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SETMA's 2012 National Quality Forum National Healthcare Improvement Award
Effective prioritization of performance improvement goals

Formed in August, 1995, Southeast Texas Medical Associates, LLP (SETMA) recognized that excellence in 21st-Century healthcare was not possible with 19th-Century-medical-record methods, i.e., pencil and paper, or with 20th Century methods, i.e., dictation and transcription. SETMA believed that the future of healthcare was going to be driven by quality performance and rejected the model of care where the healthcare provider was the constable attempting to impose health upon a passive recipient, the patient. As a result, SETMA developed a model where the patient is an active member of his/her healthcare team and the healthcare provider is a consultant, a colleague, a collaborator to facilitate healthy living, with safe, individualized and personalized care for each patient. SETMA's model is also driven by the fact that we serve a population which received disjointed, unorganized, episodic care, focused upon things done to, or for patients who have limited resources with which to support their health care goals.

Three Seminal Events

In October, 1997, SETMA attended the Medical Group Management Association meeting to preview electronic-health-record (EHR) solutions. In March, 1998, SETMA signed a contract with an EHR vendor. We deployed the enterprise practice management (EMP) side of the system in August, 1998 and the EHR on January 26, 1999. By Friday, January 29th, we documented every patient encounter in the EHR. In May, 1999, three seminal events transformed SETMA's healthcare vision and delivery.

First, we concluded that EHR was too hard and too expensive if all we gained was the ability to document an encounter electronically. EHR was only "worth it," if we leveraged electronics to improve care for each patient; to eliminate errors which were dangerous to the health of our patients; and, if we could develop electronic functionalities for improving the health and the care of our patients. We also recognized that healthcare costs were out of control and that EHR could help decrease that cost while improving care. Therefore, we began designing disease-management and population-health tools, which included "follow-up documents," allowing SETMA providers to summarize patients' healthcare goals with personalized steps of action

through which to meet those goals. We transformed our vision from how many x-rays and lab tests were done and how many patients were seen, to measurable standards of excellence of care and to actions for the reducing of the cost of care. We learned that excellence and expensive are not synonyms.

Second, from Peter Senge's *The Fifth Discipline*, we defined the principles which guided our development of an EHR and the steps of our practice transformation; they were to:

1. Pursue Electronic Patient Management rather than Electronic Patient Records
2. Bring to every patient encounter what is known, not what a particular provider knows
3. Make it easier to do "it" right than not to do it at all
4. Continually challenge providers to improve their performance
5. Infuse new knowledge and decision-making tools throughout an organization instantly
6. Promote continuity of care with patient education, information and plans of care
7. Enlist patients as partners and collaborators in their own health improvement
8. Evaluate the care of patients and populations of patients longitudinally
9. Audit provider performance based on endorsed quality measurement sets
10. Integrate electronic tools in an intuitive fashion giving patients the benefit of expert knowledge about specific conditions

The third seminal event was the preparation of a philosophical base for our future; developed in May, 1999, this blueprint was published in October, 1999. It was entitled, *More Than a Transcription Service: Revolutionizing the Practice of Medicine With Electronic Health Records which Evolves into Electronic Patient Management*". The following excerpts are from that paper:

"...when the (EHR) encounter is completed and a copy of the record is given to the patient:

- "The patient is able to review the record, further gaining confidence that if my doctor knows all of this about me, (I can trust that my care is appropriate).
- "If any data is inaccurate or has become invalid, the patient can correct the record, becoming a partner with the provider in the process of producing a complete, accurate, valid and current medical record.

"...collaboration between every person - including the patient -- participating in the patient's care... and the sharing of information...at every point of the patient's (care)...means that the emergency department, hospital, home health agency, hospice, physical therapy, reference laboratory and long-term care facility have...a seamless interface with the patient's EHR.
"...in the continuum of care model...care management drives care...which is a database function. If the patient's record is available at every point of contact...there will not be:

1. "Redundancy...
2. "Inefficiency...
3. "Excessive cost ...

"...Healthcare providers must never lose sight of the fact that they are providing care for... unique individuals... (who) deserve our respect and our best... **empowering the patient to achieve the health he/she determined to have.** "

This blue print, and subsequently hundreds of articles on Patient-Centered Medical Home are the foundation of SETMA's fourteen-year history of pursuing the three-part *National Strategy for Quality Improvement in Healthcare* as defined in the March, 2011 HHS' Report to Congress. These goals were expanded by The National Priorities Partnership convened by NQF. NQF wrote the Secretary of HHS and identified the Priorities for the 2011 National Quality Strategy, which are:

- Wellness and Prevention
- Safety
- Patient and Family Engagement
- Care Coordination
- Palliative and End of Life Care

These have been and are the priorities of SETMA. Prior to their enunciation and now pursuant to the National Strategy's goals, SETMA has achieved:

1. NCQA Tier III Patient-Centered Medical Home
2. Accreditation Association of Ambulatory Healthcare accreditation for Ambulatory Care
3. AAAHC accreditation as a Medical Home
4. Joslin Diabetes Center Affiliate at Southeast Texas Medical Associates
5. American Diabetes Association recognized Diabetes Self-Management Education Program
6. Elimination of Ethnic Disparities for diabetes and hypertension care
7. Effective Transitions of Care from inpatient to ambulatory care for 25,432 inpatient admissions since July, 2009, including Medication Reconciliation; a 99.1% efficiency of delivering to the patient and/or family, a written, personalized Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan at the time of discharge; first-day Post Hospital Discharge Telephone contact for a 12-30 minute Care Coaching call.
8. A 22% decrease in preventable readmissions
9. Improvement between 2000 to 2011 of mean HbA1cs from 7.54% to 6.65% and of standard deviations from 1.98 to 1.30.
10. NCQA Diabetes Recognition Program for each of SETMA's clinics
11. Office of National Coordinator recognition as one of thirty exemplary practices in the United States for Clinical Decision Support.
12. HIMSS peer-reviewed Stories of Success
13. HIMSS Davies Award
14. Agency for Healthcare Research and Quality publication of SETMA's LESS Initiative (Lose Weight, Exercise & Stop Smoking) on AHRQ's Innovations Exchange.

Secure Web Portal And Health Information Exchange

Recognizing the need to expand communication with our patients and to aggregate all information about a patient's health and healthcare, in 2010, SETMA deployed a secure web portal and a health information exchange (HIE). The web portal allows our patients to be more involved in managing their care by maintaining their own Personal Health Record, having access to their medication list, problem list, review of systems, chief complaint and history of present illness. Prior to appointments, patients are able to complete their chief complaint, history of present illness and review of systems. This information, once reviewed by their healthcare provider, is deposited into their EHR record.

SETMA is also supporting the development of an HIE in Southeast Texas, which will be accessible by all area providers who choose to participate. This is a major undertaking for quality, safety, and a continuum of care model of health delivery in our five-county area. SETMA is initially funding this project, which is underway and functioning. We have just employed a project manager to push the project along faster.

Population Health Promotion

SETMA's model of care, discussed later in this application, involves structured quality and safety goals. In addition, the model allows SETMA to initiate new interventions. Two such initiatives which have been added to SETMA's work flow in 2011 are the following.

HIV

SETMA is promoting an HIV Screening program for all residents between the ages of 13 and 64. In addition to performing the screening ourselves, we have television and print media promotions of the need and importance for everyone to be screened. Our CEO had his HIV Screening test drawn on live television. While encouraging everyone to be screened, he explained to the public why no one should make a public declaration of the results of such a test, even if it is negative. If all patients who have a negative test publicly report that, it creates a barrier for those who think they might be positive to be tested, as their failure to report their test result, would suggest that it was positive. If no one reports their result publicly, that barrier is removed. Each quarter, those patients who declined screening are contacted via letter to explain the program once again and to encourage them to be screened. It is explained that in public health, we're all "in it together," and that the best public health is achieved when everyone, including healthcare providers, participate.

Smoking and Diabetes

In preparation for participating in an Accountable Care Organization and while reading CMS's *Final Rule for Shared Savings: ACO* in November, 2011, it occurred to SETMA that

there is a potential leverage point with our patients who have diabetes and who also smoke. It may be that an authoritative source's declaration of the greatly increased risk of cardiovascular disease and stroke for patients with diabetes and who smoke could give some patients pause to take seriously their need to stop smoking. Using SETMA's patient registry, the following data was mined:

1. SETMA treats over **6,873** patients with diabetes
2. **714** of those use tobacco
3. **93** who use tobacco have not had a documented discussion about smoking cessation.
4. **46** of the 93 were seen by SETMA specialists who were seeing patients who are not seen by SETMA primary care.

The good news is that 99.4% of the patients SETMA has seen over the past three years who have diabetes have had smoking cessation addressed. **The bad news is** that 9.1% of the patients with diabetes who have been seen in the past three years by SETMA continue to smoke. In response to this data, a letter was sent to these 728 patients followed by a personal telephone call. An appointment was made for each patient specifically to address the issue of smoking and diabetes. Those patients with e-mail addresses will also receive web-based coaching messages. This four-pronged approach should yield significant results. Our goal for 2012 is to reduce the number of our patients who have diabetes and who smoke to below 4%.

Patient Engagement: The Baton

SETMA recognizes that patient engagement in their own care is critical to the improvement of their health. On displays in the entry to all of our clinics, we state, "We know that the race (the healthcare race) is yours to run." Therefore we designed "The Baton" which is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of "The Baton" hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

Firmly in the provider's hand
--The Baton -- the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The poster illustrates that:

1. The healthcare-team relationship, which exists between the patient and the healthcare provider is key to the success of the outcome of quality healthcare.
2. The plan of care and treatment plan -- the "Baton" -- is the engine through which the knowledge and power of the healthcare team are transmitted and sustained.
3. The means of transfer of the "Baton," is a coordinated effort between provider and patient.

4. Typically, the healthcare provider knows and understands the patient's plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.
5. It is imperative for the plan - the "Baton" - to be transferred from the provider to the patient, **if change in the life of the patient is going to make a difference in the patient's health.**
6. This transfer requires that the patient "grasps" the "Baton," i.e., the patient **receives**, **accepts**, **understands** and **comprehends**the plan, and the patient is equipped, empowered and engaged to carry out the plan successfully.
7. The patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the Baton," longer and better than any other member of the healthcare team.

Quality Goals In The Past Two Years

For 2009 and 2010, SETMA's strategic goals were to achieve both NCQA and AAAHC Medical Home status, which we did in July, 2010 and August, 2010 respectively. Within each, there are numerous quality and safety goals, including care coordination, care transitions, enhanced communications, reducing or removing barriers to care, and medication reconciliation.

Our principle safety goal has been medication reconciliation based on the AMA's *Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles.* In that more than 50% of preventable readmissions are because of medication errors, SETMA has established the following standards for medication reconciliation:

1. Medications reconciled at the time of admission to the hospital.
2. Medications reconciled at the time of discharge from the hospital with a printed copy of the medications being given to the patient including a section denoting the medications which are to be discontinued and any medications with dosage changes.
3. Medications reconciled the day following discharge by SETMA's Department of Care Coordination in their 12-30 minute, coaching call to the patient.
4. Medications reconciled at the clinic follow-up appointment from the hospital which is the next day for fragile patients, two days for those at high risk for readmission but not fragile, and within five days for all others.
5. Also, medications are reconciled at every subsequent clinic visit.

The following are critical supports required for success in our Performance Improvement:

1. Care where the same data base is being used at ALL points of care.
2. A robust EHR to accomplish the above.
3. A robust business-intelligence analytics system, which allows for real-time data analysis at the point of care.
4. A laser printer in every examination room so that personalized evaluational, educational and engagement materials can be provided to every patient at every encounter, with the