Caroline: It is now my pleasure to turn today's program over to your first presenter, Steve [Dental 00:00:06], with the American Heart Association. Mr. [Dental 00:00:08], the floor is yours.

Steve: Thank you so much, Caroline. Good afternoon and welcome to the American Heart Association and American Stroke Association's Get With The Guidelines: A-Fib Webinar, targeting a new area of A-Fib care, introducing the Get With Guidelines AFIB Ablation feature. On today's call, we will talk about the ablation tools, features, and how it can be used to improve the quality of care at your facilities.

 At this time, the American Heart Association Get With Guidelines A-fib program wants to thank ... It it made possible with funding and support from Boehringer Ingelheim, Daiichi-Sankyo and Bristol-Myers Squibb/Pfizer.

 Presenting on today's webinar are our speakers, Dr. Bill Lewis and Dr. Jonathan Piccini. Dr. Lewis is currently the Chief of the Division of Cardiology and Director of the Heart & Vascular Center at the MetroHealth system. Lewis [Rikida 00:01:17] MD and [Reese Moss 00:01:19] and the professor in cardiology at the Case Western Reserve University School of Medicine. He also serves on the National Steering committee for the American Heart Association's Get With The Guidelines program and is currently the chair of the Atrial Fibrillation Quality Improvement program.

 Dr. Jonathan Piccini serves as the Director of the EP Clinical Trials program in Arrhythmia Core Laboratory at Duke University and is a clinical cardiac electrophysiologist and Associate Professor of Medicine at Duke University Medical Center and Duke Clinical Research Institute. He, too, serves on the committee of the American Heart Association's Get With The Guidelines A-fib registry program. At this time I'd like to turn things over to Dr. Lewis. The floor is yours.

Dr. Lewis: Good afternoon and good morning, depending on where you are listening to this webinar. I appreciate the opportunity to speak to you all this morning or afternoon. We are going to talk a lot about the ablation registry, but as a matter of introduction, for those of you who are not familiar with the American Heart Association's Atrial Fibrillation Get With The Guidelines program, I wanted to go over a little bit about where we are coming from and an interesting update about the program as we move along.

 First of all, obviously, the prevalence of atrial fibrillation is significant. About 2.7 to 6.1 million people had atrial fibrillation in 2010, and that includes about 9 percent of those people over the age of 80 years. The incidence of atrial fibrillation is about 0.2 percent per year in patients between ages 15 and 44 years, and about 1.1 percent per year in patients over the age of 80. As we all know, atrial fibrillation increases as the population ages, and if the demographic is changing such that the number of patients with atrial fibrillation is going to increase dramatically.

 Next slide, Steve. The way we manage atrial fibrillation involves, really, three approaches. One is anticoagulation, the second is rate control, and the third is rhythm control. What we're going to do today is I'm going to start by focusing on how the Get With The Guidelines program manages patients with rate control and rhythm control, and then we'll get into the idea of anticoagulation.

 Actually, we'll start with anticoagulation. Next slide, please. As you all know, stroke is about five times more likely in patients with atrial fibrillation compared to those people who do not, and that the strokes that occur during atrial fibrillation, because of the thromboemboli, are twice as likely to cause death and disability compared with those of non embolic strokes. Again, we all know that patients who have atrial fibrillation and have a stroke with a-fib have devastating strokes, large disability producing strokes. Next slide.

 In anticoagulating patients with atrial fibrillation, the Get With The Guidelines program really looks at a couple of things. First of all, are we assessing what our thromboembolic risk factors are? What we want to do is we look at the percentage of patients with nonvalvular atrial fibrillation or flutter in whom an assessment of thromboembolic risk factors were used and whether or not the CHADS2-VASc score was actually used as well. We also want to find out whether they were discharged on FDA approved anticoagulant. Again, this is really the percentage of patients who were actually discharged on an anticoagulant that's approved by the FDA, and really, again, based on their CHADS2-VASc risk stratification.

 Next slide. On this slide we talk a little bit about what the CHADS2-VASc score is. Again, I think most of the people on the call probably know this, but the CHADS2-VASc score shows various risk factors, including heart failure, hypertension, age, diabetes, a prior history of stroke or TIA, coronary disease, vascular disease, and the female sex as being risk factors for stroke. As these risk factors rise, you can see the risk of stroke rises on the right side of the screen.

 It's actually very interesting because it's kind of a nice approach that when you're talking with patients you can say that basically if their risk score is one, their risk of a stroke is about one percent. If their risk score is two, it's about two percent per year. If it's three, it's three percent per year. If it's four, it's four percent per year. Then, as you can see, the scale starts to go up a lot more rapidly than that. It's a very convenient score to use from a physician standpoint an a provider standpoint.

 On this slide, also, you can see that the risk of a major bleed is about 1.3 percent, and so you can see why the guideline committee recommended the use of anticoagulants in patients with a CHADS2-VASc score of two or greater. It is because the risk of bleeding, of a major bleed, is lower at that point than the risk of a significant stroke. Next slide, please.

 Now, Get With The Guidelines is really based on the idea that we need to develop a program to improve the adherence to anticoagulation. This is really based on a lot of factors that we really don't have the time to get into today, but in general physicians and providers all have a difficulty causing harm. It's one of those things that when you become a physician you take an oath to do no harm. Unfortunately, with the use of an anticoagulant, there is a risk of bleeding with that. Now, as we mentioned, in the majority of cases the risk of bleeding is lower than the risk and the benefit that we have observed by placing a person on an anticoagulant. However, the physicians still have a lot of difficulty with that, and therefore they don't process the information about risk and benefit as well as they should. This slide shows that perceived versus actual risk/benefit discordance that we see when we look at how physicians view this.

 In the first set of bars, you can see that they perceive that the benefit of an anticoagulant is about a 50 percent reduction, but in all reality it is about 68 percent. When you ask a physician what their perceived risk of a major bleed is, they will tell you it's about 10 percent when in reality it's about 1.3 percent, which we already said. The bottom line is that physicians view the information and educational processes about atrial fibrillation anticoagulation in a skewed manner, and that causes them to decrease their utilization of this. Next slide.

 Now, we have been evaluating the use of anticoagulation in patients with atrial fibrillation through the Get With The Guidelines stroke program for many years, and this is data that we published several years ago that showed that when we use the Get With The Guidelines program, we can increase the adherence to anticoagulation to about 95 percent over about a three to four-year period. We can achieve those levels, you can see that they are very, very high and higher than has ever been seen in any kind of a quality assurance program in atrial fibrillation anticoagulation. Next slide.

 We did this, so the argument is always, "Well, you did this by just documenting complications better," and the answer is, "No, we did not. We actually increased the number of patients that were anticoagulated and we actually decreased the number of people in whom a contraindication was documented." You can see that we're able to, in this same six-year period, reduce the number of patients in whom a contraindication was documented from 48 percent to 33 percent, meaning not only were more people being anticoagulated, but more people were being anticoagulated where we had thought that they might have a contraindication in the past, but when we looked at it more carefully, we said, "No, I think we can put this patient safely on an anticoagulent." We were able to do this in a very efficient and in an excellent manner to actually improve adherence to anticoagulation in the stroke module.

 We thought, "Okay, this is a really great idea. Let's try to move this into the general atrial fibrillation population." I guess the point is we did it in the stroke module, but that's when the horse is already in the meadow and we're closing the barn door after they've gotten there. Let's try to prevent the stroke, and let's get this in the patients who have atrial fibrillation. We created the Get With The Guidelines Atrial Fibrillation program to do just that, and what did we find? Next slide, please.

 What we found is that in the early portion of this program, the Get With The Guidelines Atrial Fibrillation program, we are able to achieve adherence to anticoagulation using and FDA approved anticoagulent on patients who are eligible, about 90 percent success in anticoagulating patients in the very early portion of this program. This is, again, the highest percentage of anticoagulated patients in any quality improvement program seen today. In general, the Get With The Guidelines Atrial Fibrillation program works. Next slide, please.

 Let's talk a little bit about what the program also does with respect to rate control and rhythm control. Next slide. In rate control, the goal is not to resume sinus rhythm because we either have lack of symptoms or we have difficulty of resuming sinus rhythm due to heart structure or duration. We've had a risk/benefit analysis with the patient. We've said, "The patient has elected to remain in atrial fibrillation." The goal of rate control is to control the rate. Usually less than 110 beats per minute, and that's one of the parameters that we evaluate in the Get With The Guideline program. As you can see, there are drugs that are used to control A-fib rate, and those include beta blockers, calcium channel blockers, digoxin, and in rare cases amiodarone. Next slide, please.

 Now the other strategy that's used, and one that's going to be very important for this program, is a rhythm control strategy, and in this case, the goal is to resume sinus rhythm. These are usually symptomatic patients where they have difficulty in controlling the rate, that is you can't control the rate no matter how you try, so you make decision to try and put them back in sinus rhythm to control their rate better. They usually are patients with more normal heart structures and shorter duration, and we've again had a risk/benefit discussion with the patient with respect to either the use of ablation or drugs and they've elected to go on with control of the rhythm.

 The drugs that we use for these are really membrane active channel drugs, and they include drugs like sotalol and dofetilide, which are potassium channel blockers, flecainide and propafenone, which are sodium channel blockers, and amiodarone and dronedarone, which are classically both sodium and potassium channel blockers. In addition, ablation is also a very appropriate rhythm control strategy, and that's one of the main features of why we're talking today. Next slide, please.

 The Get With The Guidelines A-fib program is a program designed to assist hospitals in caring for their patients and consistently providing the latest evidence based treatment in their atrial fibrillation patients. The program offers a means of monitoring the quality of atrial fibrillation care in US hospitals and building a database for continued research and further quality improvement. We do this in a very important way. The data that you give us is private. It is your data. It is not anybody else's data. We do, however, accumulate this data using a third party, allowing us to look at the data across the nation and in various regions to allow you to benchmark against the data that's theirs, but the information that you give us is private. We launched the program on June 15th of 2013. Next slide.

 The goals of the program are to improve the quality of care for patients with atrial fibrillation. Improving adherence to guidelines to prevent stroke, using anticoagulants, and improving patient adherence to anticoagulation by providing education and organization. I can't overemphasize the importance of the education and organization in this situation because it makes doctors and other providers more comfortable with placing their patient on an anticoagulent when they know that their peers are doing it and that there is a structure for education that is available for their patients to take.

 Additionally, we want to improve heart rate control in patients with atrial fibrillation and assure quality drug therapy in patients with atrial fibrillation. We also want to improve the outcomes of patients by assuring adherence to treatment for comorbid conditions. Patients with atrial fibrillation often have coronary disease and need to be treated with beta blockers and statin, or they have heart failure and they often need to be treated with beta blockers and Ace inhibitors. They often smoke, and we want to provide smoking cessation counseling to them. Next slide.

 The entry criteria for this includes patients with a principle diagnosis of A-fib admitted to your hospital as an inpatient, or they can have a principle diagnosis of atrial flutter, and hospitals are encouraged to enter patients with a secondary diagnosis of atrial fibrillation or flutter admitted to the hospital as an inpatient. In addition, this is the first Get With The Guidelines module to allow entry of patients who are in observation and not admitted as inpatients. We exclude patients who are evaluated and treated for [inaudible 00:16:47] or patients less than age 18. Next slide.

 The Get With The Guidelines A-fib patient management tool is one of the things that make this such a seamless program. It allows you to follow your patients in a secure way, on the web, and evaluate and enter their data in a nice, seamless way. We're going to go through the pieces of this a little bit. You're going to see a community page, a patient grid with an electronic case [inaudible 00:17:23], real-time reporting and measures and a data download tool and an interface with Get With The Guidelines Stroke and Heart Failure, allowing you to move data from each of those so that if you are already a member of those two programs and your patient has atrial fibrillation, some of that data will move seamlessly across the program. We also have an optional CSV uploader, which you can move data into other programs where you have to submit data.

 Next slide. The community page is where you go to first when you open the program up. You can see that patients with atrial fibrillation are listed on this community page, and this community page gives you an option of opening up frequently asked questions, blank forms, patient education tools, and a host of other things where you can actually launch the program. Next slide.

 As I mentioned, the things that are in the community page include patient education materials that are available from the American Heart Association and also reporting tools that allow you to benchmark your data against other hospitals in the United States. Next slide.

 There is a patient grid, and you can see the patient grid lets you put in a patient ID and their admission data, and allows you to accurately put the patient information into the program. In addition, next slide, you then, at this point, launch into the A-fib electronic case report form, which is tabbed, as you can see at the top. It uses coding instructions, which we painstakingly went through when we first developed the program, to identify what the coder has to see to place information in this record accurately.

 Things that are in bold are actually required, and you can see to the right of the page is the pink box which is for errors and warnings for real-time data validation, so that if you put in a discharge under this date, which is before the arrival time, it will tell you this is not an appropriate way to do this. It catches errors and it goes ahead and gives you a way of identifying those errors and quickly fixing them. In addition, the records can be saved as complete or incomplete so that if you're trying to get a patient in the system and you don't have the time to finish it, you can finish it up later. Next slide.

 You can see that the medical history is very comprehensive. The reason it's so comprehensive is that much of the information that is in there is used to auto populate important areas of the record. Things like alcohol use you can see at the top. Alcohol use is a medical history piece and it's important because what it's used for is helping you understand the HAS-BLED score, which gets auto populated and calculated for you. Patients with coronary disease. Again, the CHADS2-VASc score is auto populated with respect to that. This comprehensive medical history is important because it helps you. Next slide.

 You can see that there is an in-hospital care form where you can identify things that happen to a patient while they're in the hospital. We did no procedures or we did an atrial flutter ablation using cryoablation. You can enter that data into the system there. If you perform an echo during the hospitalization, you can put the echo data into the system. There's a lot of things that if they happen during the hospitalization that we can actually go ahead and get the patient's data into the record. Next slide.

 Again, during the hospitalization, you can see that there might be antiarrhythmic drugs that are added to the patient record. There are areas where there are antiarrhythmic drugs or anticoagulants that when they are started they can be placed in the record during the hospitalization. Next slide.

 Part of the performance measures that were identified by the American Heart Association, American College of Cardiology and the American Medical Association include the assessment of risk factors. That performance measure exists, and to allow you to do that better, you can see how this page helps you do that. Was the CHADS2-VASc score recorded? The answer is, if it's 'yes,' what was the number that was recorded in the medical record? If it was not, what were the risk factors? Were there risk factors assessed during the hospitalization, and if they were all assessed, you can just check that box.

 If the CHADS2-VASc score is reported as a 'no,' the score calculator will appear below and it will automatically calculate based on a populated set of risk factors that you can see at the bottom of the page. Those risk factors are auto populated, allowing a score to be calculated for you. You can see, again, the risk of stroke from the literature is actually listed there. Next slide.

 Again, the next tab is on discharge. It looks at the discharge heart rate and allows you to identify if the discharge heart rate is greater than 110 beats per minute, which is the guideline. It asks you to indicate why that was done. Next slide. Again, discharge medications are all added to the record as well during discharge, and you can see the list of medications there is quite extensive. Next slide.

 There's also a slide that talks about the risk interventions that are performed. Things like smoking cessation, counseling, what was the rhythm or rate control strategy, how is the patient going to be educated and anticoagulation therapy education given. Again, the fact that anticoagulation therapy education is given and a PT and INR is planned at followup is very important in allowing physicians and other caregivers to feel comfortable in giving an anticoagulant to their patient. Next slide.

 The next slide is obviously way too busy to actually talk about, but what it says is that there are other risk scores that are in the background that are calculated. Now, we should emphasize they are background calculated, and the reason they're background calculated is because the atria and HAS-BLED scores are not emphasized in the guidelines for determining the use or non use of anticoagulants, thus this is there for your information only and will give you a risk of significant bleeding that you could expect in your patient over time. Again, this should be used in your shared decision making with your patients in terms of identifying whether or not to use an anticoagulant, but really is not guideline based. You can see that we give you a lot of information that is pre-populated from that medical history and other things that occur during the hospitalization. Next slide.

 There is a measures tab which you go to next. What it does is it looks at those performance measures and quality metrics that we look at, and it puts them in red if you're non compliant with them. If the patient has heart failure and is not on an Ace inhibitor, you have the opportunity to go back and indicate that they were on an Ace inhibitor or the reason why they were not, allowing you to finish the measures tab with a completely green table indicating that you are in full compliance. Next slide.

 Again, one of the important parts of the Get With The Guidelines A-fib program is the reporting function, and there are things that can allow you do to audits. There are measure reports where you can look at your own quality metrics. There are predefined measure reports which we produce to allow you to benchmark against other hospitals and, again, you can also look at your patient management tool, patient list, so if you want to provide a list of your patients that are recorded in the program. Next slide.

 As a look at what the program does, obviously we want to provide high quality care for patients with atrial fibrillation, and to do that we want to reward that quality. The achievement measures or the ability to get an achievement award involve the idea of fulfilling the measures that you can see under the achievement tab. That is an Ace or [inaudible 00:27:47] discharge for left ventricular systolic dysfunction in patients with A-fib, assessment of thromboembolic risk factors, beta blocker at discharge in patients with atrial fibrillation. You can see that for some reason we lost the bullet on that one. Discharged on an FDA approved anticoagulant. Planned PT and INR followup for patients on warfarin, anastatin and discharge in patients with coronary disease, stroke or TIA or peripheral vascular disease.

 In addition, the quality measures that we have identified as important but not necessary for achievement award are things like aldosterone at discharge for patients with heart failure, anticoagulation therapy education, atrial fibrillation education, a CHADS2-VASc score reported. Remember, the achievement measure is assessment of thromboembolic risk factors, but the quality measure is CHADS2-VASc score reported. A discharge heart rate rest at 110 beats per minute, smoking cessation, and warfarin at discharge for patients with valvular heart disease and atrial fibrillation or flutter. Next slide.

 As a result, we have a hospital recognition program that is consistent with all of the other Get With The Guidelines Achievement measure recognition programs, so that if you're in 85 percent compliance with all of these achievement measures, you're eligible for an award. If you do this for 90 days, it's bronze. If you do it for a full year, it's silver, and if you do it for two calender years, it's gold. I always believe in walking the walk and not just talking the talk. I'm proud to say that MetroHealth in Cleveland is a Silver Award winner for the American Heart Association Get With The Guideline A-fib program, and we're one of only two hospitals in the nation who have achieved that. Next slide.

 Little plug there. Sorry about that. Award winning hospitals are recognized at the national level, both scientific sessions and in circulation, and also in the best hospitals issue of US News and World Report. Hospitals are also given customizable marketing materials that they can announce their achievements locally. You're given the entire media set and the logos and all of that to allow you to celebrate your success in you community. Next slide.

 With that in mind, we have the pleasure of beginning the Get With The Guidelines Atrial Fibrillation A-fib Ablation module. This is a very important achievement that we've put together in a very short period of time. This actually was born in May of this year, and we were able to get it up and running on December the 5th just several days ago. Next slide. The first questions always, "Well, why did we do this?" Next slide.

 Why we began to do this, if you will, we kind of wanted to build a case. The first part of this case is that there is a need. It's important to do this. We also wanted to better involve the EP community in the Get With The Guidelines A-fib program. We originally designed the A-fib Get With The Guidelines program to work with hospitalists and primary care physicians as well as cardiologists, but we really wanted to make sure that we included the EP community because they're the ones who see the majority of the patients with atrial fibrillation when it becomes serious. We wanted to provide synergy, and again, that's part of that community idea.

 We had a window of opportunity to do this. The ablation registries have been talked about for years. They have been extensive. They have been unable to be done because of this expense, and we were able to put it into the Get With The Guideline A-fib program for free. If you're a member of the Get With The Guideline A-fib program, you get this module at no added cost. There is a need. Next slide.

 You can see that a-fib ablation is not a fad, that a-fib ablation is increasing every year in a linear fashion and you can see that at this point about one percent of hospital admissions, of hospitalizations for atrial fibrillation involve a catheter ablation. Next slide. The reason for this is that a-fib is just no fun to have. If you're a patient with atrial fibrillation, your quality of life is usually worse than that of a person who has suffered a heart attack. You can see that patients with a-fib feel that their general health, their physical function, their social function and their mental health are lower than those of, certainly, controls and even non-statistically below those patients who have suffered a myocardial infarction. Next slide.

 You can see that ablation works. The first thing it does is it reduces hospitalization. You can see that the number of patients who have been admitted to the hospital after an a-fib ablation is about 14 per hundred years, whereas it's 93 per hundreds years if the patient has no undergone an ablation. You can see that that's been shown in three studies, and when you do a meta-analysis on that you can see that the risk ratio is 0.15, that there is an 85 percent reduction and admission to the hospital after a patient has had an a-fib ablation. Next slide.

 You can also see that an a-fib ablation reduces symptoms so that in patients who have had a successful atrial fibrillation ablation, and that was seen in 72 percent of the patients in this study, at two-year followup, you can see that if your ablation was successful, we reduced your symptoms dramatically. That includes things like palpitations, dyspnea, dizziness, weakness, chest pain, all of these symptoms go down in patients who have a successful atrial fibrillation ablation. Next slide.

 You can see that in this same study, those patients who are off antiarrhythmic drugs, that they achieved atrial fibrillation off antiarrhythmic drugs in 72 percent of the patients. Again, at two-year followup, you can see that their atrial fibrillation symptom scores are dramatically reduced if they are not on antiarrhythmic drugs or they are controlled by the antiarrhythmic drug. If they have recurrent atrial fibrillation, you can see that there is no reduction in their symptom score. Next slide. Thus, the American Heart Association, American College of Cardiology, and the Heart Rhythm Society in their 2014 guidelines addressed the idea of atrial fibrillation ablation. Next slide.

 You can see that a class 1A indication is for patients with symptomatic paroxysmal atrial fibrillation who have failed an antiarrhythmic drug. They, again, gave them a class 1A indication for ablation. Additionally, if patients with persistent atrial fibrillation had failed an antiarrhythmic drug they were also given a class 2A indication for an atrial fibrillation ablation. In addition, you can see that as first line therapy for atrial fibrillation, which is paroxysmal in patients who have never received an antiarrhythmic drug, the committee actually assigned a class 2A with level of evidence be indication for an atrial fibrillation ablation.

 Ablation of atrial fibrillation is here. It's no going away. It has dramatic benefits and the Heart Association, ACC, and Heart Rhythm Society has indicated that it is an appropriate therapy in patients with a-fib. Next slide. You can see that a-fib is very prevalent across the United States and that ablation is also very prevalent across the United States, again, increasing over time, and that in the record AF program, about two percent of patients actually had an AF ablation, and in ORBIT-AF about five percent of patients had atrial fibrillation. Next slide.

 We all know that the number of ablation actually equals the number of atrial fibrillation ablators in the United States. However, there are some common ways of doing a-fib ablation. Most of them are used in circling of the pulmonary veins in some way to actually achieve sinus rhythm. Next slide. Now, of course, this doesn't come without some risk. That's one of the real important keys of an ablation registry is to sort of understand the benefit and risk of what we are doing, and to be able to make your ablation outcomes and complications comparable to improve the quality of the care that you're providing in your location and to be able to do it in a private way so that you can see that the risk of death during a procedure like this is about 0.8 percent. Small risk of myocardial infarction. The risk of pericardial effusion, and we'll talk about this in one second, is actually about 1.7 percent. About a 0.8 percent risk of stroke or TIA, and vascular complications are about a half a percent. Next slide.

 These complications that are vascular include things like hematomas, pseudoaneurysms, AV fistulas, retroperitoneal bleeding and need for transfusion. The intracardiac complications include tamponade, as we mentioned before, which is about 1.3 to 1.7 percent of patients, valve entrapment, again, stroke or TIA. The extracadiac or thoracic complications include pulmonary vein stenosis, which is becoming rare, phrenic nerve paralysis, which is usually very rare, but with some of the cryoablation techniques we've seen a little bit of a rise in that, and atrio-esophageal fistula, which is very rare. In total, risk of a complication is about four and a half percent with all cause of death being about 0.15 percent incidents of death, and that, again, comes from the Cappato Analysis that was published in 2010. Next slide.

 The Heart Rhythm Society understands that we need to be out in front of this problem. We need to be out in front of understanding where atrial fibrillation ablation, what its role is and be able to start to begin to manage the complication. The Heart Rhythm Society has proposed a performance measure for the technical specifications of atrial fibrillation ablation, and it includes the idea of understanding the frequency of cardiac tamponade or pericardiocentesis following an atrial fibrillation ablation. You can see this is the actual measure that was proposed by the Heart Rhythm Society. The Heart Rhythm Society is trying to get out in front of this. As you probably know, we have been working with the Heart Rhythm Society as partners with the Get With The Guidelines A-fib program, and we have proudly begun working with them to look all aspects of the quality of care in patients with atrial fibrillation. Next slide.

 We also talked about the better involvement of the EP community in Get With The Guidelines A-fib. Remember, we pushed this out as something for general internists. Next slide. Next slide. We pushed this out originally for a broad variety of participants, general internists and primary care doctors, stroke centers, cardiology centers, and we want to pull the atrial fibrillation centers into the mix. That's where the A-fib is. It's in the A-fib center. We should want those centers to be involved, and those centers are generally run or at least atrial fibrillation electrophysiologists are very involved in those programs. Next slide.

 Again, we talked about synergy, and the idea with synergy is that we want to include the patients that are having a-fib ablations. Again, you can see that we include those patients with a-fib whether as inpatients or outpatients and at hospitals with patients with atrial flutter, but the most important thing is that patients who are seen in observation and not admitted as inpatients can be included in the program. You can see that 50 percent of AF ablations are actually done on an outpatient basis. Again, we're providing synergy with the program by adding an atrial fibrillation ablation module. Next slide.

 You can see that this will allow us to change the atrial fibrillation. The population we're looking at, we're going to see representation of younger, more symptomatic patients. We'll have more balance enrollment, not just patients who have had a stroke or acute heart failure, hospitalization with atrial fibrillation, and we'll be able to better track the accuracy of readmission. Next slide. There is a window for opportunity here. Again, we mentioned the fact that other organizations have tried to build a registry for atrial fibrillation and that expense and a variety of other reasons were mentioned for not building these kinds of databases, and the heart association came out and said, "This is an important piece of the quality of care of patients with atrial fibrillation and we're going to move forward with it." Next slide. As Ferris Bueller said, "Life moves pretty fast." Next slide. Very fast is actually last Saturday. We launched the atrial fibrillation ablation registry, and hopefully we're all entering patients as we speak. Next slide.

 Let's walk a little bit through what this looks like. What does the a-fib ablation tab look like? First of all, it will show up as an extra tab. If your hospital wants to enroll in this program, you will now start seeing an extra tab on your ECRF. You'll see, first of all, that the patients that they get in a-fib ablation or an atrial flutter ablation, that those patients are actually analyzed in the main part of the Get With The Guidelines program. This is not part of the ablation tab itself. However, once you get into the a-fib ablation tab, you go to that tab, as you can see where the arrow is in the upper right part of the slide and you can see that the first thing that happens is that you're opened up into a place of "What was the indication for ablation? What were the symptoms that the patient was experiencing? Did the patient have a prior ablation for a-fib?" Next slide.

 It tries to get into a little bit of what's the left atrial diameter, either in centimeters or in just a general enlargement description. Were they treated with anticoagulation in the perioperative procedure either interrupted, uninterrupted or bridging? Next slide. You can see the type of anesthesia that was used was on there. The type of energy that was used, either irrigated tip with force sensing detection or non-force sensing detection or a cryoballoon. The imaging that was performed before the procedure, either a TEE or an intraoperative TE or a CT. What was the transseptal approach that was used for the procedure? Next slide.

 Then we get into things like "How long was the procedure? How long was the radio frequency energy lesion performed? What was the fluoro time that was performed?" Next slide. What was the ablation technique? As we know there are numerous techniques that you can use, and sometimes we use multiple techniques in a single procedure so you can check all of those if you so desire. Next slide.

 The next piece is "What was the endpoint? Was the endpoint achieved, and either atrial fibrillation was not inducible, it terminated, or there was isolation observed? Was there entrance block or exit block? Was there a provocation testing used to determine if the patient had reinducible atrial fibrillation? Next slide. Next, were there any complications to the procedure? If there were none, you just check 'no,' and then you don't have to worry about anything else. Were there complications that occurred? You can check off those that are on this list, which is rather extensive. Next slide.

 Now the most important thing about an atrial fibrillation registry that we would not have been able to exclude is followup. We want to know were there any complications, did we achieve our goal, and we wanted to achieve that at about six months. We picked six months as a time period at which to look as a time period, so 180 to 270 days post discharge you can create this followup form. You'll be prompted to create it and you will be able to create it after 180 days. Next slide.

 The 180 day followup form, which was, again, very important for this process to be able to allow you to know what your success rates and your complication rates are. It, first of all, populates the date of hospital discharge and you put in the date of your followup, and then the other questions are fairly straightforward. Were there any adverse events? Is the patient alive? Next slide. Was the patient rehospitalized? Were there any arrhythmia related hospitalizations? Did the patient undergo a cardioversion? Was there a recurrence of the arrhythmia that was documented? Was the antiarrhythmic drug discontinued? Is the patient currently taking any of the following medications? It lists that, but at the bottom of that slide you can see we want you to tell us "Is the patient on an antiarrhythmic drug?" Next slide. Last, part of this is "Is the patient currently on antithrombotic therapy, and did they have a repeat ablation? Are they having symptoms of recurrent arrhythmias? Next slide.

 I know we went through this a lot very fast, but we're very excited about adding atrial fibrillation ablation to the Get With The Guidelines A-fib program. We think it's natural for us to do this. We believe that we're the national leaders in quality improvement and that we're the natural people to be able to help you evaluate the quality of your patients who are undergoing atrial fibrillation ablation or in the treatment of atrial fibrillation. I guess at this point we are running a little late and I'm going to open it up for questions and we can go from there. Steve?

Caroline: Ladies and gentlemen, at this time we would like to take any questions that you might have for us today. To ask a question via the web, please click on the Q and A section on the lower left-hand corner of your screen, type your question in the open area, and click "ask" to submit.

Steve: Yes. Thank you so much, Caroline. While these questions are coming in, we're aware that some of the listeners today are currently participating in our Get With The Guidelines A-fib program, and these facilities can activate the ablation feature at no additional cost to them. The only thing they need to do is please contact [Quintiles 00:50:17] and request the activation of the component.

 For those currently not enrolled in the Get With The Guidelines A-fib program, please contact your local QI representative so they can actually guide your through the contracting process, or you can actually go onto heart.org/focusonafib and be able to enter some information, and we will reach out to you as soon as possible.

 At this time, I wanted to field some of the questions that have come in. "Can we download the a-fib data collection form to see the data collection points?" Yes. We will have the electronic version of the [CRF 00:51:22] up on our website, so we will provide that to you. Second question is "Can we share PMT tab views with our EP docs to make decisions on participation?" That will go hand in hand with what I just said, that it would be able to provide you with that information.

 One of the questions is "Can we enter additional followup forms for continued longer term followup?" At this point, we have it so that you would be entering it once, but we can explore looking into following that up with additional components of that. Let's see ...

Dr. Lewis: That's a great question, though. That's an excellent question.

Steve: Yeah. It really is. One of the questions is ... and Dr. Lewis, I'll let you field this. It says, "With the ACC additionally launching a registry next year, what sets apart Get With The Guidelines A-fib registry?"

Dr. Lewis: There are a number of things. First of all, the heart association has built its reputation on the quality of care and the Get With The Guidelines program has a tremendous track record in improving outcomes, not just registering information, but improving outcomes. If there is a particular success rate or a particular complication rate, you want to be able to benchmark yourself against others and you want to put in place the processes to improve. One of the most important pieces of the Get With The Guidelines program is these webinars and these educational processes and all of the pieces on the community page where you will see the ability to get better at what you're doing, and that's really the important piece.

 It's one thing to register. It's another thing to get better. Quality improvement is not registry. This is a natural addition to caring for patients with atrial fibrillation, and that's why we are in a much more superior position than the ACC. The last thing, of course, is I don't know how many people have ever done anything with the American College of Cardiology, but I think we're going to be quite competitive from the price standpoint. Looking at data, you're having the various groups look at data, is on its way, and I think we all need to get on board to looking at our own data first before someone else starts looking at it for us. Steve, did I answer that okay?

Steve: Yeah. That was perfect. Kind of one of the other things that goes hand in hand with the question with this, that you were just reiterating, is the fact that it really is a combination of not only the ablation component of it, but the comprehensive aspect of the other side of this that we currently capture the Get With The Guidelines A-fib module and the ability to be able to benchmark against all the other facilities that are out there utilizing our program currently.

Dr. Lewis: You're getting the ablation registry and you're also getting quality improvement for free, if you will.

Steve: Okay. Hold on. "Can EP physicians access the information within the patient management tool separately?"

Dr. Lewis: Every hospital is given a number of codes that you can actually give an entry code to your electrophysiologist to look at the data.

Steve: A lot of questions. "How many facilities currently participate in Get With The Guidelines A-fib registry?" I can answer that. Currently we're at 85, and the number of patients in the US registry were at roughly 15 thousand patients currently in there right now. "Is there a separate patient management tool for ablation?" That would be no. It's a tab within the Get With The Guidelines component, but there is also, as Dr. Lewis showed, a followup component to this. It says, "You had mentioned ..."

Dr. Lewis: [crosstalk 00:57:24] Steve, let me just answer that. One of the things about quality improvement is the idea of spreading, so starting off in a part of the program and moving through. If you said, "I want to start this program by just entering my ablation patients," I think that would be a perfectly good way to get started with program and then start moving through other groups of patients as you get going. Really, what you want to do is extend the opportunities to improve to as many patients as you can. We all know that Rome wasn't conquered in a day. You want to start small and spread and get better overtime.

Steve: Correct. "You mentioned being competitive from a price standpoint with ACC. We are under the impression that this was free. Is there an addition charge for the ablation component at some point?" That would be no. You have to participate in the Get With The Guidelines A-fib registry, which is approximately two thousand dollars per year, and the ablation component is free as part of being involved with the Get With the Guidelines A-fib registry. In addition to that, I would mention that we do have numerous grant funding out there to help offset your cost of the annual fee for the patient management tool.

Dr. Lewis: Steve, are we still getting discounts if you have multiple programs?

Steve: Correct. Yeah, if you're using stroke or heart failure, it actually can reduce the cost even more down to approximately about 17 hundred dollars per year for the program itself. "Are there additional measures for the ablation section?"

Dr. Lewis: No. We have not thought about how we're going to do the ... There are no additional measure. You get an achievement award by achieving the achievement measures we talked about earlier. We really have not looked at, and there are no set standards for quality in patients with atrial fibrillation ablation yet. Once those get developed, we'll be following this over time and we'll get our chance to see how the real world really works with this and we'll have an opportunity to look at it. There will become clear cut standards for achievement based on ACC, AHA, PMPI standards. We will go after those and we'll put them in place. Then they can be opportunities to become a Get With The Guidelines A-fib gold plus program, which involves quality measures.

Steve: I know we're at the top of the hour and a couple minutes over, so I kind of wanted to close things out. We do have a brief survey for you all to complete after this, and we appreciate you taking the time to complete this survey, as it will help improve our future webinar offerings. On behalf of the American Heart Association and the American Stroke Association, we'd like to thank Dr. Lewis so much or this phenomenal presentation, and also for all of you who attended and your valuable time and participation on today's webinar. Again, thank you, and I would encourage you to visit our website, and if we can provide any additional information, please reach out to us. Thank you, again.

Caroline: Thank you, and thank you to all of our participants for joining today. As a reminder, you can download a copy of today's presentation, and to do so, please click on the blue file selection in the lower left-hand corner of your screen and you will be able to access a downloadable copy of the slides from today's presentation. We hope that you found this webcast presentation informative, and this does conclude the webcast. You may now disconnect. Have a good day.