

Heart Failure Society News

An Official Publication of the Heart Failure Society of America • Volume 2, Number 3 • July 2000

In This Edition

- Fourth Annual Scientific Session
- Membership Growth
- President's Message
- Young Investigator Finalists
- Heart Failure in African-Americans
- HCFA Heart Failure Project

HFSA's Fourth Annual Scientific Session Scheduled for September 10-13, 2000

A record-breaking number of attendees are expected at the HFSA's Fourth Annual Scientific Session, which will be held September 10-13, 2000, at the Boca Raton Resort & Club, Boca Raton, Florida. This year's Scientific Session is packed with 2.5 days of late-breaking clinical trial results, basic science presentations, lively debates, practical how-to sessions, and moderated poster presentations, as well as the high-interest Young Investigators competition.

In addition to the main program, 19 satellite programs, supported by educational grants from pharmaceutical and/or device companies, cover a wide range of topics related to heart failure. Details on the satellites and the main program can be found on our website at www.hfsa.org. The final program for the session will be sent to registrants during the last week of August.

Plenary Sessions

There will be two plenary sessions: heart failure in the African-American patient, on Monday, September 11, and late-breaking clinical trials, on Wednesday, September 13. Eighteen symposia from Monday through Wednesday will explore a wide range of key issues, including: early detection and prevention; G proteins and kinase cascade signaling pathways; cardiac development and congenital heart disease; inflammatory mediators in the failing heart; new neurohormonal approaches; apoptosis; partnership in heart failure care; cancer, chemotherapy, and heart failure; cytoskeleton and extracellular matrix in the remodeled heart; addressing special population needs; gene therapy; arrhythmias and sudden death; novel approaches to the prevention

(continued on page 3)

Heart Failure Society News

Editors

Arthur M. Feldman, MD, PhD
President,
Heart Failure Society of America
Director, The Cardiovascular Institute
of the UPMC Health Systems
Pittsburgh, Pennsylvania

Gary S. Francis, MD
Director, Coronary Intensive Care
Cleveland Clinic Foundation
Cleveland, Ohio

Marvin A. Konstam, MD
Chief, Division of Cardiology
New England Medical Center
Boston, Massachusetts

Marc A. Silver, MD
Professor of Medicine
Director, Heart Failure Institute
Director, Cardiovascular Disease
Fellowship Christ Hospital and
Medical Center
Oak Lawn, Illinois

Membership in the HFSA continues to grow as the Society enters its fifth year. Initially a small group of physicians, nurses, and allied health professionals interested in focusing on heart failure issues, the Society now boasts a membership that exceeds 1400.

Marc Silver, MD, chairman of the Membership Committee since 1996, explained in an interview with the *Heart Failure Society News* that new members join the Society through a variety of venues: the annual scientific session, the website, and word of mouth. "We try to get a broad mix of types of members," he said. "We have cardiologists, cardiac surgeons, internists, geriatricians, family practitioners, nurses, rehabilitation specialists, allied health care professionals, and persons interested in heart failure issues."

Prospective members can obtain an application from the HFSA office or the website. Other committee members are Ruth Altschuld, PhD, Michael Givertz, MD, Stuart Katz, MD, and Gemma Kennedy, RN, PhD.



In discussing the benefits of membership, Dr. Silver pointed to the two journals, the annual scientific session, the reduced scientific session registration available to members, and the ability to interact with the nation's leaders in heart failure issues

and research. An additional benefit, he said, is the role that members can play in the Society. "We really do encourage members to become active. We think there is room for participation in the work of com-

(continued on page 3)

President's Message



Arthur M. Feldman, MD, PhD
President, HFSA

As I write my last President's Message for the *Heart Failure Society News*, the time seems optimal to look at both the present and the future of our Society. Our original goals for the Society, as stated in our mission statement, were "to provide a forum for all those interested in heart function, heart failure, and congestive heart failure research and patient care." As in many societies before us, this "forum" consisted of our Annual Scientific Meeting, which rapidly grew in both size and prestige, and our two journals. However, with the publication of the first Heart Failure Society clinical practice guidelines in 1999, the Society expanded the forum to include consensus expert recommendations regarding the care of patients with heart failure. Although the interested parties involved in Society activities were initially caregivers, the passage of a Senate Resolution declaring the week of February 14 as National Heart Failure Awareness Week resulted in enhanced participation of lay persons in awareness events across the country. The communication of the Society news and information to the lay public was facilitated by the development of educational materials and a Heart Failure Awareness website. Importantly, the lobbying efforts involved in passing this legislation also resulted in an enhanced awareness among the members of the U.S. Senate.

Through the efforts of the members of the Care Standards Committee and an ad hoc Task Force, the Society has also

developed meaningful relationships with health care organizations and has partnered with the Health Care Finance Administration (HCFA) in their efforts to improve care for Medicare recipients. The HCFA Heart Failure Program and the collaborative efforts between HCFA and the Society are detailed in this issue of the newsletter. The mission of the Society was broad; however, the initial committee structure was somewhat circumscribed. Thus, the Nursing Committee was formed to provide a forum for activities and issues of special interest to nurses, and a Task Force has been formed to focus on the development of a Pediatric Heart Failure Committee. Finally, a new Education Committee will develop and coordinate the educational activities of the Society. This increase in the Society's activities mandate more space. Therefore, at the end of September, the Society will move its offices from its home at the University of Minnesota to a spacious new office suite in St. Paul.

This impressive record of growth in a relatively short period of time would not have been possible without the participation of the physicians, nurses, and allied health professionals who generously contributed their time and talents. I especially want to express my appreciation to the Executive Council and officers of the HFSA. Our corporate partners – and in particular the members of the Heart Failure Awareness Roundtable – deserve my gratitude as well, for without their support, we would not have achieved our goals.

Growth and expanded activities clearly bring challenges, especially as each new venture requires administrative and financial resources.

- Our early and fruitful lobbying efforts opened a new window for more active relationships with government agencies; however, the scope of and goals for these activities need to be defined.
- The increasing national role of the Society has resulted in many requests for endorsements of local heart failure groups, an activity that clearly would expand the mission of the Society and deliver marked benefits for patients.
- There is a need to increase membership, but most importantly we must increase the number of members who are participating actively at all levels of the Society.
- Finally, as the Society grows, we must develop methods to work collaboratively with other national cardiology societies, including the American Heart Association and the American College of Cardiology. To objectively assess our present position and define our goals for the future, we will undertake a Strategic Planning Session this July. The resulting Plan for the Future will guide the Society through the challenges ahead.

I would like to thank the members of the Society for the privilege of serving as President during this exciting stage in our history. I look forward with anticipation to our bright future. ■

Arthur M. Feldman, MD, PhD

Heart Failure Society News is an official quarterly publication of the Heart Failure Society of America, Box 358, 420 Delaware Street, S.E., Minneapolis, Minnesota 55455; (612) 626-3864; www.hfsa.org. It is published by BioScience Communications, 1875 Eye Street, N.W., Washington, D.C. 20006.

© 2000 Heart Failure Society of America

Planning to relocate?

Don't forget to change your address with the HFSA corporate office as well as the publishers of the *Journal of Cardiac Failure* and *Congestive Heart Failure*. To notify the publishers, please follow the instructions in each journal.

(continued from page 1)

Fourth Annual Scientific Session

or reversal of remodeling; functional genomics as a route to discovery; clinical practice guidelines; metabolism and altered gene expression; and the lung in heart failure.

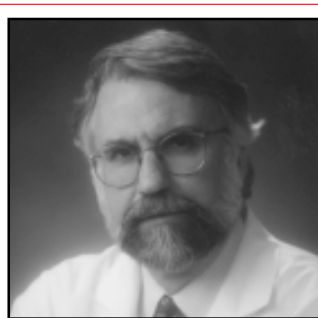
Debates

The two popular debate sessions on Monday, September 11, and Tuesday, September 12, will offer attendees the opportunity to hear controversial issues and provide their own input. Each session is divided into two parts. At the Monday session, moderated by Michael Fowler, Evan Loh and Stephen Gottlieb will debate the benefits of inotropes in chronic heart failure; Jagat Narula and Jutta Schaper will discuss the role of apoptosis in heart failure. At Tuesday's session, moderated by Lynne Warner Stevenson and Inder Anand, Henry Krum and Michael Domanski will explore the use of beta blockers in the treatment of advanced heart failure; Leslie Miller and Gary Francis will disagree of the merits of long-term LVAD treatment of heart failure.

Hype Park Hypotheses

The popular Hype Park Hypotheses Session, which made its debut in 1998, is back by popular demand on Monday, September 11. Six speakers will expound on topics in heart failure for 10 minutes each. These presentations are usually novel, frequently controversial,

and always enthusiastically received by the members of the audience, who have the opportunity to question the presenters. The speakers have the option to take an unpopular position, or they may use the time to posit, complain, cajole, or provoke those in attendance. The presenters were selected on the basis of originality and potential interest to the



Michael Bristow is chair of the Fourth Annual Scientific Meeting.

audience members. This year's presenters are Michael Fowler, "Heart Failure Does Not Exist in the Majority of Patients With Heart Failure: Time for a New Name"; Stefan Anker, "The Fatter the Better: The Gold Rule for Longevity in Chronic Heart Failure"; Paul Hauptman, "Quality of Life Should Not Be Measured in Heart Failure Trials"; Arnold Katz, "Cross-Over Between Functional and Proliferative Signaling:

The Real Problem in Heart Failure"; Randall Starling, "Surgical Left Ventricular Reconstruction and Medical therapy Optimizes Clinical Outcomes After Anterior Myocardial Infarction"; and Paul Sobotka, "Guidelines for the Eligible and Ideal Heart Failure Patient: A Solution for the Spherical Cow."

Jay N. Cohn Young Investigator Award

Five finalists have been selected by a panel of experts from the many outstanding abstracts submitted for the Jay N. Cohn Young Investigator competition. These five abstracts will be presented during the Young Investigator session on Tuesday, September 12. Abstracts will be judged on scientific merit, presentation, use of graphics, and effectiveness of discussion. Support for this program was provided by an educational grant from Novartis Pharmaceuticals. The winner will be announced at the opening session on Wednesday, September 13.

Late-breaking Clinical Trials

Jay Cohn and Alan Miller will serve as co-moderators of this session on Wednesday, September 13, from 11:00 a.m. to 12:30 p.m. Eric Eichhorn will analyze the BEST results, Milton Packer will report on COPERNICUS, and Mihai Gheorghide will discuss OPTIME. ■

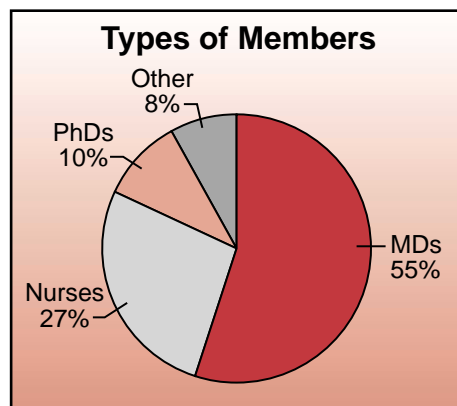
(continued from page 1)

Membership continues to grow

mittees." The current guidelines on heart failure provide an example of the two-way nature of membership. The draft guidelines were presented at the 1999 scientific session, and attendee feedback was solicited and incorporated into the revision.

The Society is constantly examining potential new benefits, including an expanded website with a members-only section, Internet portals that could facilitate research, and discounted services that may include patient management programs, books, and Internet access. "In the future," Dr. Silver stated, "we want to post material on the website and get member input to achieve a consensus on a particular issue."

The trainee program is an important part of the Membership Committee's approach. "A trainee," Dr. Silver ex-



plained, "is anyone in post-graduate education: a student or post-doctoral fellow. We offer these individuals a reduced membership fee of \$45 a year. We recognize that a lot of young people might be interested in heart failure issues, and we do not want the membership fee of \$95 to inhibit them," he said.

Application forms are available from the HFSA office at Box 358, 420 Delaware Street, S.E., Minneapolis, Minnesota 55455; 612 626-3864 (phone) or 612 624-2174 (fax). The HFSA website is www.hfesa.org. ■

— Young Investigator Finalists Named —

The five finalists for the 2000 Jay N. Cohn Young Investigator Award are:

- *Embryonic Stem Cell Transplantation Improves Cardiac Function in Postinfarcted Heart Failure*

Jiang-Yong Min,

Beth Israel Deaconess Medical Center, Boston, MA

- *In Vivo Modeling Destain-Related Cardiomyopathy with Transgenics*

Xeujun Wang

Children's Hospital Research Foundation, Cincinnati, Ohio; University of South Dakota, Sioux Falls, SD, University of Cincinnati, Cincinnati, OH

- *Akt Activation In Vivo Preserves Cardiac Function While Reducing Infarction and Apoptosis in a Rat Model of Ischemia-Reperfusion Injury*

Takashi Matsui

Massachusetts General Hospital, Boston, MA

- *Cardiac Myocyte Apoptosis and LV Remodeling in Transgenic Mice with Cardiac Restricted Overexpression of TNF-Alpha*

David Engel

Baylor College of Medicine, Houston, TX

- *Involvement of Beta-Catenin Mediated Pathway in Myocyte Remodeling During the Transition from Hypertrophy to Failure*

Faqian Li

University of South Dakota, Sioux Falls, SD

Moderated Poster Sessions Scheduled

Posters will be displayed on Monday, September 12, and Tuesday, September 13, in the exhibit hall. Presenters will be available at their posters from 5:30 p.m. to 7:00 p.m. to answer questions about their research.

In addition, 20 abstracts have been selected for presentation as moderated posters. Moderated posters will take place during the regular poster presentations from 5:30 p.m. to 7:00 p.m. There will be two simultaneous moderated poster sessions each day, each with five posters. Presenters will have 5 minutes to describe his or her research, and 5 minutes will be allotted for audience discussion. A facilitator will guide the process. Details regarding the posters and moderated poster sessions will be published in the final program.

BEST Results Highlight Need for Further Research in Racial Differences in Heart Failure Patients



Eric Eichhorn, MD

The surprising results and implications of the Beta-Blocker Evaluation of Survival Trial (BEST), in which the beta-blocker bucindolol did not improve the survival of patients with NYHA class III-IV heart failure, will be explored by Eric Eichhorn, MD, University of Texas Southwestern Medical Center, Dallas, Texas, on Wednesday, September 13, during the Late-Breaking Clinical Trials session from 11:00 a.m. to 12:30 p.m.

The BEST trial randomized 2708 patients with class III-IV heart failure to receive bucindolol daily or placebo. Bucindolol was chosen, according to Dr. Eichhorn, because it has the most anti-adrenergic effect; is nonselective, blocking both beta 1 and 2 receptors; lowers norepinephrine levels; is well tolerated; and has available

dose-ranging data. The trial was halted early by the Data and Safety Monitoring Board (DSMB) based on "the totality of evidence regarding the usefulness of beta-blocker treatment derived from BEST and other studies." Patients receiving bucindolol did show a significant decrease in the secondary endpoint of cardiovascular mortality, as well as significant reductions in norepinephrine levels and significantly increased left ventricular function.

"BEST was designed to ensure balance between bucindolol and placebo with respect to gender, etiology of disease, ventricular function, and race," Dr. Eichhorn explained. BEST is the only beta-blocker trial that had a significant number of African-Americans. "No other trial of beta blockers was stratified to ensure racial balance," he said.

"The results were surprising to us. The patient population had a heterogeneous response to treatment. African-Americans, who composed 23% of the patient population, trended to adverse effect with

bucindolol, and non-blacks had a statistically significant benefit from it," he reported.

The finding of racial differences in response to cardiovascular therapy could be the result of the particular beta blocker selected, a chance finding, or a factor inherent in the patient populations. The choice of bucindolol for this study probably cannot totally explain the results, as patients had the typical beta-blocker response to therapy – an improvement in LVEF and a reduction in heart rate. Dr. Eichhorn reported that a chance finding is unlikely, since over 200 of the 600 African-Americans in BEST experienced mortal events, compared to only 53 patients of all races in the Carvedilol trial.

Dr. Eichhorn concluded, "The BEST results highlight the need to further examine racial differences in response to heart failure treatments. It is important not to assume that, if it works in a predominantly European male white population, it applies to everyone." ■

Heart Failure in African-American Patients

The causes and treatment of heart failure in African-American patients will be the focus of a presentation by Clyde Yancy, MD, Associate Professor of Internal Medicine/Cardiology, University of Texas Southwestern Medical Center, Dallas, Texas, at the HFSA's Fourth Annual Scientific Session on Monday, September 11. Pending the presentation of new data, Dr. Yancy will recommend modifications in present approaches to treatment.

In a recent interview, Dr. Yancy prefaced his analysis and recommendations with the caveat that current knowledge is limited by the lack of representative samples in recent clinical trials. "Everything we know is based on analysis of subgroups in major clinical trials that unfortunately were not powered to detect true outcomes in subpopulations," he pointed out.

Natural History of Heart Failure in African Americans

Heart failure appears to be different in African Americans than in Caucasians in three significant ways: African-American patients exhibit a higher incidence of hypertension as a potential causal factor, more advanced left ventricular dysfunction on presentation, and higher mortality rates.

Differences in Incidence of Hypertension

According to Dr. Yancy, the disproportionate incidence of hypertension in African Americans may constitute a plausible etiology of the higher rates of heart failure in these patients. This disproportionate incidence has been observed repeatedly. For example, in the SOLVD registry of 6723 patients, 32% of African Americans versus 4% of Caucasians had hypertension as a plausible etiology. Among the non-ischemic etiologies of heart failure in the SOLVD studies, 52% of African Americans versus 24% of Caucasians had hypertension. In the SOLVD PREVENTION trial, 41% of African Americans versus 14% of Caucasians had hypertension. In the SOLVD TREATMENT trial, the respective rates of hypertension were 65% and 37%.

Differences in LV Dysfunction

African-American patients tend to have greater septal thickness, greater posterior

wall thickness, greater left ventricular mass index, and greater impairment of diastolic function. In both the BEST and the US Carvedilol Heart Failure trials, African-American patients presented with more advanced left ventricular dysfunction and more symptomatic heart failure.

Differences in Mortality

Dr. Yancy pointed out that African Americans with heart failure are at increased mortality risk. He cited the mortality rates in the SOLVD PREVENTION trial: 8.1% for African-American patients versus 1% for Caucasian patients, and in the SOLVD TREATMENT trial, in which the rates were 16% and 13.4%, respectively.

Clinical Trial Implications

V-HeFT Trials

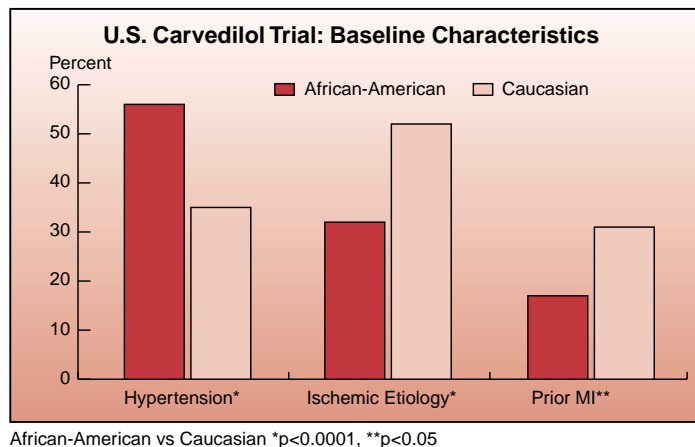
Dr. Yancy observed that, in the literature on hypertension, African-Americans are reported to respond less well to adrenergic inhibition than do Caucasians. A retrospective review of the V-HeFT I trial, for example, suggests that all of the survival benefit was seen in African-American patients on vasodilator therapy and that ACE-inhibitor therapy provided no benefit. In V-HeFT II, Caucasian patients receiving ACE-inhibitor therapy had lower

Cardiomyopathy Study

Dr. Yancy also cited the metoprolol study by Marrick Kukin at Mt. Sinai, New York, on the effect of race in dilated cardiomyopathy or ischemic cardiomyopathy. No statistically significant between-group differences were found; African-American patients receiving treatment experienced similar improvements in the 6-minute walk test, LVEF, and hemodynamics, as well as similar reductions in plasma norepinephrine.

BEST Trial

The data that have generated the greatest concern come from the recently reported BEST trial that demonstrated a lack of significant benefit of bucindolol on all-cause mortality in a 2800-patient study that included 23% African-American patients. These patients had more severe LV and RV dysfunction. In the African-American patients, not only did the beta blocker not improve survival, but there was a worrisome 17% non-statistically significant increase in mortality in the African-American patients treated with bucindolol. These data have raised concerns that beta-adrenergic blockade may not be suitable for African-American patients with advanced heart failure. Indeed there are concerns from the hypertension literature that beta blockers are less effective in African Americans. However, the severity of heart failure in this group limits making a broad assumption about beta-blocker use in heart failure for African-American patients.



mortality rates than those receiving direct vasodilator therapy, while African-American patients did not. Dr. Yancy, however, expressed concerns about the V-HeFT conclusions. He pointed out that, while African-American mortality in V-HeFT I decreased from 17% to 12% with direct vasodilator therapy, it also decreased to the same degree in V-HeFT II with ACE-inhibitor therapy. Thus, there was no difference in response to direct vasodilator therapy or ACE-inhibitor therapy. Both strategies were successful in African-American patients.

cerns from the hypertension literature that beta blockers are less effective in African Americans. However, the severity of heart failure in this group limits making a broad assumption about beta-blocker use in heart failure for African-American patients.

U.S. Carvedilol Trial

The most encouraging data regarding beta-adrenergic blockade in African-American patients with heart failure, according to Dr. Yancy, come from the U.S. Carvedilol trial, in which 217 (20%) of the 1094 patients were African Americans and represented the natural history differences cited above. The results indicate that changes in ejection fractions of African-Americans receiving carvedilol in addition to conventional therapy were identical to those of Caucasians receiving the same regimen, and the impact on heart rate and blood pressure were similar. African Americans had equal or greater benefits with respect to

(continued on page 6)

(continued from page 5)

the combined endpoint of all-cause mortality and hospitalization.

Hypertension

The natural history of hypertension in African Americans is significantly different, Dr. Yancy emphasized. More African-American patients have renal disease, more are on chronic hemodialysis, and more have end-stage renal disease; the rate of fatalities from strokes is higher; and more African-American patients have LV hypertrophy. "There appears to be a consistent vascular phenomenon in African Americans that results in more malignant end-organ disease due to hypertension," he maintained. African Americans have more concentric hypertrophy that promotes more deleterious LV remodeling, more severe LV dysfunction, and thus puts patients at higher risk. With respect to the mechanisms of this adverse response to hypertension, it has recently been shown that African American patients with hypertension overexpress transforming growth factor-beta (TGF β), which has a potential link to higher incidence of ventricular hypertrophy. "We may discover that, if we look at disease groups from the perspective of mechanisms of hypertrophy, we will find that African Americans are at higher risk," he said. "While we continue to work out nuances, and find out if real differences exist, it is inescapable that hypertension is associated with an excess incidence of heart failure in African Americans and represents a potentially preventable cause of a malignant disease," he concluded.

Advances in the Treatment of Children — With Heart Failure Can Improve Care —

The latest advances in the treatment of children with heart failure will be the focus of a presentation on Monday, September 11, by Jeffrey A. Towbin, MD, the Head of Pediatric Cardiac Research, and Professor in the Departments of Pediatrics/Cardiology, Molecular and Human Genetics, and Cardiovascular Sciences at Baylor College of Medicine, Houston, Texas. He is an Associate Chief of the Section of Pediatric Cardiology and Director of the Heart Failure and Transplant Program at



Milton Packer, MD

The COPERNICUS trial was terminated prematurely in March 2000 in light of the excellent benefits offered by the beta-blocker being evaluated.

The trial randomized 2280 patients with primarily class IV heart failure to placebo or carvedilol. All patients also received conventional therapy for heart failure consisting of digitalis, diuretics, and ACE inhibitors.

According to Milton Packer, principal investigator for the trial, carvedilol was started at a dose of 3.125 mg. twice a day

Rethinking Treatment Strategies

Much about the differences highlighted in recent trials remains unknown. For Dr. Yancy, the first step is to treat hypertension in this population aggressively; the second step is to rethink the traditional therapy of limiting treatment of African-American patients to calcium channel blockers and diuretics. While the benefits of ACE-inhibitor therapy and beta-adrenergic blockade in this population are inconsistent, ACE-inhibitor therapy and beta-blocker therapy, especially in patients with mild to moderate heart failure, appear to be associated with similar outcomes to those of other patients. Pending additional clinical research, Dr. Yancy makes a compelling case that both forms of therapy should be administered to African-American patients. ■

COPERNICUS Results Lead to Early Termination of Trial

and progressively increased until the target dose of 25 mg. twice a day was attained. The trial was stopped by the Data and Safety Monitoring Board (DSMB), he explained, "because of overwhelming evidence that carvedilol reduced the risk of death." "The DSMB noted the benefits of the drug, and also noted that the predefined monitoring boundaries had been exceeded," he said. It recommended that all patients be placed on open label treatment with carvedilol.

Dr. Packer will be presenting the main mortality results of COPERNICUS at the Late-Breaking Clinical Trials session on Wednesday, September 13. ■

How-To Workshops Offer Practical Information

The how-to sessions from 12:30 p.m. to 1:30 p.m. on Monday, September 11, and Tuesday, September 12, offer attendees the opportunity to enhance practical skills.

Monday's program includes the following topics:

- How to use and perform expression profiling in heart failure
- How to treat complicated heart failure cases
- How to transition LVAD patients to a home setting
- How to utilize a nurse-managed heart-failure program to improve outcomes and quality of life

Tuesday's program includes the following topics:

- How to obtain genetic counseling in inherited cardiomyopathies
- How to measure quality of life
- How to select and evaluate heart failure patients for AICDs
- How to mine databases
- How to obtain research funding

HCFA National Heart Failure Project: A National Effort to Improve Quality of Heart Failure Care in the U.S.

Heart failure is the leading cause of hospitalization among Medicare beneficiaries. It is associated with high morbidity and mortality, which may be reduced with proper medical treatment. It should thus come as no surprise that heart failure has been selected by the Health Care Financing Administration (HCFA) as a focus for intensive efforts to improve quality of care.

HCFA's National Heart Failure (NHF) Project aims to improve the quality of inpatient heart failure care for Medicare beneficiaries throughout the United States. Building on the successes and lessons of HCFA's Cooperative Cardiovascular Project (CCP), which focused on myocardial infarction, HCFA is requiring its contractor Peer Review Organizations (PROs) in each state to improve state performance on a set of quality indicators. The primary quality indicators for the project, developed from national consensus treatment guidelines, are the proportion of patients with evaluation of left-ventricular function and the proportion of patients with systolic dysfunction appropriately treated with ACE inhibitors. Several secondary indicators are being tested for feasibility of measurement and association with relevant outcomes, including the proportion of eligible heart failure patients treated with beta blockers, the percentage of patients with heart failure and ischemic heart disease treated with aspirin or anticoagulants, and the percentage of patients receiving appropriate instruction at discharge.

PROs strive to improve care by recruiting hospitals for voluntary participation in quality improvement efforts. PROs make available tools potentially useful for improvements in hospitals' systems of care, such as, information on how to plan and implement quality improvement projects, examples of strategies and materials that providers have found effective (e.g., clinical pathways, standing orders, check-off sheets, other tools for prompting clinicians), data collection instruments for ongoing performance monitoring, benchmark quality indicator rates, and educational materials. PROs may supplement the state-

based quality indicator data to generate hospital-specific rates for provider use. Follow-up quality indicator rates are calculated at the state level by HCFA and at the provider level by PROs and, in some states, by providers, to assess the effectiveness of the quality improvement activities.

Baseline state rates, calculated from samples of up to 800 Medicare heart failure discharges per state between April 1998 and March 1999, were made available to PROs early this year and will be published in the fall. Follow-up state rates will be measured using discharges from July 2000 through June 2001. Comparison of baseline and follow-up rates on the primary quality indicators will assess the effectiveness of PRO and provider efforts in each state.

This project represents a convergence of the interests of a major health care purchaser and the concern of heart failure specialists: patients with heart failure and diminished ejection fraction should not leave the hospital without prescriptions for medications demonstrated to reduce mortality and improve physical functioning. Heart failure care providers wishing to get involved in local or state quality improvement activities can get more information about the NHF project, including contacts in their state, at www.nationalheartfailure.org. ■

Diana Ordin, MD

Health Care Financing Administration

Edward Havranek, MD

Colorado Foundation for Medical Care
Denver Health Medical Center
University of Colorado Health
Sciences Center

Heart failure care providers wishing to get involved in local and state quality improvement activities can get more information about the NHF project at www.nationalheartfailure.org

HFSA Website Grows in Size and Traffic

The HFSA website, www.hfsa.org, is growing rapidly in size and traffic, offering information and other services to visitors and helping the Society to fulfill its mission.

Launched in July 1997, the site has grown to 115 pages, including pages on the 1999 and 2000 Scientific Sessions. The number of people visiting the site has risen substantially from an average of 32 per week in 1997 to over 300 per week in 2000. The busiest times for visits are prior to the annual Scientific Sessions. Prospective attendees can view the meeting agenda and list of speakers and events, and they can download membership forms, registration forms, and hotel information. The average time per visit is 6 minutes and 30 seconds; approximately 12% of the traffic is from international visitors.

The Home Page is the most popular area of the site, followed by "Latest Developments," the scientific session agenda, and the "Who We Are - Mission page." A particularly popular feature has been the posting of clinical practice guidelines for the management of patients with heart failure due to left-ventricular systolic dysfunction. Since their posting in January 2000, over 500 copies of the guidelines have been downloaded weekly by visitors from all over the world.

A growing number of visitors are using search engines and keywords such as "congestive heart failure," "heart failure," "heart failure society," "heart failure society of america," "chf," and "heart." Some visitors are from the lay public seeking information about heart failure. To better meet the needs of these visitors, the HFSA in February 2000 launched a sister web site for the general public, patients, and their families, at www.abouthf.org. The site offers information about heart failure, frequently asked questions and answers, patient experiences, HFSA press releases, and more.

Stay tuned: A new look for the site is under development for launch after the Annual Scientific Session in September. ■



Heart Failure Society
OF AMERICA



4th Scientific Meeting
HFSA 2000
September 10-13, 2000
Boca Raton, Florida

The program for this meeting can be viewed on the HFSA website www.hfsa.org under "Latest Developments."

Mission Statement

The Heart Failure Society of America, Inc. (HFSA) represents the first organized effort by heart failure experts from the Americas to provide a forum for all those interested in heart function, heart failure, and congestive heart failure (CHF) research and patient care.

The Mission of HFSA is to:

- **Promote research** related to all aspects of heart failure and to provide a forum for presentation of basic, clinical, and population-based research.
- **Educate** physicians and other members of the profession through programs, publications, and other media to enable them to diagnose and treat heart failure and concomitant medical conditions more effectively.
- **Encourage** primary and secondary preventive measures to reduce the incidence of heart failure; to serve as a resource for government, private industry, and health care providers to facilitate the establishment of programs and policies that will better serve the patient.
- **Enhance** quality and duration of life in those with heart failure.
- **Promote and facilitate** the formal training of physicians, scientists, and allied health care providers in the field of heart failure.

Heart Failure Society
OF AMERICA

Box 358
420 Delaware Street SE
Minneapolis, MN 55455

Bulk Rate
U.S. Postage
PAID
Bowie, MD
Permit No. 4434