Transformation of Cardiovascular Health

Presidential Address at the American Heart Association

2009 Scientific Sessions

Clyde W. Yancy, MD, FAHA

Good afternoon, my name is Clyde Yancy. Welcome to the American Heart Association’s Scientific Sessions 2009. Thank you for being here. Today, you are part of the phenomenal tapestry of those attending this meeting.

As I look out in the audience, I see accomplished and new basic and clinical scientists, clinicians, clinical and research nurses, and allied health professionals. I marvel at the collection of AHA past presidents and chairpersons, leaders of our partner national and international professional and volunteer health organizations, and my colleagues here from the American College of Cardiology.

I embrace the volunteers, patients, and family members who are here today; and I appreciate the business professionals, innovators, and media who share our interest in cardiovascular diseases and stroke. Welcome. We have all come together at Scientific Sessions for a singular purpose: to share our interest, our curiosity, our passion, and our intent to "build healthier lives, free of cardiovascular diseases and stroke."

Today, I will address the transformation of cardiovascular health. Health care is changing. One year ago, we realized the dawning of epic change—specifically, the potential transformation of American health care. Given the enormity of this moment, we were galvanized to contribute proactively to healthcare reform. Under the leadership of former AHA President Ray Gibbons, the American Heart Association outlined and published the following principles:

1. Access to care for all persons residing in the United States;
2. Enhanced focus on the prevention of disease;
3. Increased quality of care;
4. Elimination of disparate health care;
5. Advancement of research with sustained and consistent funding of the NIH and;
6. An increase in the healthcare workforce.

But healthcare reform per se is not the focus of my comments, as healthcare reform that is not accompanied by a true transformation will only shift the suite of problems. Thus, I will address the transformation of health care and will especially focus on transforming cardiovascular and stroke health.

I believe that a true transformation of cardiovascular health involves generating new science, applying best science, and continuing to improve the quality of care of patients with cardiovascular diseases and stroke with a targeted emphasis on prevention, attaining health equity, and advocating for better health for all.

Let’s turn our attention toward science. The AHA was founded in 1924 by visionary physicians, led by Paul Dudley White, Lewis Conner, and others—names that resonate within the history of American medicine. Their brilliance was eclipsed only by their humility. They were smart enough to know that our evidentiary science was woefully inadequate. Since those incipient moments of enlightenment, the AHA has held firm to its core: the generation of new knowledge; the promulgation of best evidence; and especially the nurturing of new scientists. Our resolve to support science has been relentless and will remain so.

You should know that, to date, the AHA has spent $3.2 billion—with more than $1.3 billion spent in the past decade—in our support of research on heart disease and stroke. And despite today’s precarious economic environment, we have continued to be second only to the National Institutes of Health [NIH] in the support of cardiovascular research.

The AHA, through its positive corporate partnerships and with the help of amazing private philanthropy, has established:

- The AHA–PRT–Stevie and David Spina Outcomes Research Centers to pioneer outcomes science;
- The AHA-Jon Holden DeHaan Foundation Cardiac Myogenesis Research Centers to create breakthroughs in cardiovascular regenerative medicine; and
- The AHA-Bugher Foundation Stroke Prevention Research Centers to understand how best to preempt this debilitating disease.

We have not and will not lose sight of the discovery of new science, as nothing defines the depth and breadth of this organization more profoundly. This is our core strength and this is where the transformation of cardiovascular health begins.
Generating new knowledge, though laudable, is not, however, sufficient. We must apply this knowledge to our mission. With that in mind, this organization adopted a bold vision, and set an ambitious goal in the year 1998: to reduce coronary heart disease, stroke and risk by 25% by the year 2010.

Pause for a moment and consider the enormity of this goal. In 1998, we didn’t yet have widespread use of important evidence-based therapies, such as statins, ADP [adenosine diphosphate] platelet receptor inhibitors, PCI [percutaneous coronary intervention] for ACS [acute coronary syndromes], or lytic therapy for stroke care. Secondary prevention measures were still evolving. Yet, this organization moved ahead with conviction that the cardiovascular and stroke community would respond to the challenge—and indeed you did.

By 2008, we nailed a big part of our 2010 goal—deaths from coronary disease had fallen by more than 25%, and soon after, the goal for stroke was achieved. Hypertension control is at goal and cholesterol control is nearly there. Consider that the actual reduction in death due to CAD [coronary artery disease] has been 35.7% and for stroke, 32.5%. The process of discovery, implementation, and application of best practices has been so forthcoming, so profound, and so transformational, that tens of thousands more patients are alive and well now.

That, my friends and colleagues, is no small feat. But this is not the whole story. Importantly, we recognize that we have not achieved our 2010 goals for smoking, physical activity, obesity, and diabetes. Worse, we know that a rerudescence of mortality due to heart disease and stroke is already occurring in certain areas, and it’s likely to worsen even more if we don’t impact these important factors, and especially if there is not a significant change in the worrisome incidence of obesity in our younger population.

So, how best can we drive transformational change in cardiovascular diseases and stroke?

Quality. Such a simple word but a complex rubric. In health care, “Quality” is spelled with a capital “Q.” As outlined by the Institute of Medicine, a “Quality” system or a process must be:

1. Timely,
2. Efficacious,
3. Safe,
4. Equitable,
5. Patient-centric, and

This embrace of quality in cardiovascular medicine has become one of the truly transformational movements in health care, and raising the bar for quality is now a major effort of the American Heart Association. The quality movement has revealed to us what the German poet and philosopher Goethe suggested: “Knowing is not enough, we must apply; willing is not enough, we must do.” Without a process in place to help us define and improve quality, we rely too much on recall; even the best among us fails to do the simplest things perfectly and consistently.

Let’s think about heart failure. Even today, fewer than 90% of eligible outpatients with heart failure are treated with ACE [angiotensin-converting enzyme] inhibitors/ARBs [angiotensin receptor blockers] and only 85% are treated with β-blockers; we note that device therapy use is no better than 50% for ICDs [implantable cardioverter-defibrillators] and 35% for cardiac resynchronization therapy in suitable patients. I personally agonize that combined vasodilator therapy, that is, isosorbide dinitrate and hydralazine, a dramatically effective adjunctive heart failure therapy, is used in <10% of appropriate patients.

The problem is the absence of process. The solution is process of care improvement.

The American Heart Association, American Stroke Association, and others have pioneered process of care improvements that have had remarkable success. Our Get With The Guidelines initiative is arguably one of the most exemplary quality programs in health care.

To date, more than 2 million patient records have been entered from nearly 1600 US hospitals, some of which are participating in multiple modules. Get With The Guidelines is now represented in >35% of all US acute care hospitals. Thank you for the tremendous job that so many of you have done to champion Get With The Guidelines.

What’s been the result? Consider stroke. More than 1 million of the patient records in Get With The Guidelines represent stroke care. These participating Get With The Guidelines–Stroke hospitals have dramatically improved both performance and quality metrics. Case in point: Lytic therapy for acute stroke in participating Get With The Guidelines–Stroke hospitals has increased from ≈33% to 66%, a 100% improvement. Quality of life is being preserved through evidence-based quality-driven stroke care. This is transformational change.

Let’s return to heart failure, a theme to be embraced at this meeting and one that will be highlighted in the Paul Dudley White lecture to be given by Karl Swedberg. Get With The Guidelines–Heart Failure has now accumulated over 400 000 unique patient records from 638 hospitals. Heart failure metrics of quality care are improving and, especially in those participating Get With The Guidelines hospitals that have earned quality recognition, heart failure outcomes (specifically 30-day mortality rates), are significantly better than in other hospitals. This is yet another transformational change.

To further your efforts to improve heart failure care, the AHA has just this past month launched TARGET HF, which captures the entire suite of AHA heart failure–related resources in 1 repository to facilitate best care and quality. Get With The Guidelines–Outpatient, launched earlier this month, is a performance improvement initiative also intended to help you improve quality of care for your outpatients with heart disease or stroke.

As much as breakthroughs in science have yielded important new treatments, it has been the embrace of quality by healthcare systems that is driving those treatments and building healthier lives that are free of cardiovascular diseases, and stroke. However, despite the incredible new science and focus on quality-driven systems, the state of ill health persists. Being sick is a bad thing.
Targeting the prevention of disease and promptly intervening at the earliest signs of disease, even preventing risk itself, would represent a more potent objective, especially in today’s resource-sensitive environment. Stunning epidemiological research done by AHA volunteers revealed that for the 50-year-old male or female devoid of known risk factors for heart disease, including hypertension, diabetes, smoking, dyslipidemia, and a sedentary lifestyle, life expectancy free of heart disease and stroke is at least another 40 years. To date, it is estimated that only a fraction of the US population, perhaps as low as 1%, fits this mode of “ideal health.” But, the possibility exists that preventing the onset of risk factors represents the ultimate strategy toward attaining a longer life free of disease.

The thinking here is truly transformational. The implications go beyond secondary prevention and even beyond primary prevention. This new transformational thought process targets primordial prevention, which is the prevention of risk. This will require bold new science, new processes of care, and new metrics of quality.

With this new context, the AHA underwent an intensive review of relevant clinical and prevention research with a keen focus on the attainment of ideal health. After thoughtful deliberation, the AHA has now adopted an ambitious new goal, as visionary as its 2010 goal. I am pleased to announce this new goal: By 2020, we intend to improve the cardiovascular health of all Americans by 20% and further reduce deaths from cardiovascular disease and stroke by an additional 20%.

Think about this. Consider the potential benefit. Truly we will be creating a future of healthier lives free of cardiovascular diseases and stroke. Let’s not miss the transformation here—improving the cardiovascular health of all Americans, a new goal for the AHA.

In 1966, Dr. Martin Luther King, Jr., spoke these words: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” I take this statement to heart. Now more than 40 years later, this injustice remains. The stain of disparate health care is as evident in heart disease and stroke as it is in any other disease state. This is not in keeping with the most basic commitment in medicine, to provide care and to do so compassionately for all who are ill and are suffering.

The photo in Figure 1 is the “Yancy 9.” These are the sons and daughters of my grandmother, a devoutly spiritual, fiercely independent, driven Negro woman and my grandfather, a hard-working grandson of slaves from the southeastern United States.

Their character traits were passed on to their sons and daughters, and then passed on to my generation, which includes 4 physicians, 3 chemists, 2 teachers, 1 psychologist, 1 economist, and 1 accountant. But we also received our family history of heart disease.

In Figure 1, my father is fifth from the left. He and all of his siblings suffered from or succumbed to heart disease and stroke. Only 1 remains alive. And now my generation has hypertension—me included. That is both astonishing and sobering. Clearly my heritage predisposes me to heart disease but should it also influence how effectively I am treated?

Consider the plight of many African Americans in the United States: Rates of bypass surgery, PCI, statin use, and, as seen from this recent Get With The Guidelines database analysis, even ICD use—all class I recommended treatments for heart disease—are strikingly different (Figures 2 and 3). Despite similar indications, an African-American woman is nearly 50% less likely to receive an ICD.

In part as a result of these examples of disparate health care, African Americans in this country suffer a greater toll of hospitalization and death due to heart disease and greater disability due to stroke. Similar issues are noted in other populations. Is this acceptable?

The complete explanation for the absence of health equity goes beyond the scope of today’s comments, but let me stand squarely with former AHA president Dan Jones, and share his belief that the absence of high-quality health care for any one of us should be unacceptable to every one of us.

The AHA is improving health equity; data derived from our Get With The Guidelines program now demonstrate that...
the racial/ethnic gap in quality metrics and outcomes is narrowing. Careful use of improved processes of care, more precise genomic or physiological characterizations of groups at risk, and better access to care may ultimately support the elimination of healthcare disparities. That would truly be transformational.

For many years the AHA was a sleeping giant, content to quietly push the boundaries of science and awaken only to trumpet new discoveries. But the vision of past leaders identified that the mission of the AHA would not be achieved without a more proactive position in the legislative process.

We are trusted; this allows the AHA to serve as the voice of authority on cardiovascular diseases and stroke issues. We truly advocate for best cardiovascular health for our nation. Advocacy can be a powerful vehicle of change. However, some will label those of us who advocate as supporting 1 political point of view or another. However, the AHA supports only 1 point of view: that of the patient.

Our advocacy efforts have supported increases in the NIH budget, greater uniformity in stroke care; availability of emergency cardiac care across the country including rural environments; women’s health; childhood fitness; and tobacco restrictions. This latter effort culminated in the Family Smoking Prevention and Tobacco Control Act signed this year that provides FDA [Food and Drug Administration] oversight of the tobacco industry and for the first time subjects the tobacco industry to full disclosure and greatly restricted advertising policies. This could be a transformational change affecting an important risk factor.

Many of you are aware that the AHA has been involved in the debates that are shaping healthcare reform. Importantly, we are at the table as a tireless patient advocate, understanding that any shift in focus away from the patient and the provision of ideal health is a missed opportunity. As an organization, we have heard the heartfelt stories of people who have reached the brink of bankruptcy due to healthcare costs despite good insurance; we have agonized over the plight of mothers with children who have congenital heart disease and the impossible task of staying ahead of their bills; and we have felt the anguish of people who know that they have seen loved ones suffer due to the lack of adequate, accessible, affordable health care. As Americans, we envision that the United States provides the best health care in the world, but wouldn’t we truly be one of the best healthcare systems if no Americans were left out?

The healthcare reform debate is complex, and even within the AHA we are no different than society at large: our volunteers have many points of view—all of which are respected. Components of healthcare reform such as funding, tort reform, and public options are all important issues and appropriately are being advocated passionately by many others, but any of these issues can easily obscure the quiet voice in this debate: the patient. It is the patient for whom the AHA is advocating.

Let us be indefatigable in our advocacy for the right changes and consider the challenge of immediate past AHA president Dr Tim Gardner to create a uniquely American solution for a uniquely American healthcare system. People, we can do this.

[Mohandas] Gandhi admonished us to “be the change we wish to see in the world.” Change of some sort in our healthcare system is inevitable. We can be passive and allow events to define us or we can shape events. The choice is ours: By moving boldly into new scientific arenas, we take the initiative to own and direct new science; by challenging ourselves with an audacious 2020 goal, we continue to embrace treatment but also put prevention more clearly in our prism.

As people who care, we know that the exclusion of any group or person from adequate health care is the exclusion of all from our best quality of life; we know that the mission of the AHA is best served by making certain that science, evidence, and the patient stay at the heart of healthcare reform. Thus, these initiatives represent the necessity for us, the AHA, to lead in the transformation of cardiovascular health.

In closing, let me be clear. We are grounded in science. We are driven by mission. We are focused on reducing death and disability due to cardiovascular diseases and stroke. We are committed to building healthier lives free of any disease. And we are charged with being transformational. That’s today’s message. Let us not lose this great opportunity.

Here is my call to action to you: If you aren’t a member of the AHA, join today and become a part of this extraordinary organization. Join a council; participate in Get With The Guidelines; sign up for our grassroots advocacy network “You’re the Cure.”

Exhale for a moment this week and enjoy your success, whether it’s a first abstract or a premier award—everyone matters and everyone’s work is important. This is an electric environment and this is where transformational change begins.

Thank you; have a great time at Scientific Sessions 2009!

**Key Words:** AHA Scientific Statements ■ cardiovascular disease ■ coronary heart disease ■ stroke
Transforming Cardiovascular Heath; a Post-Hoc – 2010

In the current issue of Circulation, the text of my address to you at Scientific Sessions, 2009 is published. I recall vividly drafting this text (and its many iterations), delivering this message to you in Orlando (thank you for your response) and absorbing the entirety of the AHA Scientific Sessions 2009. (I think I was the last person to leave…) Since that time, much has transpired within and beyond the American Heart Association and it seems reasonable to offer this ‘post-hoc’ on the themes that I introduced at Scientific Sessions.

The major thrust of my address was the ‘transformation of health’. This broader message was intended to go beyond addressing health care and to penetrate what has now become thematic: regardless of our assessment of health care reform, what has become clear to all has been the need for true health reform.

Since November, 2009, the Patient Protection and Affordable Care Act [PPACA or more recently truncated to “Affordable Care Act” – ACA] Act has become law – not without considerable angst and ongoing anxiety. We ultimately supported the bill, not because it was a perfect solution but because it was a reasonable template that would allow the patient-centric objectives of the AHA, and its broad-based 22 million person strong constituency, to be accomplished, specifically: increased accessibility, a greater focus on prevention, an emphasis on quality, narrowing of the disparities in care, increased funding for NIH research and an expanded and diversified healthcare workforce. Throughout the discourse on health care reform, the AHA stayed true to these six tenets and we yielded our support only when it was evident that alignment with these principles was accomplished. We yielded the dialogue regarding other issues such as practice reforms [e.g., issues that were capably advocated by our colleagues within the ACC] to appropriate professional societies; this position garnered some criticism which we fielded and respected. My hope is that we have now all come together again to focus on the greater good of preserving what is excellent about our health care system and improving what is needed.

Now, our commitment to all is to remain focused on the process of health care reform. We will work diligently to mold the direction of the subsequent programs and strategies that emerge to once again meet the stated objectives of the AHA. The new infrastructure for health care reform is being assembled; we are evaluating the proposed panels, commenting on emerging statutes and strongly advocating for talented and experienced AHA volunteers to sit on the most relevant boards and committees. We have taken proactive positions in the constitution of the Patient Outcomes and Research Institute [PCORI] Board of Governors and Methodology Committee; we have been steadfast in the definition of allowable health care expenses for insurance companies; we have worked to define corporate wellness programs and we have been proactive in support of the National Health Care Workforce Commission. Out attention to health care reform will continue.
In November, we enthusiastically announced a new goal for the AHA to be achieved by 2020. This was in the context of the successful attainment of a substantial portion of our 2010 goal which was to achieve a 25% reduction in death due to coronary disease and stroke and a 25% reduction in risk by 2010. We eclipsed the goals for population-wide mortality and achieved success with some risk factors, but several important risk factor reductions were not accomplished, and importantly, not all segments of our population benefitted equally.

For 2020, another bold goal has been embraced – to achieve an additional 20% reduction in deaths due to heart diseases and stroke and [for the first time] to achieve a 20% improvement in cardiovascular health. Note the shift from coronary artery disease to all forms of heart disease, now including heart failure, cardiomyopathies, congenital heart disease and heart valve diseases among others. As we announced our goal, we published the 2020 goal paper that provides the science which underpins this goal; specifically, we have defined ideal cardiovascular health, described the attributes of improvements cardiovascular health and created a plan to change health (insert URL for the paper). We believe this new goal and the plan created are truly transformative.

If you haven’t seen the ‘Simple 7’, visit www.heart.org/mylifecheck and first take the health assessment, then review the ‘Simple 7’. This consumer friendly tool has been visited over 500,000 times now since its launch on January 20, 2010 and well over 50,000 users have worked through the site and made a commitment to improved health. We are just beginning with the ‘Simple 7’; this simple algorithm that outlines a path to achieve better health is now being translated into multiple languages, appears on Facebook and has been highlighted in multiple consumer publications with more to follow. Already, lives are being positively impacted by this plan. You may even find that you will identify steps to improve your own health. Remember, “Them is us”.

At a deeper level, we understand that changing health requires that we focus on the built environment. We are aligned with sodium reduction policies, sugar reduction policies, clean air efforts and anti-obesity initiatives. On a scientific level, we understand that research on prevention and treatment must continue if we are to indeed achieve better health. This year we have been tireless in our advocacy for more NIH funding and we have had a seat at the table for comparative effectiveness research policies and implementation. This includes our published paper describing our view of the attributes of comparative effectiveness research (URL) and working with AHRQ and NIH to discuss their support for comparative effectiveness studies. Our 4 funded AHA-PRT-David and Stevie Spina Centers of Excellence for outcomes research are doing robust work and providing not only the science to allow for transformative change in cardiovascular care but also the training of new outcomes scientists to continue the pace and quality of these avant-garde investigations.

In addition to our focus on science and research, the AHA plays a prominent role in the assessment of data and the generation of evidence-based guidelines and statements that better inform cardiovascular care. This has been a robust activity that represents a great value to the community. Over the past year, we have been working towards making these
documents more user friendly, refining the process of evidence acquisition, assigning more structure to the assessment of evidence and adding more outcomes science to the evaluation of data and the generation of our strongest class of recommendation statements as well as our performance measures. I must share with you that the guidelines taskforce and performance measures taskforce are populated by some of the most dedicated science volunteers in the organization. There is a very serious intent to address the august task that these committees have. Please rest assured that serious heavy lifting happens within these committees and much diligence occurs to get the statements right.

We have wrestled with the issue of author relationships with industry in regards to generating these important documents. Full transparency assures that our statements are free of bias. We accept this responsibility and have generated new strategies over the last year to accomplish these goals. We have now harmonized between the AHA and ACC the requirements to participate on writing committees—requirements that now insist on our having a majority [50% + 1] of authors, including the Chair be free of any relevant relationships with industry while allowing those with expertise and appropriate relationships to contribute to the process. Voting and drafting of the final recommendations are limited to those free of relationships but deliberation by all is expected. We are evaluating these processes real-time and refining them as needed along the way.

Over the past year, we have truly experienced breakthroughs in our focus on Quality. It is my belief that the AHA is a class leader in quality improvement and outcomes science. Get With The Guidelines® has become a premier performance improvement program. In the past year, seminal publications have described performance improvement breakthroughs in stroke care in over 1 million stroke records in the GWTG database. Fonarow et al have demonstrated remarkable improvements in adherence to stroke quality measures and in turn stroke care has benefited. For the first time, definitive evidence has emerged that a performance improvement initiative not only narrows but can eliminate disparities in care. The paper by Cohen et al demonstrates in a compelling way that significant gaps in defect free care at baseline [circa 2002] for blacks and Hispanics with CAD were not only eliminated over a 5 year period but also that care for all patients was remarkably improved. As these strategies are scaled up and extrapolated to other systems, the impact on both quality of care and disparate care could be transformational. Yet another seminal publication was the work by Hernandez et al demonstrating that early follow-up after recent hospitalization for decompensated heart failure yielded significant and important reductions in the rate of re-hospitalization—a now publicly reported quality measure and an important and expensive public health concern. The GWTG taskforce under the direction previously of Gregg Fonarow, MD and currently Lee Schwann, MD has done remarkable work to bring registry data into the mainstream evidence base that informs the quality of care. Our AHA Quality of Care and Outcomes Research meeting has now become the signature meeting for those in the quality arena and again, breakthrough outcomes science is emerging.

Health equity has now replaced the original nomenclature of ‘disparate care’. Sufficient descriptions of disparate care have been offered. Effective interventions are now needed.
The success of GWTG prompted efforts in generating health equity is an appropriate segue to describe additional efforts in this space. The Cultural Competency Initiative is a collection of talented and experienced AHA volunteers with considerable expertise in the broad areas of health equity. Multiple examples of qualitative research have been vetted and first in kind research initiatives have been launched and reported. Gaps in care are real and system, provider and patient issues all contribute. We are defining new strategies that will further address health equity and working in tandem with many others who are targeting this area, we believe transformative change will occur. We have considerable enthusiasm for a soon to be convened AHA Health Equity Summit that will further refine targeted steps to improve health equity. We hope to embed within the GWTG modules an educational platform for cultural competence.

There are many other acknowledgements of work done over the past year that would be appropriate for this AHA post hoc—Scientific Sessions is thriving; alignment with the NIH is strong; collaborations with partner organizations, including the ACC are strengthening; meritorious science is continuing-- but suffice it to say that the AHA is alive and well. Over the past year I have had the privilege to meet many of you and correspond with even more of you. Your constructive criticism has been welcomed and heeded; your vigorous pushback has been acknowledged and your supportive words have been appreciated. My hope is that I have served you well; that was my goal. The AHA does good work and on a daily basis, whether its our science, our advocacy, our quality programs, our prevention theme, our public awareness programs, our cause initiatives, our fundraising or our scientific meetings and/or publications, we are making a difference.
Emerson defines success as follows:

“…To leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition; To know even one life has breathed easier because you have lived; This is to have succeeded.”

Thank you for allowing me the humbling privilege to have spent time at the helm of this organization and to have supported the success of the AHA. I am thankful. Though my experience as President of the AHA has come to closure, my commitment to contribute, support and again lead as needed to further the mission that we all embrace will continue indefinitely. I remain steadfastly committed to the Guidelines Taskforce, fully engaged in our efforts to promote health equity and available as needed to advocate for more public awareness of heart disease and stroke, greater efforts at prevention and more funding for research.

For the first time in its history, the next president of the AHA will be a neurologist; Ralph Sacco, MD, MPH, is our new President. This is a landmark moment for the organization as it highlights needed attention to the cause of stroke, the #3 killer of Americans and an increasingly important issue as our population ages. We couldn’t yield the leadership of the AHA to more capable hands. Considering the shared disease risk profile; the common objectives to prevent all forms of cardiovascular disease; and the increasing need to emphasize best practices in the treatment of heart diseases and stroke, this is the right moment in the evolution of the AHA to be directed by the thoughtful prism afforded by Dr. Sacco. I hope you will join with me in offering Ralph our absolute support.

Thank you once again.

Clyde W. Yancy, MD, FAHA, FACC, MACP