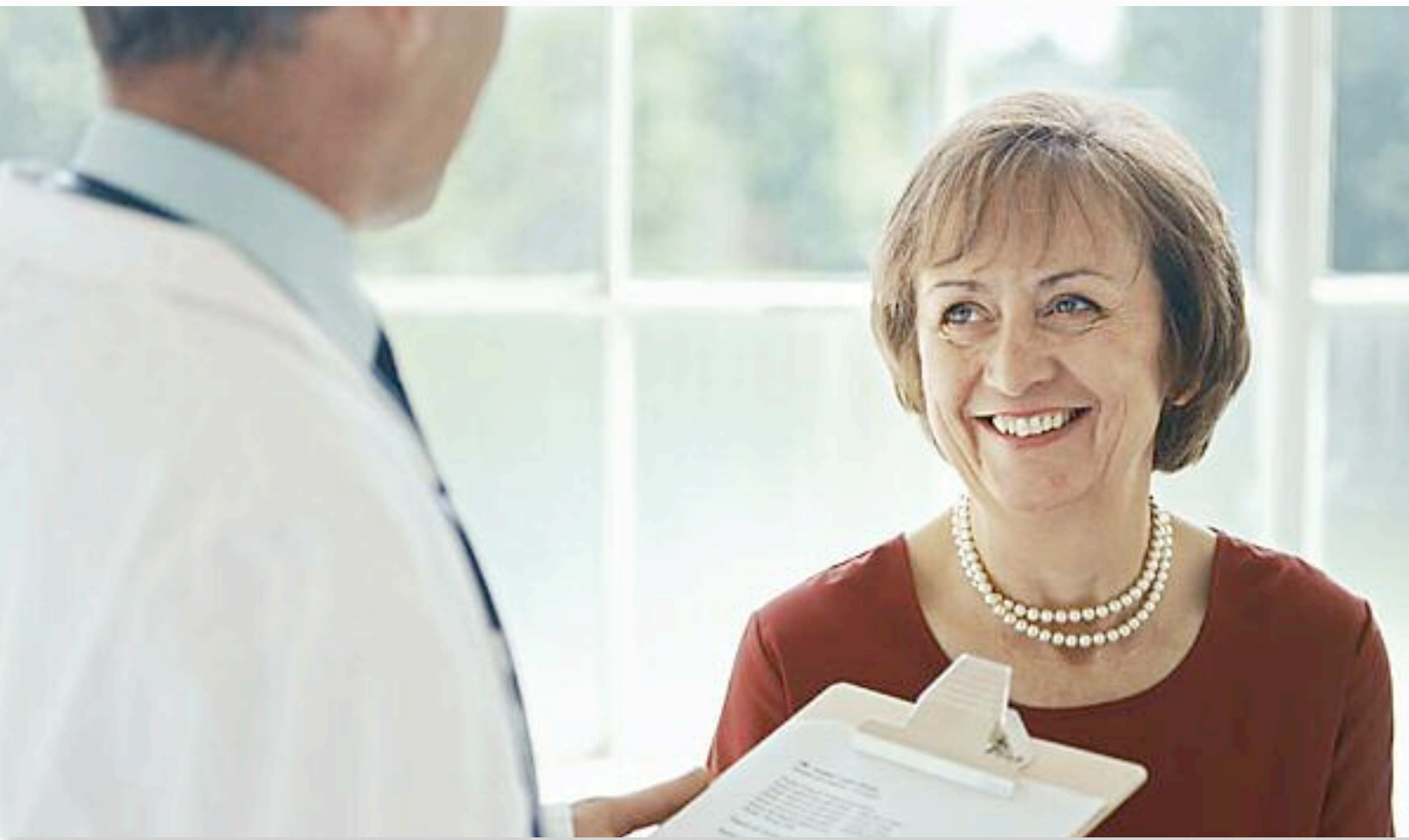
Not enough gender-specific research data

Patients

The patient voice is extremely important

Empowering patients is one of the best things we can do

Recommendations to the medical and healthcare profession and organizations involved with women's heart health...to carry on the critical work of AWHP.



EDUCATING AND CREATING AWARENESS AMONG WOMEN won't solve the problem. We need the medical community's participation. They play a critical role. So in this final report, AWHP founders, participants and supporters ask the medical profession, women themselves and organizations involved with women's heart health to carry on what the Association of Women's Heart Programs began. We make three recommendations, which if undertaken will make a significant dent in awareness, increase research and education and lower the death rate of heart disease among women.

RECOMMENDATION 1:

Elevate women's heart health to high-priority status for all medical care providers

- Communicate clearly that failure to achieve this priority status means women will continue to die needlessly
- Recognize that first-line medical care providers must be a major target of women's heart disease information initiatives, and that no organization currently has this as a primary focus
- Mobilize medical professional organizations to reach their members
- Create public policy initiatives that place greater responsibility for change on the part of providers

My perception is there is still a very big deficit of knowledge. This is based on anecdotes and reports from patients. We hear these all over the country, from women of all ages, ethnicity, economic status and education.

— LISA M. TATE, Chief Executive Officer,
WomenHeart: The National Coalition of Women with Heart Disease

We do "casting calls" to collect stories and we hear the same story from hundreds of women — they went to their doctor seeking help and were told, without any tests, that their symptoms were not due to heart disease. Often, too often, that was incorrect.

— JULIE ROBERTSON, National Cause Director, Go Red for Women

At Sister to Sister, we believe that women patients are empowered, active participants who seek reliable and understandable information from their doctors. The lack of provider awareness, regarding the specific heart disease signs for women, what actions to take and recommendations for healthy living, are severely limiting factors in our efforts to save lives. There is not only a huge gap in awareness and knowledge, but a huge need for action.

— IRENE POLLIN, MSW, PhD (Honorary)
Founder and Chairperson, Sister to Sister Foundation

RECOMMENDATION 2:

Demand major increases in funding for research on gender differences and similarities in cardiovascular disease to bridge the knowledge gap

- Prioritize gathering gender-specific data on the effectiveness and adverse effects of new drugs and devices, and new care delivery systems
- Develop a comprehensive approach to understanding the benefits and risks of a given treatment or intervention for women once utilized in clinical practice
- Turn results of effectiveness-based research about women and heart disease into practical, useful and easy-to-access information for the entire medical community



RECOMMENDATION 3:

Convince the cardiology community that progress will not be made until they become leaders in this movement

- Position the cardiology community as the leader in education and system development to improve the skills of first-line providers
- Help providers realize they are the last ones to the women's cardiovascular care table
- Celebrate the women's lives that will be saved by greater provider awareness, involvement and action

LIZ HANSON'S STORY

My grandmother had her first heart attack in her 40's and died of her second one in her 70's. My mom has heart disease. A friend's wife just died suddenly of a heart attack. I've always assumed I would die of a heart attack someday — does that sound horrible? When I told all of this to my ObGyn, Dr. David Thayer, at an annual check-up, he told me he has me on the “100-year plan.” That made me smile. Since then, not only do we discuss diet and exercise, but also next steps for monitoring my heart health.



I am a 45-year-old mom and professional who lives in Boulder — where everyone is fit and healthy. Despite a good diet (in the land of tofu and soy milk), regular exercise, no caffeine and dropping my cholesterol 25 points, my triglycerides are still too high. To counteract those family genes, I know I have to keep making the right choices in my diet and fitness. I want my feet to dance, not my heart! I want a strong heart pumping in my chest, powering my body through a long and rewarding life. Thanks to Dr. Thayer's 100-year plan, I think I'll make it.

I want my feet to dance, not my heart!
Thanks to Dr. Thayer,
I think I'll make it

The Association of Women's Heart Programs gratefully acknowledges its founding sponsors...



...and also thanks the sponsors of AWWP's Thought Leaders' Conference



APPENDIX 1 Citations

1. *Heart Disease and Stroke Statistics 2010 Update At-a-Glance*. Rep. American Heart Association. Web. 18 Jan. 2011. www.americanheart.org/presenter.jhtml?identifier=3000090.
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APPENDIX 2

Attitude and Perception Audit Participant List

Titles reflect positions at the time of the Audit.

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