

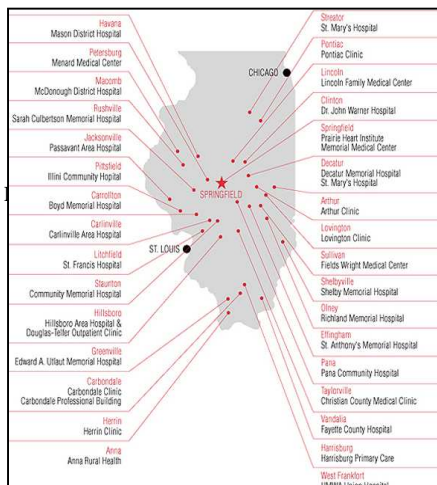
## WHO WE ARE

**Prairie Cardiovascular Consultants, Ltd (PCCL)** -was founded in 1979 in Springfield, IL with two main long term strategic visions: To establish a specialty cardiology group comprised of well trained, motivated physicians and staff who could provide state of the art cardiac care; and to devise a practice system that enhanced patient access to that care in central and southern Illinois. Given the rural, geographically dispersed nature of patients in this area, the concept was to create a network of care delivery using innovative liaisons with community hospitals and informal, but effective, partnerships with primary care physicians to assist in the delivery of advanced cardiovascular care in their communities. This local care emphasis is supported by tertiary/quaternary centers to which patients can be referred or transported for higher level, more complex care when needed. The PCCL logo, a blazen red heart with flowing wheat sheaves, symbolizes the nature of our commitments to delivery of high quality cardiac care in our rural environment. Over the subsequent 25 years, the implementation of these concepts has been enormously successful in improving access to quality care in these rural communities. Prairie has now grown to 43 cardiologists with seven offices and 27 outreach community hospital clinics serving 75 counties and almost 30,000 square miles. The two hospital centers in Springfield now represent the largest and third largest cardiovascular programs in the state of Illinois.

**Inpatient Programs-**PCCL cardiologists serve as the major providers of cardiovascular medicine at 5 major hospital facilities in Illinois. In 2003 we had 25,600 inpatient encounters at these hospital facilities and our physicians performed 9, 000 diagnostic cardiac catheterizations, 4,000 state of the art coronary interventions (including brachytherapy and drug eluting stents), 600 vascular interventions and 600 electrophysiologic procedures.

**Outpatient Programs-** Last year Prairie physicians had 89,000 patient clinic visits at our primary office facilities and 12,000 patient encounters at affiliated clinic sites. Our physicians performed 12,500 nuclear diagnostic procedures and 30,000 diagnostic echocardiographic evaluations at these facilities.

**The Prairie Network** – because the practice serves a rural environment, great distances



exist between the patients and the practice. Some live as far away as a 4-hour drive. Recognizing this, the practice has established 27 remote clinics located throughout central and southern Illinois (See Figure). These clinics are conducted in conjunction with the local community hospital where Prairie cardiologists travel to conduct general and specialized clinics.

PCCL staffed clinics allow patients in these remote areas to have access to a specialist in their community. For initial referrals, visits and follow-up care after procedures, these patients are not required to travel the distance to Springfield. In addition, the clinics have served as a basis for improving the level of cardiovascular services provided by those community hospitals. Through these clinic relationships, Prairie has assisted community hospitals to establish cardiac rehabilitation programs and initiate or improve existing cardiac services such as a nuclear cardiology program and, in select cases, diagnostic cath labs. Through our educational outreach programs, Prairie also provides a resource for training and updates to local technical staff, nurses as well as physicians.

## **TECHNOLOGY**

As we evaluated the role of technology in our practice we had three major objectives. The first was to network our primary office facilities together in order to improve office efficiency and patient management; secondly, was to streamline our billing and collection services and finally to move our patient documentation to an electronic medical record.

**Office Practice Management System-** We began the search for an office practice management system in 2000. Our primary considerations included: (1) finding a system that had integrated financial, scheduling and computerized patient record capabilities; (2) The system must be an open architecture system that allowed us to use commercially available software to create detailed billing and clinical reports; (3) The EMR system had to create useable documentation from data entry at the point of care; (4) It must have HL7 capability to allow us to integrate with hospital laboratory and transcription services and (5) It must be customizable and allow us the freedom to create custom data entry screens and create custom databases as necessitated by subspecialty data requirements. In 2001 we purchased a computerized practice management system (Medinformatix™) that included modules for billing, scheduling and EMR.

The billing and scheduling software were installed first. Since we had previously contracted out our billing services this required not only configuring the software but also hiring and training a billing and collections staff. In our practice, the nurse and secretary in each physician's office handle the clinic schedules for that physician. So deployment of the clinic scheduling system required training and customization for each individual office. The benefit to each office was immediate since they could now print and track schedules electronically.

The introduction of the electronic medical record was more problematic. Before we could deploy the EMR in our clinic facilities it required a great deal of development and customization. Menu selections had to be created for different clinic visit types. Data entry screens had to be developed for each aspect of a clinic visit (detailed patient history, review of systems, physical exam, treatment plan, etc). The layout of the documents created by the EMR, for that visit, had to be formatted and approved. One of the largest obstacles to implementation was overcoming the disparate computer literacy among physicians and nurses. Most of these clinical providers had marginal computer skills and,

for them, working through the EMR screens was more time consuming and tedious than dictating the visit information for transcription.

**Scanning-**A second major challenge was deciding what information should be input from the current paper record and how that information should be scanned into the electronic record. Many of our patients have a long and detailed history with paper charts that span multiple volumes. We identified key documents and historical information that would be entered or scanned on each chart. Centralized scanning personnel in our medical records department scan these items. The individual offices scan all new chart documents received from multiple sources.

Implementation of the EMR for outpatient visits at all of our office sites took over a year. Currently all of our physicians use the system to generate documentation for outpatient visits. The number of clinic patients seen per physician remained steady during the implementation and has increased by 10% over the past three years. The implementation of the electronic medical record has been a major success in improving patient management by allowing us to create one centralized patient record that is available at all of our office locations. Multiple providers in multiple locations can now access this centralized record simultaneously. We continue to work with our numerous clinic locations to make this electronic record available at those sites as well.

Additional benefits of the EMR have been found in its ability to track medication history and print prescriptions electronically. Previously it was almost impossible to track a patient's medications throughout the paper chart. It is now easy to identify dates and reasons for stopping or changing a medication through the EMR.

We have also worked with our affiliated hospitals to make our electronic medical record available in their facilities. All of our major hospitals have provided access from nurses' station computers to allow us to access patient records and enter patient information into our computerized record from the hospital. Since electronic prescription writing is not yet available at these locations we use our EMR to print the patients discharge prescriptions electronically and provide the patient with instructions and information about the drugs prescribed.

**Wide Area Network (WAN)-**This commitment to computerized practice management also required a major overhaul in our information technology. We began the process by networking all of our offices via T1, fiber optic cable or VPN. We also upgraded all of our computer hardware and software to include a redundant/clustered server array, Citrix™ servers to allow efficient remote access, a large storage area network (SAN), MS SQL™ server software to manage our large database volume as well as the Medinformatix™ practice management software.

**HL7 document and laboratory interfaces-**We have also worked with our affiliated hospitals to create an HL7 interface between our electronic medical record system and hospital laboratory systems. In one day, we can have as many as 1000 lab results cross our interface on both inpatients and outpatients. This interface makes these results

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available from any computer within our facility or from the hospitals. The laboratory module becomes a central repository for laboratory results even though they may be processed at different facilities. We can easily identify abnormal values and can trend laboratory results even across multiple facilities. We currently have laboratory interfaces to three of the hospital lab systems with a fourth to be implemented this summer.

This HL7 interface system has recently been expanded to receiving documents originating from hospital transcription or computerized. Last year we generated over 50,000 transcribed documents at our three major hospital facilities. This summer we will begin receiving the majority of these documents via HL7 interface directly into our EMR. This will include documents such as: procedure reports, H&P's, operative reports and hospital consults. We estimate this interface will decrease the need for scanning of documents by 85-90%.

PCCL's commitment to technological solutions has allowed us to create an electronic network which links all of our office facilities together, providing the whole organization with email, scheduling and access to our intranet. We have centralized the patient documentation into one electronic record that is accessible at any of our facilities and our electronic interfaces to affiliated hospital facilities have dramatically improved patient management by allowing access to critical laboratory information and documents deposited directly into the computerized record.

**Telemedicine** – for over a year, the practice has been augmenting its clinics through the provision of telemedicine consults. In conjunction with the community referral hospital, the cardiologist in Springfield and the nurse practitioner at the community hospital site provide diagnosis and follow-up utilizing computer interfaces which allow real-time visual and verbal communication between the patient and cardiologist.

## FINANCIAL

With the current challenges of decreased physician reimbursement, the need to provide expensive cutting-edge care along with the increasing federal regulation such as HIPPA, OSHA and Medicare compliance auditing, PCCL has focused on several creative solutions.

**Billing and Collections**-In 2001 PCCL made the decision to make billing and collection services a function of the practice. Prior to this decision, we had contracted with an outside physician billing service. By bringing the service in-house we felt we could accomplish several goals. First, and foremost, we could improve the billing process and increase collections. Even with the addition of 23 billing and collection FTE's the new billing system managed to virtually pay for itself by increasing collections by 5%. This was facilitated by unlimited access to billing and collection information that was now available through reports created in Medinformatix™. Since the system is built around a SQL database, we could use Crystal Reports™, MS Excel™ and other reporting and analysis tools to evaluate utilization, coding issues, physician performance and other information that had previously been unavailable or limited in scope. The new electronic

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system also allowed us to keep current with managed care contracts and fee-schedules. One of the most significant benefits of this new system has been the ability to electronically scan and store images of the patient's insurance card. Patient insurance card's are scanned at the clinic visit, allowing our billing, collection and clinical staff immediate access to both current and historical information regarding the patient's insurance.

Our mission of quality, compassionate care does not just involve medical treatment but extends to our billing service as well. We felt that, by bringing the billing services within the practice environment, we would be able to provide better customer service. Our patient billing statement was designed by our staff based on their experience in dealing with patient questions and requests. Recent patient satisfaction data has shown that even with the increase in collections, billing complaints from patients have decreased after bringing the service in house.

**Electronic claims submission-**With electronic claims submission and EOB processing we have reduced collection time on those claims to several days as opposed to several weeks. The majority of claims submitted by our billing office are now processed electronically. We have also developed an electronic EOB management tool that allows us to "translate" Medicare EOB files into a more workable electronic format. These files are then processed and the information is posted electronically. This system can process approximately 1200 patients and 4000 transactions in a manner of seconds. Prior to this implementation, processing of an average EOB could take up to 2 days. Commercial EOB's that are non-electronic, are scanned into a sophisticated searchable database system that allows instantaneous access.

PCCL processes approximately 8000 checks a month. These payments are now deposited electronically in a state of the art, digitally secured bank lock box. By converting to electronic processing we reduced the per-check processing fee by 70%.

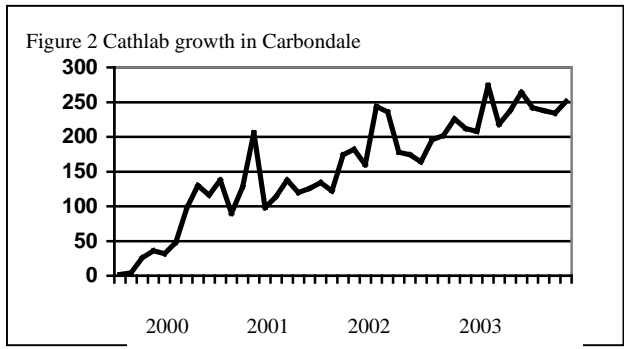
With the recent subscription to RealMed billing clearinghouse, we are now able to edit claims electronically. BCBS claims are processed with 15 minutes, can be corrected on-line and paid immediately.

**Prairie Heart Institute** – in the early 1970's, Prairie Cardiovascular Consultants, Ltd., approached St. John's Hospital with the idea of creating a joint venture heart institute. This concept was one of the first in the nation and today continues to serve as a model to other practices who desire similar partnerships and outcomes. PCCL has hosted practices from throughout the nation who have traveled to Springfield, Illinois to learn more about the concept and to get assistance in developing similar partnerships.

The Prairie Heart Institute is a joint venture between the practice and St. John's Hospital. Its purpose is to align the hospital and practice in order to develop cardiovascular services which are more responsive to the needs of the patient, referral physician, and their community. This partnership creates a streamline, entrepreneurial approach to managing the cardiovascular services of both partners by creating a dedicated management system

which streamlines bureaucracy and formally involves the practice in the management of all cardiovascular services, both outpatient and inpatient. For example, the Heart Institute has served as the basis for creating a complete cardiovascular product line that insures the practice's involvement in all decisions related to cardiovascular development. This has led to an integration of both the practice and hospital databases which insures that quality and outcomes data gathered by both partners are pooled for the purpose of quality assurance activities. Additionally, this sharing of databases insures that patients register only once regardless of whether they entered the system through the hospital or the practice. In essence, the Prairie Heart Institute has created a seamless system of providing cardiovascular care which places the patient and referral physician needs first. This program has grown to become one of the largest in Illinois and is recognized by Healthgrades.com<sup>®</sup> as the premier cardiology program in the state. Through marketing and product branding we have also created unique partnerships with several additional hospitals in our expansive market. The Prairie logo is now prominently displayed in hospitals in Springfield, Decatur and as far south as Carbondale in southern Illinois. PCCL and our affiliated hospitals have realized the mutual financial benefit in partnering on such projects as program development, cathlab ownership, computer networking, remote diagnostic evaluation and telemedicine.

Additionally, a franchised-like joint venture has been established in Carbondale, IL, the most geographically distant community, which has created a full-time tertiary cardiovascular program including cathlabs and cardiac surgery. This joint venture is much like a franchise in that the Prairie brand and quality of service is carefully managed to reflect the level of care provided in Springfield. This venture has resulted in a high growth program with potential for additional expansion to a secondary network hub (Figure2). Two other communities in that region of Illinois have attempted to establish tertiary cardiac programs but only the Prairie concept has been successful.



Other Ventures – the Prairie Heart Institute concept continues to serve as a catalyst and focal point for diverse providers of healthcare to partner for the purpose of focusing on the needs of the patient and referral physician. The most recent example of this is a joint

venture outpatient cath lab and CT/MRI diagnostic facility. What is notable about this partnership is that in addition to the practice, the two other partners are St. John's Hospital and its competitor in Springfield, Memorial Medical Center. Though both hospitals compete in the same cardiac market, the strategic vision of PCCL for the community and the practice suggested that cooperation would provide a better service. With negotiation, PCCL was able to construct a three-way venture. This unique partnership allows us to provide accessible and convenient diagnostic services for patients in the Springfield primary market area. At the same time, the structure of this partnership recognizes the technological changes occurring in the diagnostic areas and

creates a format that insures both hospitals do not have to duplicate expensive capital equipment to provide these services.

## **OFFICE MANAGEMENT**

**Multiple Offices-**Prairie Cardiology currently has 285 employees. We have permanently staffed offices in 7 locations throughout the state. Our two main offices are in Springfield, IL, an office in Pontiac, IL (106 miles) two offices in Decatur (48 miles) and office in Effingham (90 miles) and an office in Carbondale, IL (200 miles). As mentioned earlier, all offices are networked for intranet, email, billing, scheduling and EMR. Each physician is partnered with at least one secretary and one nurse. The secretaries provide clerical support for that physician including transcription. The nurse and/or secretary usually do scheduling for that physician as well.

**Non Clinical Services-**Our practice size also dictates that we have several departments to oversee specific practice functions. We have a coordinator who oversees HIPAA compliance for the practice. We have an auditor who evaluates physician compliance with current documentation standards. Our billing office consists of a managed care coordinator, Medicare coding coordinator, coders, billing staff and collection specialists. We have an education department, an IS department to manage computer and network infrastructure, an operations director, CEO, CFO and CIO. We also employ office managers and clinic facilitators at our office sites. Four of our office facilities also have nuclear cardiology facilities.

**Scheduling-**Since each office works somewhat independently, one of the major challenges has been standardization. Computerization of scheduling, for example, has allowed each office to maintain some flexibility in scheduling but allows for a centralized repository of clinic schedules that can be printed or reviewed by clinic personnel or other departments. Prior to computerization, the nurse kept each physician's schedule on paper. Computerized scheduling makes it easy for nurses to view, change or move patient appointments. Computerization has also allowed us to electronically print and track patient prescriptions. Our customized computer order entry system allows nurses to print laboratory or procedure orders for a patient and be notified electronically either prior-to or following the test date. This helps our nurses better keep track of patient results and compliance. With the implementation of the electronic medical record, our nurses can also print standardized patient letters which include laboratory results and risk information at the press of a button. Patient result letters that used to take hours to process now can be printed automatically with patients name and address, results and recommendations and placed in a windowed envelope for mailing

**Multidisciplinary Clinics-**In order to meet the needs of specific clinical populations, Prairie physicians have implemented multidisciplinary support clinics for congestive heart failure, preventative medicine and lipid management. The CHF program has achieved national recognition for its use of ancillary professionals such as dieticians, pharmacists, counselors and nurses to reduce our hospital readmission rate and hospital

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length of stay for CHF pts. This program has demonstrated the ability to provide quality care while keeping a traditionally costly program, profitable. This multidisciplinary philosophy extends to our community outreach programs as well. Our lipid management physician has just received a large grant to perform cardiac risk factor screenings on residents in rural Illinois communities.

**Outreach and education-**Prairie Cardiovascular Consultants, Ltd. has always believed that the best care is delivered through partnerships with primary care physicians and health care providers. In order to better develop this relationship referring physicians, PCCL has developed an extensive outreach program. PCCL is one of only two private physician practices in the state of Illinois to be accredited by the ACCME to provide continuing education credits to physicians. In 2003 our practice provided 60 category I CME forums to over 1800 clinical providers (physicians and non-physicians). Our physicians continue to serve as an educational resource to primary care physicians by giving lectures at educational venues throughout central and southern Illinois. PCCL cardiologists are also active in medical education by serving as the division of cardiology for the Southern Illinois School of Medicine.

**Research-**Providing quality care to patients involves having access to the most technologically sophisticated treatment strategies. In order to provide access to this cutting-edge technology, PCCL physicians are dedicated to helping design, evaluate and utilize the most sophisticated technology available. This commitment to clinical research, has led our physicians to develop and provide oversight for our own clinical research organization: the Prairie Education and Research Cooperative. This organization is staffed by full-time research nurses dedicated to providing our physicians with the support necessary to participate in ongoing clinical investigations involving cardiovascular medications and devices. We have participated in clinical trials evaluating the safety and efficacy of stenting carotid arteries, improved pharmacologic management of congestive heart failure, the use of drug eluting stents for treating narrowed coronary arteries, radiation therapy, new vascular technologies, less-invasive surgical techniques as well as many others. Unlike many practices, we do not use our research organization as a source of physician revenue, rather, the resources are used to support and grow our research endeavor.

## **PERSONNEL**

PCCL believes that that quality care comes from quality employees. To provide employees with the most efficient work environment, PCCL has focused on automation, standardization and strategies to improve employee satisfaction and retention.

**Intranet-**The Prairie intranet system was introduced to allow coordination and standardization of information throughout the various office sites and among the over 280 employees in the practice at these varying locations. Employees use the intranet system to obtain information regarding their benefits package and 401(k), general practice information and review policies and procedures. The intranet has also become the

standard educational tool for the employees of the practice. Our new employee orientation process, including introductions to such regulatory topics as OSHA, HIPAA and Medicare Compliance are all taught via intranet vehicles. Updates that are pertinent to all employees, either from an educational or regulatory point of view, are viewed and checked through the intranet. There is also an employee newsletter which is published on a regular basis.

The intranet is not the exclusive method of personal information and education. The practice also utilizes a number of personalized sessions including more traditional Employee of the Quarter and Employee of the Year recognitions, but also “Meet the Practice” lunches which invite a small number of employees for lunch with practice management and physicians. This is done on a rotating basis with a goal of including all employees. In addition, there are a series of “Power Lunches” which are utilized both as educational opportunities (for example, a recent topic was on Women’s Health Care), and also “fun” topics.

**Electronic Performance Review-**Another important program implemented is the electronic annual performance evaluation for employees. This is now intranet-based and allows employees to complete their evaluation and to receive review and feedback electronically. This has improved the efficiency of the process and significantly reduced the time and materials required for this process.

**Recruitment-**One major area of personnel activity relates to physician recruitment. In the current cardiology market, there is a significant manpower shortage of cardiologists. Indeed, the American College of Cardiology has a separate task force [Bethesda Conference #35] related to the manpower problems within cardiology. (As part of our commitment to national initiatives, 2 PCCL physicians participated in this conference). Articles focusing on this problem have also appeared in recent issues of the *Journal of the American College of Cardiology* and the American Heart Association journal *Circulation*. This has led to the need for a centralized and coordinated recruiting program. Recognizing the difficulty in recruiting, particularly to a semi-rural market, the practice has established a formal recruiting committee comprised of several physicians, the CEO and CFO, as well as an administrative person to maintain records and facilitate the administrative process. The recruiting documentation was converted to an electronic-based system on the intranet so that contacts and information on recruiting efforts could be available to all members instantaneously. The ability to talk to recruits and know what contacts have been made with them and prior discussions as well as their individual needs has proven invaluable in the recruiting process that has allowed us to successfully recruit several cardiologists in the last 18 months. This approach has emphasized Prairie’s long-standing philosophy that our recruiting process should not be a “job opening” process, which was somewhat erratic, but rather a sustained and continuous process of looking for high quality and well trained physicians. In fact, the process itself has been quite educational in allowing the practice to recognize that if a highly capable person is available, then that person should be hired regardless of whether there is “an opening”. We believe this is an example of how an improved process has also resulted in an improved strategic position. We frequently see strategic thinking leading to improved

processes, but this is an example of where an improvement in process has generated a change in strategic thought.

**Mentorship**-Another program that has been introduced with success has been a formal mentoring program for new physicians to facilitate their transition from fellowship training to a private practice environment. In many practices, there may be mentoring of other employees, but it is rare to “mentor” physicians as sometimes this is viewed as somewhat demeaning. Our mentorship program is in place until the new physician attains partnership level. The mentors regularly visit with the new physician to discuss progress, orientation and performance issues. They are also available to review information regarding the business aspects of the practice. In addition, new physicians are transitioned into both the call schedule and out of town clinics by attending several clinics with regular physicians and by being on call simultaneously with other more experienced physicians to allow phase-in into these important aspects of the practice. The mentors also report on a regular basis to the Board of Directors regarding the progress of these non-partner physicians. This process has led to improved satisfaction, less crisis intervention for problems and improved retention with less physician burnout.

## **PATIENT SATISFACTION**

**Patient Satisfaction**-At Prairie, the major emphasis on patient satisfaction relates to the patient’s access to timely and quality care and the delivery of high quality evidence-based medicine that conforms to current guidelines. We believe that these two areas are the most important drivers of patient satisfaction although our practice does emphasize and focus extensively on providing excellent customer service as well. We monitor patient satisfaction in the practice via a standardized patient satisfaction questionnaire; and we do this on an annual basis. The results of our most recent survey in January of this year, show PCCL physicians and employees to be consistently ranked higher than commercially available benchmarks in all areas measured, including perceived quality of care, business office performance, communication with physician and nurses and overall satisfaction. Over 99.5% of respondents reported they would recommend their PCCL physician to others.

**Patient Access to Care**-Access to care and the delivery of evidence-based quality medicine are key drivers in our approach to maintaining a high level of patient satisfaction. With regard to access, the entire structure of the practice has been strategically developed to try to improve access. The formation of 27 clinics in small town rural hospitals or offices is the fundamental key to improving access to the technology driven more complex cardiology care delivered in a tertiary center. We use the clinic locations, both to screen patients who might need additional tertiary or quaternary services and to follow these patients in longer-term follow-up when needed after such procedures. These clinics also allow ongoing management of patients with chronic disease states such as congestive heart failure or chronic coronary artery disease. In the largest of these smaller communities, the clinic concept has matured to the point of having full-time PCCL physicians available in the community. In one instance PCCL physician presence grew into the development of a full-service cardiac program including

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cardiac catheterization and open heart surgery facilities. Other clinics are supplied, depending on size and need. Remote clinic visits vary from one clinic every other week to a clinic three times weekly in one location. This location has been very successful and we are in the process of trying to recruit a full-time cardiology to provide care in this community.

In our central offices in Springfield, we maintain busy outpatient practices in offices attached to each of the two major hospitals to ensure that there is access according to patient preference for hospital as well as appropriate access for individual insurance product requirements.

**Quality Initiatives-**We consider the single most important driver of patient satisfaction to be the delivery of high quality, evidence-based medical practice and we expend a large amount of strategic thought, effort and manpower in this effort. The primary example of this has been the development of web-based tools to allow for the appropriate monitoring and “prompting” of the evidence-based guidelines developed by the American College of Cardiology and the American Heart Association. These web-based tools have been introduced as adjuncts to our EMR. To accomplish this, we employ a staff that includes a full-time manager/developer for our EMR system and a full-time programmer devoted only to the development of tools related to the EMR. We also have a full-time EMR nurse educator. These personnel are in addition to our IS staff and are basically focused only on the development and maintenance of the EMR as well educating physicians and nurses on the use of these quality tools. These web-based quality solutions have been developed to aid in treating patients with myocardial infarction, angina, CHF, high cholesterol and hypertension. The concept and content of these pages have been presented at several national quality forums with an overwhelming response from participants. A preliminary study done this spring to compare compliance with guidelines in the outpatient setting indicates that we can receive 100% compliance with guidelines when these tools are used. This study has being submitted as an abstract to the upcoming meeting of the American Heart Association. A table summarizing this data follows.

Use of PCCL Quality Improvement Tool for CAD and Acute MI-Results				
	EMR Only (N=3504)		EMR+Quality Improvement Tool(N=76)	
	Prescribed/Documented Exception	Compliance	Prescribed/Documented Exception	Compliance
ASA	2702/625	96.3%	72/4	100%
Beta Blockers	2505/20	73%	67/9	100%
ACE/ARB	2469/33	72.4%	61/15	100%
Statins	2699/78	80.3%	70/6	100%

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In addition to these measures, the practice monitors its inpatient compliance and performance on quality indicators through a number of quality initiatives and national registries including The National Registry of Acute MI (NRM), CRUSADE (a national quality data initiative for evaluating the treatment of patients with acute coronary syndromes) and ADHERE for congestive heart failure. PCCL physicians also participate in the National Cardiovascular Data Registry (NCDR) a national database of information on patients undergoing cardiovascular diagnostic testing or interventions. We continually monitor our performance in these quality initiative areas and present performance data regarding outcomes and compliance to guidelines in our regular group meetings. An example of this type of quality feedback is the adherence of individual practitioners in the use of Aspirin following myocardial infarction.

Monitoring of adherence to all the current guidelines in the acute coronary syndromes and coronary artery disease are presented in the meetings. We believe that this is the best way to ensure quality and the data is transparent.

**The Future** – For the last 25 years, the effort at implementing our strategic visions has allowed us the privilege of serving our patients and many smaller communities in central and southern Illinois. Commitment to quality, willingness to embrace technology and ethical vision-oriented governance will continue to guide our efforts to ensure delivery of, and access to, state-of-the-art cardiovascular care. Our most exciting work remains ahead.