

The Future of Cardiac CT: Workforce, Technology, and Clinical Outcomes

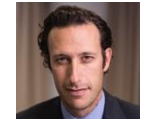
Sat July 19th, 2025
7am – 7:50 am EST



The Future of Cardiac CT: Workforce, Technology, and Clinical Outcomes

Agenda

Topic	Speaker	Title
Welcome	Sayali Tarlekar, MBA, MPH	Global Head of Marketing, Arineta
Scaling a Coronary CTA Program with a Dedicated Small Footprint Cardiac CT	Jonathon A. Leipsic, M.D., F.R.C.P.C. M.S.C.C.T	Past President – SCCT and SCCT Gold Medal Winner
The State of the CT Tech: Workforce Transformation for Cardiac CT Growth	Jaime Warren Ed.D, MBA, BHS, CNMT, NCT, FACC	Vice President, Care Transformation Services, MedAxiom
The Eradication of Heart Attack – The Role of Coronary CTA	Jeffrey Boone, MD, MS	Founder and Director, Boone Heart Institute
Q&A and Ending Comments	Doug Ryan	CEO, Arineta








Arineta Vision

Dedicated to growing cardio-thoracic CT as the front-line non-invasive test for diagnosing, therapy planning and monitoring of Cardiovascular and Thoracic disease – the leading causes of death and healthcare costs worldwide.



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Shifting to a CCTA first strategy- The ARINETA Story

Jonathon Leipsic MD FRCPC MSCCT

Professor and Chair Department of Radiology
University of British Columbia
Professor of Medicine (Division of Cardiology)
Canada Research Chair - Advanced Cardiac Imaging
Past President Society of Cardiovascular CT



Disclosures

Grant Support- CIHR, NIH, GE Healthcare,

Consultant-Heartflow, Circle CVI, Arineta

Core Lab- NIH, Edwards, Neovasc, Tendyne, Abbott,
Medtronic, Boston Scientific, PI Cardia

Stock options- Circl CVI and Heartflow

ACC/AHA Chest Pain Guidelines



Elevating Coronary CTA: CCTA is the only Class 1 noninvasive test with Level A evidence for **diagnosing** CAD and **guiding** treatment decisions

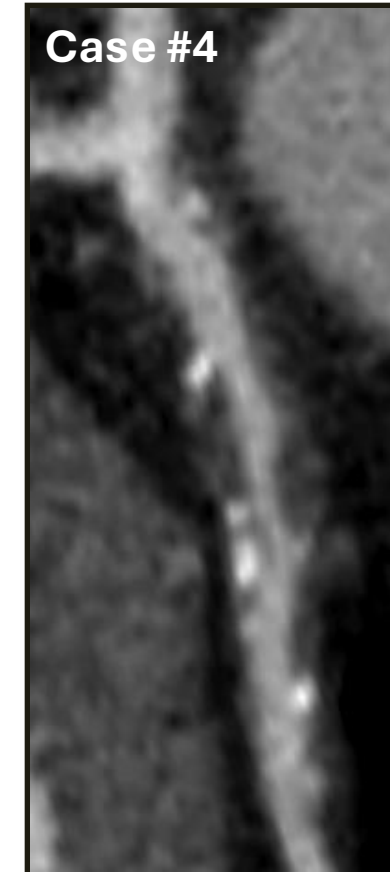
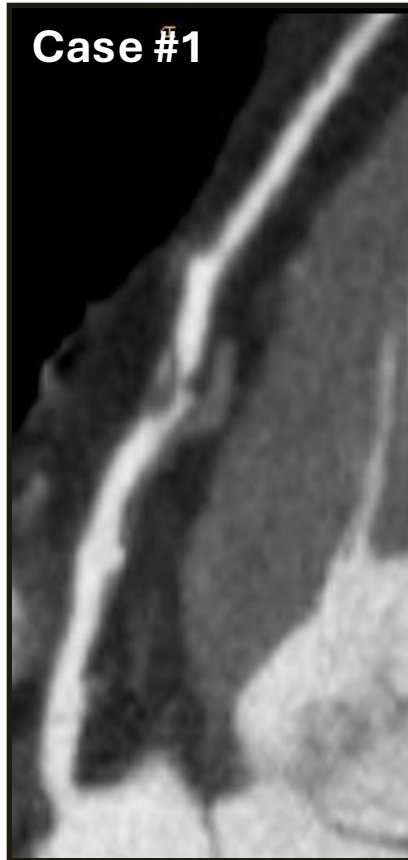
COR	LOE	RECOMMENDATIONS
Index Diagnostic Testing		
Anatomic Testing		
1	A	1. For intermediate-high risk patients with stable chest pain and no known CAD, CCTA is effective for diagnosis of CAD, for risk stratification, and for guiding treatment decisions (1-12).

- **Diagnose** CAD
- **Stratify** patient risk
- **Guide** treatment decisions











Coronary CTA enables clinicians to
Take Informed Action

What is the Real Story?

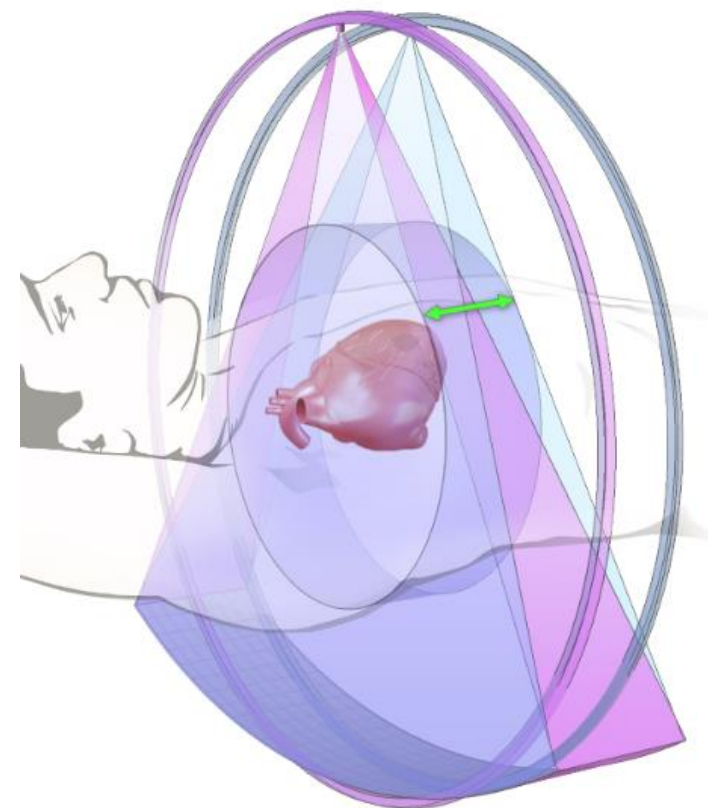
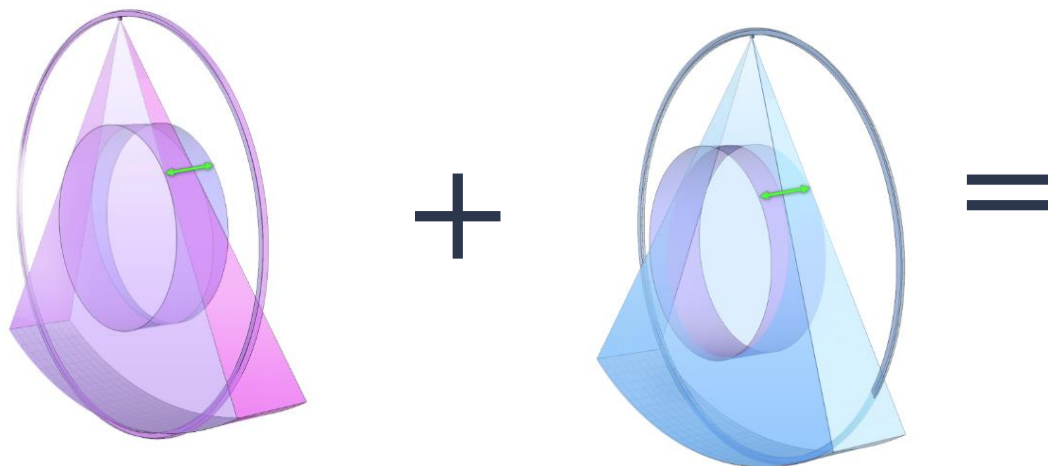


The Role of CTA + FFRct

	Stable Chest Pain	Acute Chest Pain
Suspected CAD	 1A +  2a	 1A +  2a
Known CAD	 2a +  2a	 2a +  2a

Arineta SpotLight: Stereo CT™ Technology

- Dual overlapping beams from different directions (like human vision)
- Eliminates the cone beam artifacts !
- Superb 3D imaging
- Reduced detector size and cost
- Improves dose utilization

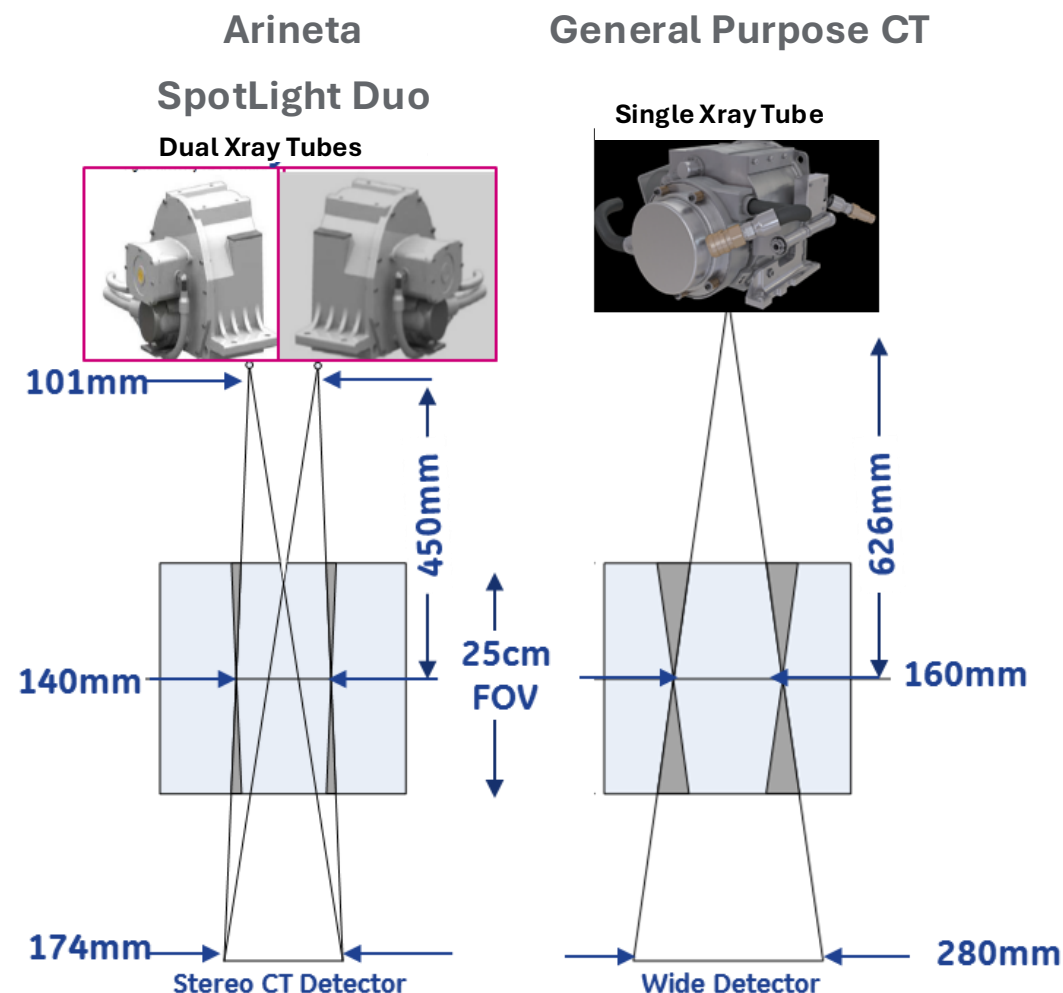
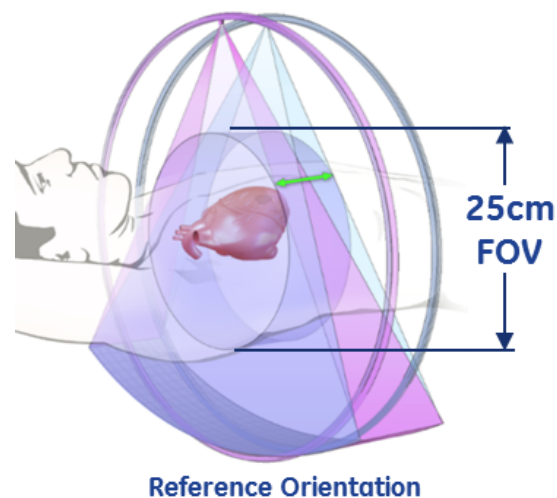


Arineta SpotLight: One-Beat Whole-Heart Coverage

Reduced detector size and cost for same coverage

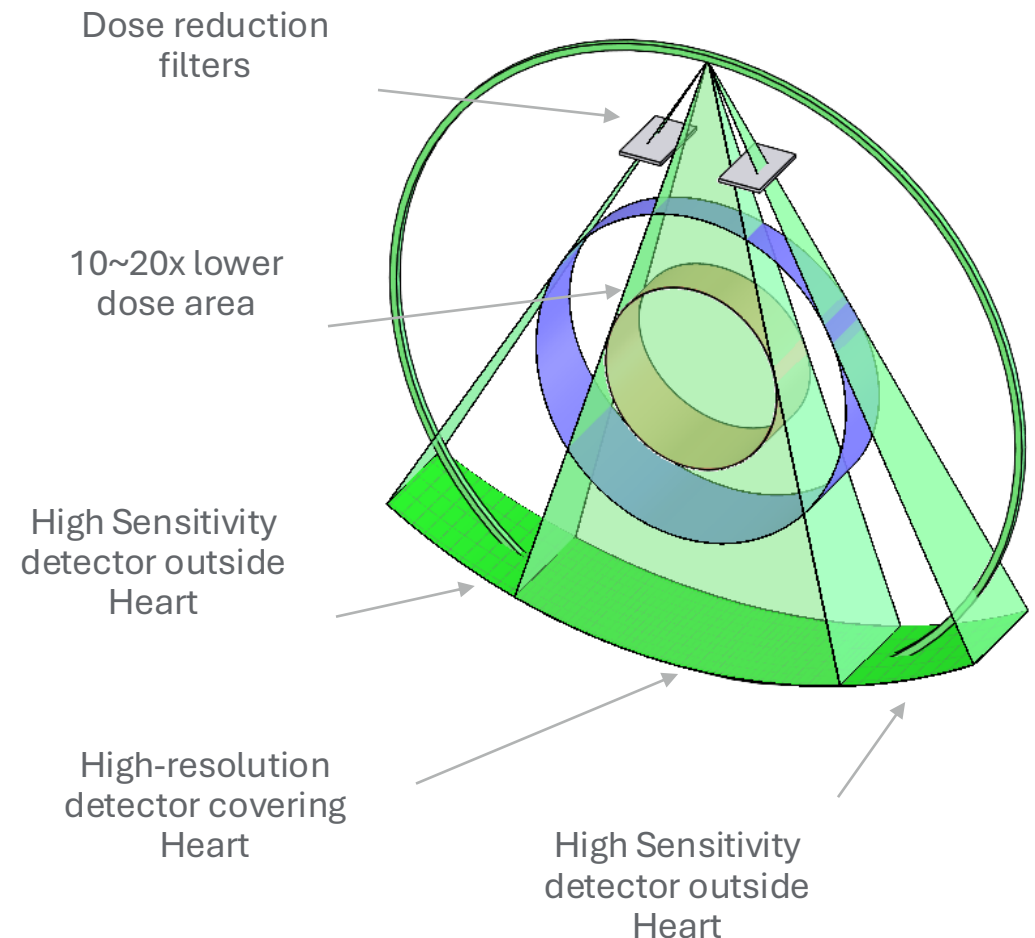
Dual overlapping beams

- Reduces cone beam artifacts



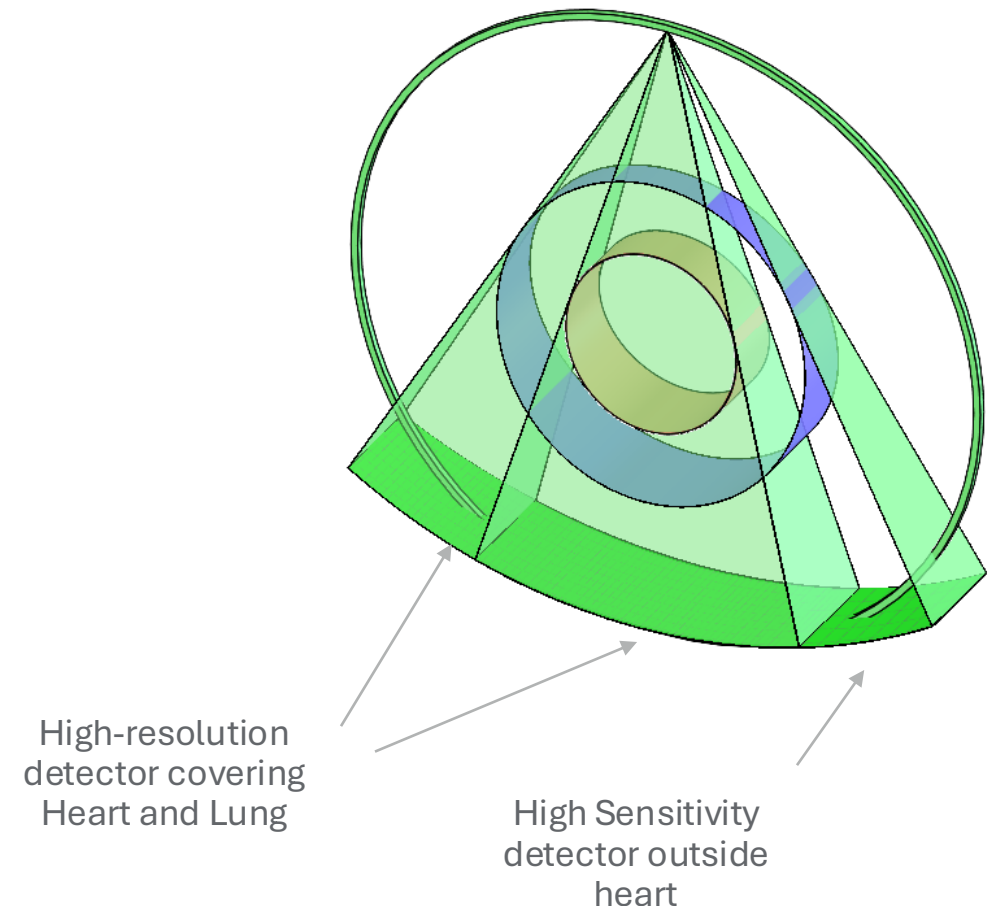
Arineta SpotLight: Focused Field Of View

- In CT, body parts outside the FOV affect the image reconstruction inside the FOV.
- SpotLight solution:
 - Radiation outside FOV attenuated by 10~20 x
- High sensitivity peripheral detectors acquire data out of the FOV
- 250mm Focused Field Of View
- Less incidental finding in lungs



Arineta SpotLight Duo: Wide Field Of View

- High resolution detectors out to full 450mm FOV
- Asymmetric detector provides full field of view high resolution coverage and lower cost
- 360-degree acquisition and reconstruction for full thoracic coverage



Arineta SpotLight: Room Layout & Siting

Compact design for office, cath lab, ED or mobile

Advantages

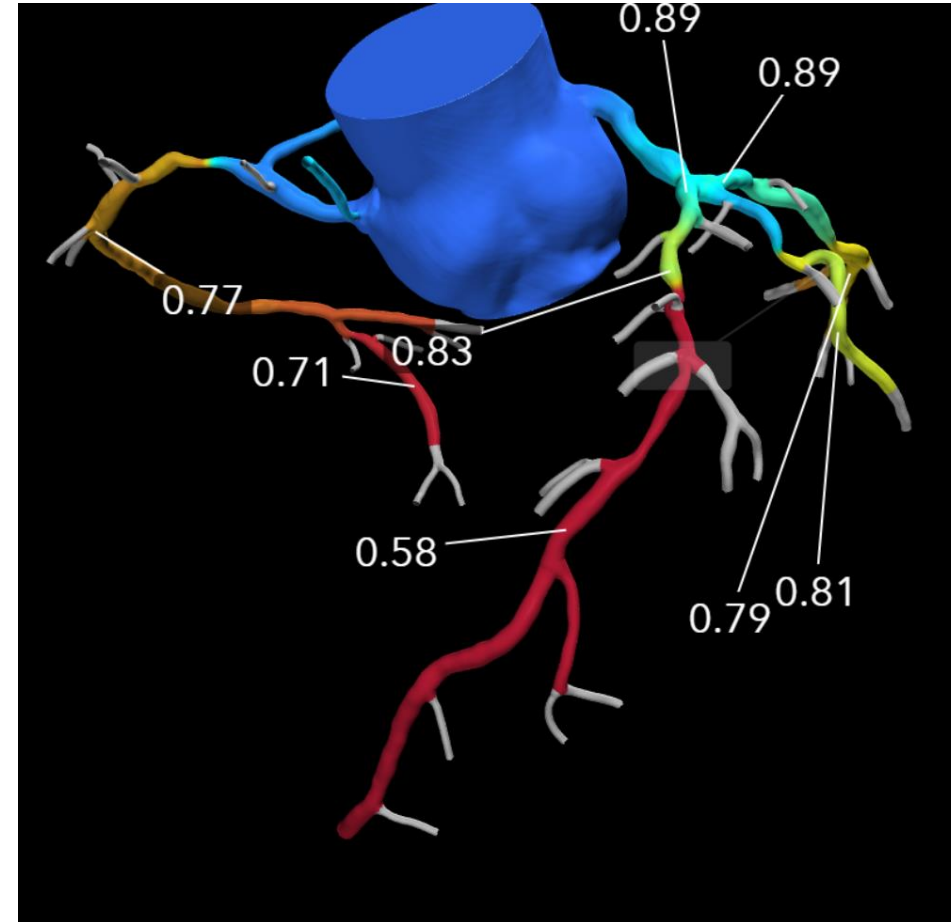
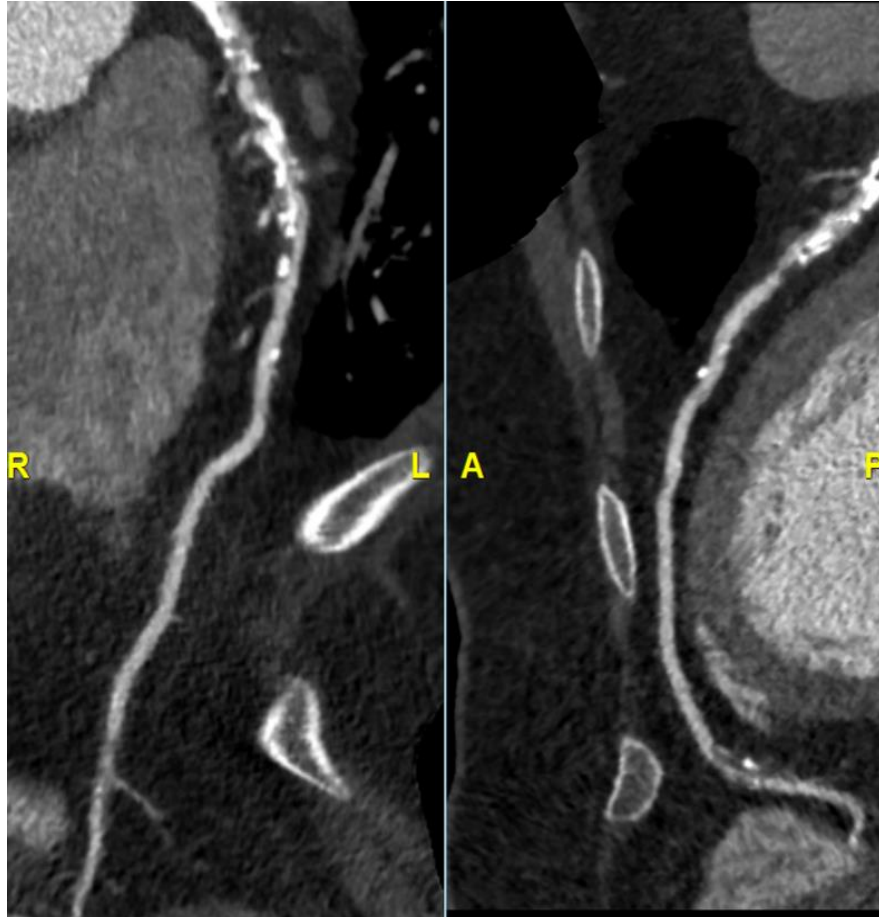
- Fits through standard doorways
- Safe for standard elevators
- Sites in a small room: 15m²

Comparisons (vs Rev CT)

- 40% smaller room size (23m²)
- 40% lighter weight gantry (6335lb)
- 50% smaller gantry (6.44m³)



62 yo with chest pain



Comparable image quality to traditional high end scanners at lower cost and higher efficiency

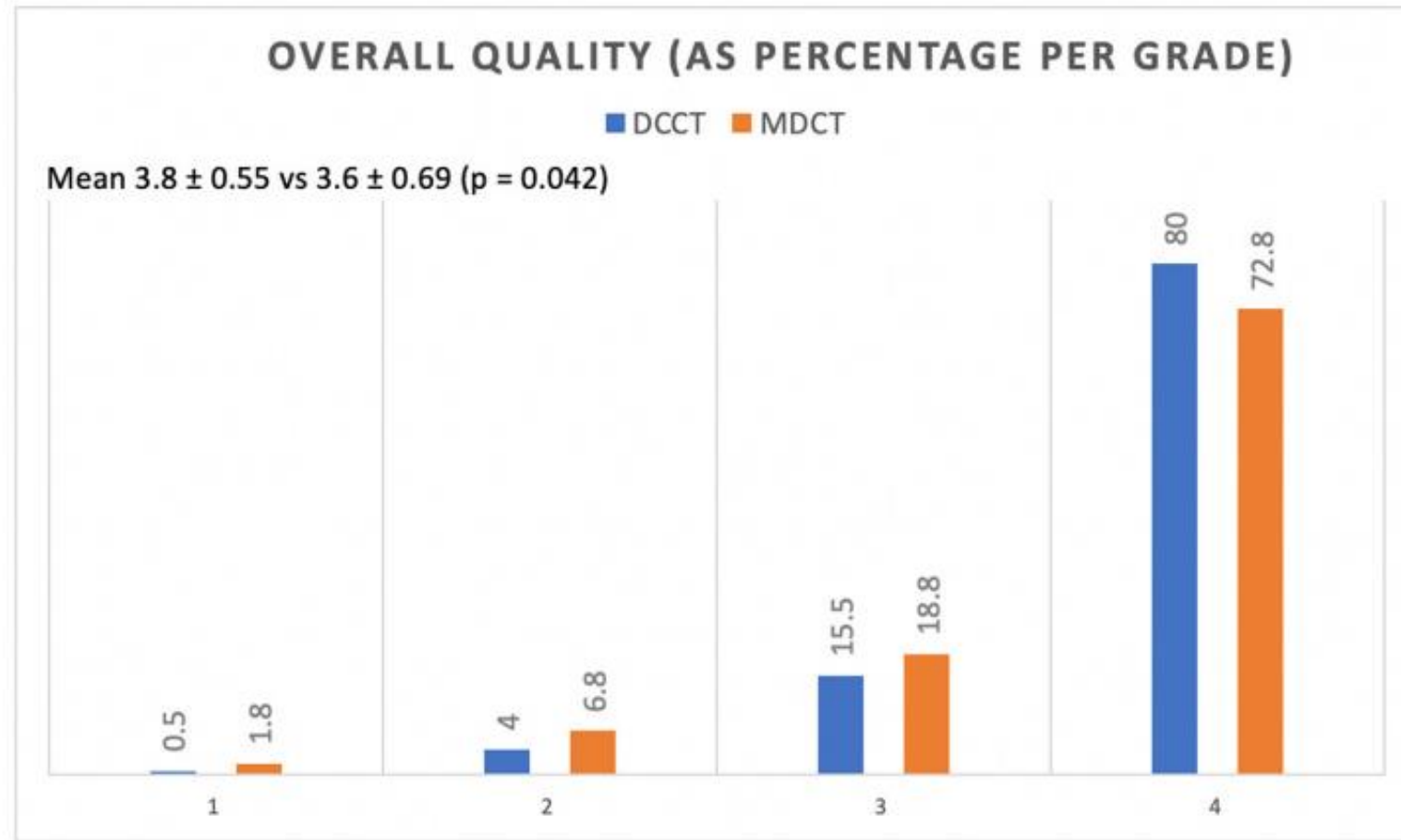
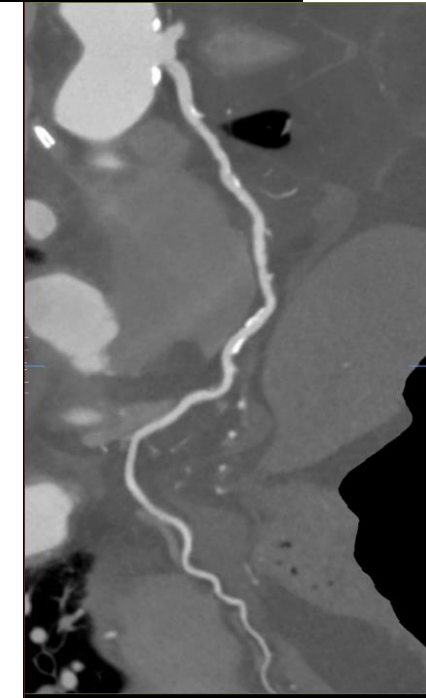
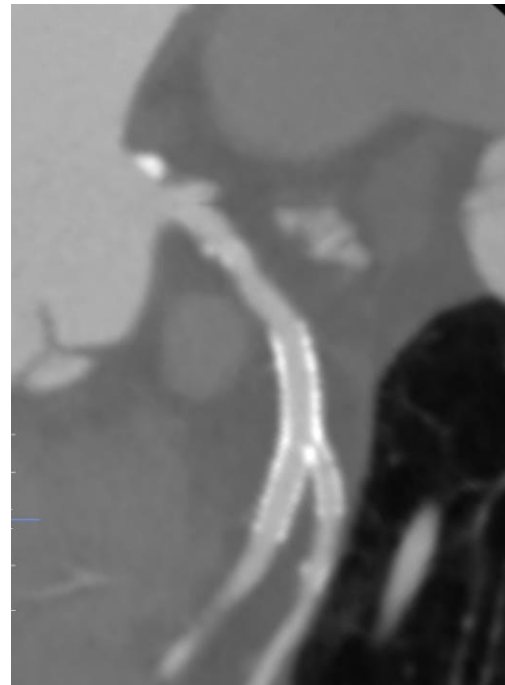
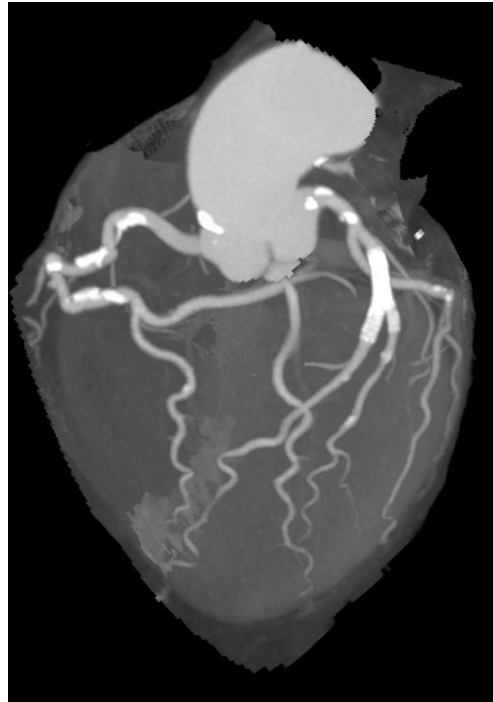
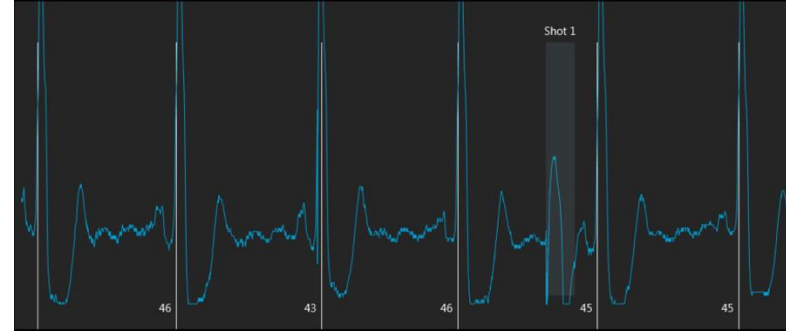


Fig. 1. Overall image quality.

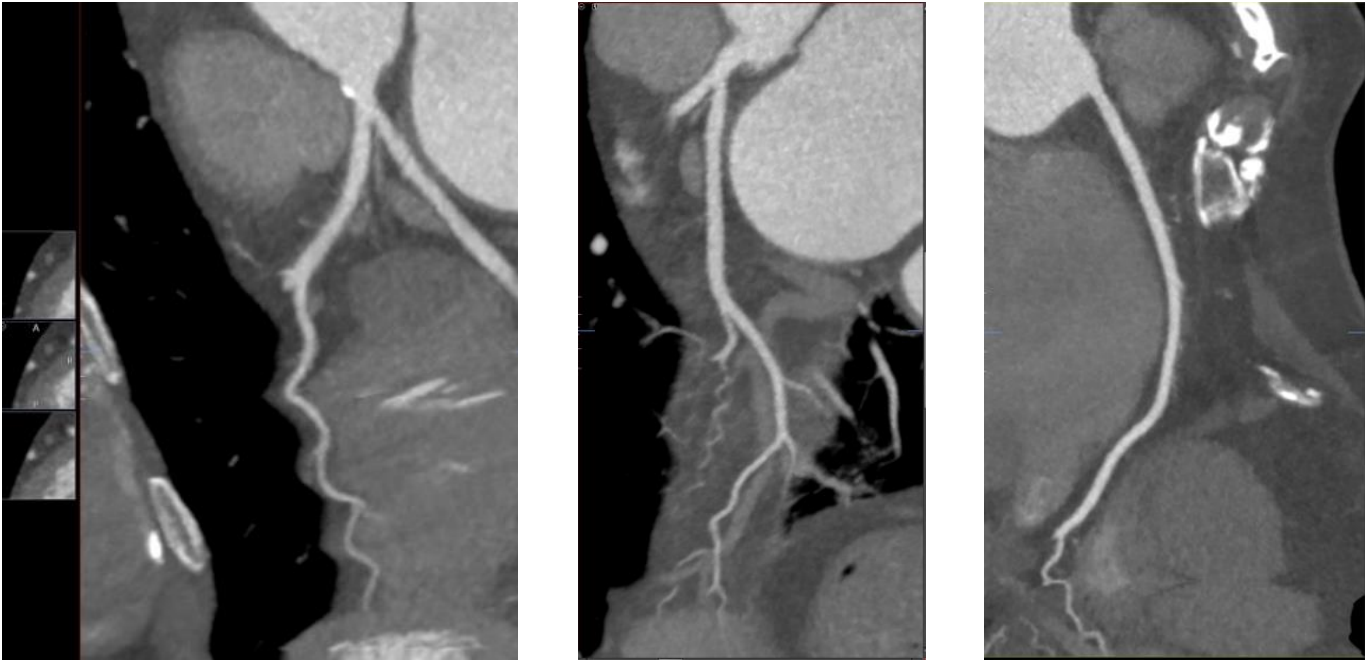
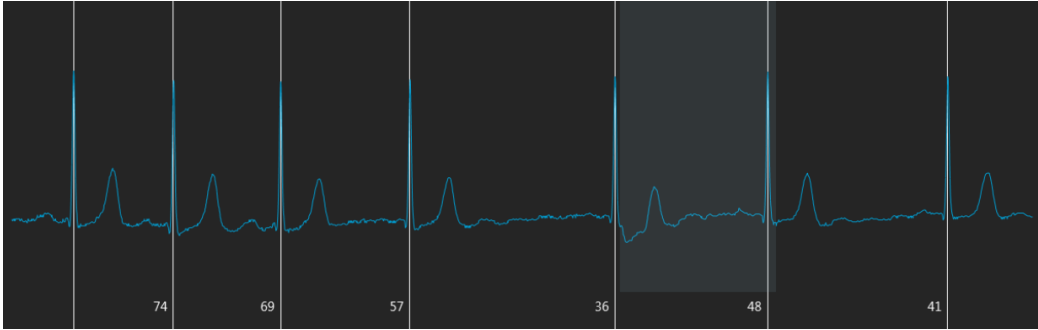
High spatial and temporal resolution delivers excellent stent visualization

BMI	27.8
Slice, mm	0.5
kV	120
mA	500
Contrast ml	75
mgI/ml	350
Kernel	Standard
CTDIvol, mGy	12.2
DLP, mGy-cm	170.9
Effective dose mSv	2.4
k	0.014



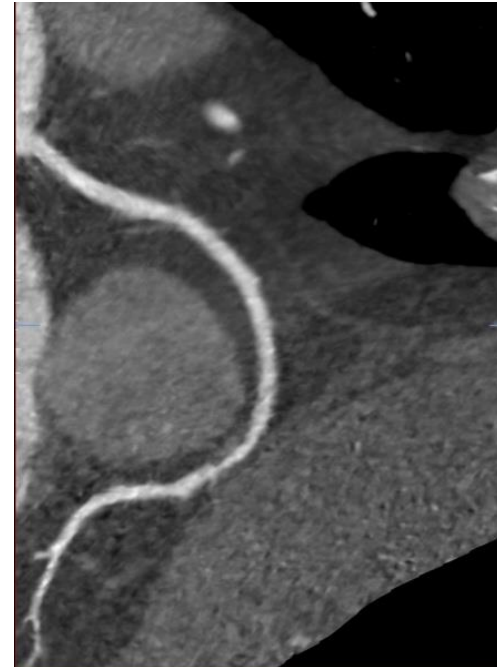
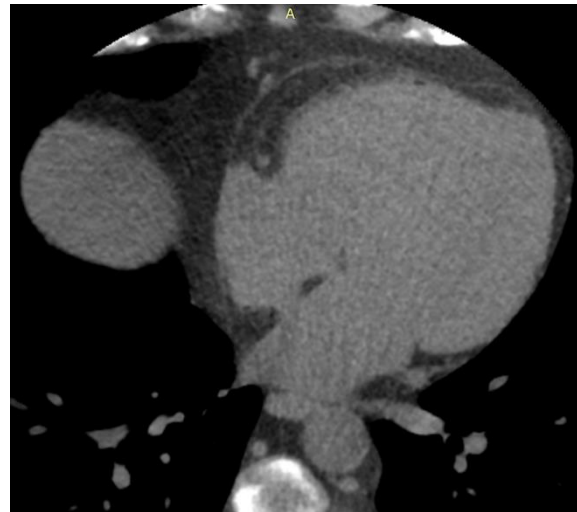
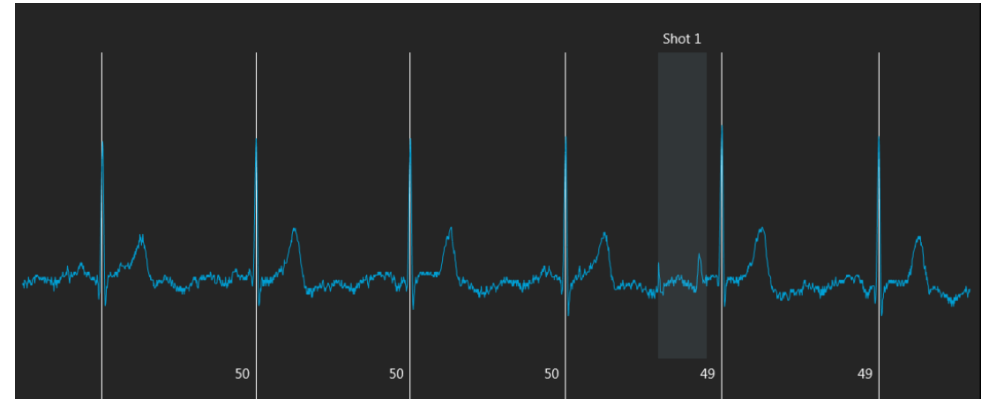
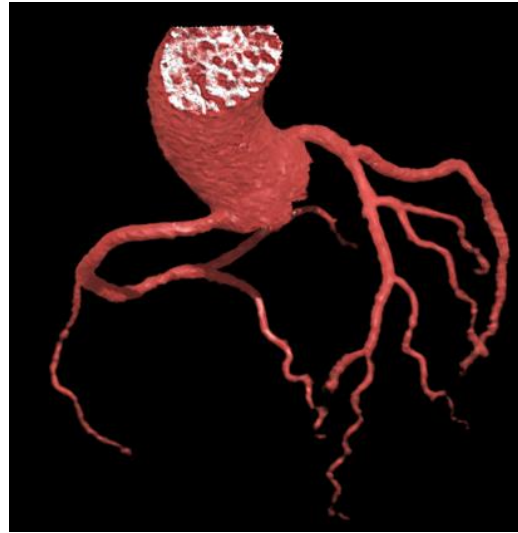
Motionless imaging in patient with challenging unstable heartrate

Contrast ml	75
mgI/ml	350
Kernel	Standard
CTDIvol, mGy	44
DLP, mGy-cm	616.5
Effective dose mSv	8.6
k	0.014

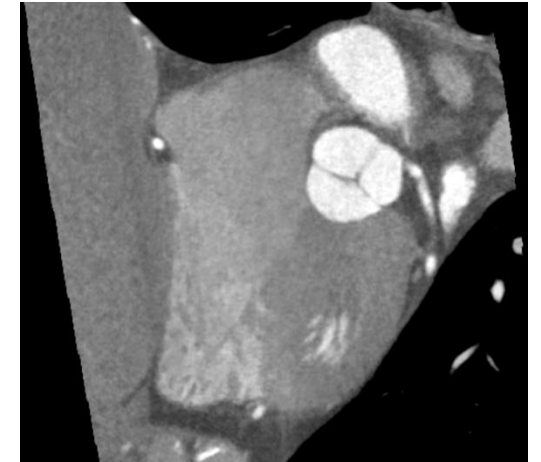
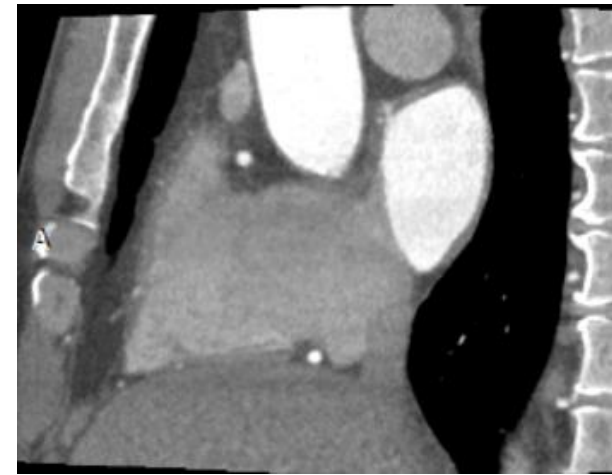
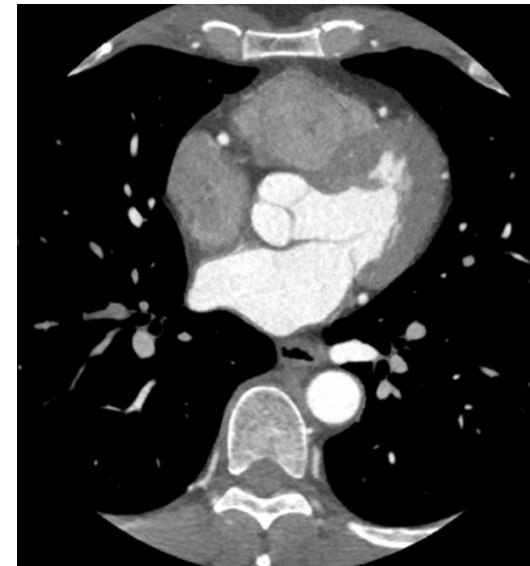
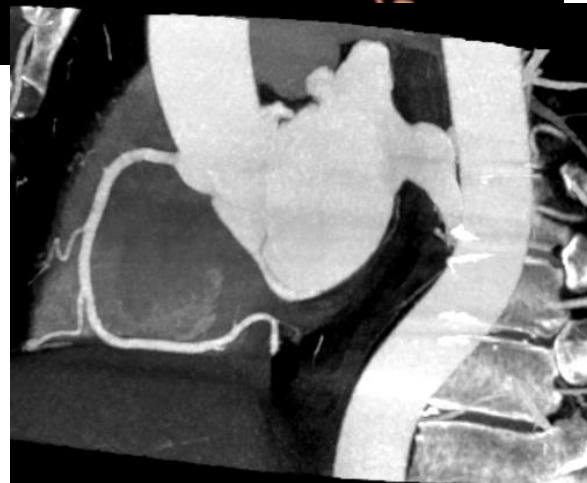
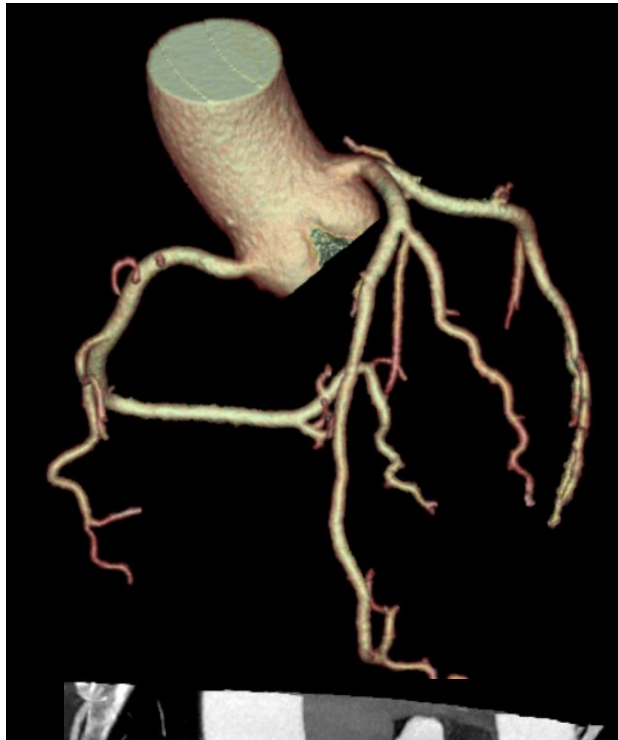


55 with good quality and <4 mSv dose

BMI	55
Slice, mm	0.5
kV	120
mA	600
Contrast ml	90
mgI/ml	350
Kernel	Standard
CTDIvol, mGy	20.3
DLP	284.2
Effective dose	3.97
mSv	
k	0.014



Sharp and motionless coronaries



Slice, mm	0.5
Scan length, mm	140
kV	100
mA (mAs)	600 (222)
Contrast	
ml	75
mgI/ml	350
Kernel	Standard
CTDIvol, mGy	12.8
DLP, mGy-cm	179.6
Effective dose mSv	2.5
k	0.014
BMI	26.6
Phase	75%

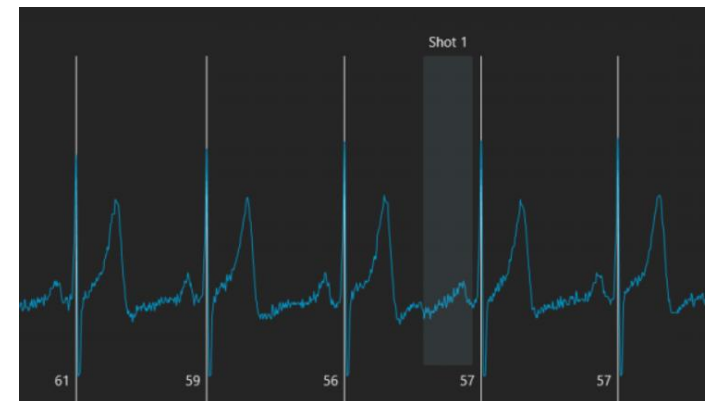
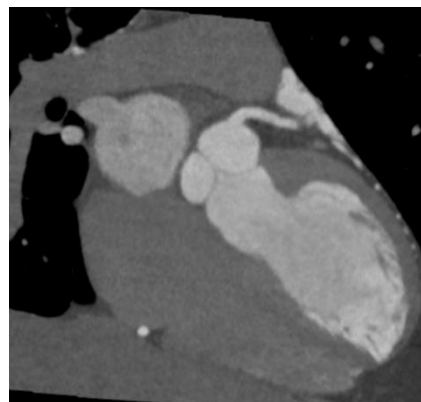
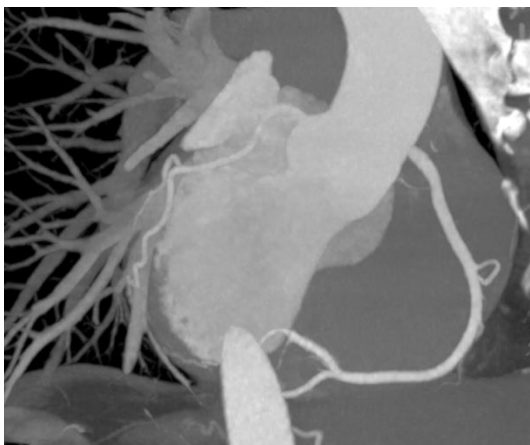
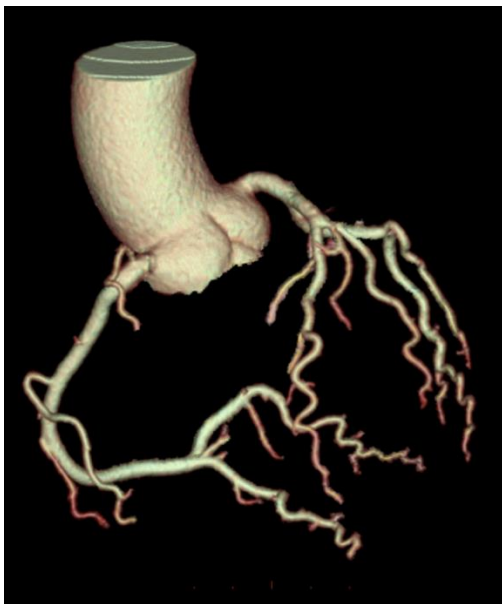
1.9 mSv CCTA

Exceptional quality with Deep Learning Image Reconstruction

Rotation time, s	0.24
Slice, mm	0.5
Scan length, mm	140
kV	100
mA (mAs)	450 (171)
Contrast	
ml	75
mgI/ml	350
Kernel	Standard
CTDIvol, mGy	9.3
DLP, mGy-cm	138.08

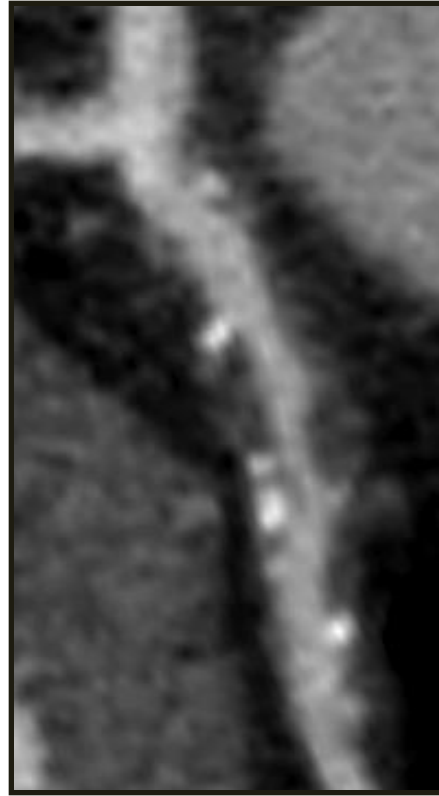
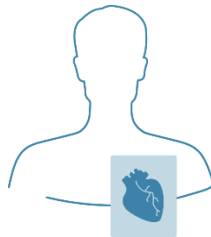
Effective dose mSv	1.9
k	0.014
BMI	24

Phase	75%
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You would not do a TAVR without a
non-invasive evaluation of the annulus

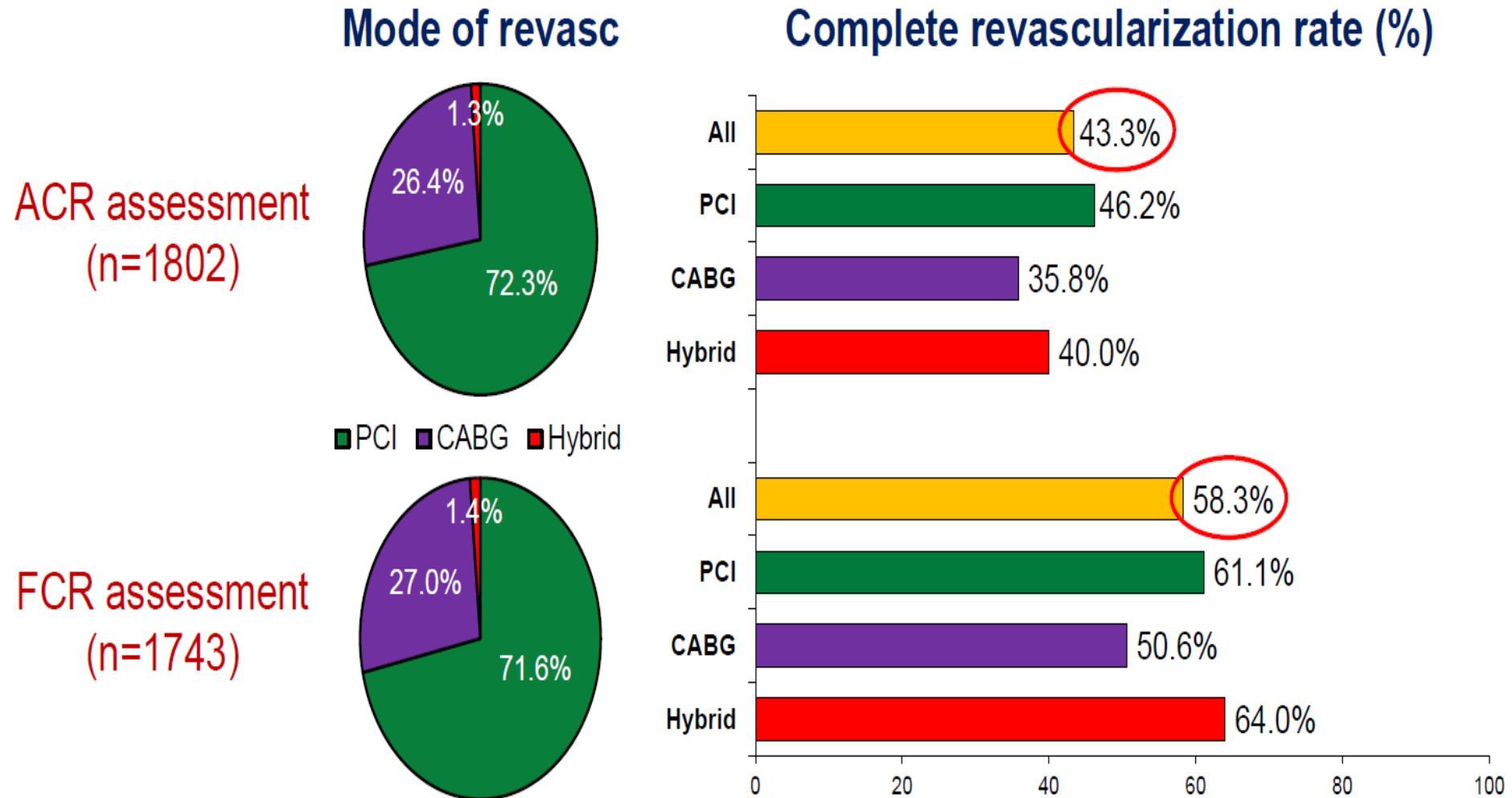
Would you rather make decisions around ICA with this



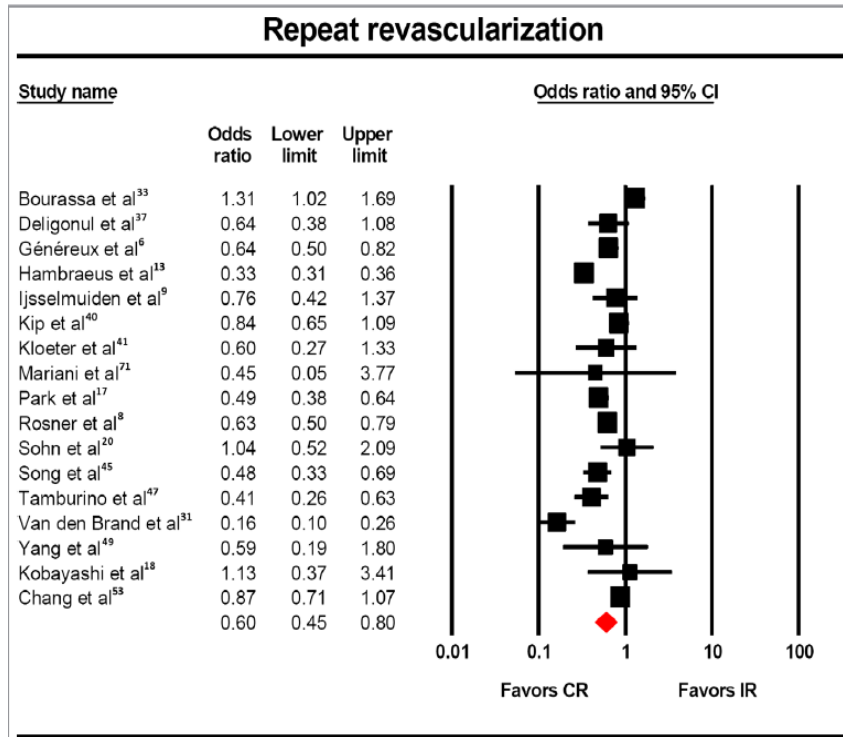
Objective 1: Completeness of Revascularization (INV)



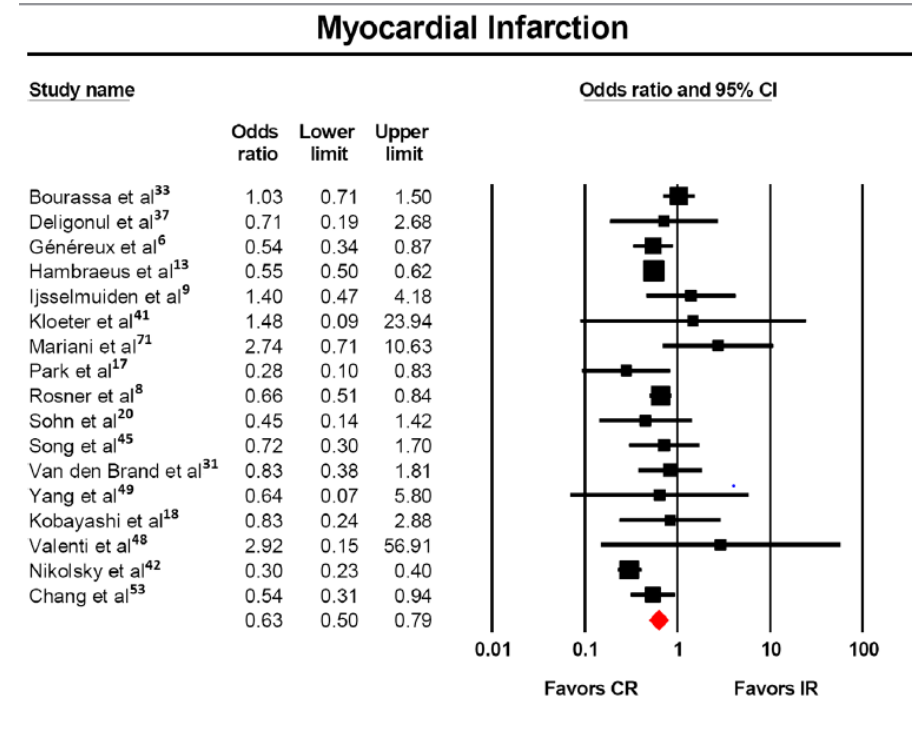
Among 1825 pts randomized to INV in whom a revasc procedure was performed within 6 months, prior to a primary endpoint event



Consistent event reduction with complete revascularization

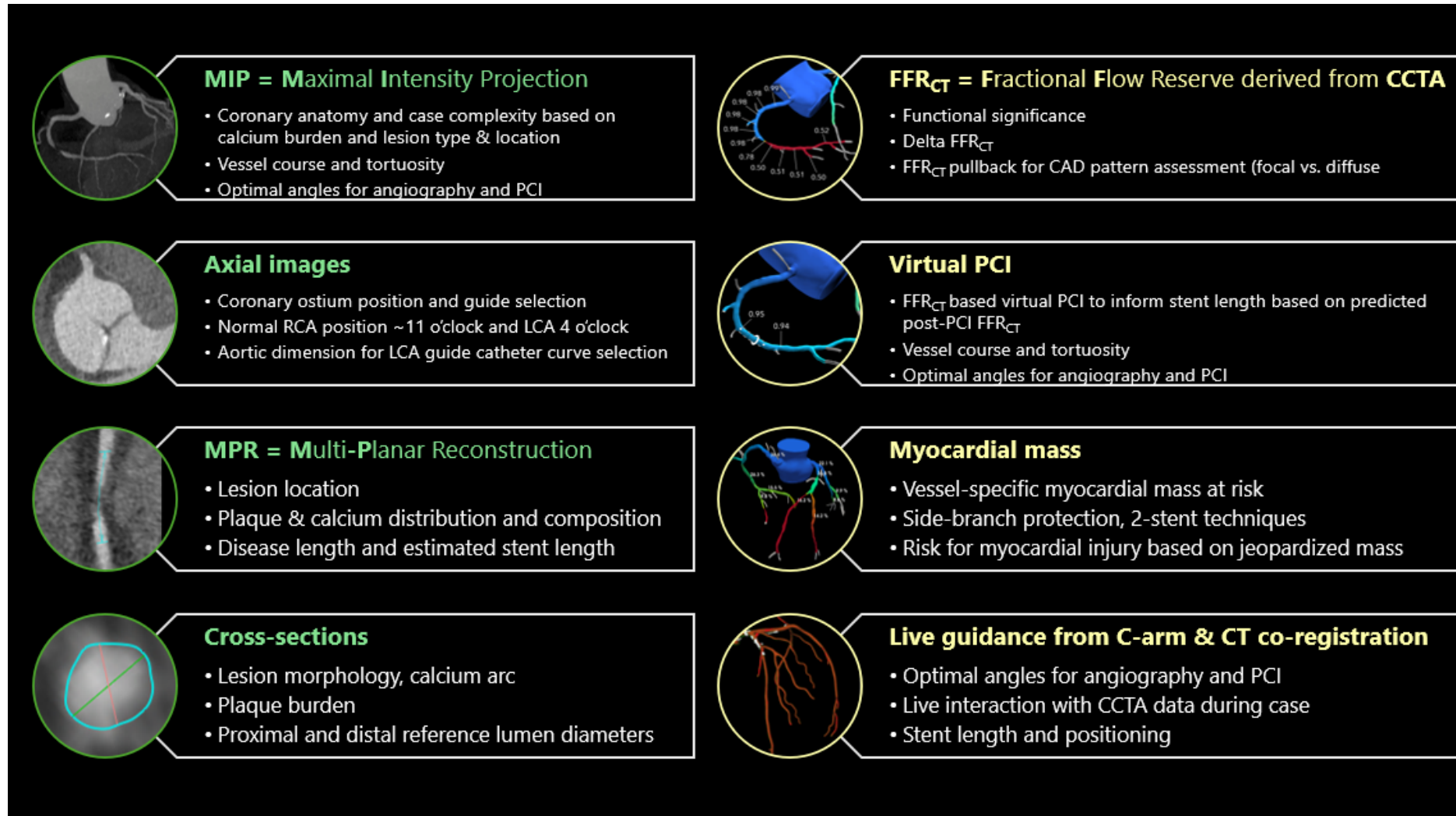


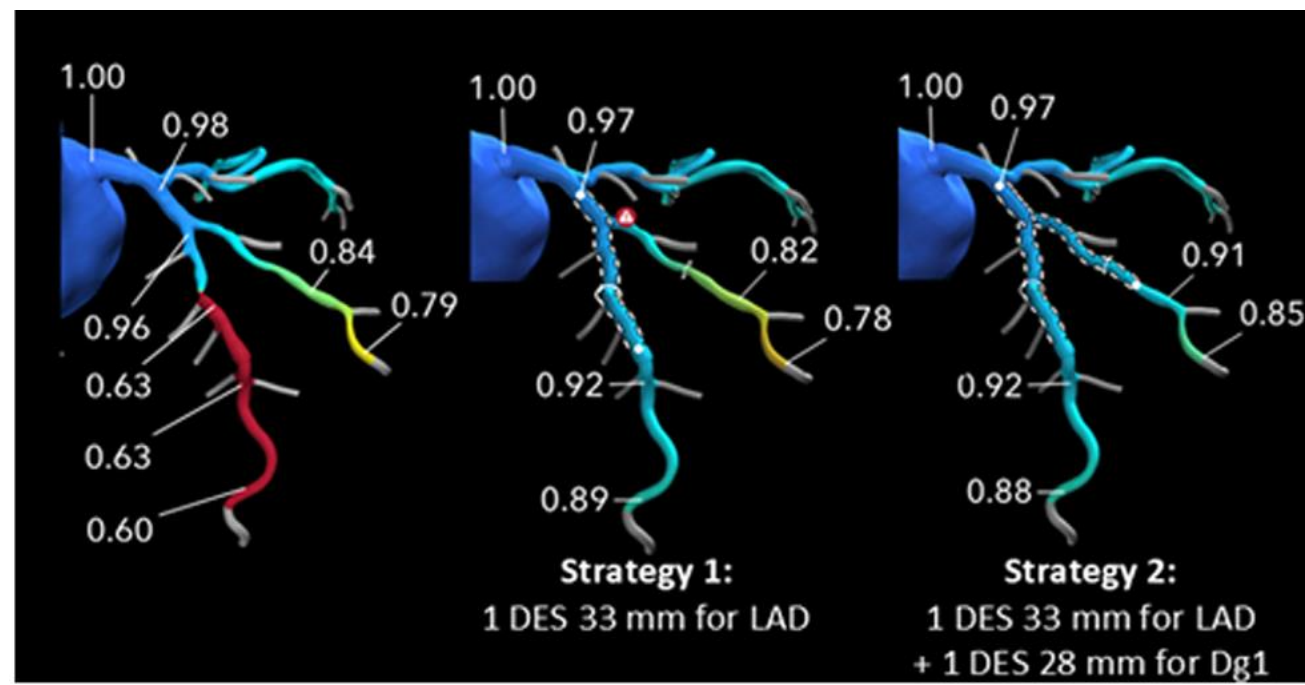
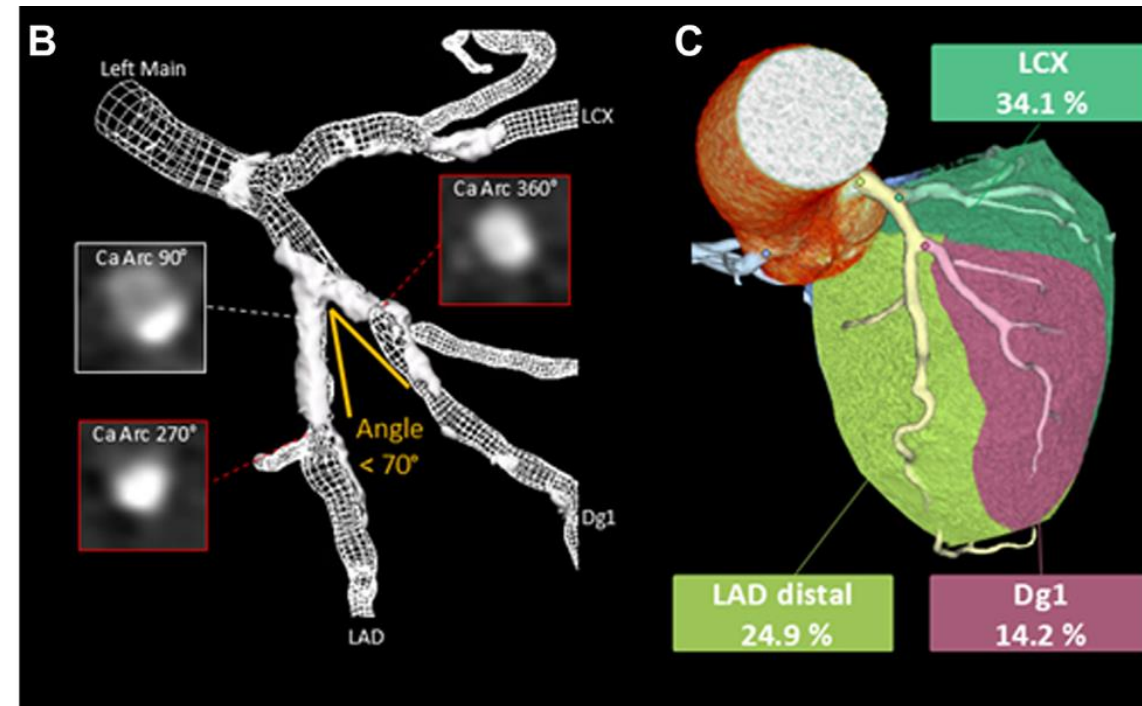
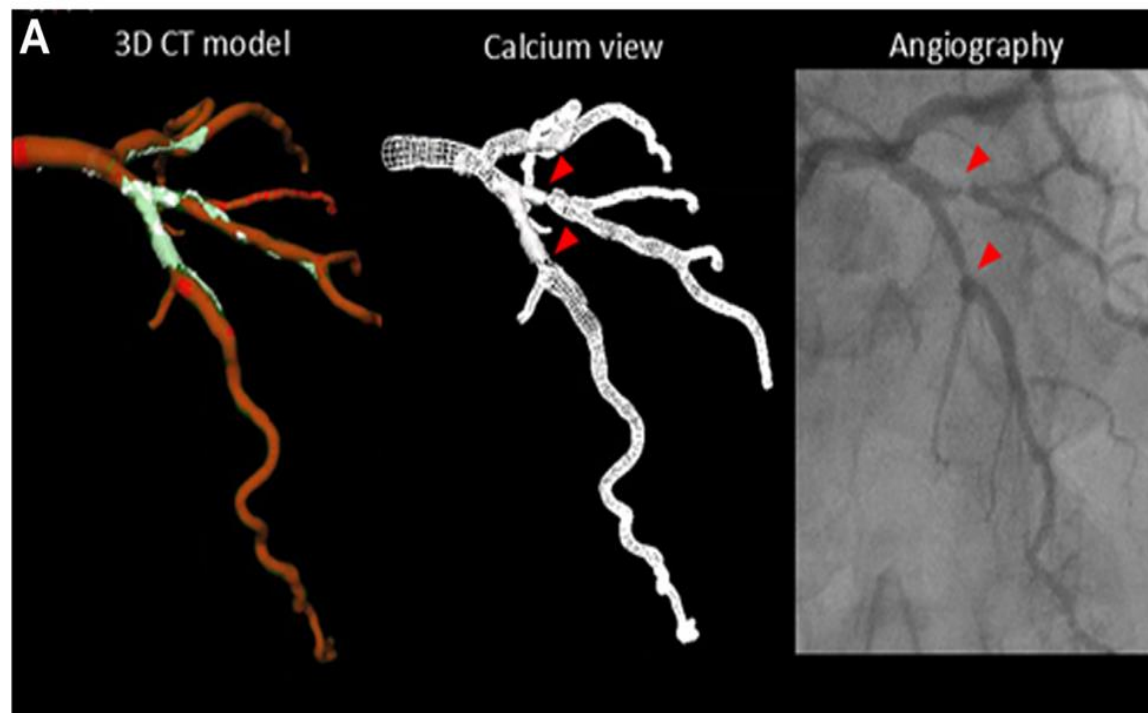
CR- (OR: 0.60, 95%CI: 0.45–0.80)



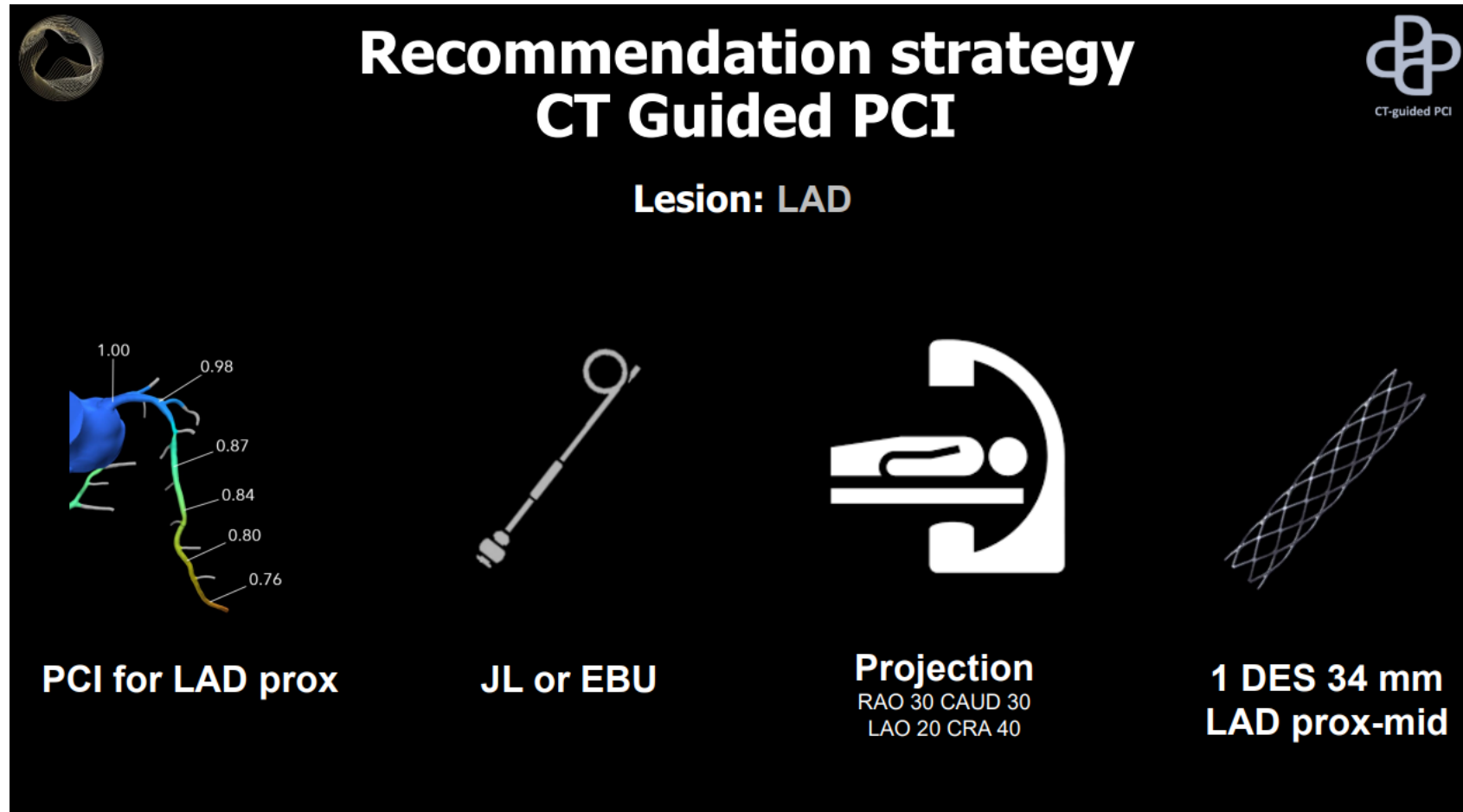
CR- OR: 0.64, 95% CI:0.50–0.81)

Rich pre-procedural data now available prior to PCI





The way forward??








Conclusions

- CCTA has established itself as the dominant first line strategy for suspected but not confirmed CAD
- Shifting practice patterns will require significant improvements in access in an efficient fashion
- Dedicated small foot print Cardiac CT scanners will play a growing role in delivering high quality care cost effectively

The Future of Cardiac CT: Workforce, Technology, and Clinical Outcomes

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THE STATE OF THE CT TECHNOLOGIST

Workforce Transformation for Cardiac CT Growth

Jaime Warren, Ed.D, MBA, BHS, CNMT, NCT, FACC
VP, Care Transformation
MedAxiom



DISCLOSURES

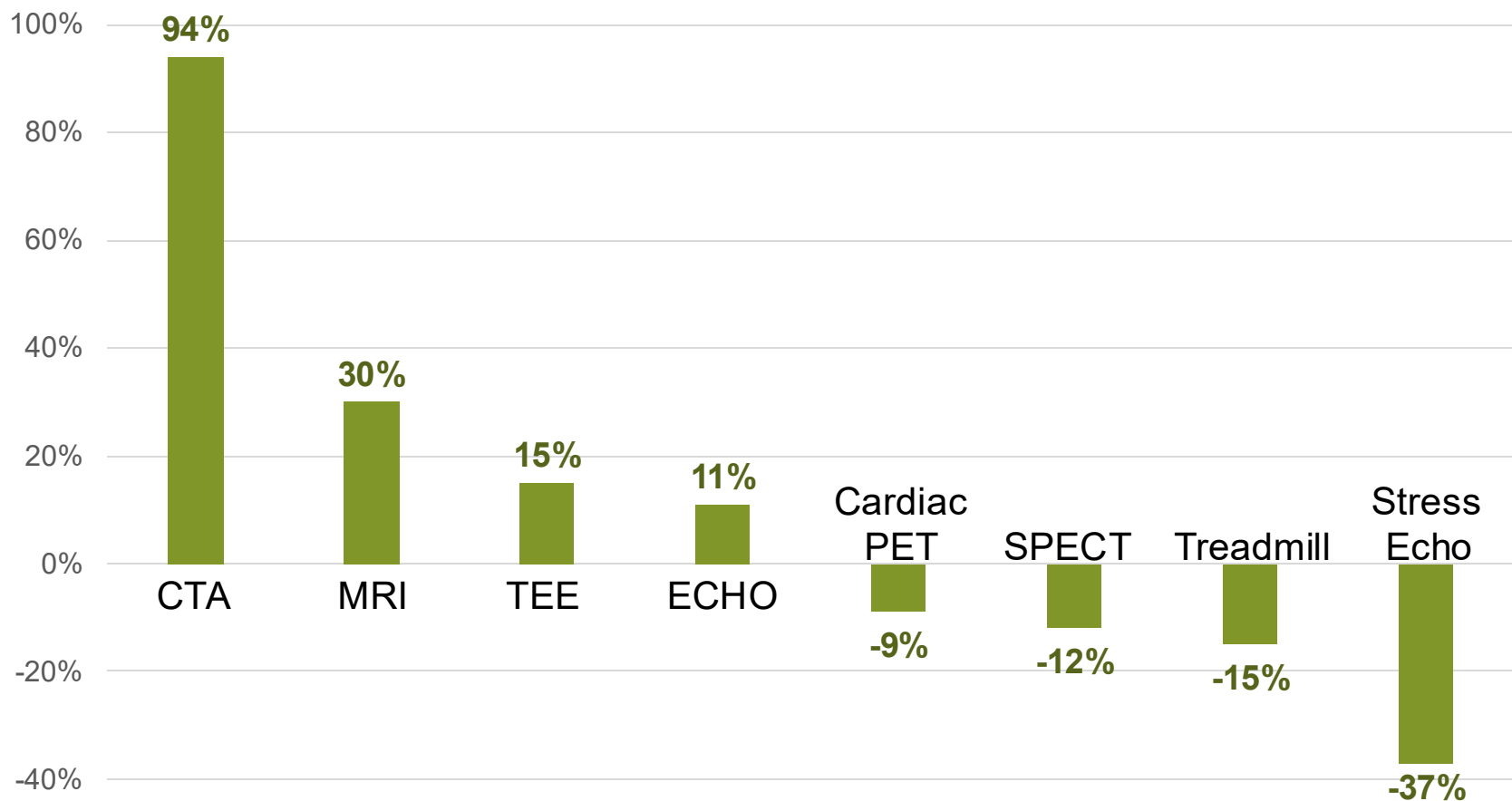
None

**WE DON'T HAVE A
TECHNOLOGY PROBLEM.
WE HAVE A A
PEOPLE PROBLEM.**



CARDIAC CT IS BOOMING – BUT ARE WE READY?

Percent Change from 2019 to 2024 Average Volume Per Physician FTE

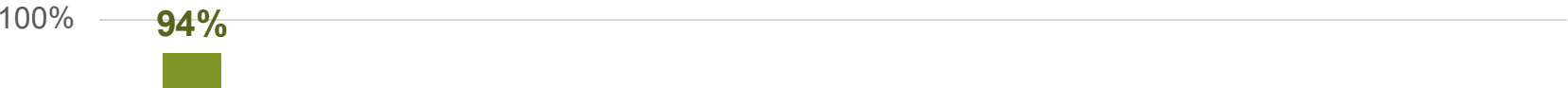


CTA volumes are up 94% in just 5 years

This shift is happening in real time, but workforce planning isn't keeping pace.

CARDIAC CT IS BOOMING – BUT ARE WE READY?

Percent Change from 2019 to 2024 Average Volume Per Physician FTE



CTA volumes are up

You can't scale Cardiac CT on yesterday's staffing model..



THE CURRENT TECHNOLOGIST LANDSCAPE



AGING OUT

25% of imaging techs are 55+, with retirements accelerating

Source: ASRT 2023



BURNED OUT & BAILING

44% report burnout, with turnover up to 17.5%

Source: ASRT 2023



CREDENTIALING CONFUSION

Licensing + credentialing varies wildly across states

Source: ARRT



RURAL STAFFING GAPS

25%+ vacancy rates in underserved areas

Source: HRSA 2023

“Cardiac CT demand is climbing—but scanner time is being cut to protect the techs who are left.”
– *Cardiovascular Business, 2024*

CT STAFFING REALITIES: VOICES FROM THE FIELD

Top Challenges:

✔ Recruitment & Retention:

- ✓ Competing with sign-on bonuses and outpatient facilities.
- ✓ Struggles with 3rd shift, weekends, call—techs often job-hop for better pay.
- ✓ Some hospitals enjoy stable teams - but that's the exception.

VARIETY

BONUSES

DEDICATED
TEAMS

Schedules & Workload:

- ✓ Scan schedules cut; techs cover multiple roles (e.g., chest x-rays).
- ✓ Workforce stretched thin—ratios may look good on paper, but real-life downtime and unpredictable demand add stress.

✔ Credentialing & Burnout:

- ✓ Varying credentialing timelines; some allow a year before board certification.
- ✓ Burnout is real—weekends, holidays, high ER volume.
- ✓ Clear roles and supportive teams help prevent burnout.

What's Actually Working:

- Variety: Cross-training in PET/nuclear or other departments keeps techs engaged.
- Incentives: Quarterly bonuses based on volume or performance.
- Structure: Dedicated teams under cardiology feel more valued and focused.



IT'S TIME TO INVEST IN OUR TECHS



WHY IT MATTERS:

CT Techs = Strategic Leverage

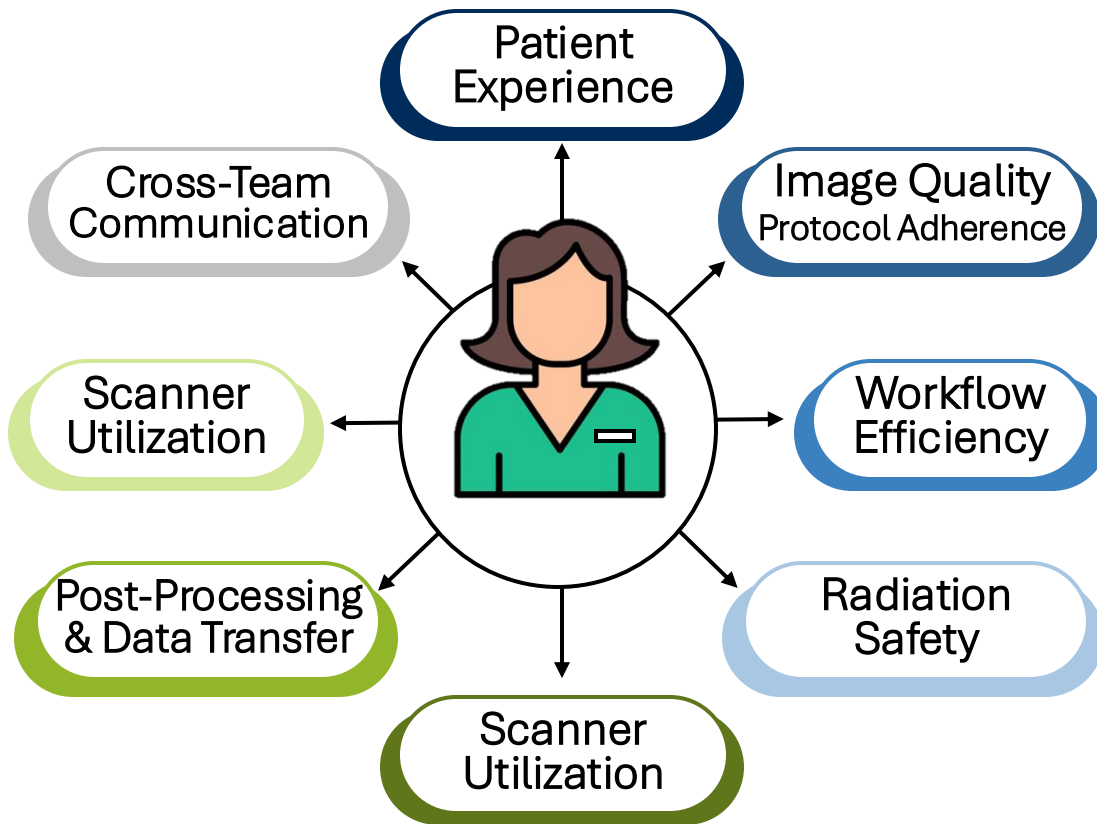


Image Quality → Drives diagnostic accuracy + provider trust

Workflow Efficiency → Enables higher throughput + better patient flow

Post-Processing → Accelerates turnaround + reporting

Patient Experience → Boosts satisfaction + retention

Protocol Expertise → Reduces variability + elevates care standards

BECOMING A CT TECHNOLOGIST



NAVIGATING STATE LICENSURE

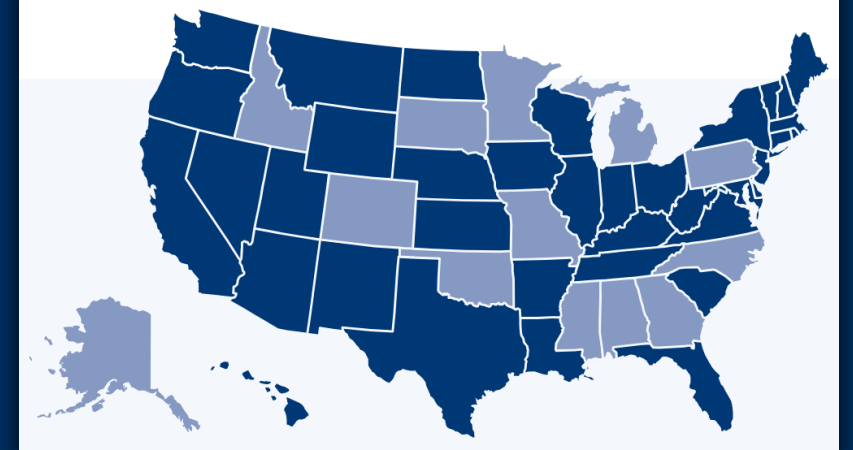
Why it matters:

State licensure requirements define who can legally perform CT procedures

Not every technologist who is ARRT(CT) or NMTCB(CT) certified can automatically work in your state.

Licensure and regulations vary by state

ARRT.org



What you need to know:

- State-by-State Rules
 - ✓ Some states require a specific CT license or add-on credential (ARRT-CT and/or NMTCB-CT)
- Employer Responsibility
 - ✓ Health systems/physician offices must verify state licensure before assigning technologist
 - ✓ Failure to comply can risk fines and penalties

CT CERTIFICATION PATHWAYS

Category	Radiologic Technologist (RT)	Nuclear Medicine Technologist (NMT)
Starting Point	ARRT Radiography Certification	ARRT(N) or NMTCB Certification
Pathway to CT	ARRT (CT) or NMTCB (CT)	
Structured Education	Education Hour Requirement covering physics, protocols, safety, etc.	
Clinical Experience	Documented CT procedures/hours	
State Licensure	Varies based on state requirements	

CT certification ≠ state licensure. Some states require a separate CT license or accept only ARRT cert + state application. Eligibility varies—check local regulations

SCOPE OF PRACTICE



Varies widely across states



Credentialing is not always aligned with scope
(e.g., NMT may need additional approvals depending on state)



Admins and MDs need to understand the limits and advocate for standardization
(Support national licensing models or collaborate with state societies)



Discussion Point: How does your organization handle scope-of-practice challenges?

RETENTION
STARTS WITH
CULTURE

Hello
my name is

BECOMING THE EMPLOYER OF CHOICE

Top Strategies to Attract and Retain Talent:



Cross-Training Opportunities - Offer training across other imaging modalities to broaden skills and reduce burnout.



Credentialing Support - Pay for licensing, certification, and continuing education to show investment in staff.



Flexible Scheduling - Provide shift options like split shifts or 4x10s to support work-life balance.



Tech Input - Involve technologists in department decisions



Technician vs. Technologist - Recognize the difference in training, responsibilities, and pay. Ensure titles align w/ scope of practice & expectations.



Use Real-World Language - Communicate clearly: avoid corporate jargon—connect with techs through authentic conversations.

WHY IT MATTERS:
The best techs do have options. If you're not flexible, someone else is.

FORECASTING STAFFING AS YOU SCALE



- ✓ 1 scanner \neq 1 tech
- ✓ Include: prep, post-processing, QA, downtime coverage

Don't just scale equipment. Scale people, training, and culture.



You can buy a scanner. But if no one's there to run it? It's just an expensive paperweight.

Advocate. Invest. Ask Your Techs What They Need






Q&A

Jaime Warren, Ed.D, MBA, BHS, CNMT, NCT, FACC
VP, Care Transformation
MedAxiom (an ACC company)
jwarren@medaxiom.com



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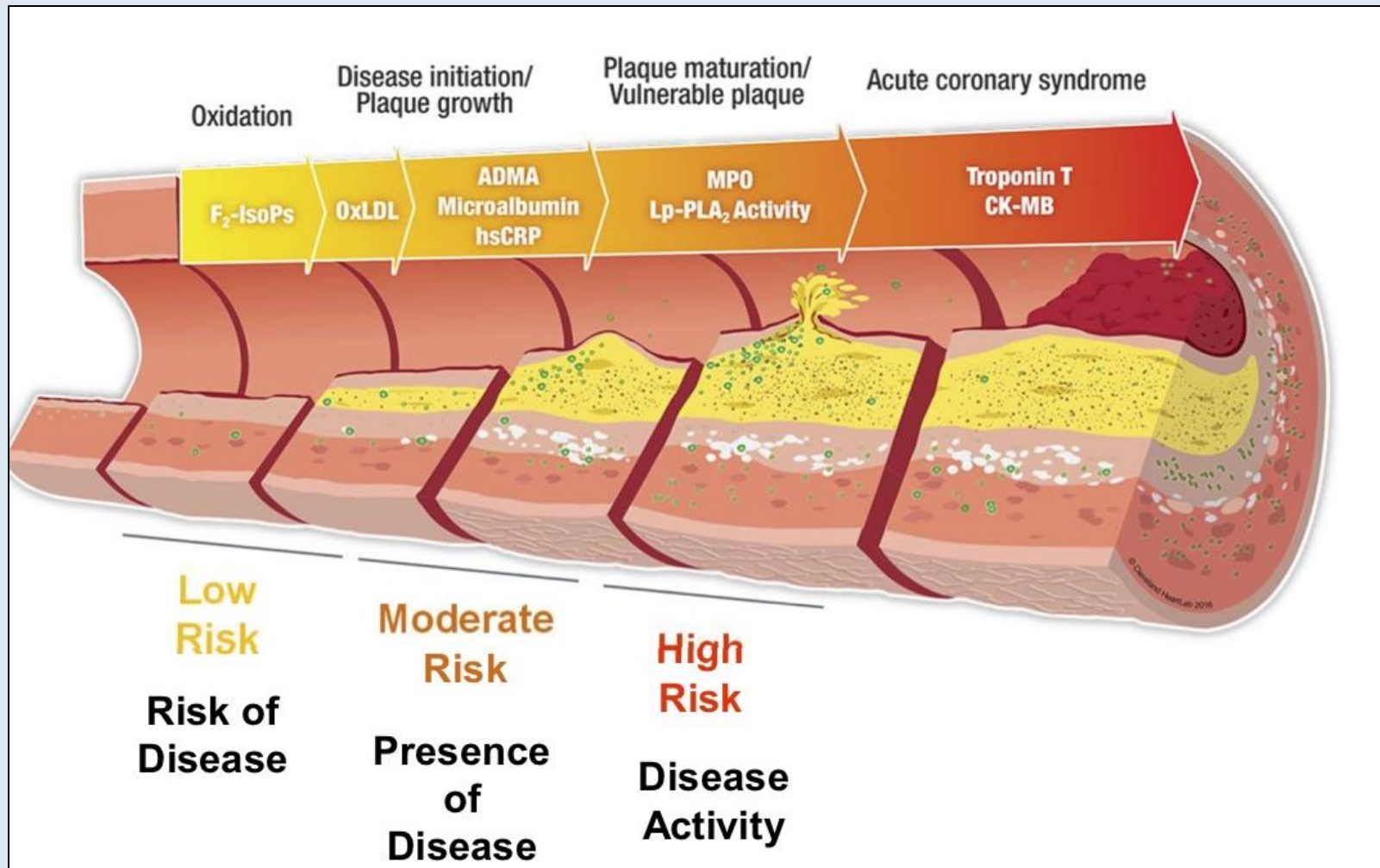
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The Eradication of Heart Attack: The Role of Coronary CTA



Inflammation Testing





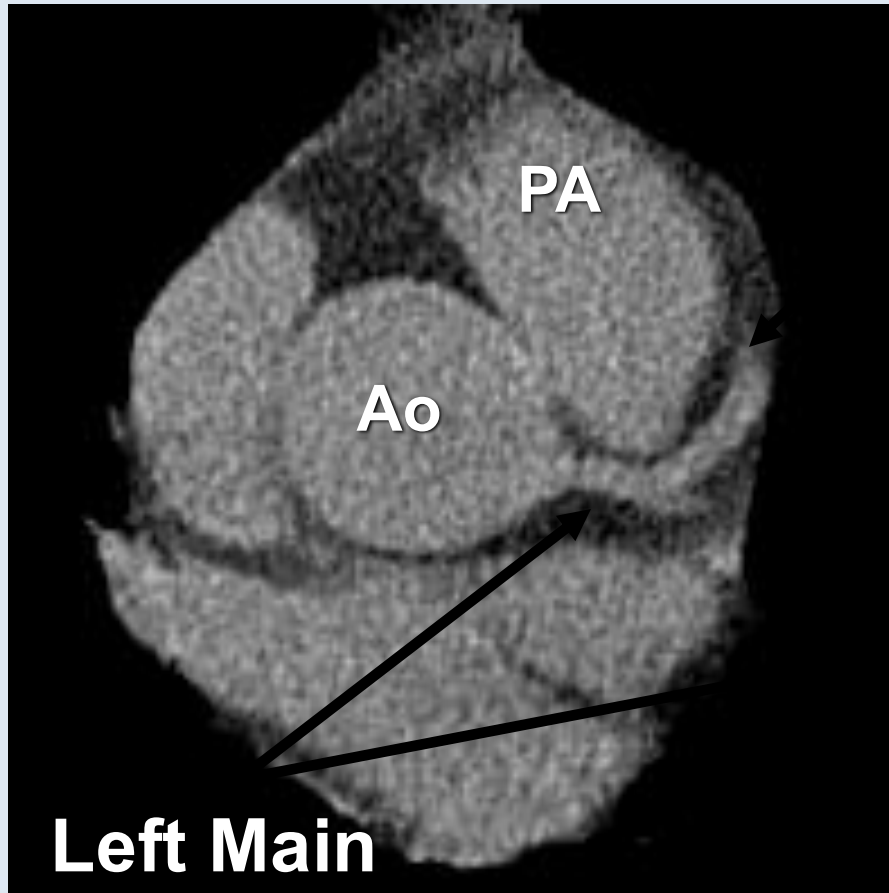
MISSION & OBJECTIVES

Atherosclerosis: Redefining Significant and Aggressive

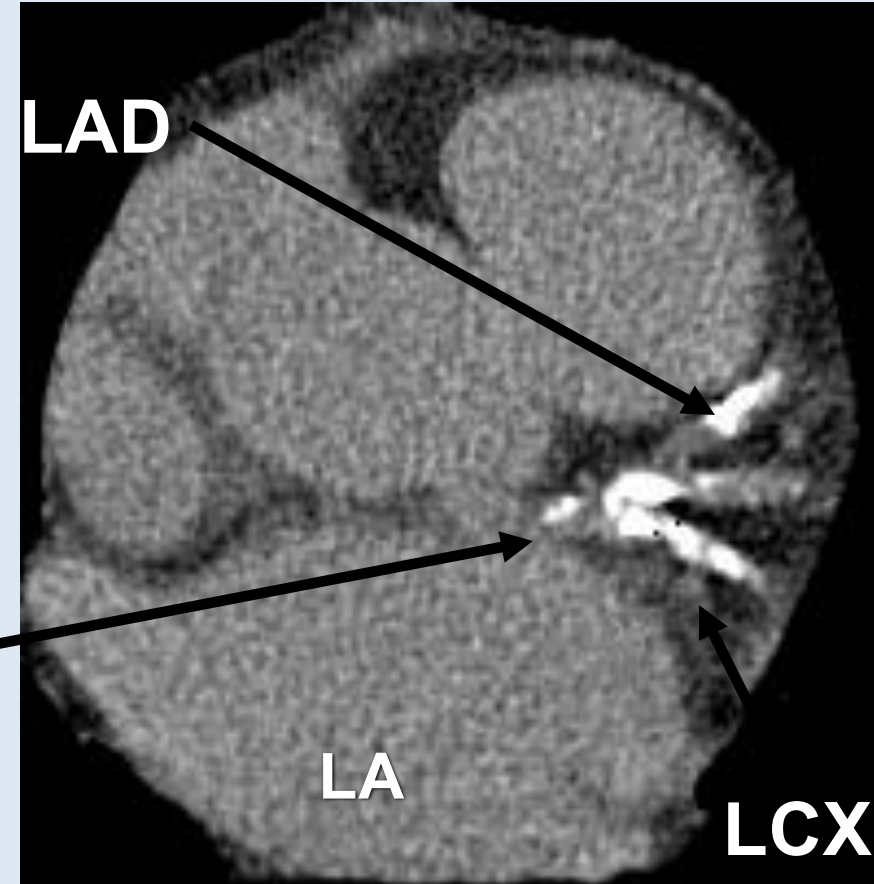
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|--------------|------------------|
| 1. Imaging | 3. Vulnerability |
| 2. Causation | 4. Treatment |

Electron Beam Tomography

No Calcification



Severe Calcification



Carotid Plaque Assessment



Boone Arterial Risk (BAR Score)

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VOL. 84, NO. 15, 2024

Influence of Subclinical Atherosclerosis Burden and Progression on Mortality

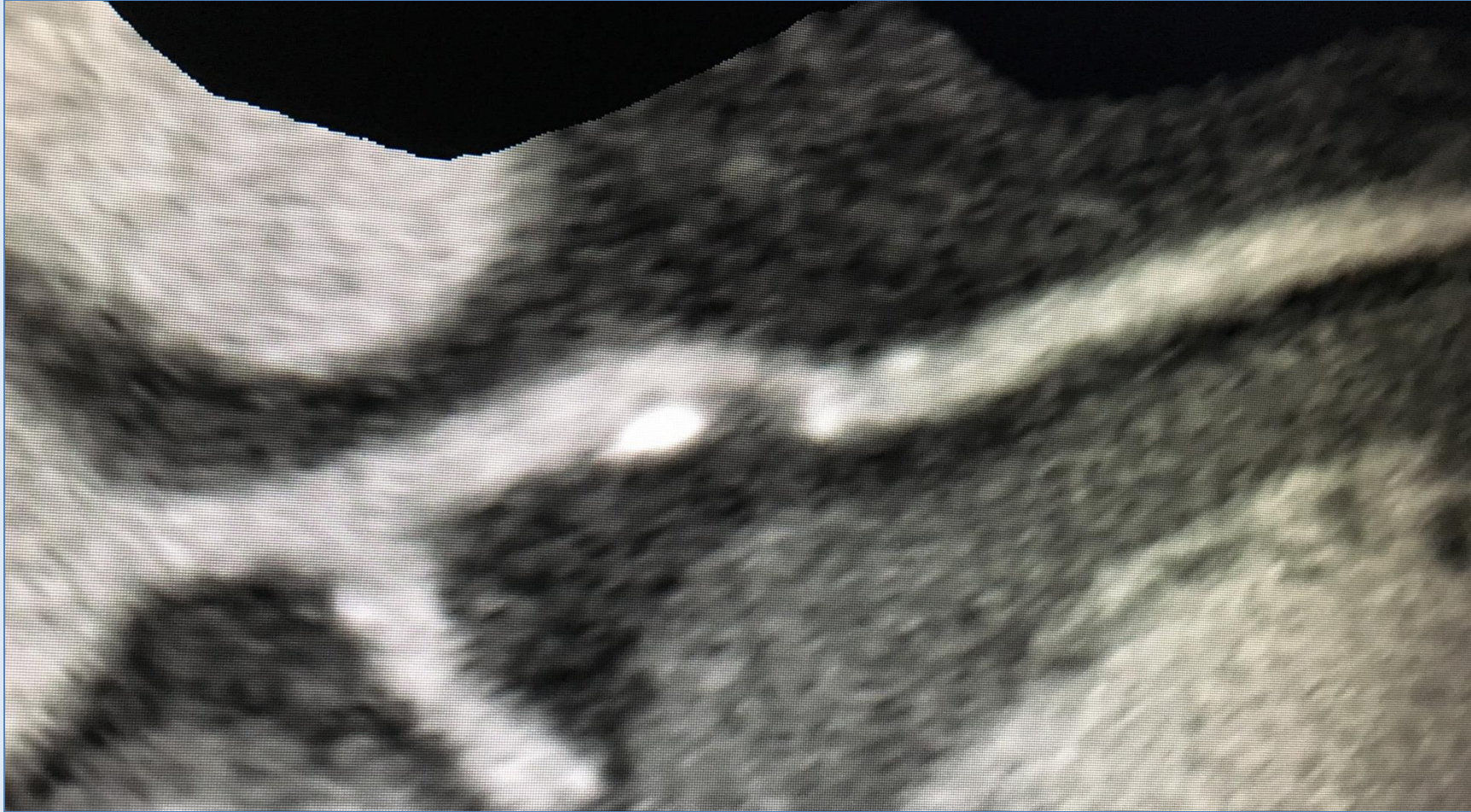


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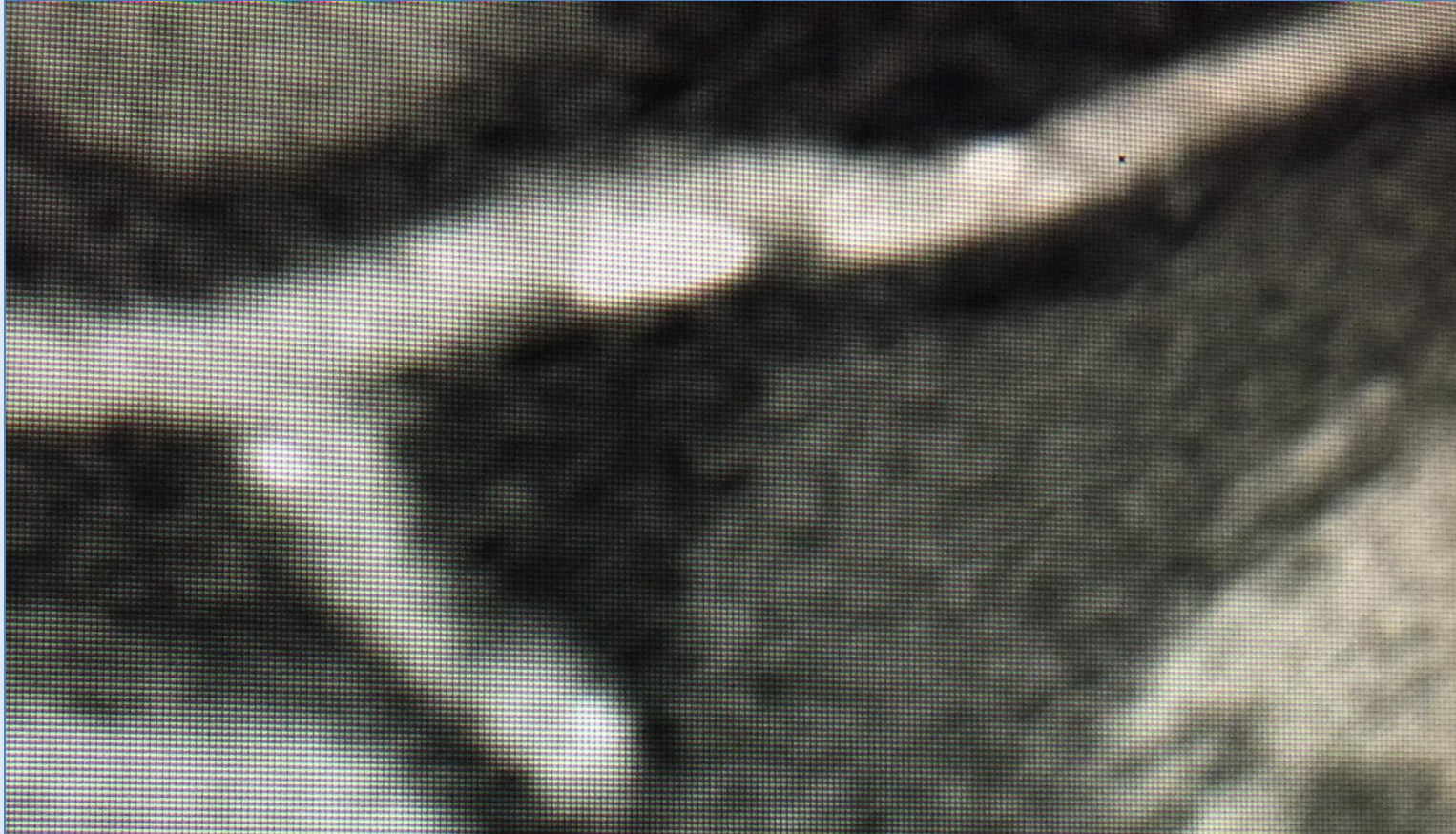


**Boone Arterial Risk
(BAR Score)**

CT Angiography (2007) – 71% LAD Lesion with 20 – 40 HU and CAC of 260

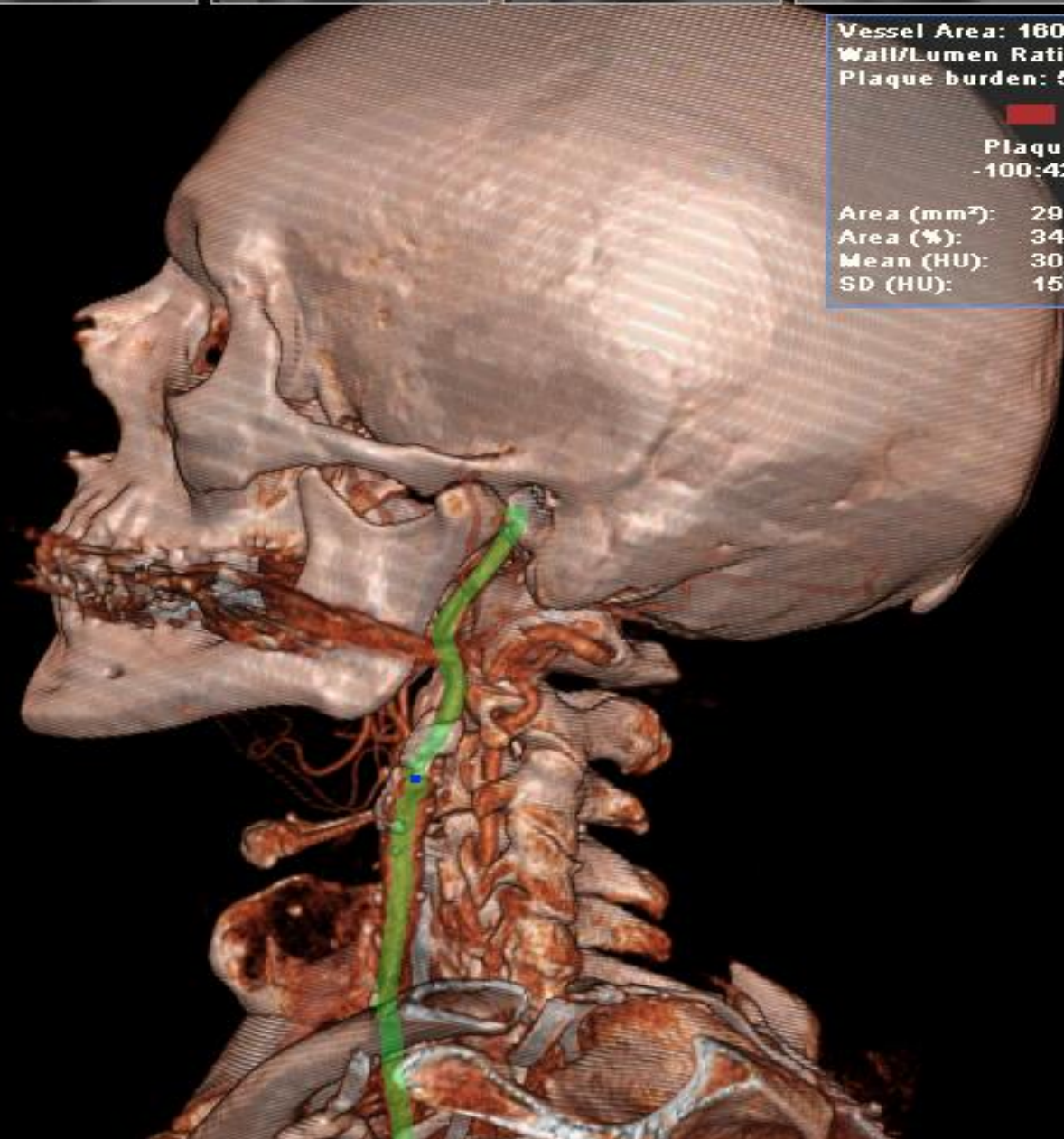
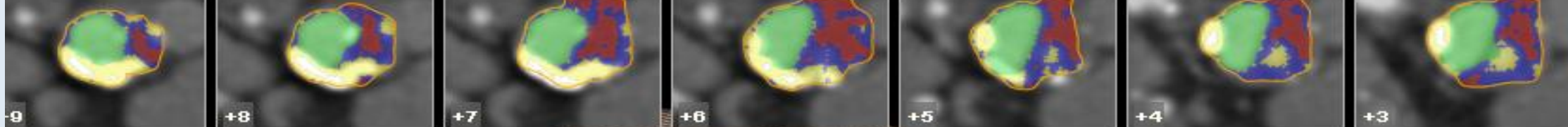


CT Angiography (2016) – 28% LAD Lesion with 90 – 110 HU and CAC of 973



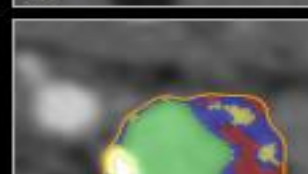
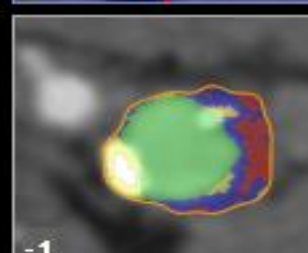
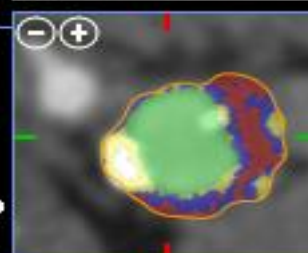
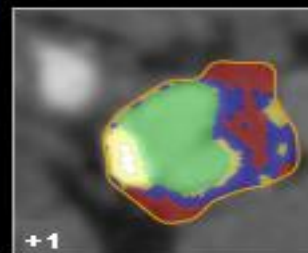
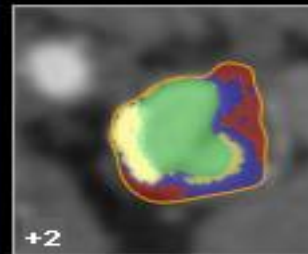
	2007	2016
Age	52	61
Arterial Age	63	41
C-IMT	0.773 mm	0.671 mm
CT Angiography	71% LAD	28% LAD
Hounsfield Units	20 – 40 HU	90 – 110 HU
Coronary Calcium	260	973
Total Cholesterol	268	128
LDL-Cholesterol	158	69
HDL-Cholesterol	41	37
Triglycerides	345	95
Apo B	114	70
hs-CRP	3.5	0.3
Lp-PLA2	175	150
11-dehydro-TXB2	998	574
Blood Pressure (sitting)	161/92	118/86



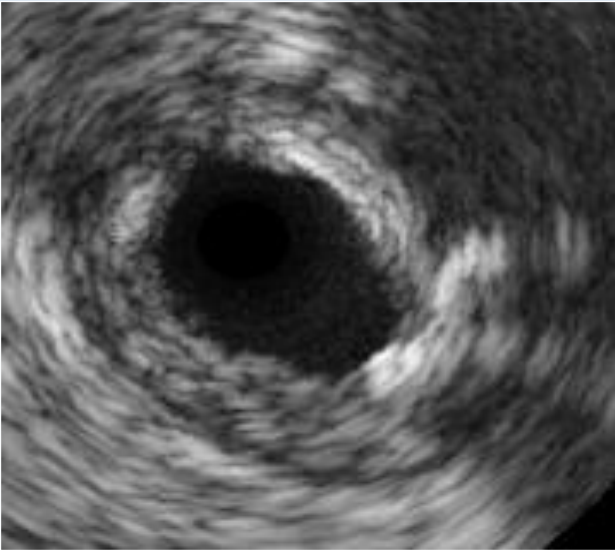


Vessel Area: 160mm²
Wall/Lumen Ratio (Area): 129%
Plaque burden: 56%

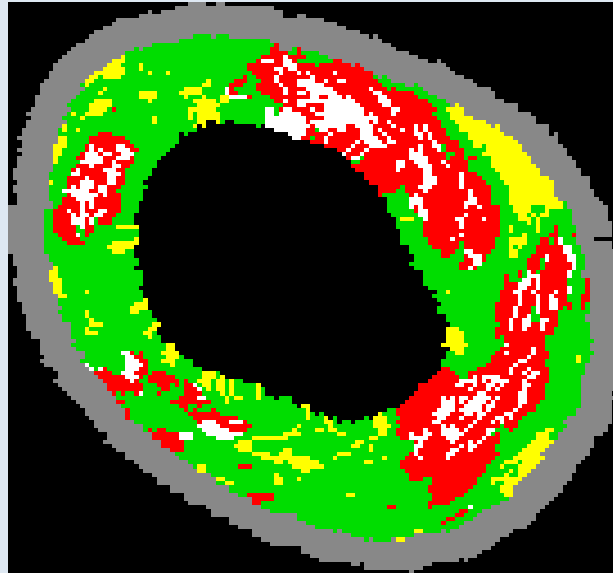
	Plaque1 -100:42	Plaque2 43:149	Calcium 150:1300	All
Area (mm ²):	29.5	34.0	22.6	86
Area (%):	34	39	26	100
Mean (HU):	30	81	425	
SD (HU):	15	35	336	



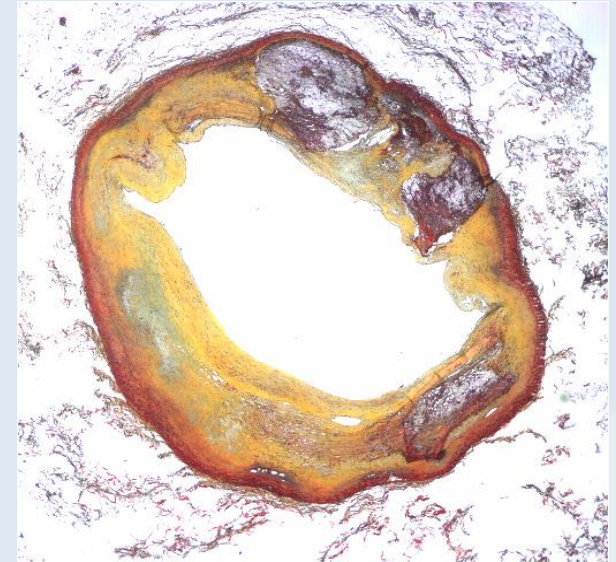
Virtual Histology IVUS vs. Grayscale IVUS



Grayscale IVUS



Virtual Histology



Death (Autopsy)



Founded in 2008, the Boone Heart Institute is driven by a steadfast commitment: eradicating heart disease and stroke within a generation. For over fifteen years, we have led the charge in preventive cardiology, guided by the pioneering spirit of our founder, Dr. Jeffrey Boone. His three-decade journey in preventive medicine, coupled with international lecturing, has shaped our institute into a national leader.

Did you know 70 percent of heart attack victims are considered 'low-risk' by conventional standards? At Boone Heart Institute, we aim to rewrite this statistic. Through advanced testing, early detection methods, and innovative treatments, we transform potential risks into tales of success. Whether you carry a family history of heart disease, have experienced a heart attack, or seek reassurance about your cardiovascular future, Boone Heart stands ready as your ally.

The Boone Heart Executive Physical is a cornerstone of our approach, combining ground-breaking genetic blood tests, advanced full-body imaging, and thorough mental and physical stress assessments. This holistic evaluation identifies your unique cardiovascular risk profile and crafts a personalized plan to optimize your heart health. But our commitment to your health extends beyond the heart. Our growing team of experts in CT imaging, hormone optimization, and high-performance longevity ensure that we stay at the forefront of disease prevention.

At Boone Heart, our physicians take the time to know you, understand your health goals, and empower you to take control of your well-being. To learn more about our Executive Physical or to schedule a free consultation, please visit our website or give us a call.

INTERNAL MEDICINE

BOONE HEART INSTITUTE

JEFFREY L. BOONE, M.D.

5280 Top Doctor 2025

M.D. University of Iowa Roy J. and Lucille A. Carver College of Medicine; Diplomate of the American Board of Internal Medicine; Member of the NFL Cardiovascular Committee from 2010-2013; Preventive Cardiology Consultant for the Denver Broncos of the National Football League

YAZID FADL, MD, MPH, FACC
JAMALUDDIN MOLOO, MD, MPH, FSCCT
BARRY MOLK, MD, FACC
SHERI FOX, PA-C, MMSC, IFMCP
SHANNON TANKERSLEY, PA-C
KARLIE BOONE, PA-C



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BOONE HEART IMAGING

RIBBON CUTTING & GRAND OPENING

Thursday, August 15th, 4-7pm

5:30 Remarks & Ribbon Cutting
 Drinks & Light Snacks Provided

Boone Heart Imaging

7355 E. Orchard Rd., Suite 200
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Scan Here to Learn
 More & RSVP



Arineta SpotLight Duo

Coronary CT Scanner

560 Slices in One Heartbeat





Atherosclerosis Case Study: 53 Year Old Male CEO



Boone Heart Protocol plus PCSK9i

	Initial
Right Carotid Plaque	42%
Left Carotid Plaque	40%
Carotid-IMT (C-IMT)	0.568 mm
Carotid Artery Age	35
Left Femoral Plaque	48%
LDL-Cholesterol	106
Lp-PLA2	224
LAD Stenosis – CLEERLY CTA	61%

Cardiometabolic Report

Test Name	Current		Reference Range/Relative Risk Categories			
	Result & Relative Risk		Optimal	Moderate	High	Units
	Optimal	Non-Optimal				
INFLAMMATION						
Myeloperoxidase ⁽⁷⁾	158		<470	470-539	≥540	pmol/L
Lp-PLA ₂ Activity ⁽⁶⁾	39		≤123	N/A	>123	nmol/min/mL
hs-CRP	0.4		<1.0	1.0-3.0	>3.0	mg/L
Microalbumin/Creatinine	UND		<3.9	N/A	≥3.9	mg/g
Microalbumin	<3.0					mg/L
Creatinine, Urine, Random	24.9			20.0-300.0		mg/dL
ADMA (Asymmetric dimethylarginine) ⁽¹⁾	96		<100	100-123	>123	ng/mL
SDMA (Symmetric dimethylarginine)	91			73-135		ng/mL
F ₂ -Isoprostane/Creatinine ⁽⁵⁾	<0.80		<0.86	N/A	≥0.86	ng/mg
F ₂ -Isoprostane	<0.20					ng/mL
Creatinine, Urine, Random	24.9			20.0-300.0		mg/dL
LIPIDS						
Lipid Panel						
Cholesterol, Total	88		<200	N/A	≥200	mg/dL
HDL Cholesterol	56		≥40	N/A	<40	mg/dL
Triglycerides			<150	150-199	≥200	mg/dL
LDL Cholesterol, Calculated	7		<100	100-129	≥130	mg/dL (calc)
Chol/HDL-C	1.6		≤3.5	3.6-5.0	>5.0	calc
Non-HDL Cholesterol	32		<130	130-189	≥190	mg/dL (calc)

**Boone Heart Protocol
Plus PCSK9i Therapy
for 9 Months**

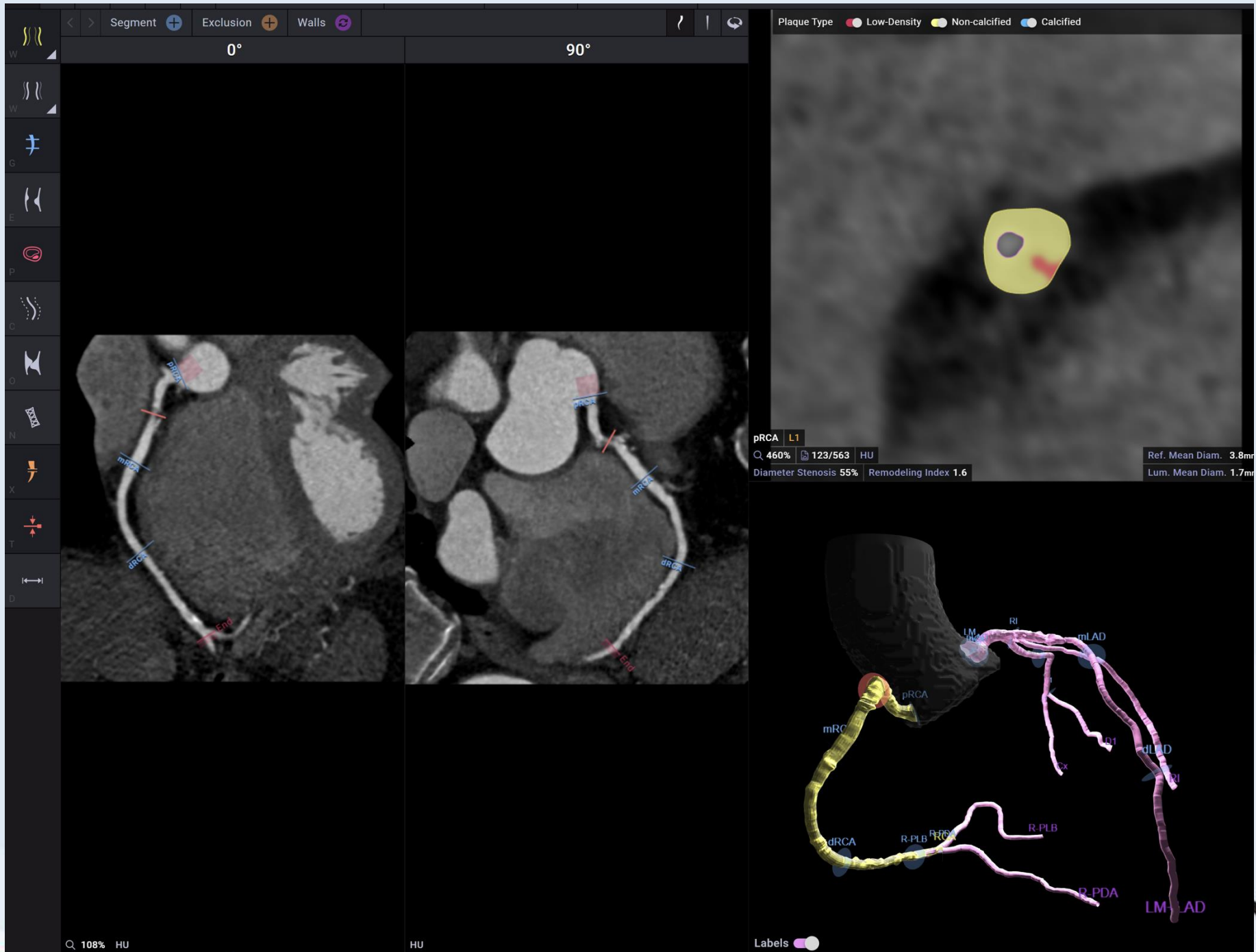


Atherosclerosis Case Study: 53 Year Old Male CEO

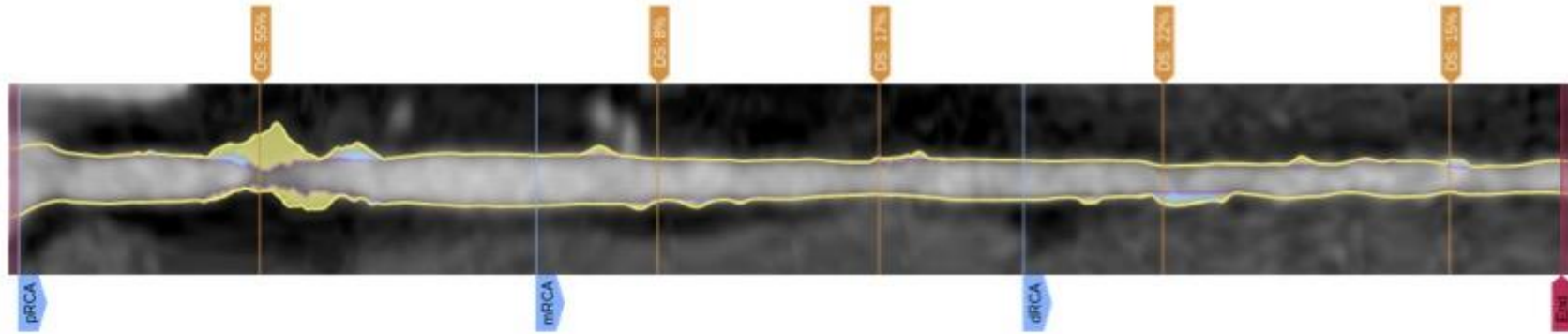


Boone Heart Protocol plus PCSK9i

	Initial	Follow Up
Right Carotid Plaque	42%	28%
Left Carotid Plaque	40%	28%
Carotid-IMT (C-IMT)	0.568 mm	0.442 mm
Carotid Artery Age	35	13
Left Femoral Plaque	48%	30%
LDL-Cholesterol	106	7
Lp-PLA2	224	39
LAD Stenosis – CLEERLY CTA	61%	34%



Right Coronary Artery (RCA)



332.8 mm³ 22.8% PAV
Total Plaque Volume

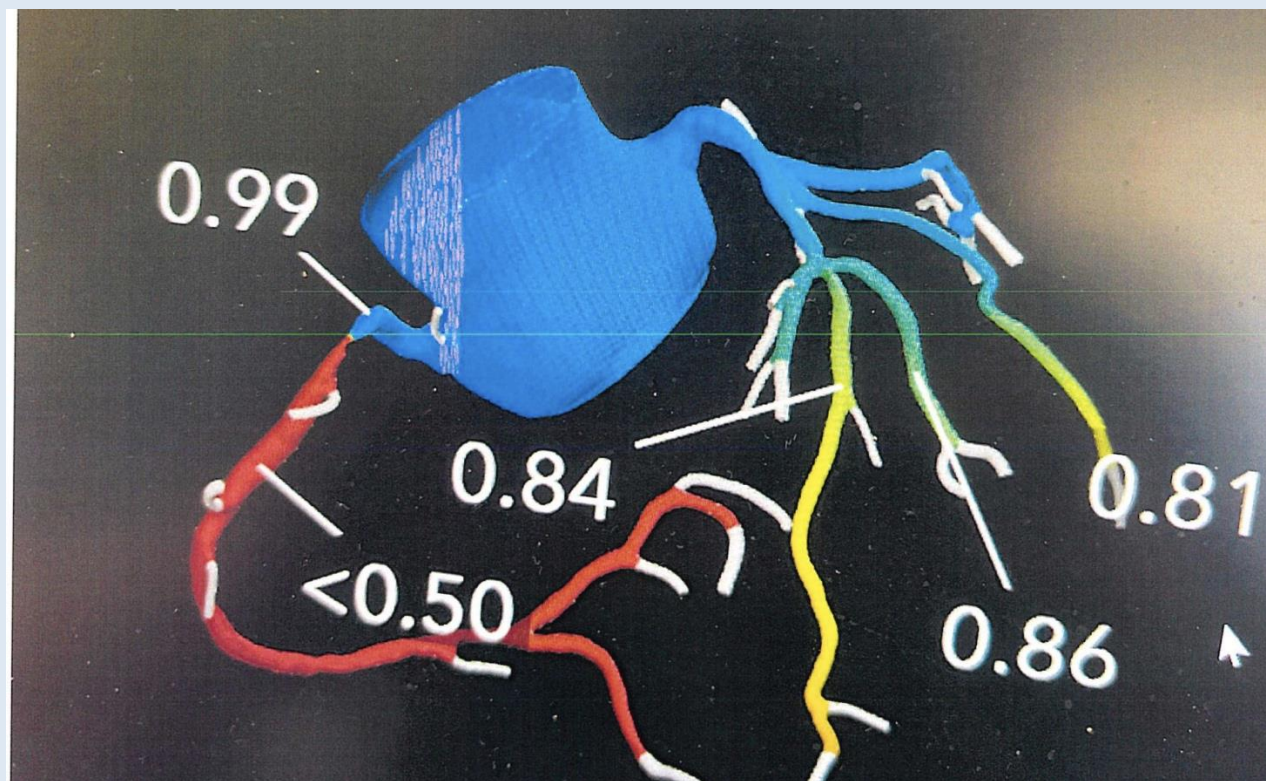
1.7 mm³ 0.1% PAV
Low-Density-Non-Calcified Plaque Volume

238.2 mm³ 16.3% PAV
Total Non-Calcified Plaque Volume

94.6 mm³ 6.5% PAV
Total Calcified Plaque Volume

55% Greatest Diameter Stenosis

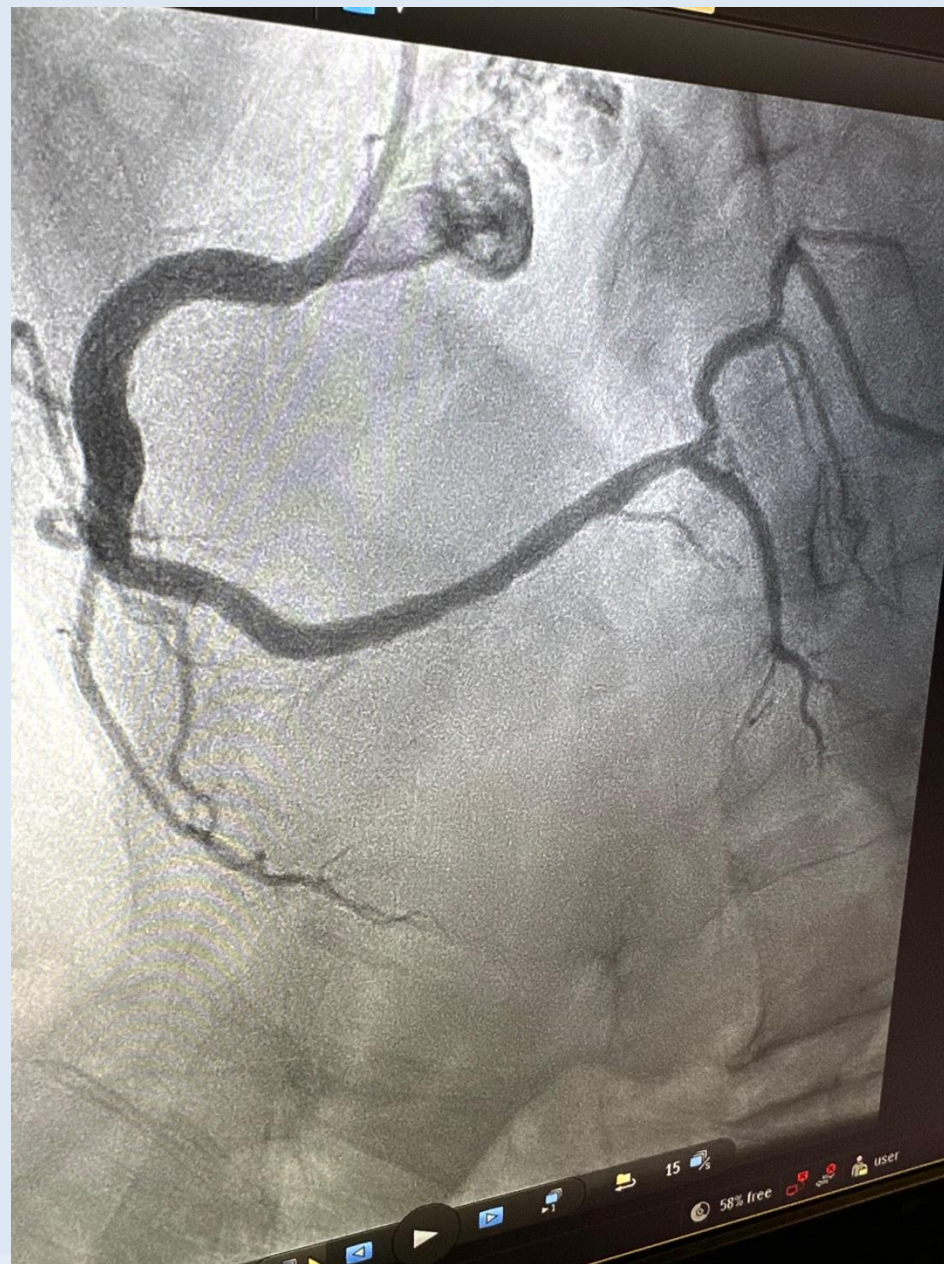
1.6 Highest Remodeling Index





79 Year Old Retired Veterinarian

Coronary Angiography before Stent.



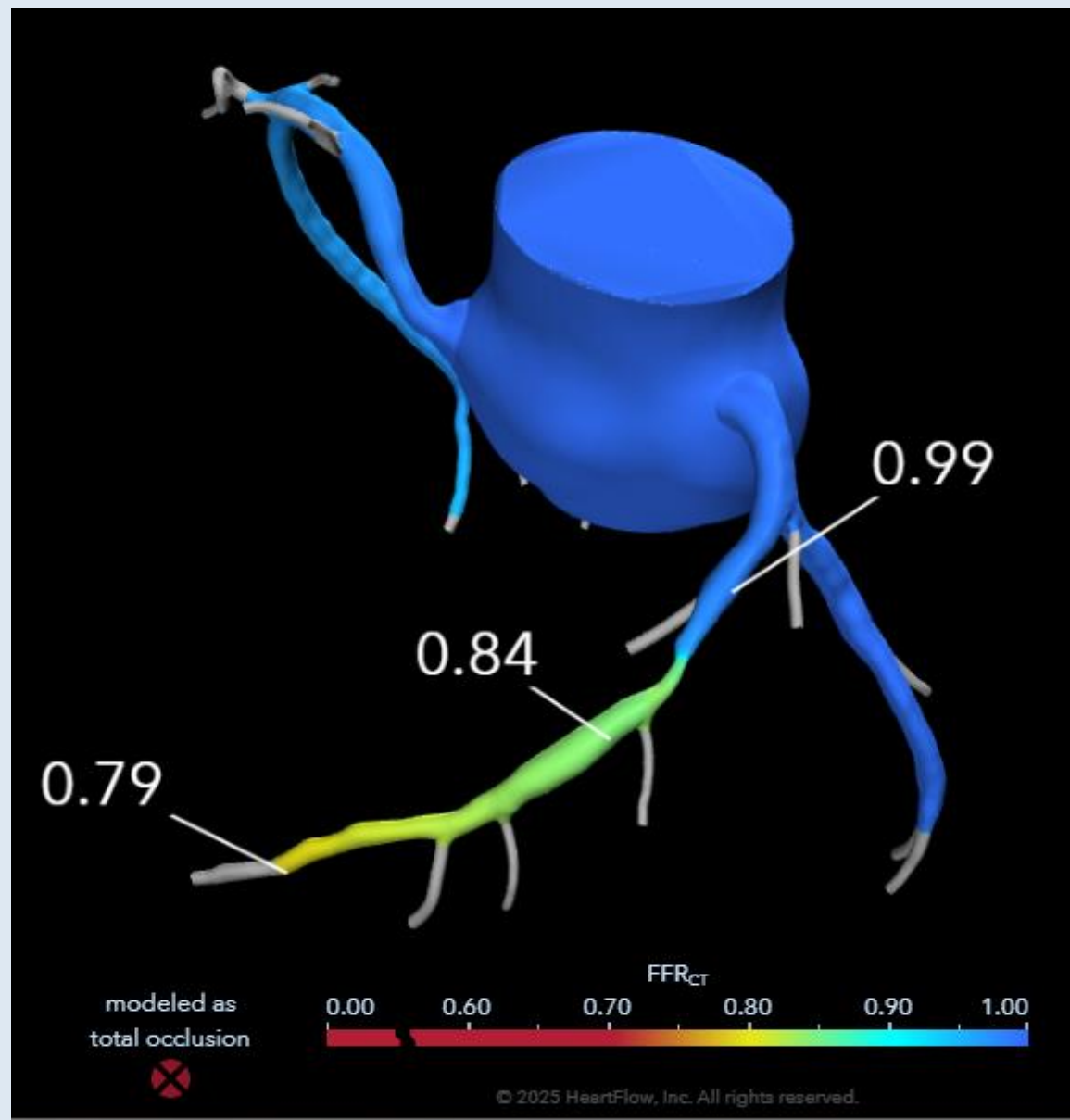
79 Year Old Retired Veterinarian

Coronary Angiography after Stent.



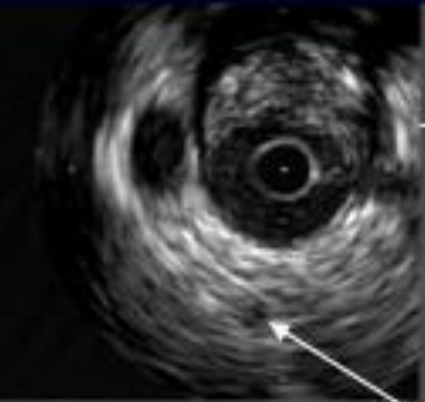
65 y/o Male Former Professional Skier

- Calcium Score of 0 at age 60
- Scanned with Arineta Spotlight Duo 360 CCTA January 2025 at Boone Heart Imaging
- Cleerly, HeartFlow, Elucid AI Plaque and FFR Analysis
- 68% proximal luminal LAD stenosis (Cleerly)
- 0.79 Initial FFR-CT (HeartFlow)
- 23.6 mm³ of Lipid-Rich Necrotic Core in atherosclerotic lesion (Elucid)

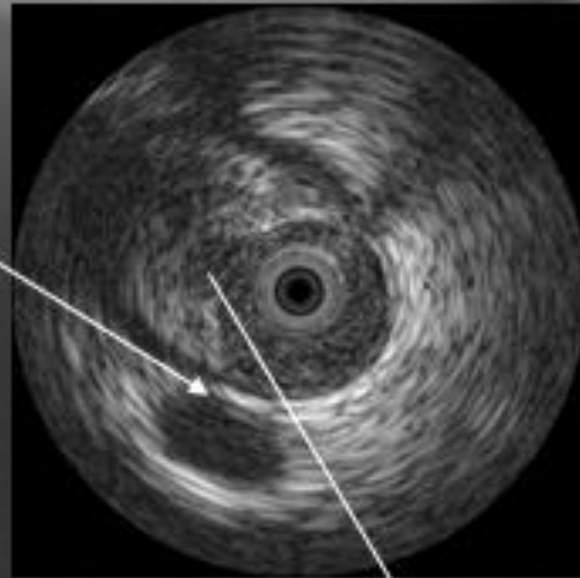


Assessing both Anatomy and Biology

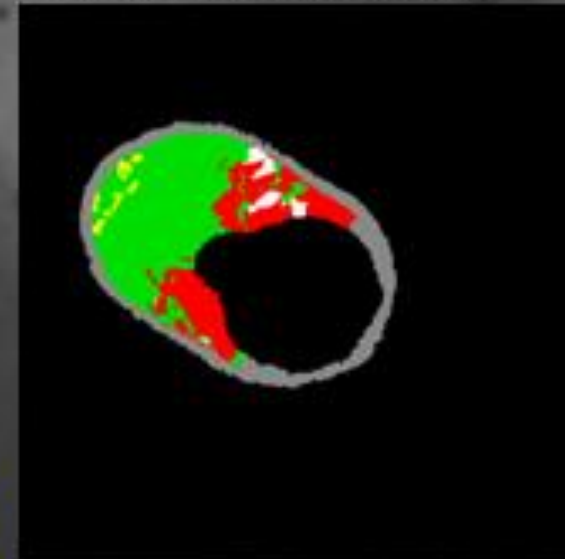
Conventional IVUS



RF-backscatter IVUS

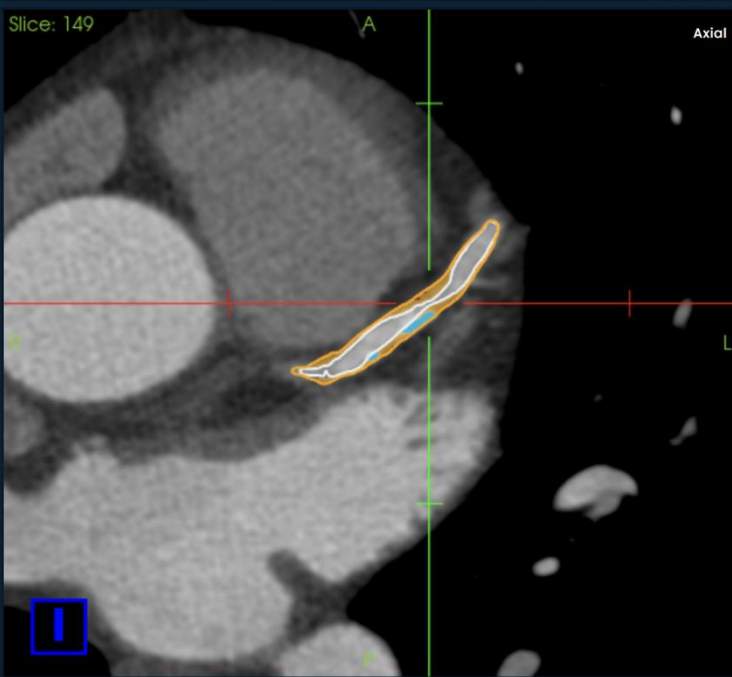
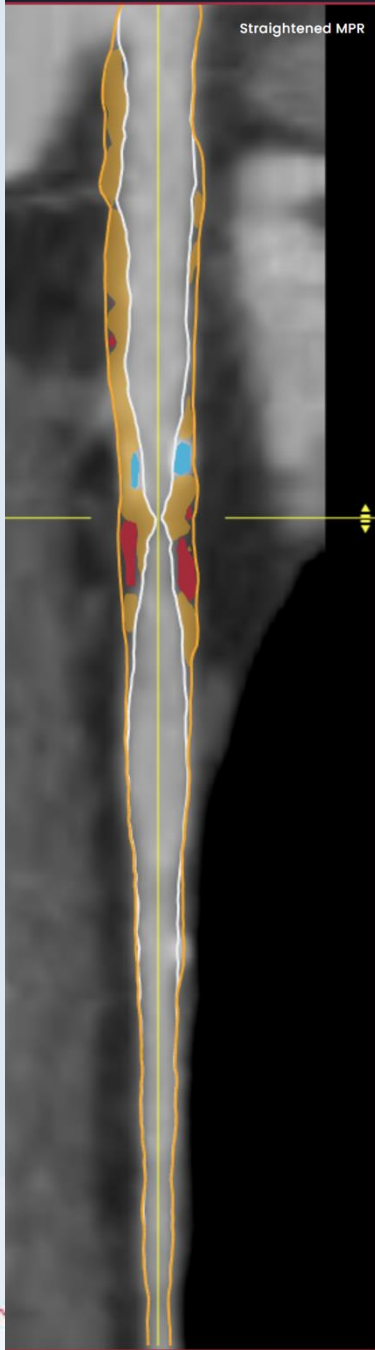


Virtual Histology IVUS

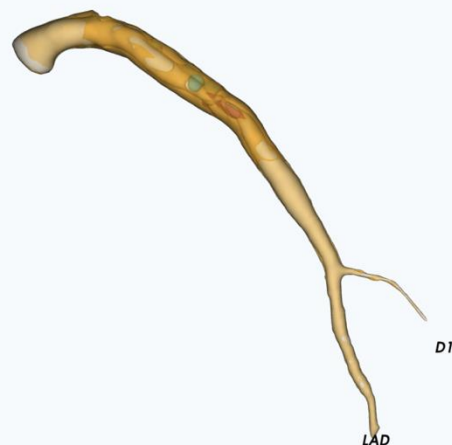


**Both shoulders of the plaque filled
with lipid necrosis at the proximal LAD**

Courtesy of Stanford

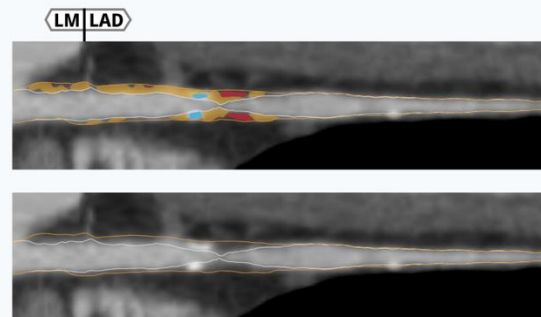


Plaque Components: Left Main + Left Anterior Descending



LM + LAD · Plaque

Distal

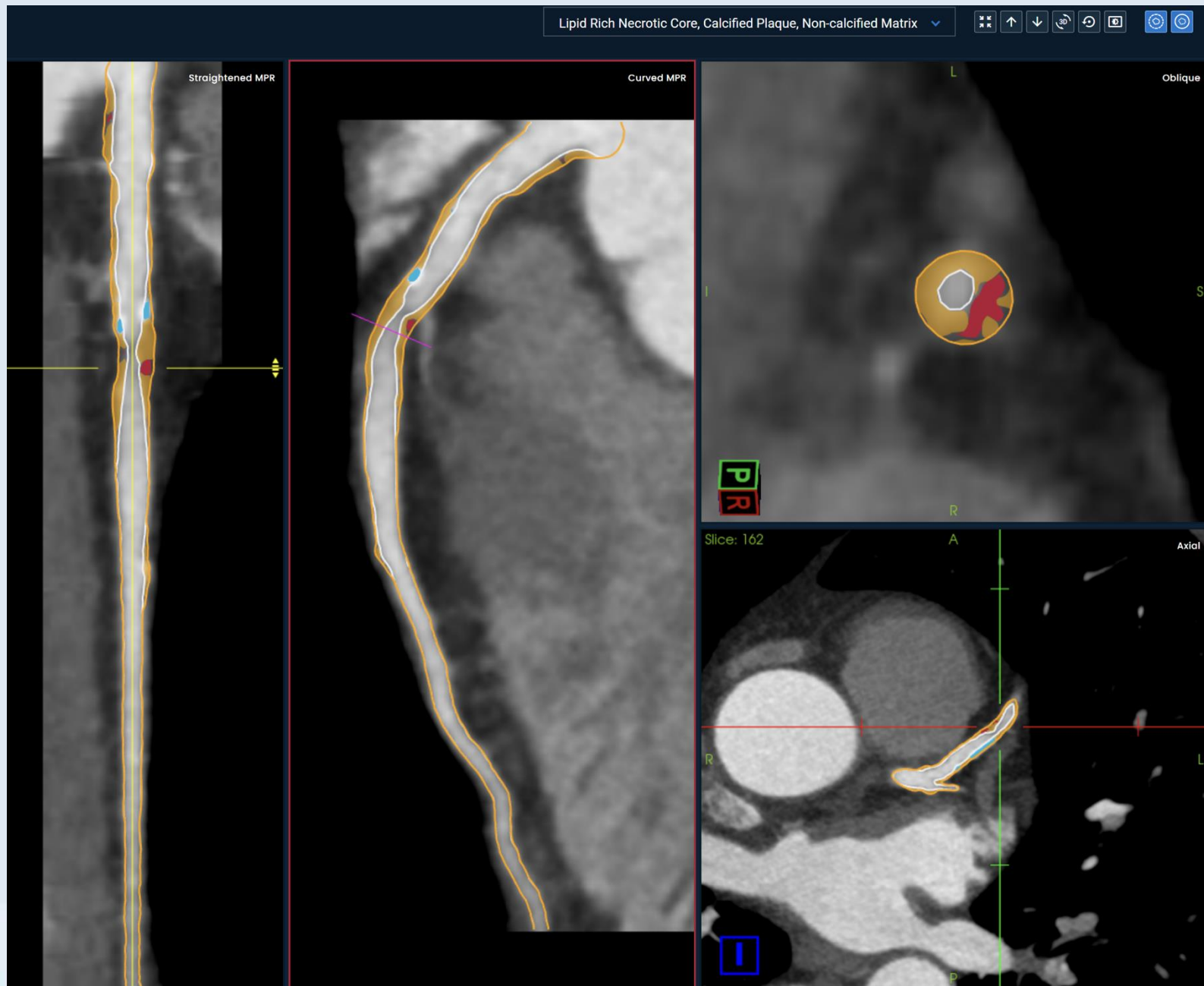


D1 · Plaque

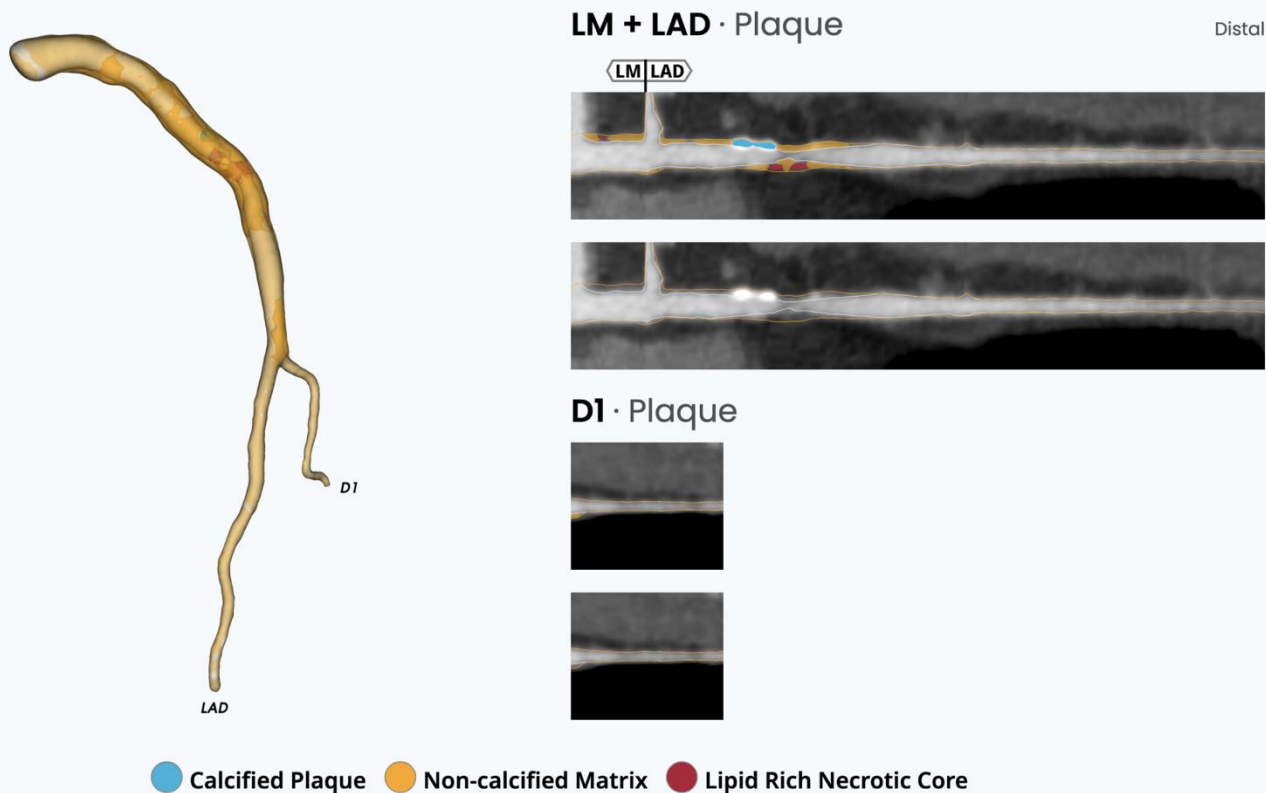


● Calcified Plaque ● Non-calcified Matrix ● Lipid Rich Necrotic Core

Territory	Calcified Plaque (mm ³)	Non-calcified Matrix (mm ³)	Lipid Rich Necrotic Core (mm ³)	Total Plaque Volume (mm ³)
LM	0	40.7	4.3	45
LAD	33	227	23.6	283.6
D1	0	0	0	0



Plaque Components: Left Main + Left Anterior Descending



Territory	Calcified Plaque (mm³)	Non-calcified Matrix (mm³)	Lipid Rich Necrotic Core (mm³)	Total Plaque Volume (mm³)
LM	0	42.9	3.7	46.5
LAD	27.3	184.2	14.9	226.3
D1	0	1.4	0	1.4



- Boone Heart PCSK9i treatment 1/06/25
- Initial CCTA 1/06/25
- Repeat CCTA 6/12/25
- LDL Cholesterol: **129** → **1**
- Apo B Atherogenic Particles: **91** → **9**
- Clearly Luminal Stenosis: **68%** → **68%**
- Heartflow FFR: **0.79** → **0.74**
- Elucid Total Plaque Volume (LAD):
283.6 mm³ → **226.3 mm³**
- Elucid Lipid-Rich Necrotic Core (LAD):
23.6 mm³ → **14.9 mm³**








The Eradication of Heart Attack: The Role of Coronary CTA



The Future of Cardiac CT: Workforce, Technology, and Clinical Outcomes

Agenda

Topic	Speaker	Title	
Welcome	Sayali Tarlekar, MBA, MPH	Global Head of Marketing, Arineta	
Scaling a Coronary CTA Program with a Dedicated Small Footprint Cardiac CT	Jonathon A. Leipsic, M.D., F.R.C.P.C. M.S.C.C.T	Past President – SCCT and SCCT Gold Medal Winner	
The State of the CT Tech: Workforce Transformation for Cardiac CT Growth	Jaime Warren Ed.D, MBA, BHS, CNMT, NCT, FACC	Vice President, Care Transformation Services, MedAxiom	
The Eradication of Heart Attack – The Role of Coronary CTA	Jeffrey Boone, MD, MS	Founder and Director, Boone Heart Institute	
Q&A and Ending Comments	Doug Ryan	CEO, Arineta	

Q&A

- Contact info: marketing@arineta.com
- Visit www.arineta.com

