Improving Outcomes and Quality Monitoring in the Outpatient Setting

NCAHQ

4/19/13

American Heart Association | American Stroke Association

GET WITH THE GUIDELINES.

Elynor Wilson, MPH

AHA/ASA QI Director for NC

Presentation Outline

1. Background on AHA

2. The Need for QI: Chronic Disease in NC

- Epidemiological Background

3. The Affordable Care Act

- Brief Overview of Market Forces & EHRs

4. AHA's Suite of QI Programs

- Overview of In-Hospital Programs: Get With the Guidelines (GWTG)
- Guideline Advantage: Improving Outcomes in Outpatient Settings

Focus on Quality

AHA's Mission

Building healthier lives, free of cardiovascular diseases and stroke

Focus on Quality

American Heart Association | American Stroke Association

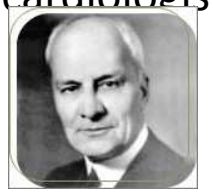
AHA's Ten Year Impact Goal

To improve the cardiovascular health of the entire nation by 20% by 2020, while reducing deaths from cardiovascular diseases and stroke by 20%

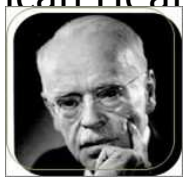
History of our Mission:

- **1900's Conversation Starter:**
  - Can a man go back to work after having a heart attack?

- **1924:** 6 cardiologists founded the American Heart Association


Dr. Robert Halsey


Dr. Joseph Sailer


Dr. Paul Dudley White

- **May 26, 1925:** First Scientific Sessions held – 200 guests in Atlantic City

- **1949:** small staff in NYC launched the first national fundraising campaign in February of 1949, raising $2.7 million

American Heart Association Mission Today…

- Since 1949, funded **over $3.5 billion in research**

- Funded **13 Nobel Prize winners**
  - 2012 : Dr. Robert Lefkowitz, Duke University

- **Research advancements**
  - First artificial heart valve, heart transplants, CPR techniques & guidelines

- Engaging **over 22.5 million volunteers & donors** annually

- **AHA's Scientific Sessions:** leading cardiovascular meeting for scientists & healthcare professionals; 22,000+ guests annually (Nov. 2013 – Dallas)

- Jump Rope & Hoops for Heart, You're the Cure, Heart-Check Mark, Teaching Gardens, Health Strategies, Get with the Guidelines…*and more*

2020 Impact Goal: both a 20% improvement in cardiovascular health for ***ALL*** Americans and a 20% reduction in cardiovascular & stroke deaths

American Heart Association Mission Today…

- Works toward the Ten Year Impact goal as the nation's oldest and largest voluntary health organization devoted to fighting heart disease and stroke.
- Supported by nearly 150 local offices.
- We train more than 13 million people a year in CPR.
- We publish popular cookbooks and certify heart-healthy foods in grocery stores.
- Our programs improve the health of America, fight childhood obesity and reach audiences facing unique health risks, including women, African-Americans and Hispanics.

Funding our Mission

The AHA determines what approved research grants can be funded the next fiscal year based upon donor commitments given by June 30.

- **MAA Research – current funding:**
  - 216 projects totaling $37,216,251 currently being conducted
    - **DC =** 5 awards totaling $708k
    - **MD =** 68 awards totaling $13M
    - **NC =** 83 awards totaling $14.6M
    - **SC =** 16 awards totaling $2.8M
    - **VA =** 43 awards totaling $5.9M

→ - In the MAA, 61 proposals totaling $5.85M went unfunded

2013 NC AHA Top Policy Priorities and

Top Three Policy Priorities for the 2013 Legislative Session

1. Require every newborn to be screened for congenital heart defects using pulse oximetry.
2. Create a coordinated stroke systems of care that ensure the designation of Primary Stroke Centers based on Joint Commission/AHA/ASA accreditation or an equivalent process by a guidelines-based, nationally recognized accrediting organization.
3. Protect and secure dedicated, recurring tobacco use prevention and cessation program funding.

American Heart Association | American Stroke Association

Focus on Quality

heart.org/quality

GET WITH THE GUIDELINES® STROKE

GET WITH THE GUIDELINES® HEART FAILURE

GET WITH THE GUIDELINES® RESUSCITATION

GET WITH THE GUIDELINES® AFIB

ACTION Registry®-GWTG™

THE GUIDELINE ADVANTAGE™

American Cancer Society® | American Diabetes Association® | American Heart Association | American Stroke Association®

MISSION: LIFELINE™

HOSPITAL Accreditation & Certification

TARGET: STROKE™

TARGET: HF™

AN UPDATE ON THE STATE OF CHRONIC DISEASE IN NORTH CAROLINA

SAMUEL TCHWENKO, MD, MPH
Epidemiologist
Heart Disease & Stroke Prevention Branch
Chronic Disease & Injury Section; Division of Public Health
NC Department of Health & Human Services

NC LEGISLATIVE BREAKFAST BRIEFING
FEBRUARY 06, 2013

PLAN

- INTRODUCTION
- MORTALITY AND MORBIDITY
- ECONOMIC COSTS
- MAJOR RISK FACTORS
- DISPARITIES, INEQUALITIES AND INEQUITY
- OPPORTUNITIES FOR PREVENTION
- CONCLUSION

WHAT IS CHRONIC DISEASE?

- Definition: “one which is inveterate, of long continuance, or progresses slowly”
- Several hundred disease conditions could be classified as chronic
- This presentation will focus on the following chronic disease conditions and risk factors :
  - Cancer
  - Heart disease
  - Chronic lower respiratory diseases
  - Stroke
  - Diabetes
  - Hypertension (High Blood Pressure)
  - Obesity
  - Smoking

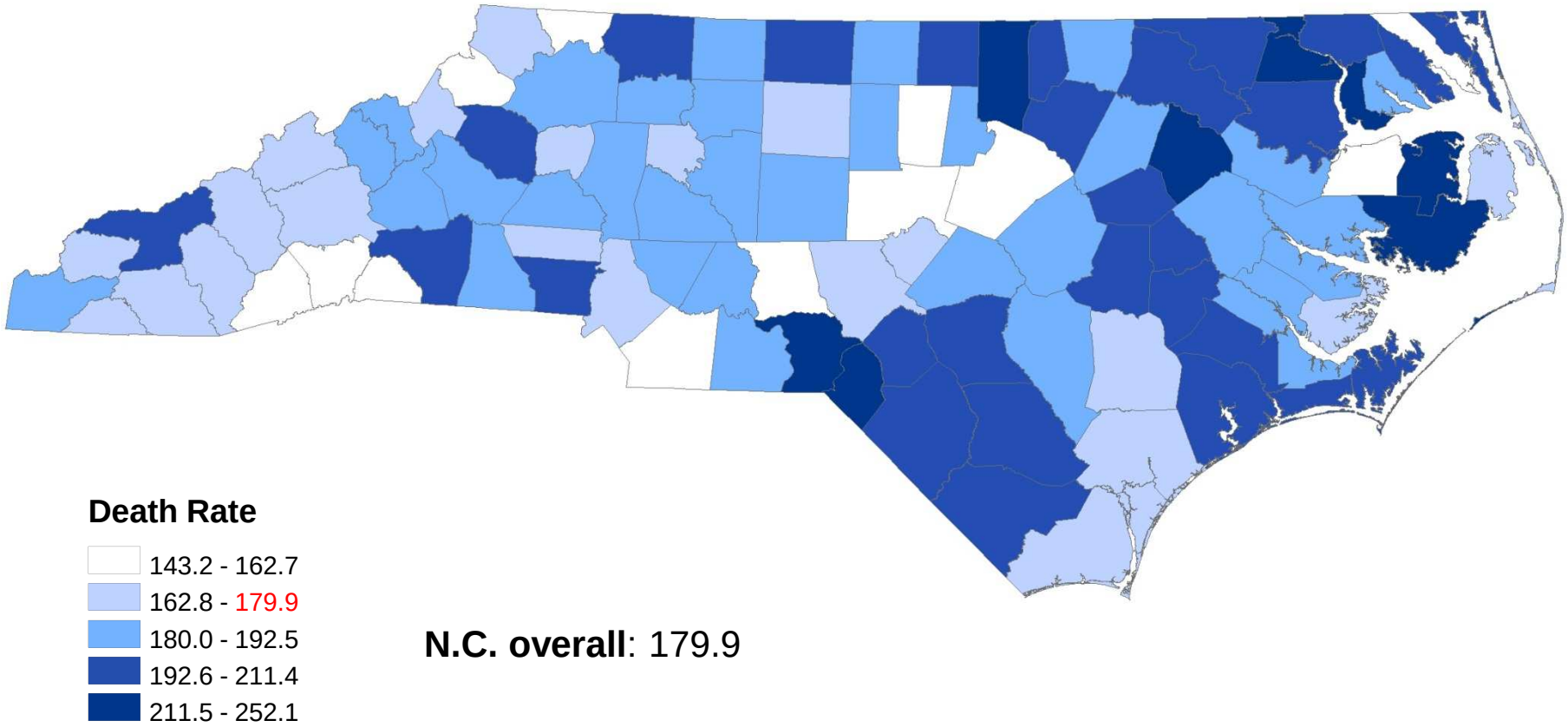
Leading Causes of Death, N.C., 2011

Rank	Cause	Number	%
1	CANCER	18,201	22.8
2	HEART DISEASE	16,959	21.3
3	CHRONIC LOWER RESPIRATORY DISEASES	4,705	5.9
4	STROKE	4,290	5.4
5	All other unintentional injuries*	2,996	3.8
6	ALZHEIMER'S DISEASE	2,820	3.5
7	DIABETES MELLITUS	2,276	2.9
8	NEPHRITIS, NEPHROTIC SYNDROME AND NEPHROSIS	1,705	2.1
9	Influenza and pneumonia	1,616	2.0
10	Septicemia	1,319	1.7
	All other causes (Residual)	22,793	28.6
	Total Deaths -- All Causes	79,680	100

Source: North Carolina Division of Public Health, State Center for Health Statistics. Leading Causes of Death 2011, SCHS Online Database *2012*. http://www.schs.state.nc.us/schs/data/lcd/lcd.cfm.

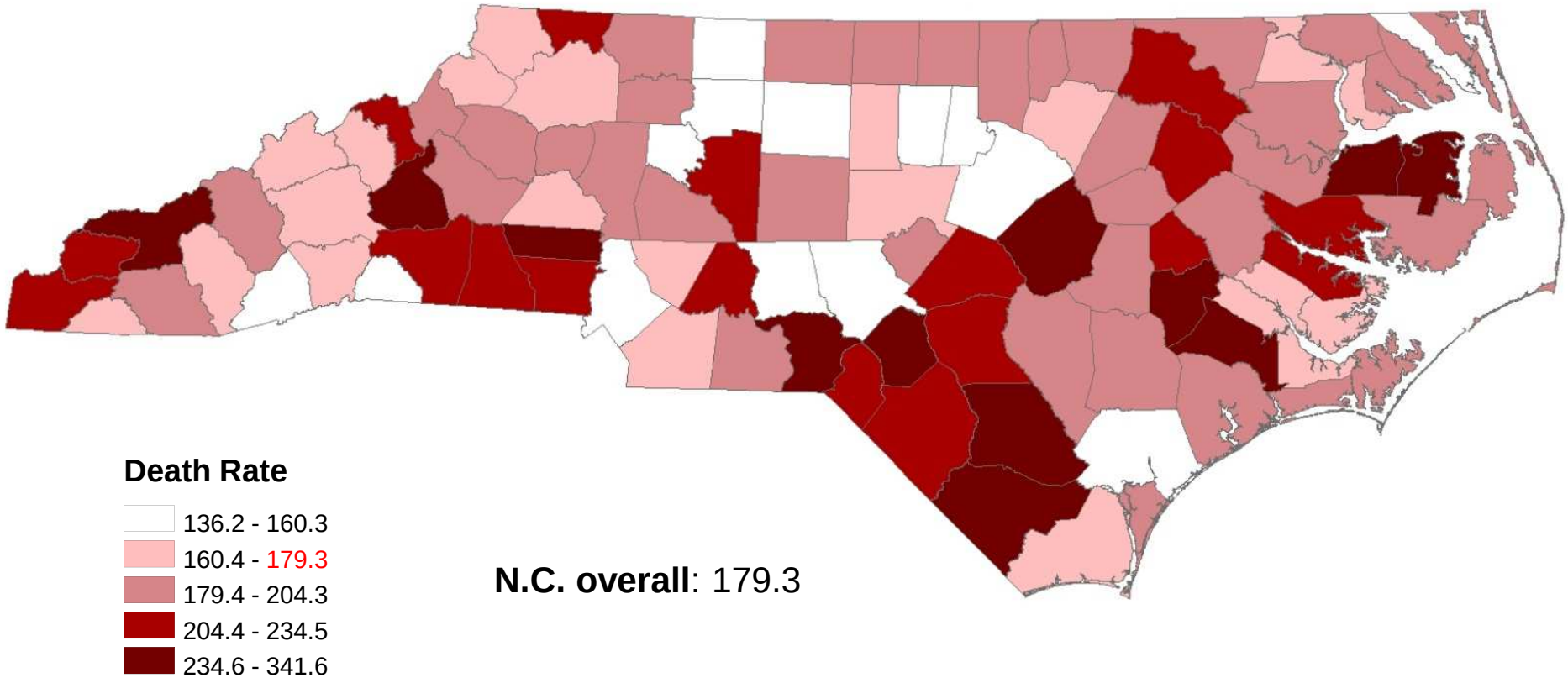
*Excludes motor vehicle injuries, suicide and homicide.

Cancer Death Rates by County of Residence, N.C., 2007-2011



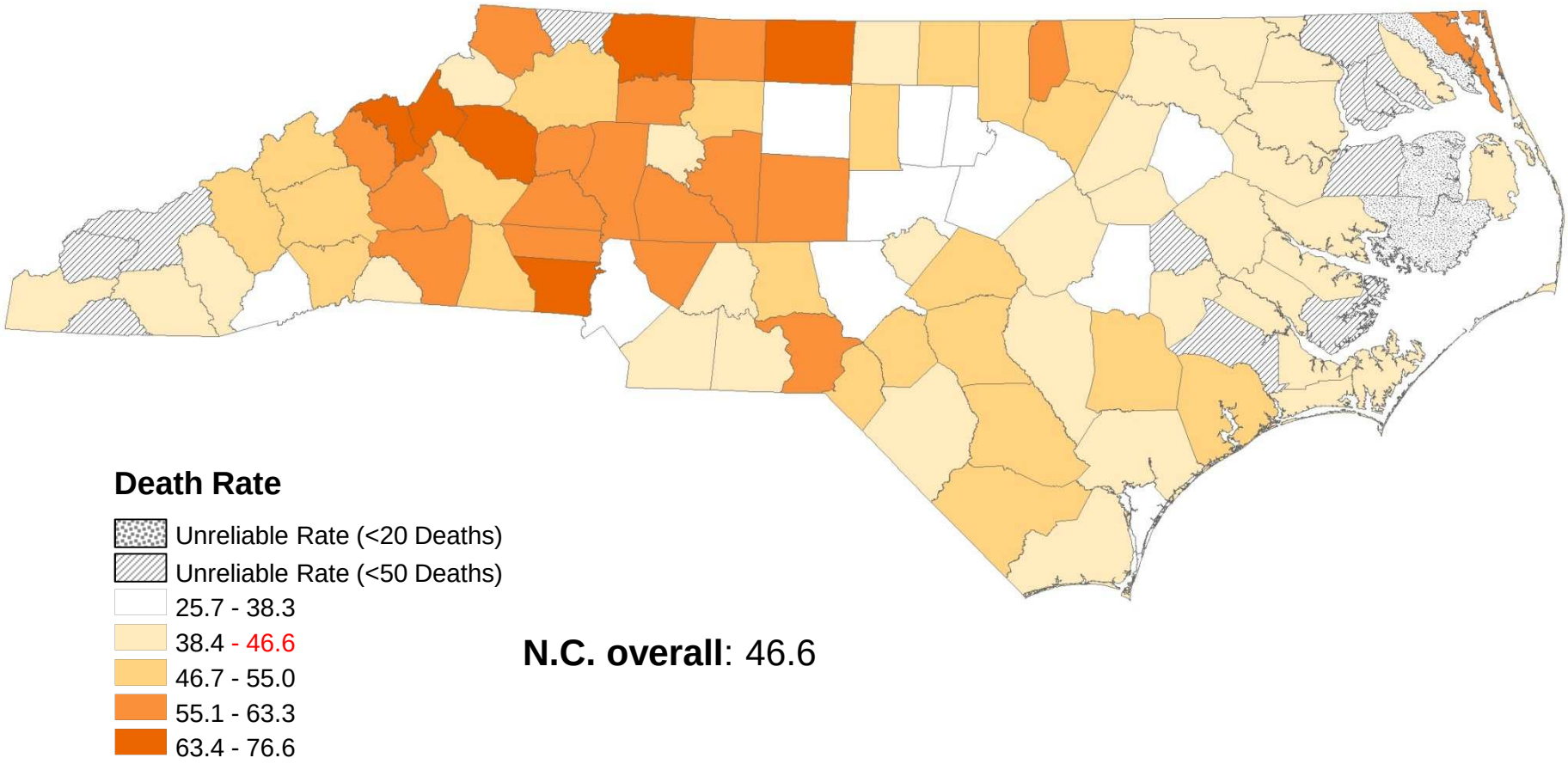
Cancer: ICD-10 codes C00-C97.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
Data Source: North Carolina Division of Public Health, State Center for Health Statistics. Cancer Mortality Rates by County for Specified Sites, *SCHS Online Database* 2013. http://www.schs.state.nc.us/schs/CCR/mortality.html.

Heart Disease Death Rates by County of Residence, N.C., 2007-2011



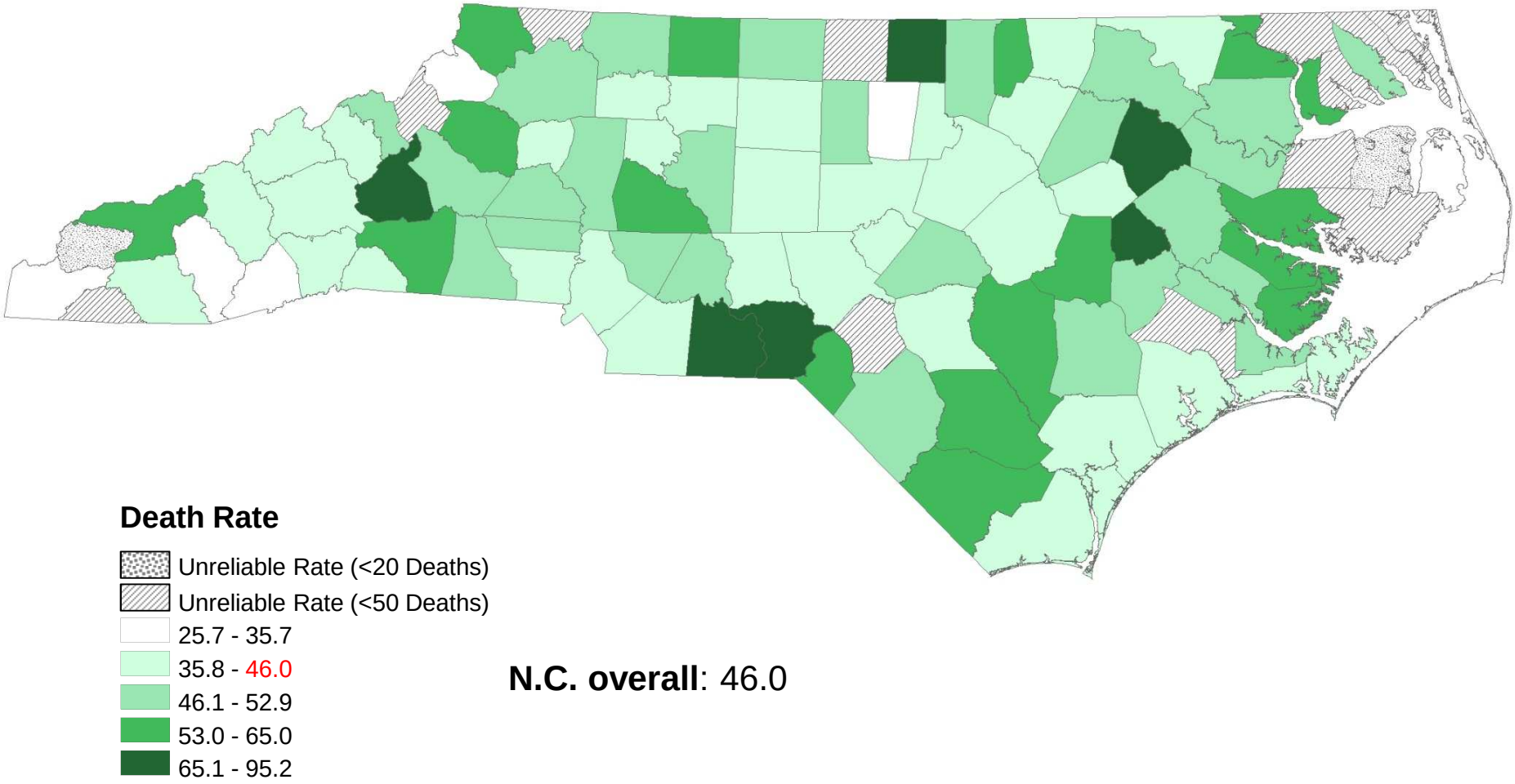
Heart Disease: ICD-10 codes I00-I09, I11, I13, I20-I51.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
N.C. Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *Volume 2: Leading Causes of Death in North Carolina 2011, SCHS Online Database* 2013. http://www.schs.state.nc.us/schs/deaths/lcd/2011/.

Chronic Lower Respiratory Disease Death Rates by County of Residence, N.C., 2007-2011



Chronic Lower Respiratory: ICD-10 codes J40-J47.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
N.C. Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *Volume 2: Leading Causes of Death in North Carolina 2011, SCHS Online Database* 2013. http://www.schs.state.nc.us/schs/deaths/lcd/2011/.

Stroke Death Rates by County of Residence, N.C., 2007-2011



Stroke: ICD-10 codes I60-I69.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
N.C. Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *Volume 2: Leading Causes of Death in North Carolina 2011, SCHS Online Database* 2013. http://www.schs.state.nc.us/schs/deaths/lcd/2011/.

Hospitalization Charges for Selected Chronic Disease Categories, N.C., 2011

DIAGNOSTIC CATEGORY	TOTAL CHARGES	CASES	CHARGE PER CASE
HEART DISEASE	$4.1 BILLION	105,219	$38,785
CANCER	$1.4 BILLION	30,556	$44,854
STROKE	$864 MILLION	29,265	$29,558
CHRONIC LOWER RESPIRATORY DISEASES	$530 MILLION	31,041	$17,086
DIABETES	$412 MILLION	18,860	$21,870
HYPERTENSIVE DISEASE	$243 MILLION	9,403	$25,915
OBESITY	$176 MILLION	4,293	$41,146
TOTAL	**$7.7 BILLION**	**228,627 cases *(24% of all hosp.)***	

*ICD-9 codes for specified chronic diseases.

Source: North Carolina Division of Public Health, State Center for Health Statistics. Inpatient Hospital Utilization and Charges by Principal Diagnosis (excluding newborns & discharges from out of state hospitals), North Carolina*, 2012*. Produced by: State Center for Health Statistics, 01/24/2013.

Annual Medicaid Costs for Selected Chronic Disease Categories, N.C., 2011

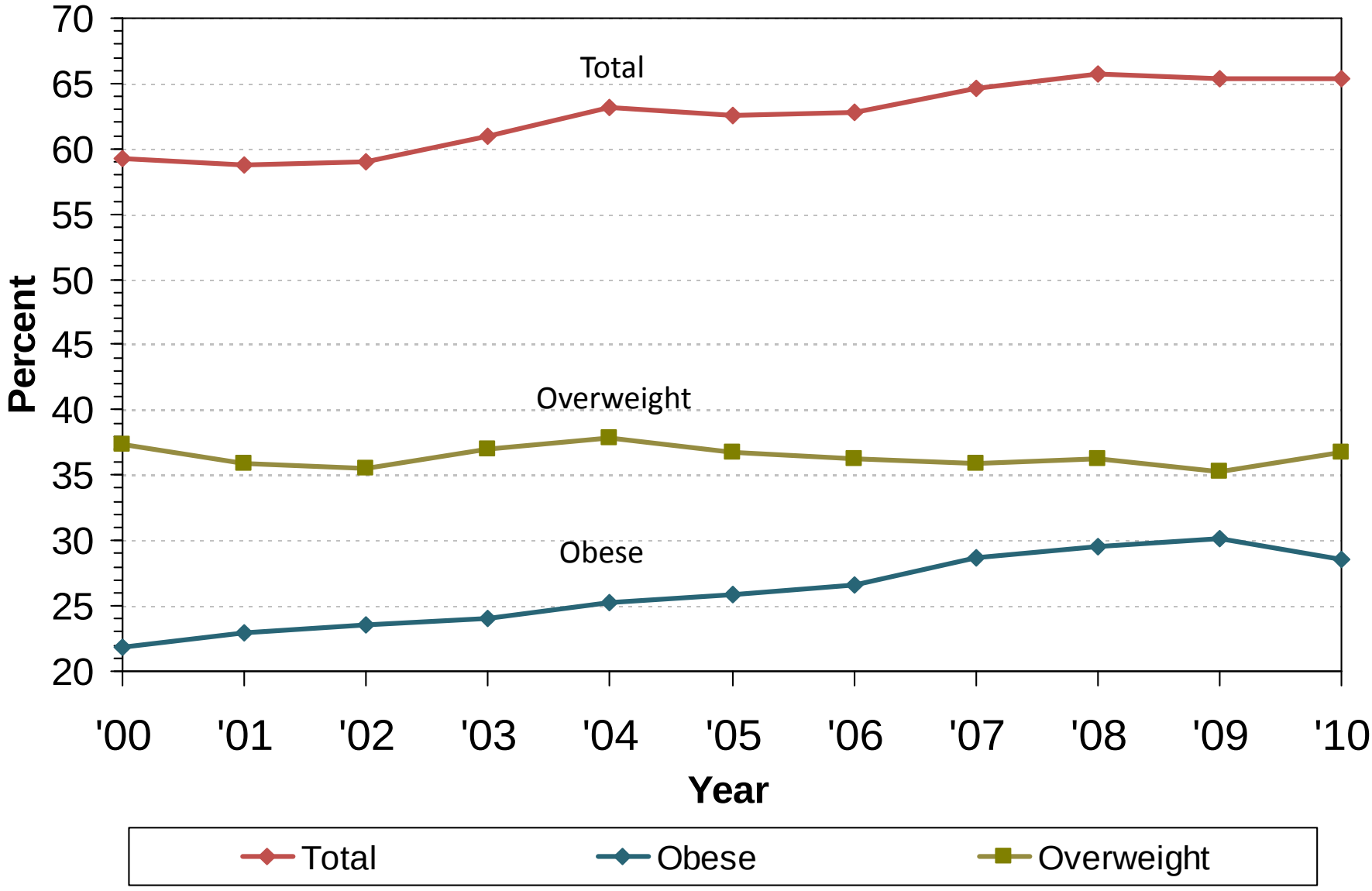
DIAGNOSTIC CATEGORY	TOTAL CHARGES	# OF BENEFICIARIES	CHARGES PER BENEFICIARY
CANCER	$152 MILLION	34,112	$4,459
HEART DISEASE	$231 MILLION	104,566	$2,213
CHRONIC LOWER RESPIRATORY DISEASES	$138 MILLION	171,044	$808
STROKE	$177 MILLION	38,808	$4,571
ESSENTIAL HYPERTENSION	$189 MILLION	166,700	$1,134
DIABETES	$171 MILLION	113,608	$1,508
TOTAL	**$1.1 BILLION**	**628,828 Beneficiaries**	-

Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Annual Medicaid Cost due to Chronic Disease, 2011*. Produced by: State Center for Health Statistics, 01/24/2013.

MAJOR CONTROLLABLE RISK FACTORS FOR CHRONIC DISEASE

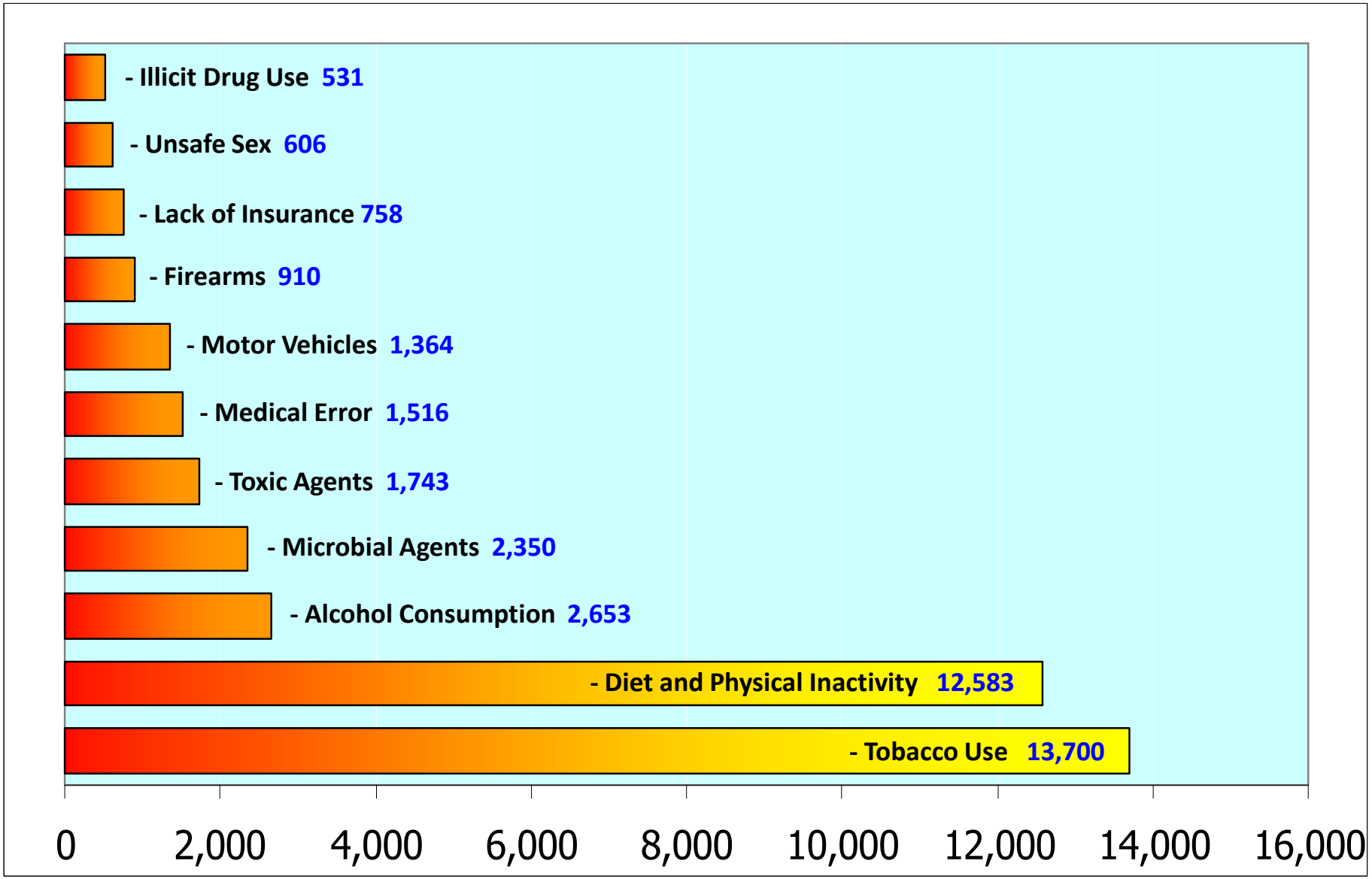
- Smoking
- Secondhand smoke
- Unhealthy diet (lack of fruits and vegetables, high fat, high sodium, low fiber etc.)
- Insufficient physical activity
- Overweight/Obesity
- Dyslipidemia (e.g. High cholesterol)
- Hypertension
- Diabetes

Overweight & Obesity, N.C. 2000-2010



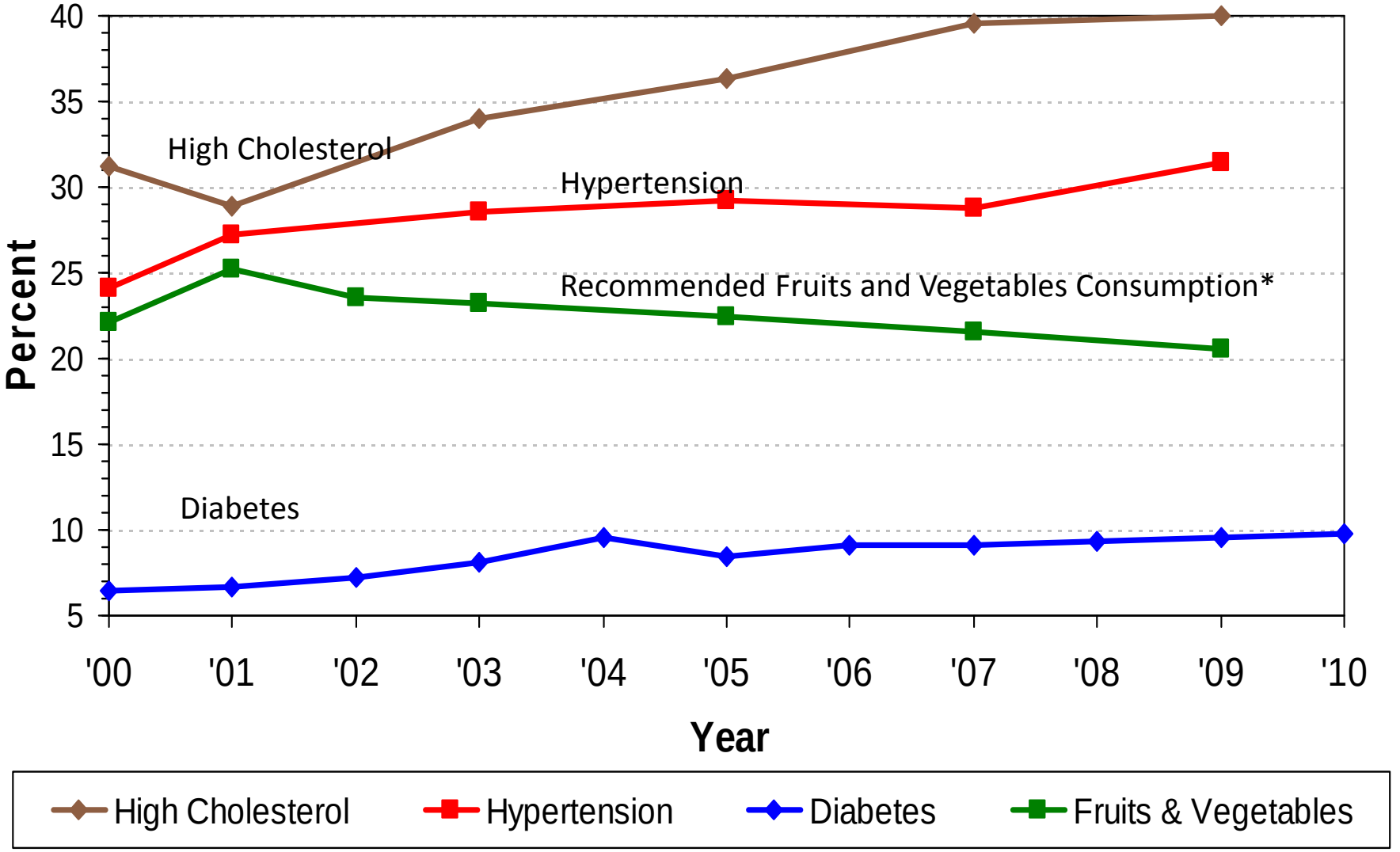
Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Behavioral Risk Factor Surveillance System, 2012*. Extracted by: Heart Disease and Stroke Branch: 10/11/2012.

Preventable Causes of Death, NC, 2009



Source: North Carolina State Center for Health Statistics (NC-SCHS). Health profile of North Carolinians: 2011 update

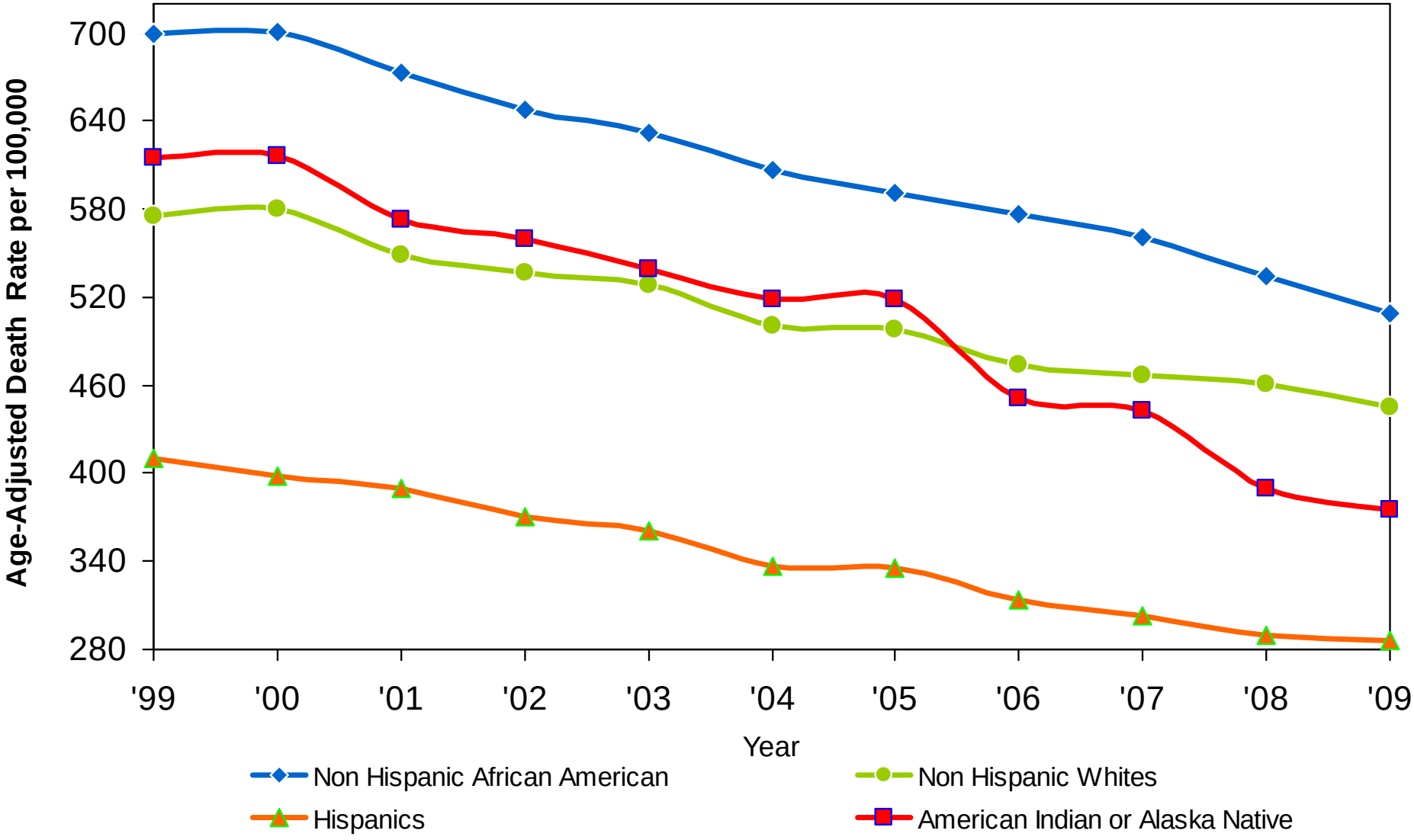
High Cholesterol, Hypertension, Diabetes, and Recommended Fruits and Vegetables Consumption, N.C. 2000-2010



*Consumed five or more servings of fruits or vegetables per day

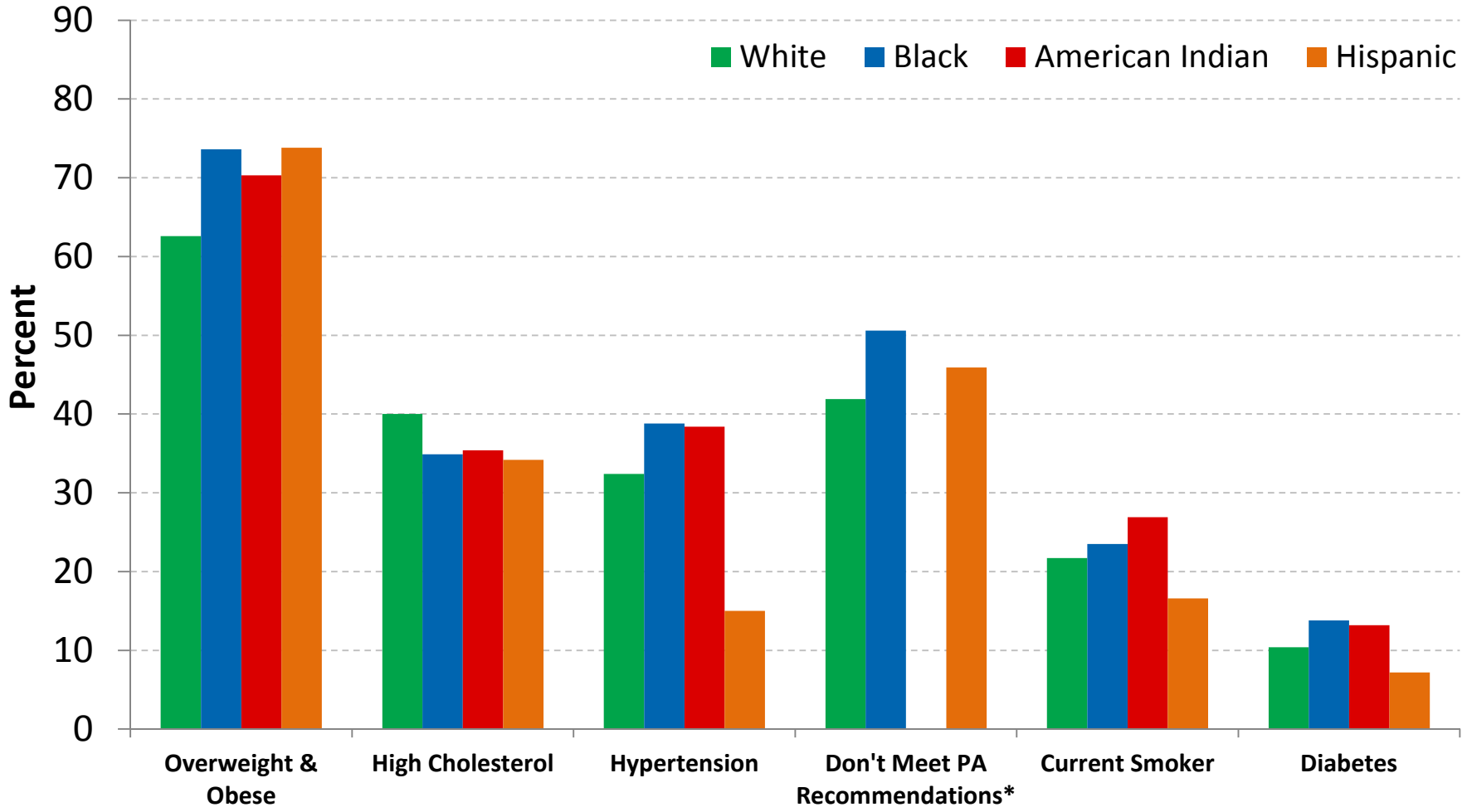
Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Behavioral Risk Factor Surveillance System, 2012*. Extracted by: Heart Disease and Stroke Branch: 10/11/2012.

Chronic Disease Death Rates by Race/Ethnicity, N.C., 1999-2009



ICD-10 codes: Cancer C00-C97, Chronic Lower Respiratory J40-J47, Heart Disease I00-I09, I11, I13, I20-I51, Stroke I60-I69.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. *Compressed Mortality File, 1999-2009*.
CDC WONDER Online Database, 2012. http://wonder.cdc.gov/mortSQL.html

Modifiable Risk Factors for Chronic Disease by Race and Ethnicity, N.C., 2011

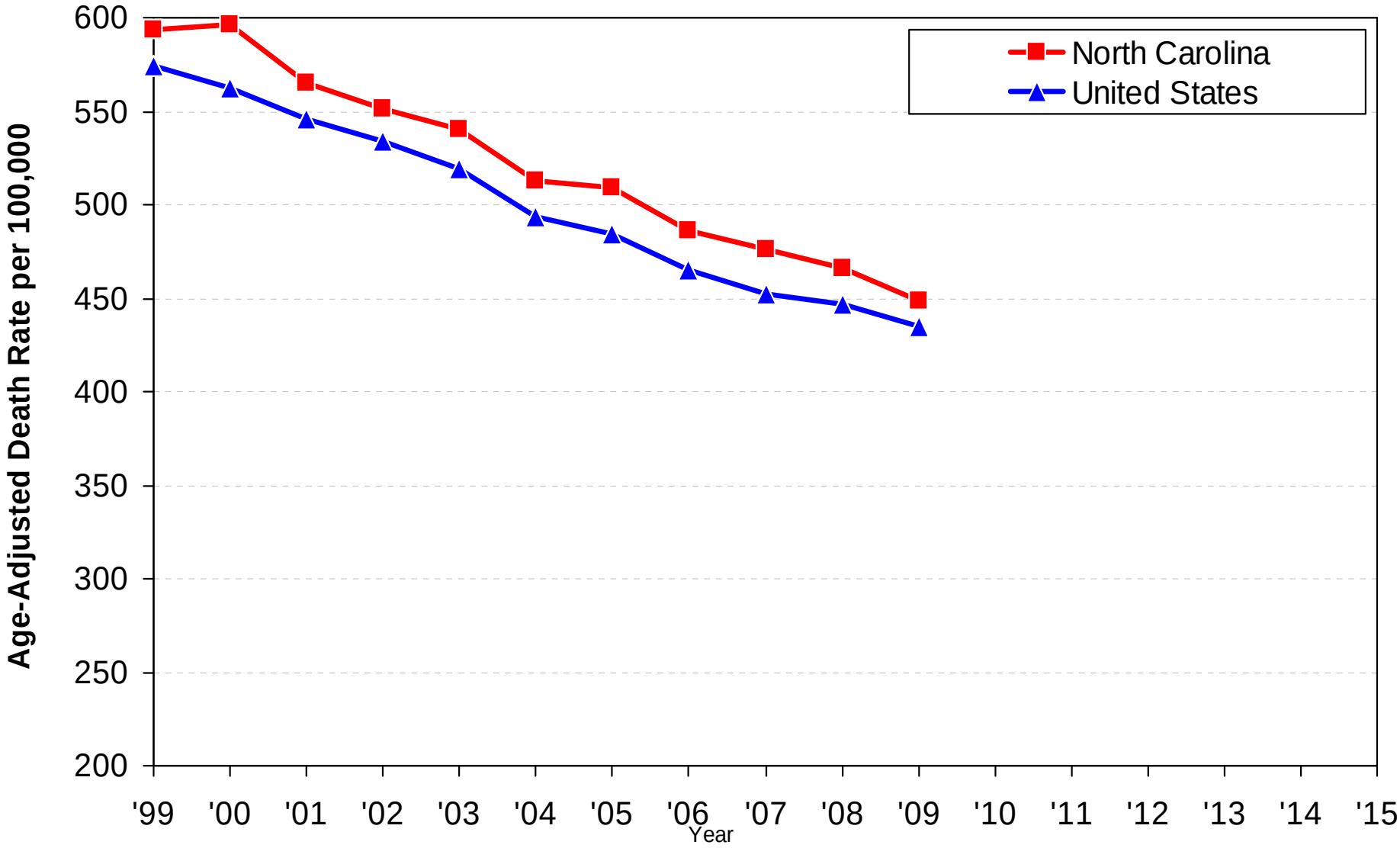


Adults=18+

*PA = Physical Activity

Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Behavioral Risk Factor Surveillance System, 2012*. Extracted by: Heart Disease and Stroke Branch: 10/16/2012.

Chronic Disease Death Rates, N.C. vs. U.S., 1999-2009



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CDC WONDER Online Database, 2012. http://wonder.cdc.gov/mortSQL.html

ACKNOWLEDGEMENTS

- Chronic Disease and Injury Section
- Cancer Prevention and Control Branch
- Diabetes Prevention and Control Branch
- Heart Disease and Stroke Prevention Branch
- Physical Activity and Nutrition Branch
- State Center for Health Statistics
- Tobacco Prevention and Control Branch
- Partners: AHA/ASA, ACS CAN, ADA, ALA, CCME

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Affordable Care Act- Quality and Outcomes

TITLE III

IMPROVING THE QUALITY AND EFFICIENCY OF HEALTHCARE

Subtitle A

Transforming the Healthcare Delivery System

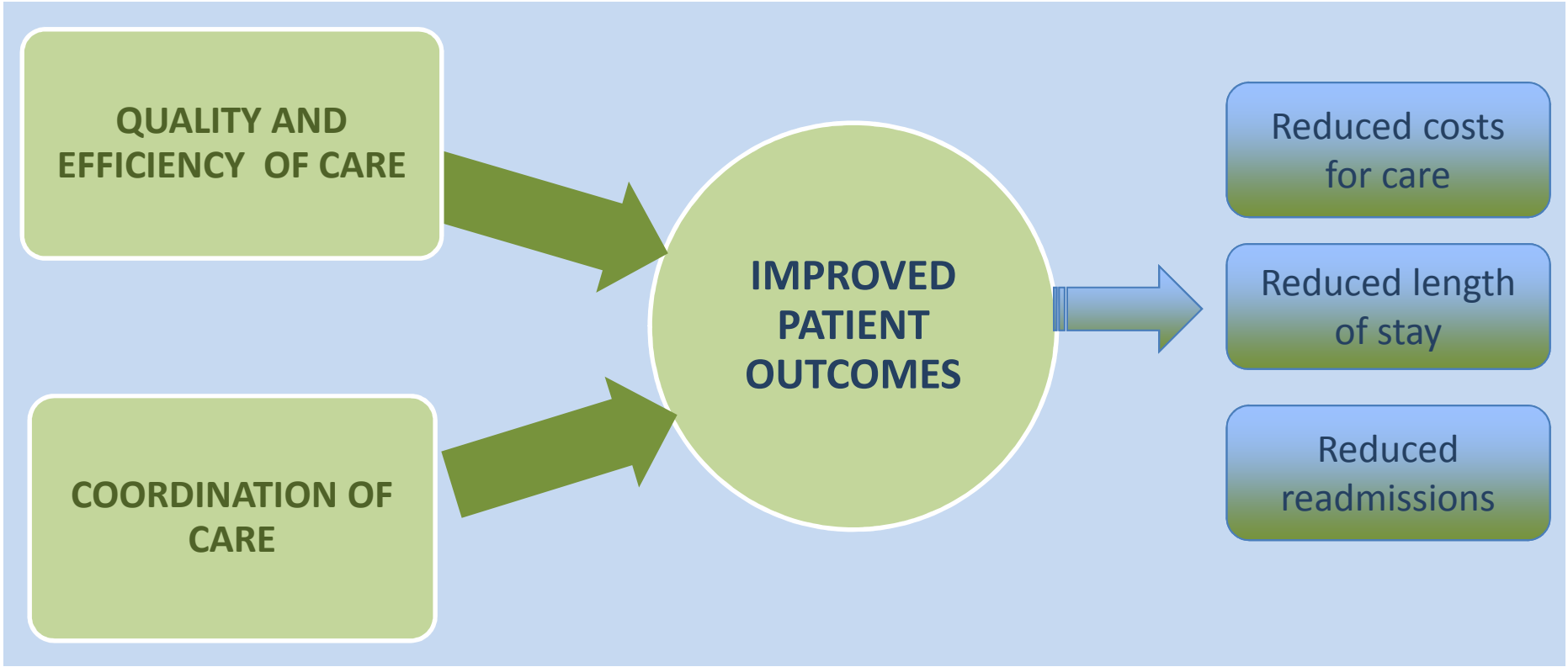
Affordable Care Act Summary

- Focusing care around exceptional patient experience and shared clinical outcome goals
- Expanding the use of EHR
- Redesigning care to include a team approach
- Establishing patient care teams—accountable care organizations and patient-centered medical homes
- Collaborative efforts with all healthcare providers to reduce readmissions
- Engaging in shared decision-making discussions regarding treatment goals and approaches
- Incorporating patient-centered outcomes research to tailor care appropriate for specific patient populations

Meaningful Use Goals

- Improve quality, safety, efficiency and reduce disparities
- Engage patients in their care
- Improve coordination of care
- Ensure privacy and security of PHI
- Improve population health and interact with public health programs

GET WITH THE GUIDELINES— ALIGNMENT WITH AFFORDABLE CARE ACT



Focus on Quality

American Heart Association | American Stroke Association

ONGOING QUALITY AND EFFICIENCY PROCESS

Get With The Guidelines can assist in the following:

- Compliance with evidence-based medicine and proven guidelines
- Patient safety/patient outcomes
- Positioning for true Pay-for-Quality environment
- Reduced operational variability in treatment and improved operational efficiencies
- Clinical Strings--The link between improved patient results (quality outcomes) and improved financial performance

Market Forces

State of the Industry

- EHR Adoption among Family Physicians doubled between 2005 and 2011 to reach 68% nationally
- Family Physician EHR adoption likely to surpass 80% by 2013
- Significant state-level variation in adoption

The Rise of Electronic Health Record Adoption Among Family Physicians

ABSTRACT

PURPOSE Realizing the benefits of adopting electronic health records (EHRs) in large measure depends heavily on clinicians and providers' uptake and meaningful use of the technology. This study examines EHR adoption among family physicians using 2 different data sources, compares family physicians with other office-based medical specialists, assesses variation in EHR adoption among family physicians across states, and shows the possibility for data sharing among various medical boards and federal agencies in monitoring and guiding EHR adoption.

METHOD We undertook a secondary analysis of American Board of Family Medicine (ABFM) administrative data (2005-2011) and data from the National Ambulatory Medical Care Survey (NAMCS) (2001-2011).

RESULTS The EHR adoption rate by family physicians reached 68% nationally in 2011. NAMCS family physician adoption rates and ABFM adoption rates (2005-2011) were similar. Family physicians are adopting EHRs at a higher rate than other office-based physicians as a group; however, significant state-level variation exists, indicating geographical gaps in EHR adoption.

CONCLUSION Two independent data sets yielded convergent results, showing that adoption of EHRs by family physicians has doubled since 2005, exceeds other office-based physicians as a group, and is likely to surpass 80% by 2013. Adoption varies at a state level. Further monitoring of trends in EHR adoption and characterizing their capacities are important to achieve comprehensive data exchange necessary for better, affordable health care.

Ann Fam Med 2013;11:14-19. doi:10.1370/afm.1461.

NC Medical Journal (March/April 2013)

MARCH / APRIL 2013 :: 74(2)

Improving Quality of Care

This issue focuses on current efforts to improve the quality of health care in North Carolina, including the work of the NC Quality Center, Community Care of North Carolina, and The Carolinas Center for Medical Excellence. Commentaries also discuss local quality improvement initiatives and provide insight from public health departments, hospital administrators, physicians, and insurers. Original articles examine the state's Silver Alert program and factors affecting the density of tanning facilities in North Carolina.

NC Medical Journal (March/April 2013)

1. Reward for reporting < effort/expense of reporting (system implementation, maintenance);
2. Smaller practices can be "hard hit" by reporting requirements;
3. Physician low participation in PQRS;
4. Incentives, flexibility of recognition may improve participation.

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INVITED COMMENTARY

The Perils of Quality Improvement Activities: A Physician's Perspective

W. James Stackhouse

N C Med J. 2013;74(2):155-158.

PDF | TABLE OF CONTENTS

Clinical quality measurement remains an elusive goal, and it has the potential to result in adverse outcomes and unexpected consequences. Practicing physicians are wary of current efforts but should remain professionally committed to the development of effective, evidence-based quality measures.

In 34 years of practicing medicine, I have yet to be paid based on any measured quality outcome. Instead, my sense of professionalism, my interest in evidence-based decision making and clinical outcomes, and my respect for my patients have driven my interest in quality improvement activities. I have no reason to think that the experiences of my physician colleagues have been any different.

The role of quality measurement may change in the near future, however, when programs such as the Physician Quality Reporting System (PQRS) of the Centers for Medicare & Medicaid Services (CMS) move from merely requiring the reporting of processes and numbers to providing rewards when targets are met or imposing financial punishments when targets are missed [1]. Other payers and insurers in North Carolina and nationwide are gradually moving from "reward for reporting" programs to true pay-for-performance activities. The development of accountable care organizations in North

http://www.ncmedicaljournal.com/wp-content/uploads/2013/04/74214_Stackhouse-FINAL.pdf

NC Medical Journal (March/April 2013) continued…

5. Variable evidence-base of guidelines; and difficult application to complex patients;
6. Unintended consequences of pay-for-performance (cherry picking, skewed claims);
7. Smaller practices with more at-risk pts penalized with data;
8. Data on charges alone is incomplete

Improving Quality of Care

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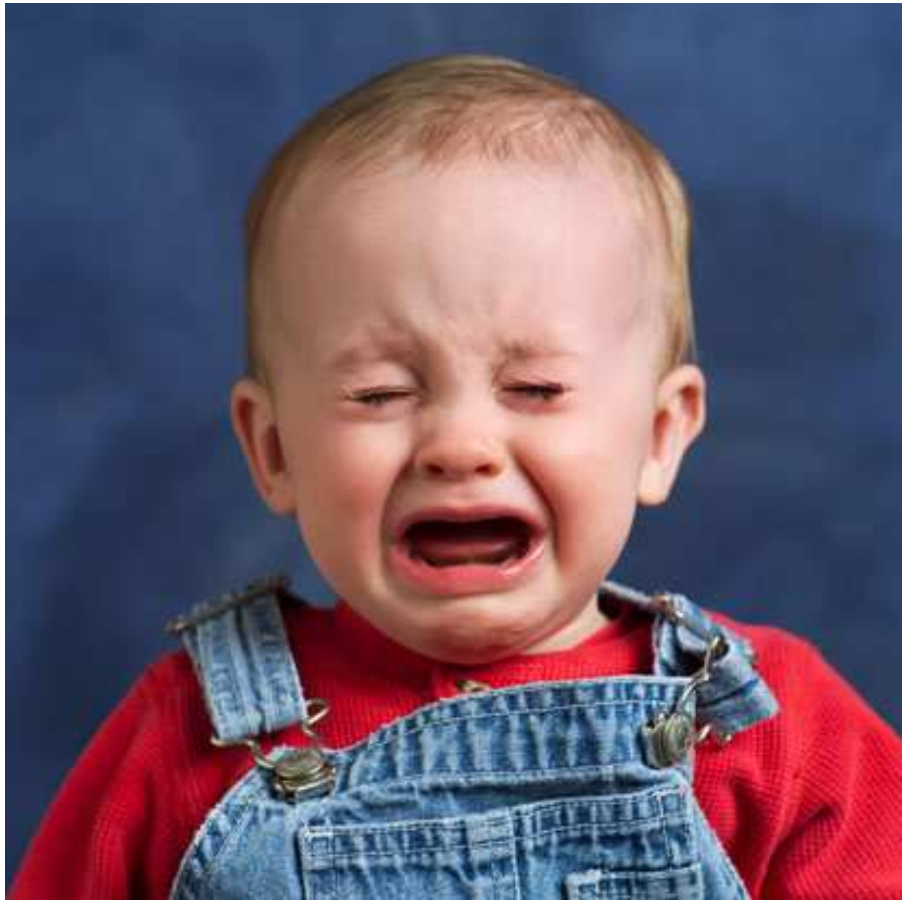
American Heart Association | American Stroke Association

We can do better…

It’s time for data and information to replace anecdotes and impressions surrounding chronic disease risk factor management…

How do you know about your care quality, if you don’t measure performance and outcomes?

Don’t get mad…get data!



Focus on Quality

Why GWTG?

1. Need for stroke, HF, CVD care support
2. Part of a suite of robust AHA Quality Improvement Tools
3. AHA has over 10 years of expertise in CVD QI promotion
4. Improves quality of care
5. Comparative, real-time, “drill-down” data
6. Helps with Core Measure reporting
7. Provides hospital & practice recognition (awards, US News & World Report ad)

Key Elements to Quality Improvement: Why Do Some Programs Succeed?

- Access to current and accurate data on treatment and outcomes
- Have stated goals
- Administrative support
- Support among clinicians
- Use of care maps and pathways
- Use of data to provide feedback

Bradley. *JAMA.* 2001;285:2604-2611.

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Focus on Quality

heart.org/quality

GET WITH THE GUIDELINES® STROKE

GET WITH THE GUIDELINES® HEART FAILURE

GET WITH THE GUIDELINES® RESUSCITATION

GET WITH THE GUIDELINES® AFIB

ACTION Registry®-GWTG™

THE GUIDELINE ADVANTAGE™

American Cancer Society® | American Diabetes Association® | American Heart Association | American Stroke Association®

MISSION: LIFELINE™

HOSPITAL Accreditation & Certification

TARGET: STROKE™

TARGET: HF™

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Since 2001: Get With The Guidelines®

- Over 2004 Hospitals Nationwide
- Over 4 Million Patient Records
- Over 1800 Hospitals Receiving Recognition
- 211 Peer Reviewed Publications

As of October 2012

Get With The Guidelines has Six Modules

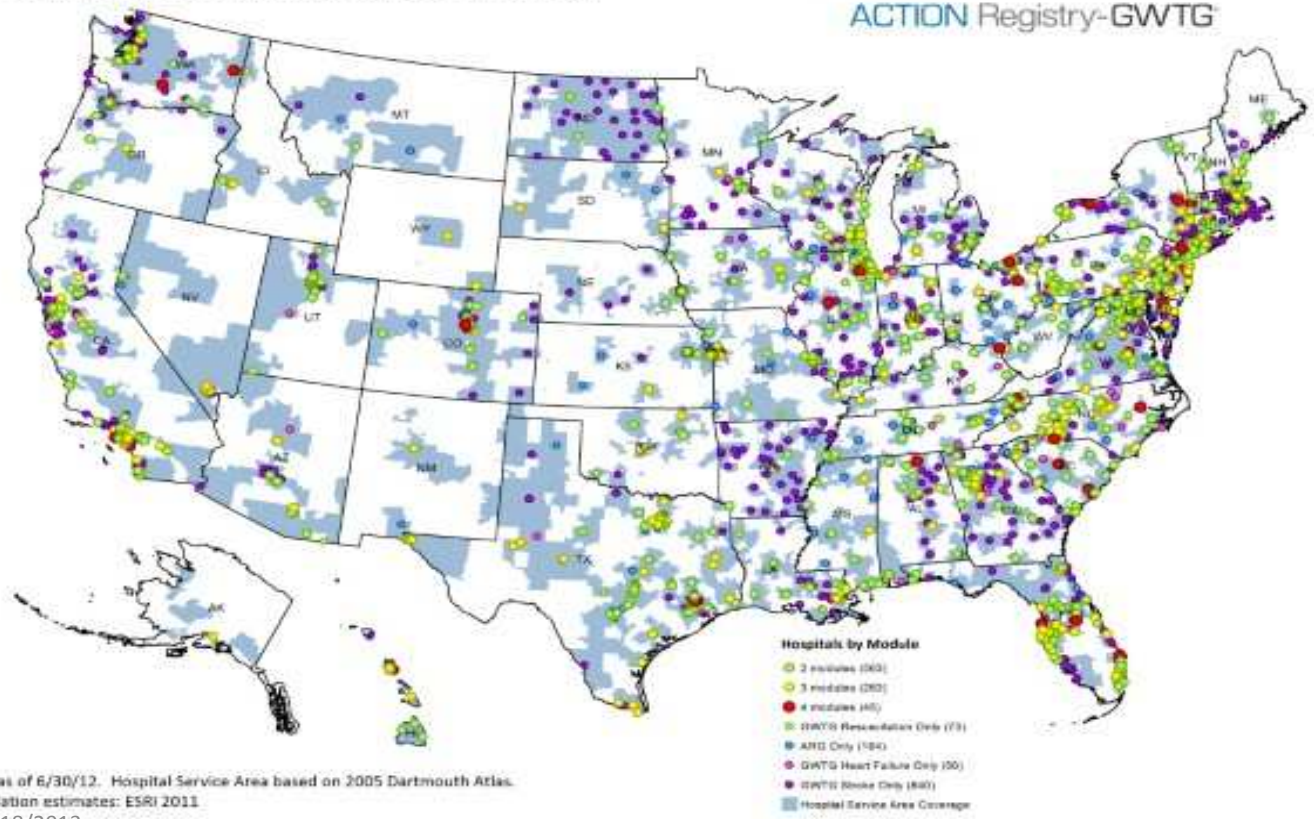
GWTG

- **Action Registry & Mission Lifeline** — Joint program with American College Cardiology, **STEMI & NSTEMI** patients and systems for care coordination
- **Heart Failure** — Data collection and optimization of care for **Heart Failure patients** with a focus on decreasing **30-day** HF **re-admission rates**
- **Stroke** — **TIA, Ischemic & Hemorrhagic** stroke data collection and quality improvement
- **Resuscitation** — Data collection and tracking of **cardiac and respiratory emergencies**
- **The Guideline Advantage** — Joint program offered by AHA, ADA & ACS, data aggregation to improve **primary prevention** in **Outpatient** setting
- **Atrial Fibrillation** — ***Coming June 2013***

GWTG Market Penetration

Get With the Guidelines® - Stroke, Heart Failure, Resuscitation and ACTION Registry®–GWTG™ Hospitals

(Count: 2004; 77.6% population coverage as of 6/30/12)



Data as of 6/30/12. Hospital Service Area based on 2005 Dartmouth Atlas.
Population estimates: ESRI 2011

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Quality System Improvement Programs
Weekly Overview Summary - November 26, 2012

	Year Initiated	Number of Hospitals, Systems or Physicians' Practices Participating	Total Patients Entered	Total Patient Records Entered
GWTG-CAD*	2000	n/a	563,407	615,184
ACTION-Registry-GWTG	2008	781	n/a	358,379
GWTG-HF	2005	575	632,523	750,696
GWTG-Stroke	2003	1,703	2,259,731	2,329,279
GWTG-Resuscitation	2000	321	448,217	533,794
Totals		3,380	3,903,878	4,587,332
The Guideline Advantage Physician Practices	2009	33	246,350	1,521,669
Target: Stroke Registered	2010	1,497	n/a	n/a
Target: Heart Failure Registered	2011	319	n/a	n/a
Mission: Lifeline STEMI Systems Registered	2007	652	n/a	n/a
Hospital Accreditation & Certification				
Mission: Lifeline STEMI Receiving Centers	2011	17	n/a	n/a
The Joint Commission - Primary Stroke Center (AHA/ASA)	2003	1001	n/a	n/a
The Joint Commission AHA Advanced Certification in Heart Failure	2009	41	n/a	n/a
Totals			4,150,228	6,109,001

GWTG-CAD: Program completed transition to ACTION-Registry GWTG 12/31/09*

ACTION Registry-GWTG Patient Record numbers as reported by ACC. This data will be updated quarterly.

NRCPR became GWTG-Resuscitation in 2010

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North Carolina Hospitals

GWTG-Stroke: 33

GWTG-HF: 22

GWTG-R: 9

AR-G: 31

TGA: 1

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Quality Research Programs

Years through 11/28/12

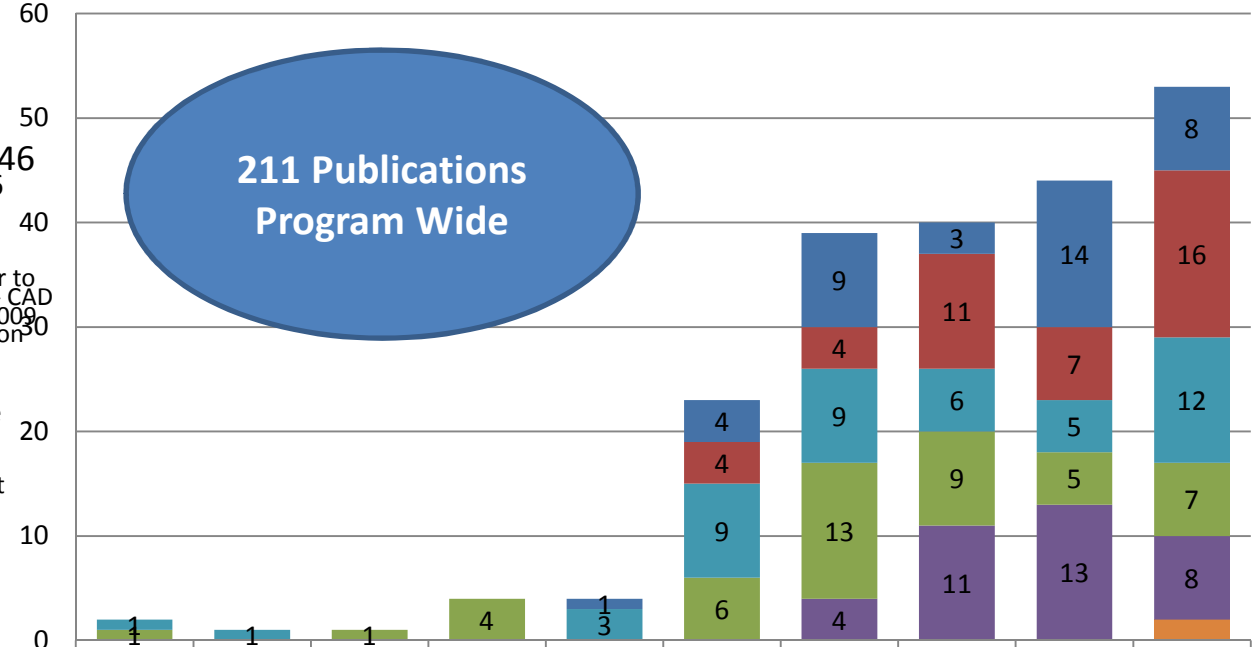
Total Pubs by Program :

*GWTG HF: 39
*GWTG Stroke: 42
*GWTG CAD: 46
*GWTG Resuscitation: 46
*Action-Registry GWTG: 36
*Mission: Lifeline: 2

Note: "Due to the transition over to ACTION Registry-GWTG, GWTG - CAD closed effective December 31, 2009 with final data entry completed on March 31, 2010"

*Pubs for more than module are counted in both module

*Pubs counted in year they went online or print



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
GWTG Heart Failure					1	4	9	3	14	8
GWTG Stroke						4	4	11	7	16
GWTG CAD	1	1			3	9	9	6	5	12
GWTG Resuscitation	1		1	4		6	13	9	5	7
ACTION-GWTG							4	11	13	8
Mission: Lifeline										2

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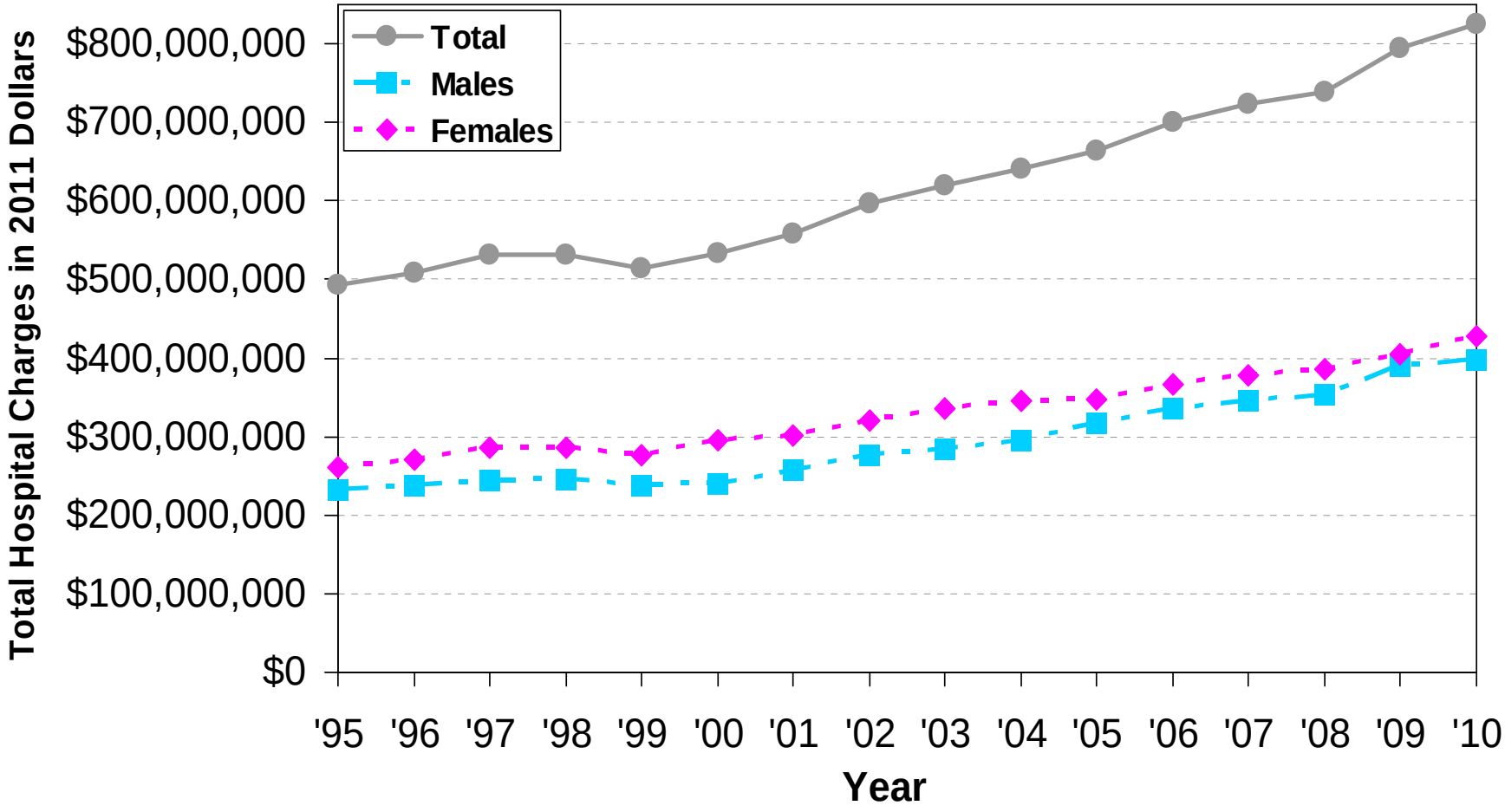
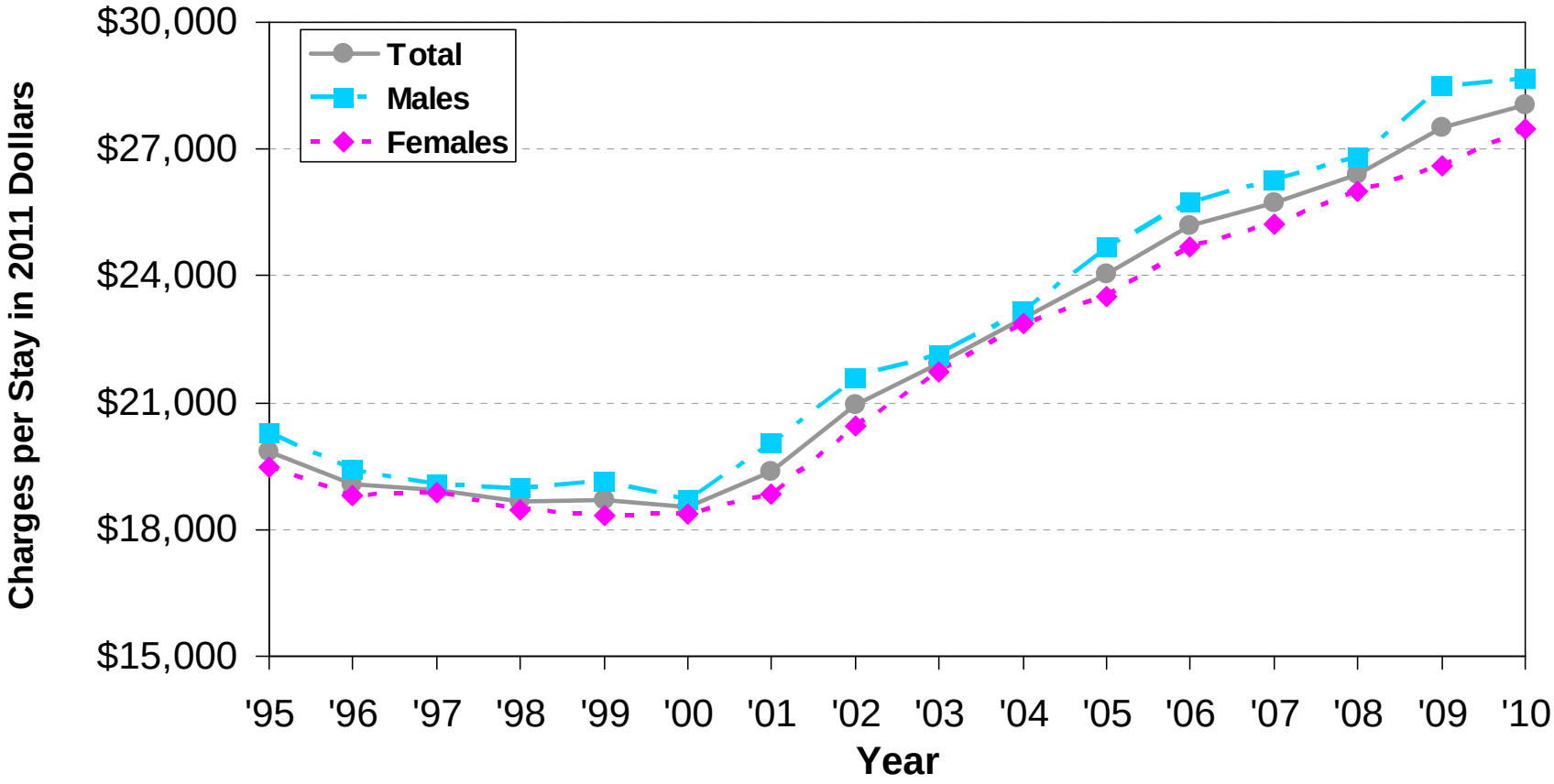
STROKE

Figure 2.21. Stroke Hospital Charges, N.C., 1995-2010



Stroke: ICD-9-CM codes 430-438; Principal diagnosis only.
Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Inpatient Hospital Discharges, 1995-2010*. Produced by: State Center for Health Statistics, 06/08/2012. Charges adjusted to 2011 dollars using the Bureau of Labor Statistics Consumer Price Index tables for Medical Care for years 1995-2012, U.S. city average, not seasonally adjusted.

Figure 2.22. Stroke Average Hospital Charges per Stay, N.C., 1995-2010

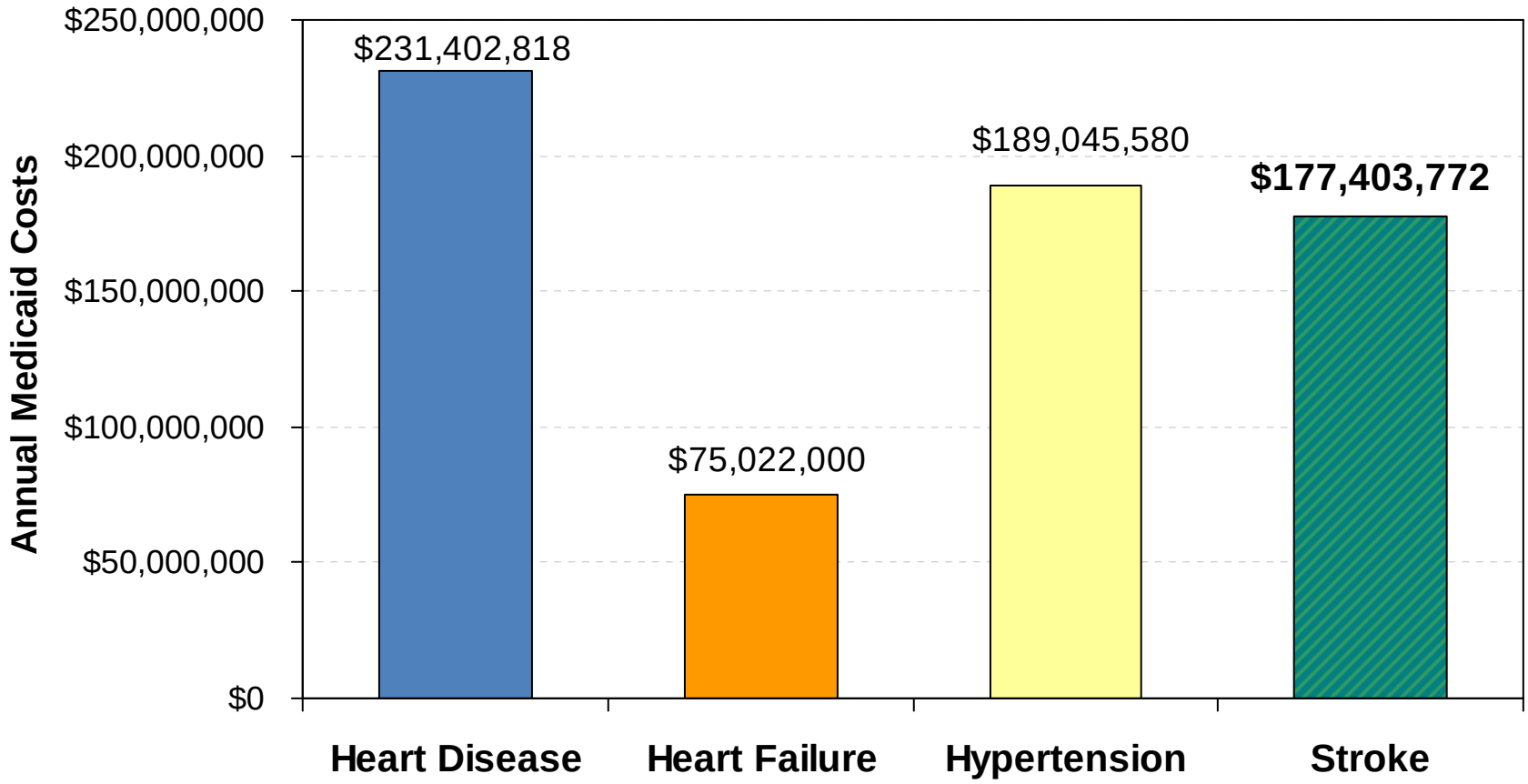


Stroke: ICD-9-CM codes 430-438; Principal diagnosis only.

Data Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Inpatient Hospital Discharges, 1995-2010*. Produced by: State Center for Health Statistics, 06/08/2012.

Charges adjusted to 2011 dollars using the Bureau of Labor Statistics Consumer Price Index tables for Medical Care for years 1995-2012, U.S. city average, not seasonally adjusted.

Figure 2.23. Annual Medicaid Costs due to Stroke and Other CVD, N.C., 2011



Source: North Carolina Division of Public Health, State Center for Health Statistics. *North Carolina Annual Medicaid Cost due to CVD, 2011*.
Produced by: State Center for Health Statistics, 09/19/2012.

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Get With The Guidelines® - Stroke Module

(Count: 1653; 72.7% population coverage as of 6/30/12)

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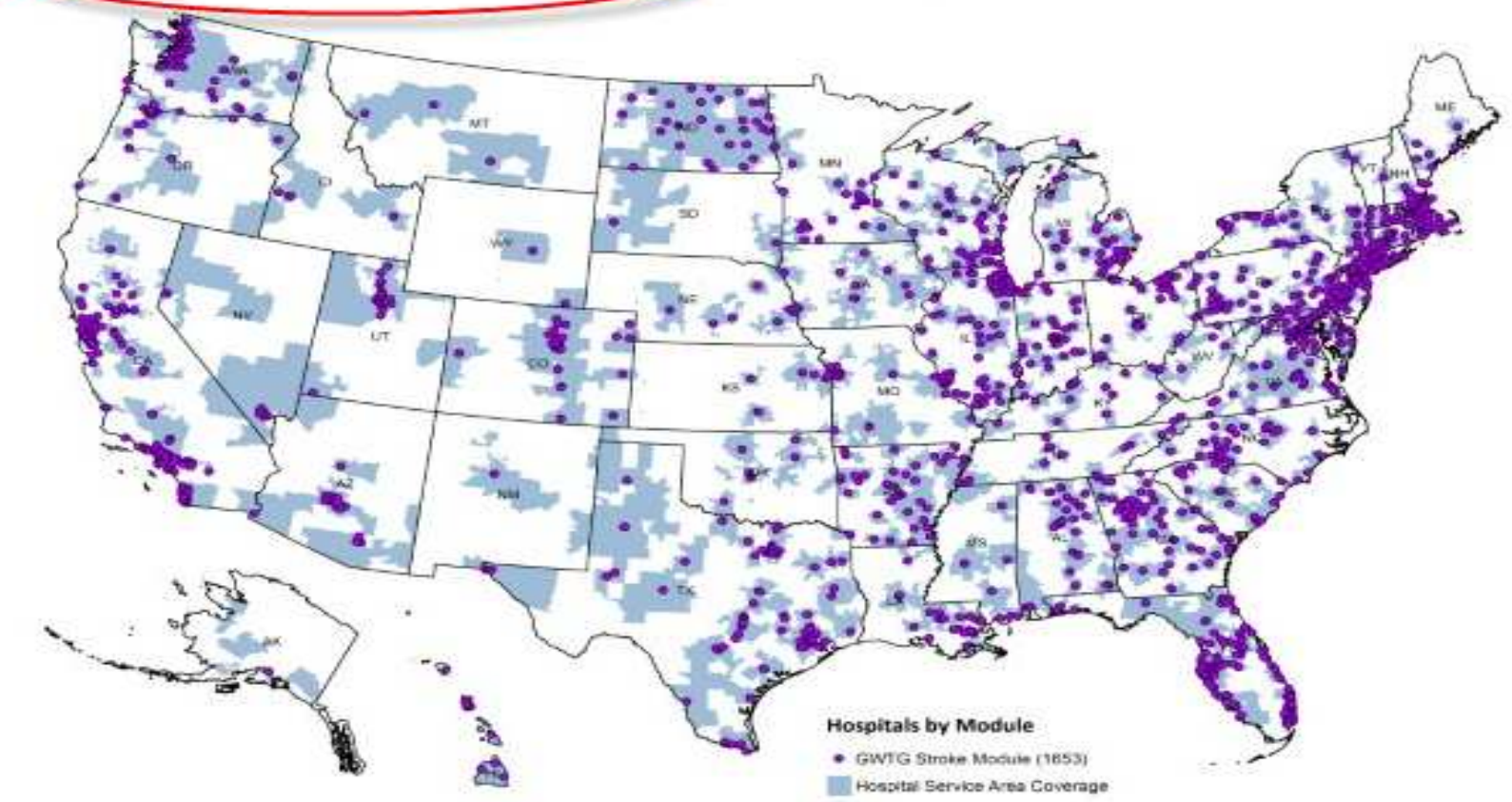
GET WITH THE GUIDELINES

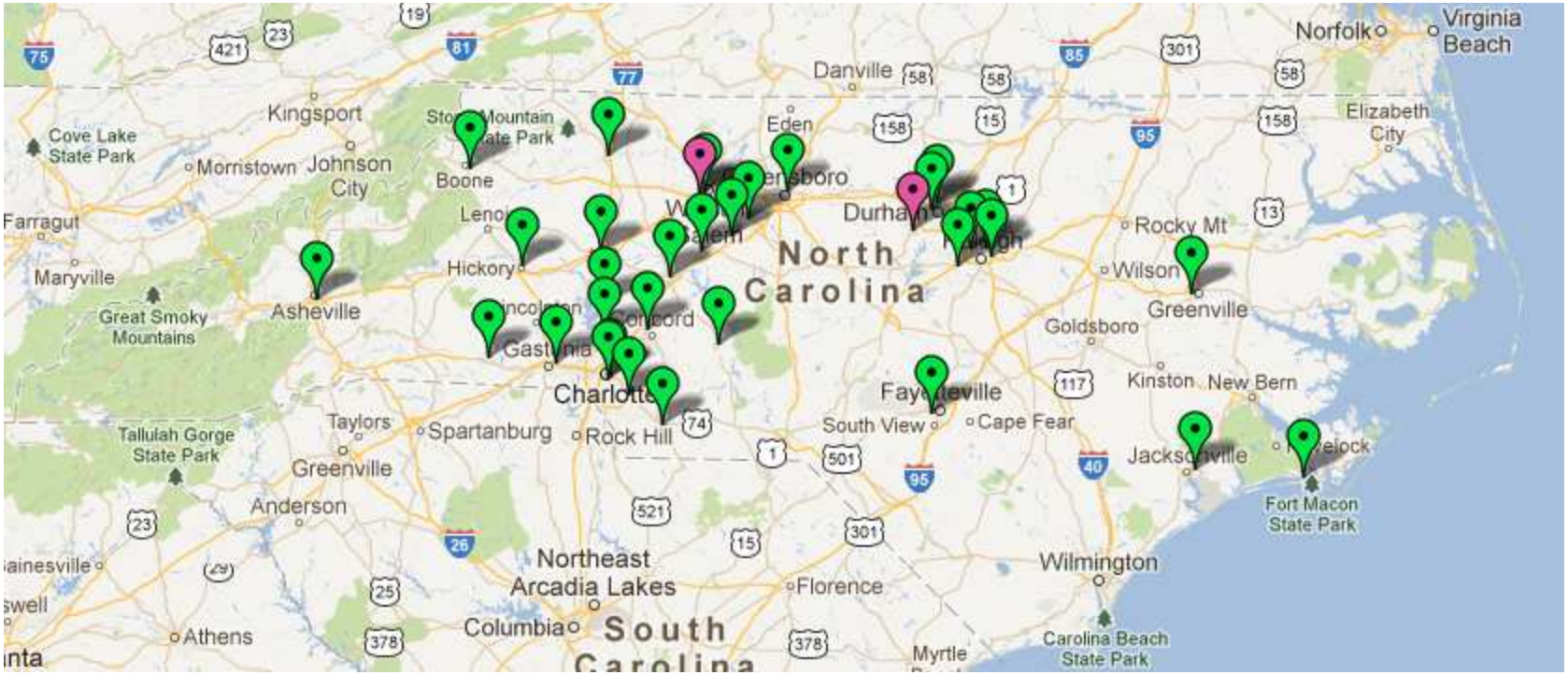


Data as of 6/30/12. Hospital Service Area based on 2005 Dartmouth Atlas.
Population estimates: ESRI 2011

Joint Commission Primary Stroke Centers

(as of 4/15/13)

(Creator: Elynor Wilson, MPH: AHA QI Director)



Icon Key	
Green	TJC Primary Stroke Center
Pink	TJC Comprehensive Stroke Center

SAVE THE DATE!

NORTH CAROLINA STROKE WORKSHOP

IMPROVING STROKE TREATMENT & OUTCOMES IN NORTH CAROLINA

Tuesday, June 4, 2013

8:00AM until 4:00PM

NORTH CAROLINA RESEARCH CAMPUS
150 RESEARCH CAMPUS DRIVE
KANNAPOLIS, NC 28081
Directions

Registration opening soon!

Early Bird Registration Fee - $75*

This will be an accredited workshop offering CME/CE certificates.

WHO SHOULD ATTEND THIS STROKE WORKSHOP?

Prospective participants include physicians, physician assistants, researchers, EMS professionals, stroke program coordinators, nurse practitioners, nurses, and anyone interested in advancing the stroke systems of care.

If you have any questions, please contact us at maa.gwtg@heart.org

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HEART FAILURE

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Get With The Guidelines® - Heart Failure Module

(Count: 554; 40.4% population coverage as of 6/30/12)

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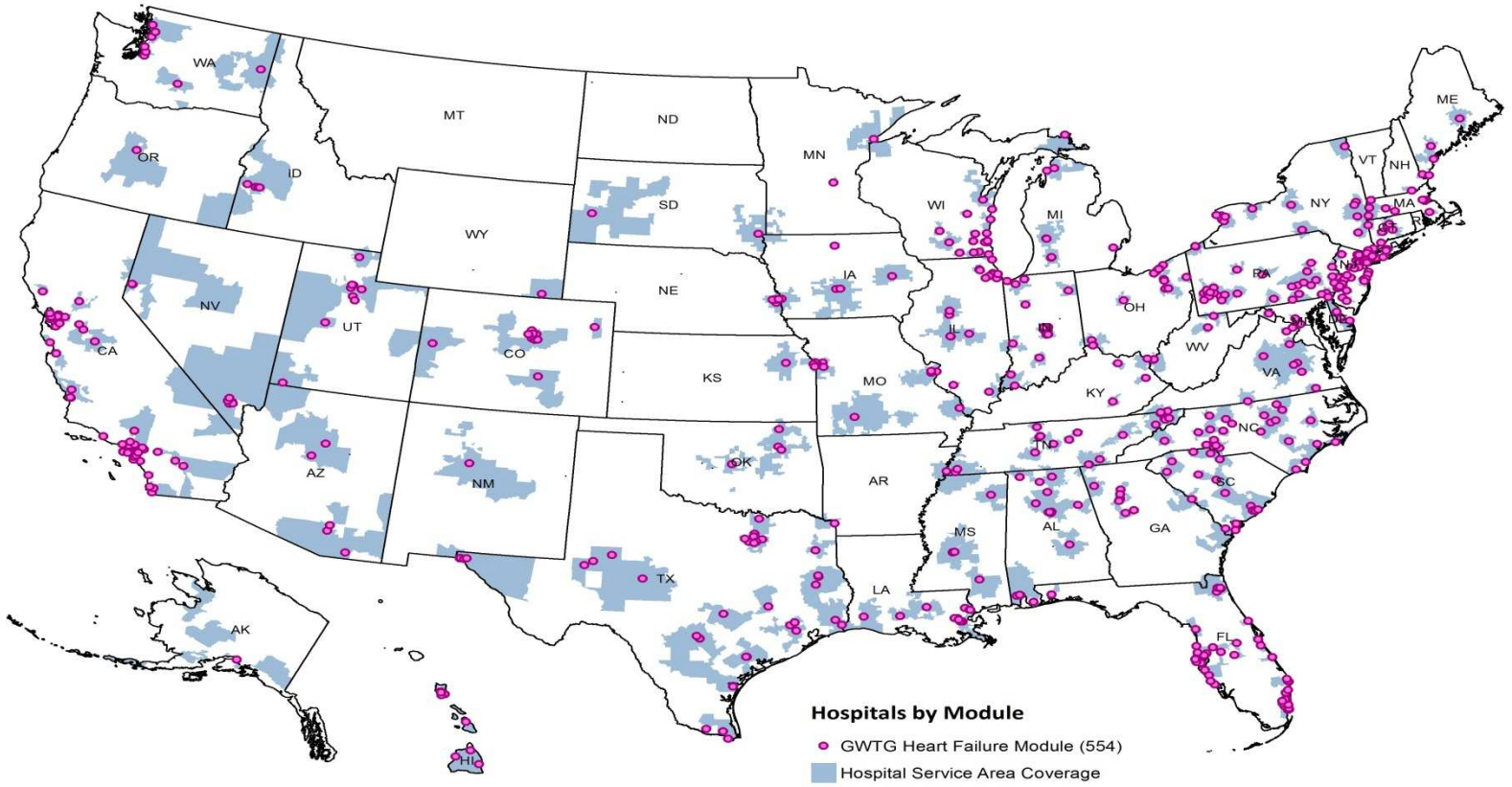
GET WITH THE GUIDELINES®



Data as of 6/30/12. Hospital Service Area based on 2005 Dartmouth Atlas.
Population estimates: ESRI 2011

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RESUSCITATION

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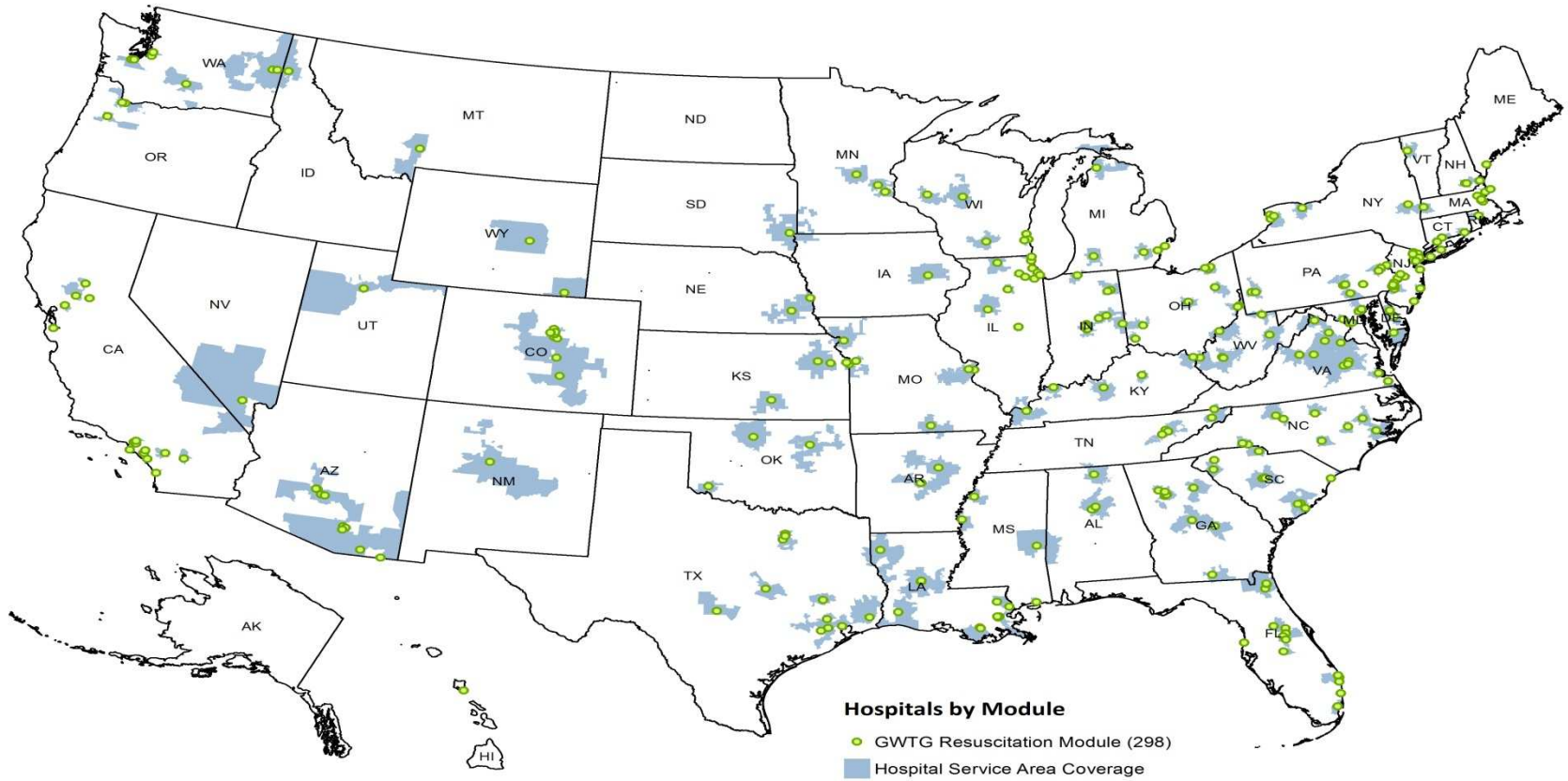
Get With The Guidelines® - Resuscitation

(Count: 298; 27.6% population coverage as of 6/30/12)

American Heart Association | American Stroke Association | GET WITH THE GUIDELINES®



Data as of 6/30/12. Hospital Service Area based on 2005 Dartmouth Atlas.
Population estimates: ESRI 2011

AHA Adult Chain of Survival

- Immediate recognition & activation of emergency response system
- Early CPR
- Rapid defibrillation
- Effective advanced life support
- Integrated post-cardiac arrest care

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American Heart Association® | MISSION: LIFELINE®

New Mission: Lifeline Program

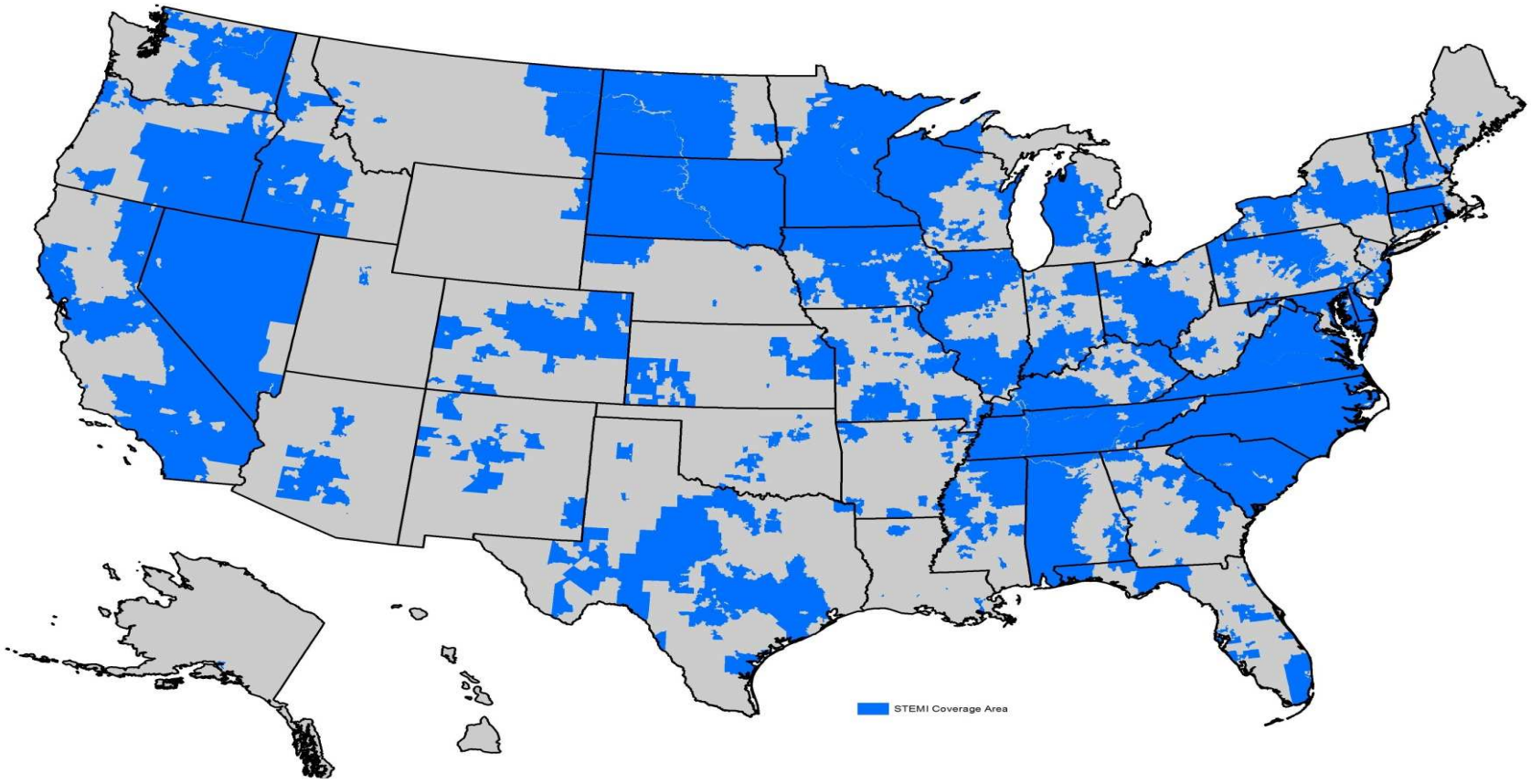
Mission: Lifeline Cardiac Resuscitation Systems of Care

- 300,000 Out-of-Hospital cardiac arrests occur annually
- Less than 25% receive bystander CPR
- 50% of cardiac arrest victims have STEMI
- Out-of-Hospital cardiac arrest has a survival rate of 11.4%
- At least a 5 fold regional variation in the median survival to hospital discharge after OOHCA

- Systematic and Collaboration approach to Out-of-Hospital cardiac arrest patients
- Supported by AHA Science and in *Circulation*
- Community is a added and vital participant
- CPR instruction and administration are most important factors to system success

STEMI Systems Coverage

As of 6/21/2012 (630 Systems; 62.7% Population Coverage)



heart.org/focusonafib

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GET WITH THE GUIDELINES. AFIB

Customer Webinars

AHA and AANN: Novel Oral Anticoagulants

Thursday, May 1, 2013

12 – 1 pm CST

Presenter: Mintu Turhakia, MD

Introduction to Get With The Guidelines-AFIB

Thursday, June 10, 2013

12 – 1 pm CST

Presenter: William Lewis, MD

SAVE THE DATE!

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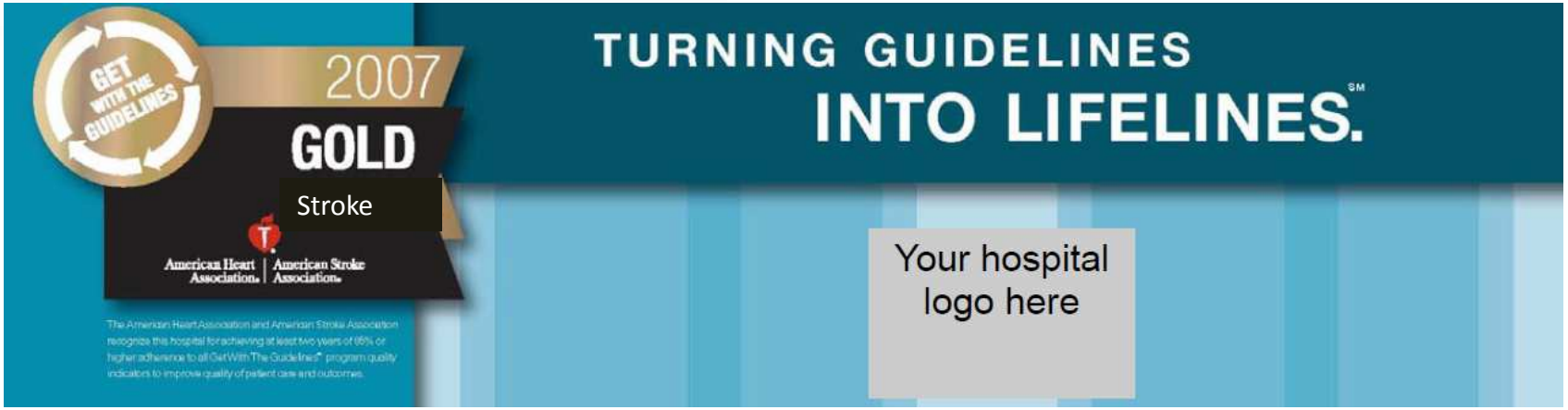
Performance Recognition!

GET WITH THE GUIDELINES® STROKE

GET WITH THE GUIDELINES® HEART FAILURE



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Recognition from the American Heart Association

- Our goal is help hospitals improve care processes to therefore help us reach our Mission of *Building Healthier Lives Free of Cardiovascular Disease and Stroke.*
- Because our hospitals join us in this mission and see measurable results, we want to congratulate them for a job well done.
- Hospitals that meet eligibility criteria may apply for the Get With The Guidelines® Performance Achievement Awards and will be recognized in **USNWR advertisement, Circulation advertisement and the International Stroke Conference and Scientific Sessions**

Get With The Guidelines® Achievement Awards

85% compliance for module specific Achievement Measures
Bronze: 90 consecutive days
Silver: 12 consecutive months
Gold: 24 consecutive months

Get With The Guidelines® Plus Awards

Must have current Silver or Gold Award for Get With The Guidelines®
Hospital may self select group of Quality Measures and demonstrate 75% compliance for same time period as Silver or Gold Award

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GWTG-Stroke Achievement Award Recognition

2012 GWTG-Stroke

US News and World Report Ad in "Best Hospitals" issue

http://www.heart.org/HEARTORG/HealthcareResearch/GetWithTheGuidelinesHFStroke/GetWithTheGuidelinesHeartFailureHomePage/Get-With-The-Guidelines-Recognition-Ads_UCM_310981_Article.jsp

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Find your Hospital | When to call 9-1-1? | What do awards mean? | Patient/Caregiver Information | Contact us

Find award-winning hospitals near you.

Being informed is important. Especially when it comes to health care. Our easy-to-use map puts information about area hospitals at your fingertips.

25mi | Search | Reset Map

SEARCH FOR AWARD-WINNING HOSPITALS NEAR YOUR ADDRESS

www.heart.org/myhealthcare

Why the Overview of GWTG Inpatient Programs?

It's all connected…

Lessons Learned/Success from In-Hospital GWTG Programs

→

Apply to Implementation of Outpatient Program: The Guideline Advantage

guidelineadvantage.org

THE GUIDELINE ADVANTAGE™

American Cancer Society

American Diabetes Association.

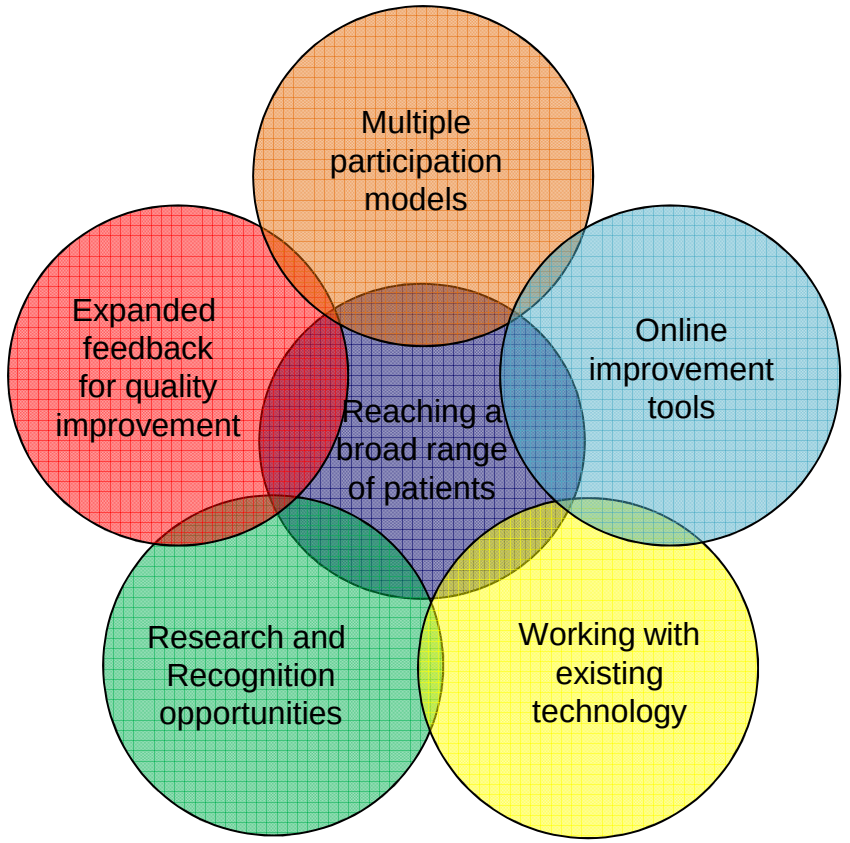
American Heart Association | American Stroke Association.

The Tri-Agency Relationship

What is The Guideline Advantage?

- A joint program of the American Cancer Society, the American Diabetes Association, and the American Heart Association
- Each organization has long developed scientific statements and guidelines specific to prevention and disease management
- Shared goals:
  - Sets national goals and objectives that compliment their guidelines
  - Common interest in translating those guidelines into practice

Program Advantages



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Vision & Goal

Vision

To improve the health of all patients through widespread application of primary and secondary prevention guidelines in the United States through data collection, analysis, feedback and quality improvement in the ambulatory setting.

Goal

To improve the long-term compliance with the ACS, ADA and AHA/ACC guidelines, which in turn supports our **shared organizational mission** to prevent chronic diseases and to improve the lives of those living with the nation's most prevalent chronic diseases.

The Guideline Advantage is based on the success of nearly 10 years experience in inpatient quality improvement and over 2 millions lives touched.

Focus on Quality

Guideline Advantage Fact Sheet: Overview

- Combines the expertise of ACS, ADA, & AHA to advance prevention and disease management in the outpatient setting.
- Evidence-based treatment guidelines, performance measurement tools, and QI strategies.
- Works with existing EHR, requiring no additional data entry;
- Provides on-demand access to data via web-based platform;
- System, practice, and physician-level measure reporting;
- Benchmarking performance internally and externally at state and national levels;
- Recognition for participation and QI achievement;
- Delivering QI resources, knowledge sharing, and research;
- Aligns with Million Hearts and UDS (Uniform Data Systems) adult quality measures;
- Includes patient action list functionality to initiate QI directly from the platform;

Guideline Advantage: Program Description

- Transforms outpatient practice data into actionable data to improve quality of patient care.
- Captures many of Meaningful Use Stage 1 core clinical quality measures most directly related to conditions of interest to ACS/ASA/AHA.
- Reports on measures of interest to Million Hearts initiative created by DHHS and the uniform Data System's (UDS) adult quality measures.
- Measure selection based on nationally accepted ambulatory care measures, and will be updated periodically to reflect measure maintenance, HER reporting changes, and alignment with national programs.

Guideline Advantage: Measures Overview

- Includes two primary measure sets:
  - **Reporting Measure Set**
    - Consists of measures included in Universal Data System (UDS) from Health Resources and Services Administration (HRSA) and Million Hearts (DHHS). Both programs utilize measures from Physician Quality Reporting System (PQRS) and will be calculated with strict adherence to these definitions.
  - **Common Measure Set** will provide quality improvement feedback based on a simplified version of established measures (ie. measures may have similar titles or description, but may have different measure constructs).

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THE GUIDELINE ADVANTAGE™

Program Models

Basic Model

- ✓ Common Measure Set & Reporting Measure Set, with clinic & provider views and one-click access to patient lists
- ✓ Patient Lists with filtering options and action list functionality
- ✓ Demographic Information & detail patient views
- ✓ Comparison, Benchmarking & Historical Trending by clinic and provider
- ✓ **No Cost** program implementation

Premium Model

- ✓ An Additional Measure Set available as defined by the customer
- ✓ Views & filtering options for Teams
- ✓ Customer Driven Functionality, including demographic information displays, incentive program tracking, & non-clinical custom groupings
- ✓ Complete data advisory service, including comprehensive consultations and guidance in identifying data sources, mapping, data cleansing and alignment
- ✓ Fixed implementation fee and annual licenses

Guideline Advantage: Basic vs. Premium Functionality

Functionality	Basic	Premium ★
Data Submission Guidance	X	X
Manual Data Upload	X	
Forward Health Group Data Service		X
Guideline Advantage QI Measure Set	X	X
Guideline Advantage Reporting Measure Set	X	X
Custom Measure Set(s)		X
Custom Population Tracking		X
Custom Measure Tracking		X
Manual Patient Attribution	X	

Guideline Advantage: Basic vs. Premium Functionality

Functionality	Basic	Premium
Custom Patient Attribution		X
Visualization Toolkit	X	X
Enhanced Visualization Toolkit		X
Guideline Advantage Benchmarking	X	X
Custom Benchmarking		X
Action Lists	X	X
Accountable Care Organization Support		X
Pay for Performance Monitoring		X
Custom Reports		X
Cost to Participate	(FREE)	X

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THE GUIDELINE ADVANTAGE

The Guideline Advantage's Measures

Diabetes Mellitus	Preventive Care Screening	Cancer	Cardiovascular
• HbA1c Control • LDL Control • High Blood Pressure Control • Annual nephropathy screening (urine albumin)	• BMI Screening & Follow-up • Influenza Vaccination • Tobacco Use and Counseling • Blood Pressure Screening • LDL Measurement	• Colorectal Cancer Screening • Mammography Screening • Cervical Cancer Screening	• Ischemic Vascular Disease: Aspirin Use & Lipid panel • Hypertension: Blood Pressure Control • CAD: Lipid-lowering Therapy • CAD: Antiplatelet Therapy • CAD: Blood Pressure Control • CAD: Tobacco Use

*Measures are subject to change

Guideline Advantage: Common Measure Definitions

- Coronary Artery Disease
- Cancer Screening
- Diabetes Mellitus
- Hypertension
- Ischemic Vascular Disease
- Preventive Care and Screening

Guideline Advantage: Reporting Measure Set

- Hypertension
- Ischemic Vascular Disease
- Coronary Artery Disease
- Cancer
- Diabetes Mellitus
- Asthma
- Preventive Care and Screening for Chronic Diseases & Stroke

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THE GUIDELINE ADVANTAGE™

Program Model

2 Practices submit collective clinical data to Forward Health Group for The Guideline Advantage

THE GUIDELINE ADVANTAGE

American Cancer Society · American Diabetes Association · American Heart Association · American Stroke Association

1 Providers can use several different technology platforms

3 Data are processed, analyzed and provided back to the practice via a practice portal

4 Performance is measured, Professionals can set measureable goals and chart improvements in performance

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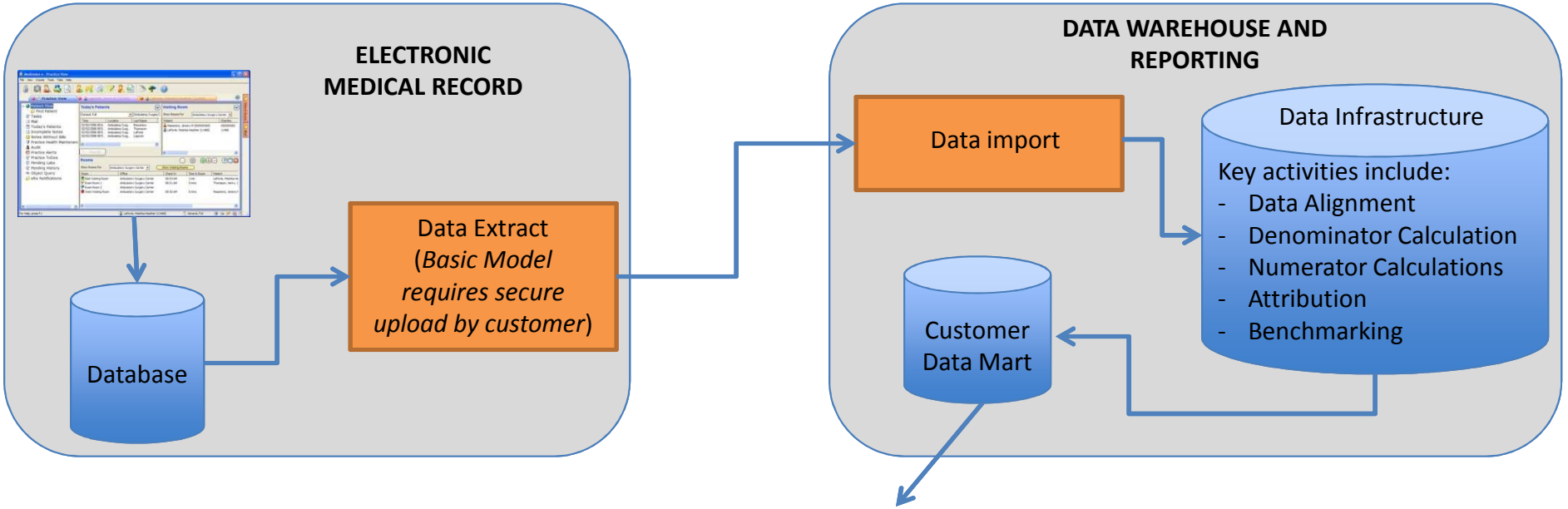
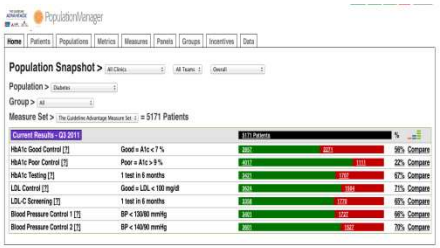
Technically speaking… how does it work?

As a part of quality improvement, clinical data must be aggregated into a data warehouse to facilitate analysis and reporting.





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THE GUIDELINE ADVANTAGE™ | American Cancer Society | American Diabetes Association | American Heart Association | American Stroke Association

What specialties are eligible to participate?

- Cardiology
- Family Medicine
- Geriatric Medicine
- Internal Medicine
- Neurology
- OB/GYNs
- Osteopathic Medicine
- Oncology
- Endocrinology

Patient Inclusion Criteria
ALL Patients 18 and Over

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Advantages to Practices & Physicians

- On-demand access to quality improvement data using a web-based tool
- Available physician-level reporting
- Clinic and system aggregation
- Tools for creating action lists
- Alignment with key national initiatives
- National and State Benchmarking
- Practice Network opportunities including virtual workshops and national recognition

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Program Platform

PopulationManager

Home | Patients | Patient Search | Populations | Measures | Panels | Data

Population Snapshot

View > All Clinics | Overall

Population > CAD

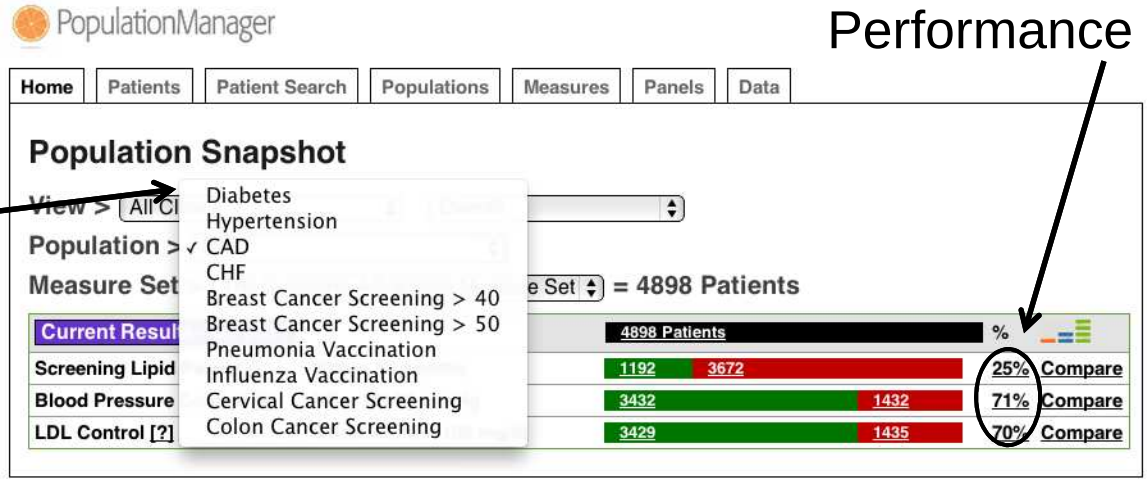
Measure Set > The Guideline Advantage Measure Set = 4898 Patients

Current Results - Q3 2011		4898 Patients	%	
Screening Lipid Panel [?]	Within 12 months	1192 / 3672	25%	Compare
Blood Pressure Control [?]	BP < 130/80 mmHg	3432 / 1432	71%	Compare
LDL Control [?]	Good = LDL < 100 mg/dl	3429 / 1435	70%	Compare

One-click access to patient lists

Measure Performance

Populations



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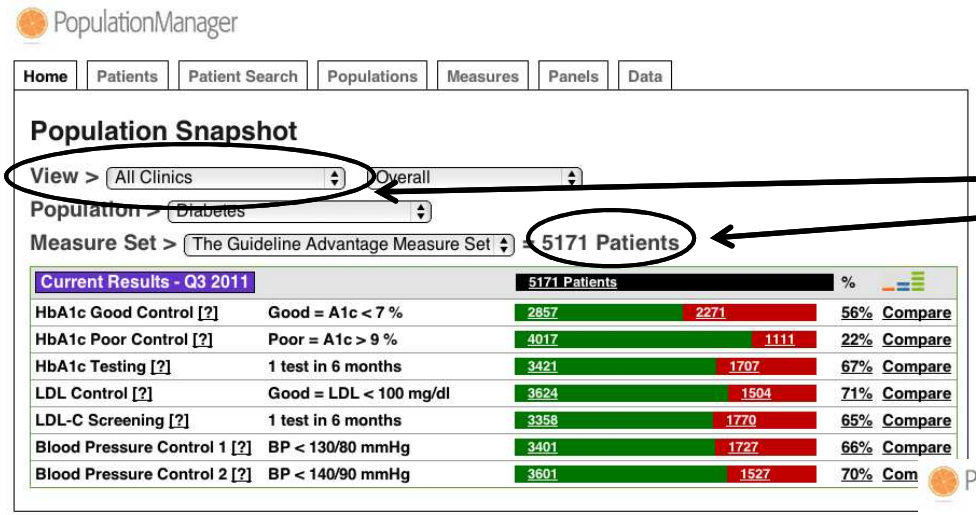
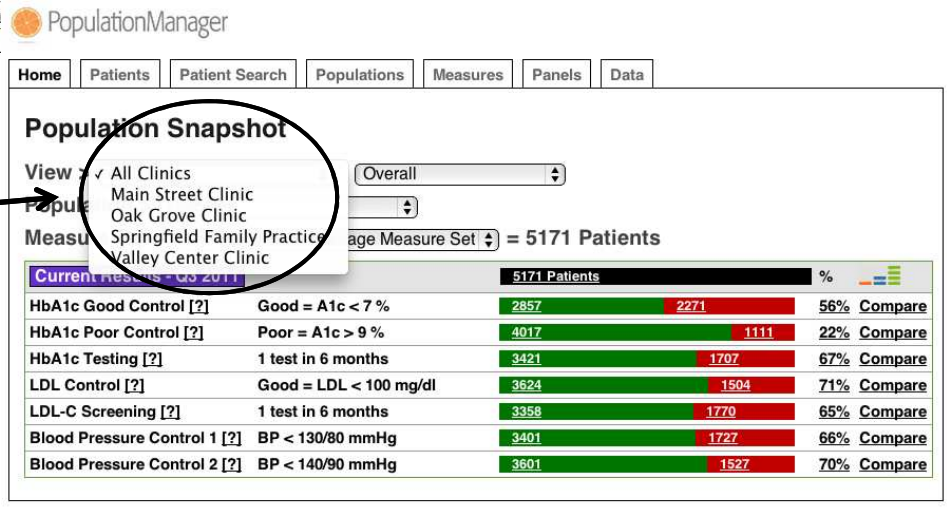
Available Data aggregation



System Level

Clinic View Options



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Action Lists

Filters to create action lists

PopulationManager

Home | Patients | Patient Search | Populations | Measures | Panels | Data

Patients in List = 11

Panel > Oak Grove Clinic | Jayson Vongsakda, MD **> All = Active + Dropped**

Population > Diabetes

Measure Set > The Guideline Advantage Measure Set **Measure >** HbA1c Poor Control

Metric > Select Metric

Filtered By > Population: Diabetes, Payer: Medicare, Measure: HbA1c Poor Control, Category : A1c > 9

Group the Patients Below Into an Action List

Medicare A1c Improvement | Create Action List

Number of Patients = 1 - 11 of 11

Last Name	First Name	ID	Next Appointment	Age (All)	Gender (All)	Payor (Medicare)	Numerator Category (A1c > 9)
Aumiller	Maribel	8190680		75	F	Medicare	A1c > 9
Benwell	Ronald	8226660		74	M	Medicare	A1c > 9
Everroad	Ian	8403100		72	M	Medicare	A1c > 9
Feekes	Lea	8627896		70	F	Medicare	A1c > 9
Foston	Gerard	8404890		73	M	Medicare	A1c > 9
Gestether	Brad	8594151		66	M	Medicare	A1c > 9
Lalande	Helen	8616521		76	F	Medicare	A1c > 9
Mihaila	Liliana	8028710		68	F	Medicare	A1c > 9
Scalf	Holly	8073294		70	F	Medicare	A1c > 9
Speed	Constance	8629898		84	F	Medicare	A1c > 9
Tauscher	Thaddeus	8806589		67	M	Medicare	A1c > 9

Number of Patients = 1 - 11 of 11

PopulationManager

Home | Patients | Patient Search | Populations | Measures | Panels | Data

Patients > Action List > Medicare A1c Improvement

List was saved successfully on Today at 02:46 PM by James Mattes

List was created on Today at 02:46 PM

Patient Count: 11 | Panel: | Filtered By: None

Send to Team | Save as Excel | Print | All Patients In List...

Action List Successfully Updated

Number of Patients = 11 Update List

Last Name	First Name	ID	Next Appointment	Action	Status	Notes	Action Taken
Aumiller	Maribel	8190680		Called			Today at 02:49 PM [?]
Benwell	Ronald	8226660		Choose...			
Everroad	Ian	8403100		Missed-Appointment			Today at 02:49 PM [?]
Feekes	Lea	8627896		Scheduled			Today at 02:49 PM [?]
Foston	Gerard	8404890		Choose...			
Gestether	Brad	8594151		Mailed			Today at 02:49 PM [?]
Lalande	Helen	8616521					
Mihaila	Liliana	8028710					
Scalf	Holly	8073294					
Speed	Constance	8629898					
Tauscher	Thaddeus	8806589					

Choose...
Called
Mailed
Missed-Appointment
Non-Compliant
Other
Referral-Ordered
Referral-Reviewed
Referral-Scheduled
Scheduled

Number of Patients = 11 Update List

Action items

Focus on Quality

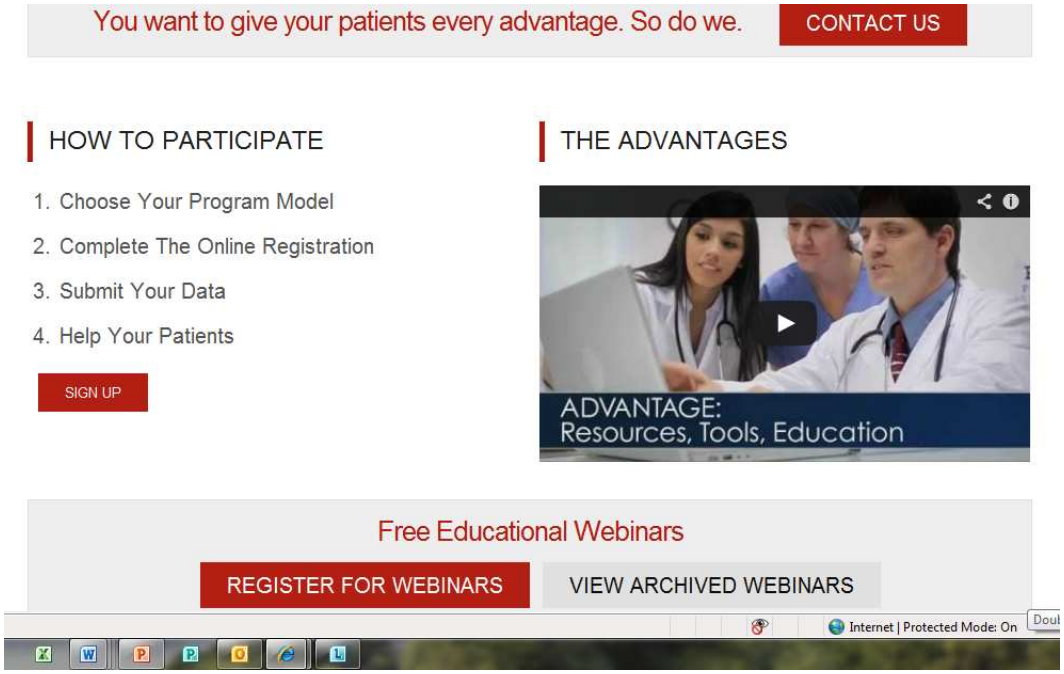
American Heart Association | American Stroke Association

Benchmarking

Physician Panel Comparison

Historical Panel

How does a provider register?



Key Takeaways

- Register on our website at guidelineadvantage.org to express your interest.
- Upon registration, a member of our team will contact you and begin work to identify which data transfer model may be best for your practice.

Additional information at: GuidelineAdvantage.org

Summary: Why join an AHA QI program?

- To improve patient care and health outcomes
- To keep up-to-date on best practices and treatment
- To gain statewide and national recognition with Achievement Awards (in USNWR annual ad; on the AHA online Quality map; at national AHA conferences; and in local news events)
- To avoid federal reimbursement reductions (CMS-Medicaid/Medicare)
- To improve their publicly reported quality improvement data (i.e. Hospital Compare)
- To meet requirements for Accreditation (Joint Commission, SCPC, PCMH)
- To avoid being left out of statewide systems of care initiatives
- To reduce care costs and make health care delivery more efficient

Questions?

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