This transcript is intended to provide webinar content in an alternate format to aid accessibility. We apologize for any inaudible or unclear content as a result of audio quality.

Prevention Cardiac Learning and Action Network

Presented by Hilary K. Wall, MPH, Centers for Disease Control and Prevention and Katy Vennum, MPH, American Heart Association * 47 minute webinar * 04-11-2012

Jeri Hiniker: Thank you, and welcome everyone this afternoon to the Prevention Cardiac Learning and Action Network’s first webinar. I’m going to get started because we have a lot of information to cover.

Our presenters today will be Hilary Wall, a Health Scientist from the Division of Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention. She currently provides scientific expertise to support the Department of Health and Human Services, Million Hearts Initiative and areas including clinical quality measurement, clinical support and health information technology. Prior to joining the CDC in 2009, Hilary spent five years as an epidemiologist for the Massachusetts Department of Public Health, Heart Disease and Stroke Prevention and Control Program.

We also have Katy Vennum, a health IT program consultant at the American Heart Association National Center, supporting the Guideline Advantage Program. Katy has been in quality and health IT for the American Heart Association since 2010.

My name is Jeri Hiniker and I’m a program manager at Stratis Health and QIO for Minnesota.

For our agenda today we’ll first be covering a quick outline of the Prevention Cardiac Project. Many of you are probably familiar with this already. Then we’ll have the Million Hearts Campaign and Guideline Advantage, and we should have time after each presentation for Q&A. We also have a time that we can take care of any other questions you might have and also to discuss the opportunities that are open as part of this collaboration.

An outline of the prevention project, the focus of the overall prevention project is to improve health for populations and community. We started this work at the Quality Improvement Organization for each of the states in August of 2011 and it runs through July 31, 2014, the work that we’re doing.

There are a number of areas that the entire prevention project focuses on. We’re working with clinics and providers to improve specific cardiovascular measures, which is what we’re going to focus on today as part of the Cardiac Learning and Action Network. Some of the other work in part of this prevention project that many of you might be part of is looking at improving participation in the physician quality reporting system or PQRS.

We’re also working with our regional extension centers and clinics to improve population health overall and prevention measures. We’re also working to integrate health information technology to improve care coordination and prevention.

So since today we’re talking about the Cardiac Learning and Action Network, I just wanted to talk a little more about what the cardiovascular health learning and action network is looking at.
Our goal is to support the clinics and providers in achieving improvement into specific cardiovascular measures, which we'll discuss in more detail later.

**How can we help you look at those specific measures which many of you are already pulling data on?**

**How can we look at using core improvement and health information technology to help you do better in those measures?**

We'll also be supporting the clinics and providers in being able to pull that quarterly data per those measures and then using those measures to help them improve their care. Then we'll be providing you with best practices and learning opportunities and resources such as Million Hearts Initiative and Guideline Advantage, both are different ways that you can look at best practices and how you can improve in providing cardiac care to your patients. So the overall goal then is to show improvement in the specified cardiac measures.

The measures in our Cardiac Learning and Action Network, many of you when I've talked with you and the other QIOs are measures that everyone is already pulling or looking at improving, so its looking at and improving in the percentage of Medicare patients with coronary artery disease or peripheral vascular disease with blood pressure greater than 140/90, so getting improvement in that area.

Looking at Medicare patients again, whose LDL screening was greater than 100 also, showing improvement for Medicare patients with ischemic vascular disease who have documented use of aspirin and then the percentage of Medicare patients and improvement for those who have received smoking cessation.

A quick overview of the Learning and Action Network, it's a kind of term that you may be familiar with, but its looking at mechanisms for proctoring large scale improvement. It's seeing things that many of you have done before, that rapid cycle improvement, taking what you've learned and putting it in place with your clinic with your providers and have you seen improvement and then what do we need to treat to help you make those improvements.

Consciously managing the knowledge that is a valuable resource, so providing you with those tools and resources, learning from those best practices and getting that information out to the larger group, as well as making sure there are opportunities for you to use this information, look at the skills you have in place and how you can use what you have in your clinic to better provide care.

Then, not only do we want to bring everybody together in collaboratives, most of you have participated in different collaboratives before but it's that spread so even though I gave you years of when this started and how far it goes. What our hope is for this is that really this is a group that can come together as part of this collaborative that we're forming right now but is something that even after 2014 everybody continues with it. You have the resources and connections so you can continue to share best practices with each other.

I'm going to move on to the Million Hearts Campaign. First we'll hear from Hilary Wall.

**Hilary Wall:** Thank you for the opportunity to talk with you all today about an initiative that's very near and dear to my heart, probably because it contains some of my blood, sweat and tears and that is the Million Hearts Initiative.

This initiative was kicked off in September of 2011, but myself and others at CDC and Centers for Medicare and Medicaid Services (CMS), have been working on this initiative since fall of 2010, so there has been a lot of thought and preparation that's gone into the launch of Million Hearts.
Why focus on heart disease and stroke?

You’re likely all familiar with the statistics from the slide showing heart disease and stroke account for a large burden of both morbidity and mortality in the U.S. There are more than 2 million heart attacks and strokes each year and almost 800,000 of those result in death. Heart attack and stroke are also a financial burden on the healthcare system, accounting for one out of every six healthcare dollars spent.

We know there are a handful of proven aspects of care that are shown to prevent heart attack and strokes. At CDC we lovingly refer to these as the ABCs. We have aspirin for those who need it, blood pressure control and cholesterol management and smoking cessation. We know that implementing the ABCs holds potential and can save tens of thousands of lives each year.

When we look at national surveillance data on delivery of the ABCs, there is definitely room for improvement. As you can see on this slide, less than half of hypertensives have their blood pressure controlled, fewer than one in three people have their high cholesterol controlled and smoking tactics look even worse.

Of the 65 million Americans with hypertension, 37 million are uncontrolled and/or unaware of their condition, 17 million are treated but aren’t controlled and 6 million are aware that they have hypertension but aren’t currently treated. Some of this can be explained by people not seeking regular medical attention or not adhering to their medication regimen.

When we look at Medicare data, which on the slide happened to be 2008, the most common conditions among Medicare beneficiaries are hypertension, high cholesterol, heart disease and diabetes, all of which can benefit from optimizing treatment from the ABCs.

So, to address this burden that I’ve just outlined of cardio vascular disease in our country, the U.S. Department of Health and Human Services launched the Million Hearts Initiative. Million Hearts is being co-led by the CDC and CMS and the goal overall is to prevent one million heart attacks and strokes in the next five years by engaging the public and private sectors to implement a focused and coordinated approach to a set of levers that will reduce the number of people who need treatment and provide optimal care for those who do.

If you’re interested in formally becoming part of the Million Hearts Initiative, you can take a pledge if you visit our website at MillionHearts.hhs.gov and there’s quite a bit of informative information on the website, which will be updated periodically with tools and other resources that may be useful to everyone.

In addition to CDC and CMS, there are a number of public partners who are working on this initiative which include: Health Resources and Services Administration (HRSA), which does a lot of work with health centers across the country; Office of the National Coordinator for Health Information Technology (ONC), who are pushing the agenda on implementation of electronic health records in our country and also have a lot of wonderful grantees they fund including the Regional Extension Centers and Beacon Communities; Agency for Healthcare Research and Quality (AHRQ); Indian Health Services and a number of other agencies who are at the table and actively engaged in this initiative.

Next you’ll see a sample of the private partners who have come to the table to be part of Million Hearts. For example, we’re partnering with the American Medical Association, the American Nurses Association, the American Pharmacists Association and we have advocacy organizations like the American Heart Association at the table, corporate pharmacy’s, insurance providers and a number of other folks, again who are all actively engaged in the Million Hearts agenda.
Million Hearts aims to impact heart attacks and strokes through a two-pronged approach—community and clinical prevention.

On the community side, we’re focused on mostly policy work designed to reduce tobacco use and exposure to second-hand smoke, things like health warnings on cigarette packaging, reducing sodium content of food, so things like menu labeling requirements for restaurants as well as eliminating artificial trans fats, much of which is working with the industry to expand voluntary food reformulation initiatives.

On the clinical side, we’ve got initiatives that revolve around the ABCs, health information technology and clinical innovations.

So based on the folks around us I’m going to focus in on these three a little further.

Focusing on the ABCs is a priority so that over the next five years we can monitor progress of the concerted efforts behind Million Hearts using a simplified, uniformed evidence-based set of measures. Multiple federal agencies are actively working on performance on the ABCs intentions as well, which I think is an important piece of the puzzle.

On the next slide there is a lot of information, but I want to take a little time to go through this. A winding of the ABCs clinical quality measures across public and private sector activities is a real priority for Million Hearts and is actually where I spend much of my time. The purple text on the slide highlights alignment activities that have occurred as a result of the Million Hearts Initiative.

The overall take home message from the slide is that many of the partners involved in Million Hearts are working hard behind the scenes to streamline public health reporting and focus on similar clinical quality measures, at least as they relate to cardiovascular disease, but I can’t speak beyond that. We have heard loud and clear that providers have so many options for voluntary reporting, as well as mandates for reporting and it just makes good common sense to try to streamline the measures across those different initiatives, in this case as it pertains to cardiovascular disease but my hope is that we’ll set an example for cardiovascular disease that can then prescribe to other conditions.

The first column shows you the domains of the Million Hearts clinical quality measures and when the Million Hearts team, which is comprised of clinicians and scientists from CDC, CMS and ONC, we selected our focus set of ABC clinical quality measures. Great care was used to achieve measures that were evidence-based, supported the goals of the initiative and best reflected population outcome. Whenever possible we selected measures that had been extensively evaluated and widely vetted.

So, I will tell you that CMS staff has worked incredibly hard to incorporate these measures into a variety of their sponsored activities. For example, in the second column they incorporated all the Million Hearts measures into the voluntary twenty-fold, physician quality reporting system or PQRS, which Jeri highlighted as a focus of this Learning and Action Network.

By doing so they spread that to the development of a cardiovascular prevention measures group, which is the third column in the table and again is part of PQRS as one of the reporting options. And, they also included the Million Hearts measures in the group practice reporting option, which is the fourth column.

Choosing to voluntarily report on the Million Hearts measures is a really easy way for providers to support our initiative. So if you’re interested in participating in PQRS, you have a number of different reporting options, all of which support the Million Hearts measures.
The next column shows that if your practice is planning to be an accountable care organization through the Medicare shared savings program then you will also be required to report on the Million Hearts measures. Many of you are likely also with the Medicare and Medicaid electronic health record incentive program, often known as Meaningful Use and stage one of Meaningful Use was already under way when we chose the Million Hearts measure set, so we used the clinical quality measures in Meaningful Use to inform our work.

As column six shows, many of the Million Hearts measures were in the optional menu set of clinical quality measures in Meaningful Use for stage one. Then in March of 2012, a notice of proposed rule making for stage two of Meaningful Use was published and in it the main Million Hearts clinical quality measures are now part of the proposed core stats, which is reflected by the purple text in the Meaningful Use column.

I think that’s a huge accomplishment that we’ve been able to move the levers on some of these policy heavy hitters of PQRS and Meaningful Use to get a streamline set of clinical quality measures.

I’ll briefly mention the last column in that most of the Million Hearts measures are endorsed by the National Quality Forum (NQF), which if you’re not familiar with them, is basically a clearinghouse of quality measures. They endorse national consensus standards for measuring and publicly reporting performance. When we compiled the Million Hearts clinical quality measures we looked at the NQF endorsed measures as one of our starting points. So as a result, most of the Million Hearts measures are already endorsed by NQF and the new Million Hearts cholesterol control measure was recently submitted to NQF for endorsement as well. To me this is a huge accomplishment.

Million Hearts also recognizes the value of Health Information Technology in managing patients with chronic conditions. For example, population locations with a given condition like hypertension or high cholesterol can all be managed using electronic registries. Clinical decision support tools like prompts and point of care assessments can be employed to support provider decision-making and patient reminders and education materials can be generated for each patient’s context.

I think we’re actually very lucky that we have this national momentum behind the implementation of electronic health records, because with it comes an entire army of technical assistance providers, who are in the field to specifically help clinicians implement electronic health records. Some of those include your quality improvement organizations, who we have here with us, regional extension planners, your state departments of health are geared up to try and help in this area.

Some communities across the country have beacon communities as well and there are others who are poised to provide assistance in this area.

I can’t stress this point enough, we recognize in the Million Hearts team as well as other federal partners, that health IT is not the be all end all. It’s important though to acknowledge that technology is one tool in a clinician’s toolbox and it will never replace a provider’s clinical decision-making ability. As all of you with us here know too well, the bottom line is that computers do not practice medicine.

On the next line I think this is funny but, in order for health IT to really be effective it must be implemented in a comprehensive fashion and well integrated into clinical practice in a very meaningful way.

Our third area for clinical prevention levers is clinical innovation and much of the Million Hearts innovation work is being spearheaded by the CMS Innovation Center, HRQ and CDC and that work includes developing new models of care delivery, like a combo care organization and vetting the ABCs within those programs and then incentivizing delivery of related quality services.
Million Hearts is also doing a wide variety of work that supports the use of multi-disciplinary teams that utilize pharmacists, community health workers and other non-traditional providers. HRQ and CDC are also convening an innovation summit this month to identify and disseminate strategies that improve ABC delivery.

Where do all of you fit in, because to me that’s the important piece and takeaway from this call? As you participate in this Cardiac Learning and Action Network, the work you do focused on the ABCs will greatly help move forward the national agenda for heart disease and stroke prevention, I can’t stress that enough.

Participating in this learning and action network, I think, offers many potentially synergistic opportunities. I think it allows you to learn from other providers who are trying to make some more impacts in their patient populations. It offers you access to great partners like your QIO, department calls and the heart association, all of whom have expertise in quality improvement, health promotion and disease prevention. Lastly, it offers you an outlet for innovation, which I think is important.

I personally look at participating in the Cardiac Learning and Action Network encourages you to think outside the box and implement creative solutions. All across the country state quality improvement organizations are convening groups of providers just like yourselves to address cardiovascular disease. Federal agencies like CMS and CDC will be looking to your leadership and the great work that you’re doing to help identify best practices that we can then share with other providers.

One way that Million Hearts does this is a mechanism called ‘Progress Notes’. If you go to the Million Hearts website you’ll find a tab that shows some of the progress notes we’ve started to highlight and we would love to be able to highlight your good work in this manner as well. So I encourage you that as you find initiatives that work with your patient population, as you put new innovations into practice, I encourage you to share those with the Million Hearts team and you can always reach out to me or others through the contact information on the website, because we would love to highlight the good work you’re doing.

Next is a list of Million Hearts resources if you’re interested in learning more about the initiatives. The website does have great information and we’ll be posting more information periodically. I’ve also listed a few publications that have been written which summarize Million Hearts and some of the data behind the initiatives. I’ve also listed my email address, so if you have any questions or comments. If you just have thoughts to share I would be open to hearing from you, so feel free to drop me an email.

With that I’m happy to take any questions you might have.

Jeri Hiniker: I was wondering if you could talk a little more about… part of what we’re doing with the Cardiac LAN is asking them to submit data on those core measures. I know you, as part of the Million Hearts campaign, have a data repository that you’re working with. I know it’s not mandatory for them to join that to be a partner, but I was wondering if you could talk a little more about it.

Hilary Wall: We’re trying to not get in the business of being a data repository. What we are more doing is working with partners to right now, informally report out on progress they’ve made. We work with folks like the Guideline Advantage, the American College of Cardiology Pinnacle Registry and a host of others to gather some baseline data for our measures and then we have plans to informally collect data on those measures in the future.

We don’t have any concrete plans as to how we intend to report on those measures formally, but what we would rather do is see practices and health plans and others, adopt the Million Hearts measures and make a commitment to reporting out on those measures in some way or make a commitment to using those measures internally for quality improvement purposes.
The list on the table, with the various measure alignment progress, provides you the PQRS numbers and the NQF numbers, which correspond to each other where you can look up the actual measures that Million Hearts is supporting. Again, right now we’re not a formal data repository. That may change in the future, but our big goal is to have folks get on board and use these measures so we’re all monitoring the progress for cardiovascular in the same way.

**Jeri Hiniker:** I apologize for using the word repository. That is what I was getting at, is the way people can use their data and do some comparisons to what’s happening nationally. Certainly we can do that on a state level, but that they can get an idea of where they fit in nationally also.

**Hilary Wall:** Yes and it’s tricky, because right now we don’t have a national repository for electronic health record data, so a lot of the “national systems” that we get data from like PQRS are not necessarily representative at the national level. PQRS is voluntary so it just represents to help you report on those measures. So it is a challenge, which is why we don’t have something formal put into place just yet.

Again that may change over time but for me, one of the best ways that we can use data from practices or providers is through those progress notes. I would love to generate some progress notes from the Learning and Action Network that you are all doing that highlight, here’s where we were at baseline, we implemented these types of quality improvement, PSA rapid cycle interventions and we saw an improvement in the ABCs or an improvement in blood pressure control, that’s the kind of data I would love to highlight.

I think we can do that on our website as I mentioned.

**Amanda:** With the Million Hearts campaign, that’s not focused solely on Medicare patients, correct?

**Hilary Wall:** That’s correct. Its focused on adults 18+. The reason you’ve heard Medicare talked about so much is because its one of these policy levers that we can work with CMS in a synergistic way on and obviously older folks carry a greater burden of cardiovascular disease, but certainly the initiative is to focus on all adult Americans.

**Jeri Hiniker:** We’ll move on now to the next presentation, which is on the **Guideline Advantage**, which I’ll turn over to Katy Vennum.

**Katy Vennum:** Thank you. Good afternoon everyone, I’m here to talk to you a little more about the Guideline Advantage Program, which is a quality improvement program from the American Cancer Society, American Diabetes Association and American Heart Association aimed at improving outpatient care nationwide.

The Guideline Advantage targeted four of the ten leading causes of death in the United States.

- Heart disease
- Cancer
- Stroke, and
- Diabetes

The program provides a basis for evaluating and improving outpatient treatment and prevention of these four disease states, which all have similar trackers. The Guideline Advantage applies evidence-based treatment guidelines, performance measurement tools and quality improvement strategies in the outpatient setting at no charge to practices.

The partnership of the three organizations capitalizes on prevention, focus, health, organization efforts, guideline development, chronic disease approach and consumer appeal.
The three organizations originally partnered in what’s known as the Preventative Health Partnership back in 2004. The groups engaged to harness the individual strengths of each agency around prevention. They wanted to create consistent prevention and screening guidelines in region-wide constituencies to increase awareness and inspire action.

As I’m sure many of you are aware, 81 million American adults have one or more types of cardiovascular disease and as many as one in three adults will have been diagnosed with diabetes in 2050 if present trends continue. Additionally and constantly, one-third of cancer deaths are related to overweight or obesity, physical inactivity and poor nutrition and nearly one-third are caused by tobacco use. More than two-thirds of cancer deaths are potentially preventable.

Improved screening and counseling can result in prevention treatment and early detection of these chronic diseases.

The three words for the collaboration of the American Cancer Society, American Diabetes and American Heart Associations focus on four things that help prevent cancer, diabetes, heart disease and stroke which include:

- Being physically active
- Eating well
- Maintaining a healthy weight
- Seeing a healthcare provider on a regular basis

The American Cancer Society, American Diabetes Association and American Heart Association have long developed scientific guidelines and statements specific to prevention and disease management. Each organization sets national goals and objectives that compliment their guidelines.

The three organizations share a common interest in translating those guidelines into practice to help achieve those objectives. Increase inherence to guidelines, improve patient outcomes and the program now addresses a broad audience, by focusing on prevention and disease management in the outpatient setting. The program can reach the greatest number of individuals at all levels of health.

The program also offers more relevant reporting. Quarterly data analysis provides participants with valuable feedback for pinpointing obstacles and guideline issues. Benchmarking, measures performance against other participating practices at a state and national level. The Guideline Advantage is also enhanced for recognition opportunities. Participating practices will be invited to take part in high profile research projects and inaugural participants and practices that achieve high performance are eligible for public recognition.

Essentially the program facilitates reporting. Because the Guideline Advantage works directly through participating practices existing electronic health record or health technology systems are programs that comfortably interact with practices current workflow. Lastly, the program now addresses a broad mix by focusing on prevention in disease management in the outpatient setting.

So the vision and goal of the program are very simple, to improve the health of patients through widespread application of primary and secondary prevention guidelines. With a goal to improve the long-term compliance of ACS, ADA and AHA ACC guidelines, which in turn supports our shared organizational mission, to prevent chronic disease and improve the life of those living through the nations most troubling chronic diseases.
The next slide provided a visual depiction of the program model, which I’ve outlined previously in that practices will send in data via their health technology vendor or EHR vendor data to our data analytics warehouse Duke clinical research institute and the data will be processed and analyzed on a quarterly basis and provided back in the form of feedback reports that show adherence to treatment guidelines.

Participation in the program can come in one of three forms.

i. Through EHR or health technology vendor that will map and send data directly for a practice.

ii. For a practice to participate directly from their practices without coordination with their EHR vendor are to submit data directly from the practice using technical resources at the practice level or by escorting some sort of flat file and allowing our data analytics warehouse to provide the majority of the support for data mapping and validation.

iii. The data quality performance reports are generated on a quarterly basis as noted. The program also operates a variety of CE opportunities as practices sharing resources that are available to all participating practices.

Next was shown a blown up picture of the technical aspect of the program like where the data is coming from and where its going and it shows data coming from the EHR at the medical practice and the types of data that are submitted from their database to our warehouse and reporting that is to be analyzed and then ultimately reported out for research and analytic purposes.

Next is an overview of the idle data elements that would be submitted to the Guideline Advantage program. The Guideline Advantage is actually looking for clinical data from a practices EHR system, so this covers a number of those pieces like demographics, contraindications, medications, medical histories, labs, vital signs, etc. all important pieces with which to generate the measures of interest in the Guideline Advantage program.

Let me give you a mock up of the list of measures that the Guideline Advantage Program will be reporting on. We have recently expanded the support of Guideline Advantage tri-agency initiative to include: bladder, cancer and diabetes measures and also specifically focus on the ABCs, similar to those that Hilary mentioned previously so that we can support programs like Million Hearts.

Our feedback reports could be released later this month will now include all those measures that Hilary listed during her presentation, as well.

One thing to note is alignment with similar programs like Million Hearts. The Guideline Advantage program is a give of what you’ve got program. We do not have data on it, requirements but found we have run a number of measures as metrics because, as many of you may know, and I know sometimes it is a challenge to obtain all the codes that are required to report measures. Our measures are run with the data that practices submit and in some instances those don’t always carry the full bracket of codes required to run the measures as PQRS has intended.

Therefore, the Guideline Advantage in some instances run what we call metrics and are comparable to those measures at PQRS has put out, but may not be exactly apples to apples, given the code to run them are not entirely the same.

Next is a sampling of the specialties that we are looking to offer the program to, which essentially is everyone in the outpatient setting. If you notice from the listing of measures they do cover a lot of preventative care, so the program is supportive of family, family practice and primary care groups, but also is upgraded to groups like OBGYNs as well as cardiology and internal medicine groups.
I’m also showing a snapshot of how providers can participate in the Guideline Advantage Program. You can visit our website at GuidelineAdvantage.org to find out more information, as well as registering for the program, which expresses your interest and essentially allows the program to know you’re interested so we can then contact you to talk more about how your specific practice would participate in a program in terms of data submissions and what you’re most interested in.

One thing we found in talking to QIO is that many practices are interested in what would be required of them to participate in the program, so the next slide provides a general overview of what it takes to participate in the Guideline Advantage Program, since we are driven by data submission which does require some work on the side of the practice. Note that the process takes a few weeks, but the resources allocated for the program aren’t an insurmountable task to submit your electronic data to the program and receive feedback on a quarterly basis.

A flyer we like to include covers many of the questions we’ve had in previous meetings with other QIO organizations, and it just says since it does apply to the Guideline Advantage that we are collecting protected health information, but the Guideline Advantage is a quality improvement program as opposed to a clinical trial or research registry, so disclosure of PHI could be allowable including direct patient identifiers all under healthcare operations, so you wouldn’t need to have individual patient consent for participation in the Guideline Advantage Program.

Next let me provide you with a few of the best practices to share from the Guideline Advantage Program. Using existence electronic health records platforms, as Hilary said we’re definitely in a great time to be doing programs and initiatives like these because the federal support across so many programs to bring practitioners on board with electronic health records, so we’re trying to find the best ways to support practices in quality improvement using what they’re already doing with electronic health records.

We’re providing tools and resources, including monthly webinars that we do on a variety of topics from quality improvement and specifically for cancer related topics, heart disease and stroke related topics as well. This is important to develop a culture of quality improvement within practices so it becomes a part of their processes and something they do every day. So we’re providing feedback reports and consulting with practices on how to share their information.

So not only do you receive a quarterly feedback report, at this point in the program we meet with every practice to review those reports and to make sure your data is accurate and share strategies on how to improve upon your reported results.

One way we do that is by encouraging practices to limit their focus to one or two things. Even today with practices that are participating, have come in with a focus area and in some cases, ABCs and that’s the data they want to focus on so it’s the data they submit to help them limit their burden technically as well as giving them the information they need and can do the most work with right now.

We also direct practices to a number of resources to support their improvement through other organizations that may have quality improvement resources, as well as our partner organizations ACS and ADA who have much more specific information about those related diseases.

Lastly, we plan to recognize and encourage improvement by developing a line with valuable incentive programs to encourage continued improvement and progress within the practices.

That’s all I have for my presentation today.
Jeri Hiniker: As we wait for questions, I just want to thank both Hilary and Katy for their presentations. One of the reasons we have them present to you today is that these are different programs that are available to help the Cardiac Learning and Action Network. You don’t have to join them to be part of the Cardiac LAN but certainly they are good resources.

I was wondering if any of the clinics who have best practices, some of which are already shared as part of the presentation I know, but do you have any that maybe have already been put in place for improvement on cardiac measures.

In closing I would say either Katy or Hilary; did you have anything else you wanted to add before we close the webinar today?

Hilary Wall: I just want to reiterate the fact that the folks who have signed up to participate in the Cardiac LAN and those of you who are considering it, I consider you to be leaders in this country and I think you can help set the stage for the work that other providers do. I think you’re putting yourselves out there on a limb, to some extent, and really doing innovative work or will be if not already. From folks who are involved I want to say thank you for your willingness to participate in these kinds of networks and I hope that you get as much from it as the folks who are looking to learn from you.

Katy Vennum: I don’t have anything else to add, but to reiterate what Hilary said in applauding all those who are participating, because we know it’s something they are committed to doing in order to improve their patients, along with everything else they’re doing. We appreciate their commitment to work to improve the quality of their practices.

Jeri Hiniker: Well, thank you again and thanks to everyone who has participated with us today. If you have any questions about Cardiac LAN you can contact me, Jeri Hiniker and a host of others who are here to be of assistance to you. All contact information is posted where you can retrieve it.

With that I’ll close the webinar. I’ll be sending each of you an evaluation for feedback we would appreciate you taking time to send that back so we can make our webinars better.

Thank you everyone.