

## National Quality Forum National Quality Healthcare Award – 2012

### 1. Priors for Performance Improvement

Formed in August, 1995, Southeast Texas Medical Associates, LLP (SETMA) recognized that excellence in 21<sup>st</sup>-Century healthcare was not possible with 19<sup>th</sup>-Century-medical-record methods, i.e., pencil and paper, or with 20<sup>th</sup> 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* (<http://www.setma.com/article.cfm?ID=556>). 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 ([www.setma.com](http://www.setma.com) *Your Life Your Health*) 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 patient's personal health data displayed and analyzed for individual goal setting and decision making.
5. Quality metric tracking, auditing and statistical analysis.
6. Public Reporting of quality metric performance by provider name.
7. Quality Improvement initiatives based on tracking, auditing and analysis of metrics.
8. Shared vision among all providers, support staff and administrators – a personal passion for excellence -- which creates its own internalized, sustainable energy for the work of healthcare transformation.
9. Celebratory culture which does not compete with others but continually improves the organization's own performance, using others as motivation but not as a standard.
10. Monthly peer-review sessions with all providers, to review provider performance and to provide education in the use of electronic tools.
11. Adequate financial support for the infrastructure of transformation.
12. Respect of the personal value of others and the caring for people as individuals.
13. An active Department of Care Coordination and a hospital-care support team which is in the hospital twenty-four hours a day, seven days a week.
14. Aggressive end-of-life counseling with all patients over fifty, and active employment of hospice in the care of patients when appropriate.

## 2. Dashboard to Measure and Manage Whole System Performance

The SETMA Model of Care includes five steps:

- The **tracking** by each provider on each patient of the provider’s performance on preventive and screening care and on quality standards for acute and chronic care. This occurs simultaneously with care given by the healthcare team, including personal provider, nurse and clerk. Data aggregation occurs automatically at all points-of-care.
- The **auditing** on the above standards is done for the practice, each clinic, or each provider. The focus of the audit is an individual patient, a unique population of patients, or a panel of patients.
- The **statistical analyzing** of audit results to measure improvement by practice, by clinic, or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, payer class, socio-economic groupings, education, frequency of visit, frequency of testing, etc. This allows SETMA to look for leverage points through which to improve care and/or to design quality improvement initiatives.
- The **public reporting** by provider name of performance over 200 quality measures. This helps overcome “clinical inertia,” by pressuring all providers to improve; it also allows providers and patients to know what is expected of them. The disease management tools “plans of care” and the medical-home-coordination document summarize a patient’s care and encourages him/her to ask the provider for any preventive or screening care which has not been provided.
- The design of **Quality Assessment and Performance Improvement Initiatives** – SETMA’s 2011 initiatives involved the elimination of all ethnic disparities of care for diabetes, hypertension and dyslipidemia, and reducing hospital preventable readmissions.

The key to this Model is the real-time ability of providers to measure their own performance at the point-of-care. This is done with multiple displays of quality metric sets, with real-time aggregation of performance, **incidental** to excellent care. The following are several examples which are used by SETMA providers.

The screenshot shows a software window titled "Pre-Visit/Preventive Screening" with a blue header. It contains several sections of questions with checkboxes and buttons:

- General Measures (Patients >18):**
  - Has the patient had a tetanus vaccine within the last 10 years? [Yes]
  - Has the patient had a flu vaccine within the last year? [Yes]
  - Has the patient ever had a pneumo pneumonia shot? [Yes]
  - Does the patient have an abnormal ECG? [Yes]
  - Has the patient had a lipid panel within the last year? [Yes]
- Elderly Patients (Patients >65):**
  - Has the patient had an annual blood test within the last year? [No]
  - Has the patient had a fall risk assessment complete within the last year? [Yes]
  - Has the patient had a functional assessment within the last year? [Yes]
  - Has the patient had a pain screening within the last year? [Yes]
  - Has the patient had a depression screen (within a year) within the last year? [Yes]
  - Has the patient been hospitalized due to falls or have they been admitted with the patient? [No]
  - Is the patient on one or more medications which are considered high risk in the elderly? [No]
- Diabetic Patients:**
  - Has the patient had a HbA1c within the last year? [Click to Complete]
  - Has the patient had a lipid test over within the last year? [Click to Complete]
  - Has the patient had a 10-gene nonfasting exam within the last year? [Click to Complete]
  - Has the patient had counseling for hypertension within the last year? [Click to Complete]
- Female Patients:**
  - Has the patient had a pap smear within the last two years? (Ages 21 to 65) [Click to Complete]
  - Has the patient had a mammogram within the last two years? (Ages 40 to 65) [Click to Complete]
  - Has the patient had a breast exam within the last two years? (Age >40) [Click to Complete]
- Male Patients:**
  - Has the patient had a PSA within the last year? (Age >45) [Click to Complete]
  - Has the patient had a bone density within the last two years? (Age >65) [Click to Complete]
- Referrals (Click On To Add Ref):**
  - Referral: [Text Field]
  - Status: [Text Field]
  - Referring: [Text Field]

There are similar tools for all of the quality metrics which SETMA providers track each day. The following is the tool for NQF measures currently tracked and audited by SETMA:

**National Quality Forum (NQF)  
National Voluntary Consensus Standards**

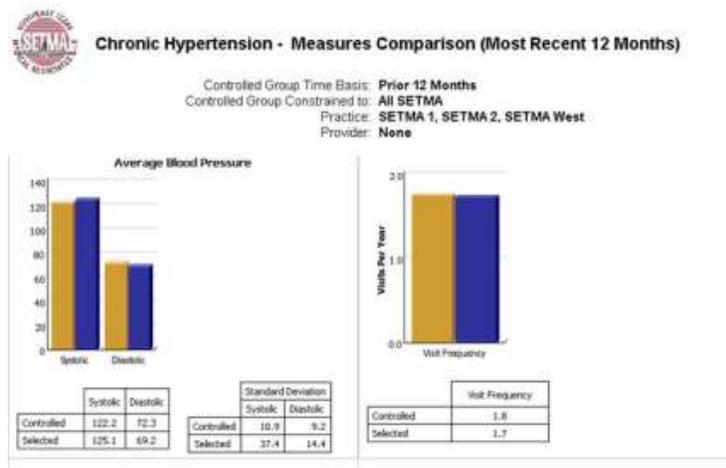
**Legend** Measures in red are measures which apply to this patient that are not in compliance.  
Measures in black are measures which apply to this patient that are in compliance.  
Measures in gray are measures which do not apply to this patient.

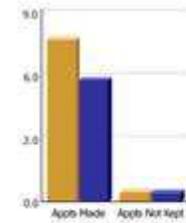
<p><b>General Health Measures</b></p> <p><a href="#">View</a> <b>Body Mass Index Measurement</b></p> <p><a href="#">View</a> <b>Smoking Cessation</b></p> <p>Proper Assessment for Chronic COPD</p> <p>Adult Immunization Status</p> <p><b>Blood Pressure Measures</b></p> <p><a href="#">View</a> <b>Blood Pressure Measurement</b></p> <p><a href="#">View</a> <b>Blood Pressure Classification/Control</b></p> <p><b>Medication Measures</b></p> <p><a href="#">View</a> <b>Current Medication List</b></p> <p><a href="#">View</a> <b>Documentation of Allergies/Reactions</b></p> <p><a href="#">View</a> <b>Therapeutic Monitoring of Long Term Medications</b></p> <p>Drugs Taken in the Entry</p> <p><a href="#">View</a> <b>Appropriate Medications for Asthma</b></p> <p><a href="#">View</a> <b>Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis</b></p> <p><a href="#">View</a> <b>LDL Drug Therapy for Patients with CAD</b></p> <p><b>Chronic Conditions Measures</b></p> <p><a href="#">View</a> <b>Comprehensive CHF Care</b></p> <p>Dissemination Care</p>	<p><b>Care for Older Adults</b></p> <p>Counseling on Physical Activity</p> <p><a href="#">View</a> <b>Urinary Incontinence in Older Adults</b></p> <p>Colorectal Cancer Screening</p> <p>Fall Risk Management</p> <p><b>Diabetes Measures</b></p> <p><a href="#">View</a> <b>Dilated Eye Exam</b></p> <p><a href="#">View</a> <b>Foot Exam</b></p> <p><a href="#">View</a> <b>Hemoglobin A1c Testing/Control</b></p> <p><a href="#">View</a> <b>Blood Pressure</b></p> <p><a href="#">View</a> <b>Urine Protein Screening</b></p> <p><a href="#">View</a> <b>Lead Screening</b></p> <p><b>Female Specific Measures</b></p> <p>Breast Cancer Screening</p> <p>Cervical Cancer Screening</p> <p>Chlamydia Screening</p> <p>Depression Management</p> <p><b>Pediatric Measures</b></p> <p>Appropriate Screening for Children with Pharyngitis</p> <p>Childhood Immunization Status</p>
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Providers' compliance with these measures is color coded for quick reference: "Black" means that the measure applies to the patient and has been done; "Red" means the measure applies and has not been done; "Gray" means that the measure does not apply. The "view" button allows the provider to review the content of the metric and the patient's results. Real-time auditing of performance by providers at the point-of-care provides leverage for performance improvement.

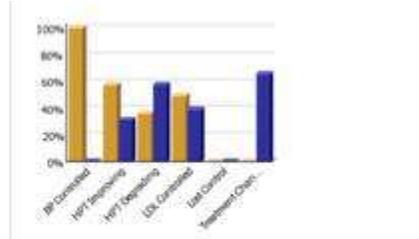
**Dashboards**

Below are examples of auditing dashboards for provider performance analysis. Note: Columns in gold represent patients treated to goal and those in purple are the patients not treated to goal.

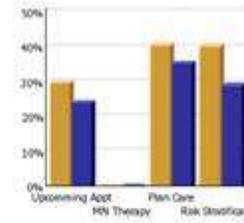




	Appointments Made	Appointments Not Kept
Controlled	7.9	0.5
Selected	5.8	0.4



	BP Controlled	HPT Improving	HPT Degrading	LDL Controlled	Lost Control	Treatment Changed
Controlled	100.0%	57.8%	36.0%	49.5%	0.0%	0.0%
Selected	0.0%	31.5%	57.5%	39.1%	0.0%	65.5%



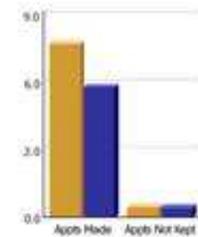
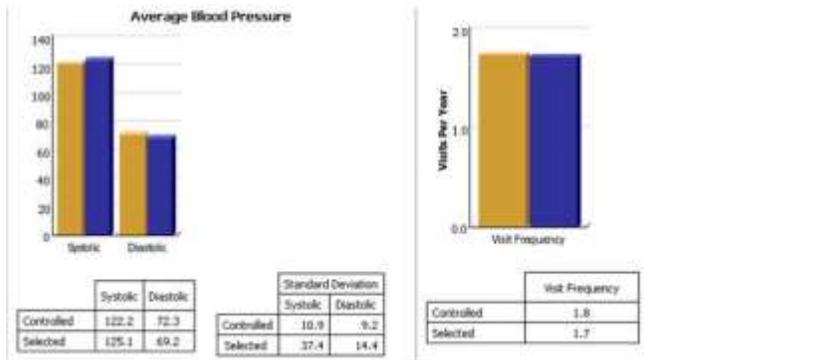
	Upcoming Appt	Med Therapy	Plan Care	Risk Stratification
Controlled	29.7%	0.0%	40.4%	40.3%
Selected	24.0%	0.0%	35.3%	28.9%

SETMA is able to look at differences between the care of patients who are treated to goal and those who are not. Patients can be compared as to socio-economic characteristics, ethnicity, frequency of evaluation by visits, and by laboratory analysis, numbers of medications, payer class, cultural, financial and other barriers to care, gender and other differences. This analysis can suggest ways in which to modify care in order to get all patients to goal.

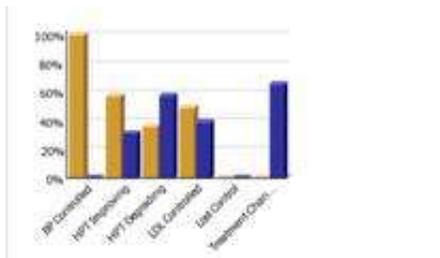


### Chronic Hypertension - Measures Comparison (Most Recent 12 Months)

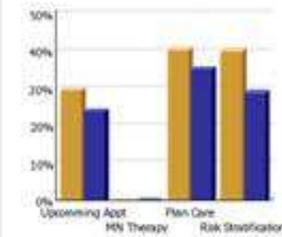
Controlled Group Time Basis: **Prior 12 Months**  
 Controlled Group Constrained to: **All SETMA**  
 Practice: **SETMA 1, SETMA 2, SETMA West**  
 Provider: **None**



	Appointments Made	Appointments Not Kept
Controlled	7.9	0.5
Selected	5.8	0.4



	BP Controlled	HPT Improving	HPT Degrading	LDL Controlled	Lost Control	Treatment Changed
Controlled	100.0%	57.8%	36.0%	49.5%	0.0%	0.0%
Selected	0.0%	31.5%	57.5%	39.1%	0.0%	65.5%

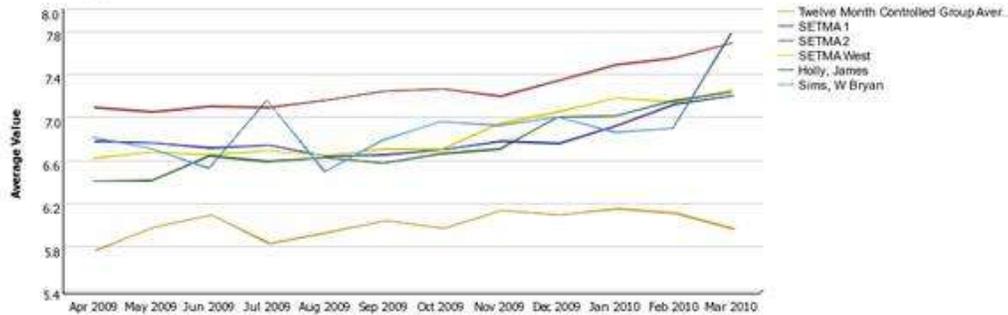


	Upcoming Appt	Med Therapy	Plan Care	Risk Stratification
Controlled	29.7%	0.0%	40.4%	40.3%
Selected	24.0%	0.0%	35.3%	28.9%

SETMA can also compare different providers and different clinics with one another:



### Chronic Diabetes - HgbA1c Trending



SETMA’s provider performance is benchmarked against published, evidence-based, national standards of care. Because SETMA has deployed a robust Business Intelligence (BI) solution for data auditing and analytics, and because we have bought multiple licenses, practice leadership, informatics staff and healthcare providers can review performance outcomes. SETMA also has monthly peer-review sessions with all providers. The clinic is closed for a morning, and performance on quality metrics, patient satisfaction and gaps in care are discussed openly among all providers. Collegial relationships and an organizational-cultural commitment to excellence make it possible for SETMA to be specific about needs for improvement in these monthly meetings.

Dashboards are color coded: “white” is to goal, “yellow” needs improvement, and “red” is unacceptable. This display is of NQF Diabetes Metrics on HbA1c and LDL:



### NQF - Diabetes Measures - Glyco and LDL

E & M Codes: Clinic Only  
 Encounter Date(s): Jan 1, 2007 through Dec 31, 2007

Location	Provider	HgbA1c Frequency	HgbA1c Level			LDL Screening	LDL Control	
		Within 12 Months	> 9.0	Between 6.5 - 9.0	< 6.5	Within 12 Months	< 130	< 100
SETMA 1	Aziz	85.3%	11.0%	41.2%	38.1%	91.0%	79.5%	54.1%
	Duncan	78.0%	8.1%	39.5%	43.1%	76.0%	76.7%	59.6%
	Murphy	83.8%	6.8%	27.5%	53.4%	80.9%	78.3%	56.6%
	Vardiman	81.8%	11.4%	28.1%	53.5%	85.1%	71.1%	38.6%
<b>SETMA 1 Totals:</b>		82.4%	8.7%	35.4%	45.5%	82.9%	77.9%	55.9%
SETMA 2	Ahmed	94.7%	22.2%	47.2%	26.4%	84.6%	73.6%	56.2%
	Anthony	87.9%	8.8%	37.2%	47.2%	82.9%	76.3%	55.0%
	Henderson	83.4%	13.0%	34.9%	44.3%	77.8%	72.9%	52.2%
	Holly	87.5%	9.2%	28.7%	52.6%	77.8%	70.2%	52.6%
	Leifeste	73.9%	7.7%	26.1%	45.0%	74.8%	69.0%	52.4%
	Murphy	80.0%	5.7%	22.9%	55.7%	87.1%	85.7%	67.1%
	Vardiman	66.5%	5.1%	33.5%	43.3%	71.2%	65.1%	40.6%
	Wheeler	81.8%	8.0%	27.0%	54.4%	83.2%	69.7%	47.3%
<b>SETMA 2 Totals:</b>		86.3%	13.7%	37.0%	40.5%	81.1%	72.6%	53.3%
SETMA West	Curry	61.5%	0.0%	23.1%	46.2%	69.2%	61.5%	53.6%
	Halbert	71.1%	8.8%	31.7%	44.1%	71.2%	66.2%	42.2%
	Vardiman	41.7%	16.7%	25.0%	25.0%	58.3%	58.3%	41.7%
<b>SETMA West Totals:</b>		70.5%	8.8%	31.5%	43.9%	71.0%	66.0%	42.3%
<b>SETMA Totals:</b>		83.5%	11.7%	35.9%	42.4%	80.5%	73.4%	52.9%

Comparing 2007 results with 1/1/2011-12/31/2011, shows that the quality standards are still being met. HbA1c percentages above 9.0% are shown in red as SETMA "standard" is that this value should be zero, but the NCQA benchmark is less than 15% of the patients being treated for diabetes. All but one SETMA provider exceeds that standard.



**NQF - Diabetes Measures - Glyco and LDL**

E & M Codes: Clinic Only  
Encounter Date(s): Jan 1, 2011 through Oct 31, 2011

Location	Provider	HgbA1c Frequency	HgbA1c Level			LDL Screening	LDL Control	
		Within 12 Months	> 9.0	Between 6.5 - 9.0	< 6.5	Within 12 Months	< 130	< 100
SETMA 1	Adiz	89.0%	11.0%	35.2%	42.9%	94.7%	80.9%	64.6%
	Duncan	89.7%	12.4%	37.0%	43.7%	90.0%	79.8%	61.8%
	Henderson	90.1%	10.0%	38.2%	44.8%	89.2%	84.4%	63.8%
	Murphy	83.1%	8.4%	34.8%	52.9%	95.2%	85.9%	73.0%
	Paling	65.2%	8.0%	24.8%	32.8%	65.2%	60.4%	46.7%
	Thomas	92.0%	10.0%	33.1%	32.7%	88.5%	79.6%	58.4%
<b>SETMA 1 Totals:</b>		<b>87.3%</b>	<b>10.1%</b>	<b>35.6%</b>	<b>45.0%</b>	<b>90.1%</b>	<b>80.8%</b>	<b>64.5%</b>
SETMA 2	Abbas	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%
	Ahmed	88.5%	18.1%	33.4%	19.8%	88.3%	77.8%	61.7%
	Anthony	84.5%	13.4%	40.0%	42.8%	84.3%	88.3%	65.2%
	Anwar	92.0%	10.6%	43.8%	39.8%	95.6%	84.6%	68.5%
	Cricchio, A	83.0%	12.0%	33.2%	15.8%	90.8%	84.5%	67.8%
	Cricchio, M	91.8%	7.8%	41.3%	45.5%	94.8%	88.0%	64.1%
	Holly	87.2%	5.8%	42.1%	50.3%	87.8%	84.8%	59.0%
	Lefkete	88.2%	7.0%	28.4%	55.8%	90.8%	85.9%	68.8%
	Wheeler	91.8%	8.9%	32.0%	54.1%	94.2%	84.9%	58.4%
	<b>SETMA 2 Totals:</b>		<b>88.6%</b>	<b>11.9%</b>	<b>35.7%</b>	<b>34.5%</b>	<b>91.1%</b>	<b>83.0%</b>
SETMA West	Cury	88.8%	10.7%	38.0%	43.5%	92.3%	81.2%	64.6%
	Depparine	78.8%	10.4%	32.0%	40.2%	81.2%	74.4%	56.2%
	Halbert	81.8%	11.2%	38.7%	44.1%	85.4%	78.8%	56.7%
	Horn	85.4%	6.2%	35.0%	51.7%	88.2%	79.0%	64.8%
	Qureshi	78.8%	18.8%	28.8%	40.1%	80.3%	70.7%	52.3%
	Sattarwhite	79.7%	17.9%	38.8%	31.8%	80.4%	70.1%	49.8%
	Vardman	78.5%	8.8%	38.4%	40.4%	82.2%	74.7%	63.5%
	<b>SETMA West Totals:</b>		<b>81.2%</b>	<b>11.3%</b>	<b>35.4%</b>	<b>42.7%</b>	<b>84.4%</b>	<b>76.2%</b>
<b>SETMA Totals:</b>		<b>82.4%</b>	<b>11.3%</b>	<b>35.6%</b>	<b>39.2%</b>	<b>89.1%</b>	<b>80.7%</b>	<b>61.7%</b>

**Special Dashboards – NCQA Diabetes Recognition Program Audit**



**NCQA Diabetes Measures**

Encounter Date(s): January 1, 2011 to September 30, 2011

Location Name	Provider	Encounters	A1c > 9.0 => 15%	A1c < 9.0 => 60%	A1c < 7.0 => 40%	BP > 140/90 => 35%	BP < 130/80 => 25%	Eye Exam => 60%	Smoking Cessation => 80%	LDL >= 130 => 37%	LDL < 100 => 30%	Nephropathy => 80%	Foot Exam => 80%	Total Points
SETMA 1	Adiz	769	9.9%	75.7%	59.2%	18.7%	54.2%	59.7%	96.9%	13.9%	68.8%	81.7%	74.9%	85
	Duncan	537	8.9%	81.2%	67.6%	11.9%	68.9%	59.0%	93.5%	14.2%	68.7%	83.4%	82.3%	90
	Henderson	821	10.5%	79.4%	66.2%	10.1%	69.1%	61.5%	95.1%	12.1%	67.5%	84.1%	95.3%	100
	Murphy	1,093	5.7%	86.3%	69.6%	14.0%	58.5%	46.9%	82.0%	12.3%	73.3%	87.3%	81.5%	90
	Paling	329	4.6%	47.2%	37.2%	19.5%	53.5%	23.1%	92.3%	6.7%	46.8%	31.0%	31.3%	67
	Thomas	156	9.6%	69.2%	45.5%	18.6%	55.8%	77.6%	100.0%	12.2%	60.9%	75.3%	62.7%	95
SETMA 2	Ahmed	2,078	16.3%	48.3%	32.8%	8.6%	62.6%	64.3%	72.2%	11.3%	63.5%	68.3%	95.5%	68
	Anthony	680	10.3%	78.2%	64.0%	13.4%	66.5%	65.6%	81.7%	10.4%	68.8%	92.6%	96.6%	100
	Anwar	1,013	8.5%	79.9%	65.2%	4.2%	81.2%	65.7%	96.8%	11.8%	63.6%	91.6%	75.5%	95
	Cricchio, A	829	12.1%	46.6%	30.5%	8.9%	71.7%	65.1%	79.8%	10.0%	69.5%	75.5%	99.3%	72
	Cricchio, M	632	7.8%	78.2%	64.4%	14.2%	61.2%	61.9%	66.4%	10.1%	66.6%	91.0%	85.8%	90
	Holly	219	5.4%	83.6%	71.2%	5.0%	82.6%	80.4%	71.9%	11.4%	71.2%	97.3%	95.0%	90
	Lefkete	756	7.3%	81.5%	70.8%	13.0%	65.2%	71.6%	59.6%	8.7%	69.2%	88.6%	82.7%	90
	Wheeler	406	7.6%	84.4%	73.9%	22.6%	36.8%	58.6%	81.4%	13.0%	61.9%	89.3%	88.7%	90
SETMA West	Cury	303	10.2%	77.9%	59.1%	15.8%	60.7%	70.3%	86.5%	13.2%	65.7%	87.1%	92.4%	100
	Depparine	557	9.2%	72.2%	56.6%	25.3%	49.7%	51.3%	95.8%	13.8%	58.9%	78.7%	85.6%	85
	Halbert	811	10.9%	75.7%	62.5%	20.6%	55.5%	39.2%	88.0%	14.7%	68.9%	57.8%	84.5%	85
	Horn	563	5.2%	79.8%	65.9%	1.4%	70.5%	49.9%	90.6%	16.2%	55.1%	81.2%	95.2%	90
	Qureshi	309	19.4%	63.1%	52.1%	7.8%	71.2%	52.4%	88.3%	17.2%	59.2%	66.3%	95.8%	73
	Sattarwhite	323	16.4%	60.1%	47.7%	22.6%	55.1%	53.6%	94.3%	19.2%	50.8%	76.8%	81.3%	73
	Vardman	416	10.1%	74.0%	59.9%	19.5%	48.6%	61.1%	98.4%	13.5%	60.2%	66.1%	87.0%	95

Specific dashboards, such as the one above, have also been developed for programs such as the **NCQA Diabetes Recognition Program**. All SETMA clinics and providers qualified for this recognition in 2010-2013. Quarterly and annually, we now measure this standard so as to make sure that we continue to improve. As can be seen below, the dashboard gives the metric, the benchmark, the provider’s performance and the aggregate score required for recognition. This material is given to the provider and it is posted on our website at [www.setma.com](http://www.setma.com) under **Provider Performance, NCQA Diabetes Recognition Program Audit**. Because all deficiencies in care are displayed in “red,” SETMA providers have developed their own commitment to “get the **RED** out.”

**Medical Home Feedback Report – CMS Study Contracted with RTI International -- 2011**

This study compared 312 Medical Home Practices with matched, benchmark practices which did not employ care coordination. It contrasted the practices on “Quality, Coordination & Cost for the years 2007-2008, 2008-2009 and 2009-2010. This result is for the SETMA II Clinic.

**Table 1**

Measure	Your Practice (N beneficiaries=3682)	Benchmark (N beneficiaries=124,210)	Your Practice versus Benchmark	Average across all study NCQA Medical Homes (N beneficiaries=146,410 N practices=312)
<b>Quality of Care (% of beneficiaries)</b>				
LDL-C Screening (n=233)	93 %	86 %		85 %
HbA1c Testing (n=180)	97 %	86 %		90 %
Influenza Vaccination	51 %	39 %		50 %
<b>Coordination and Continuity of Care</b>				
Hospitalization (rate per 100 beneficiaries)	24.5	47.4		16.9
Follow-up within 2 weeks of hospital discharge (rate per 100 hospital discharges, n=114)	56.5	40.4		57.3
30-day hospital readmission (rate per 100 hospital discharges, n=114)	17.5	30.9		13.2
ER Visits (rate per 100 beneficiaries)	47.4	60.5		32.3
Primary Care Visits (rate per beneficiary)	4.3	4.5		4.3
Medical Specialist Visits (rate per beneficiary)	3.3	3.9		3.0
Surgical Specialist Visits (rate per beneficiary)	0.6	0.8		0.5
<b>Annual Payments (Average \$ per beneficiary)</b>				
Durable Medical Equipment (DME) Payments	\$336	\$369		\$238
Hospice Payments	\$328	\$297		\$148
Home Health Payments	\$1,259	\$1,100		\$283
Physician Payments	\$2,780	\$3,160		\$2,033
Outpatient Department Payments	\$905	\$1,373		\$904
Skilled Nursing Facility (SNF) Payments	\$43	\$710		\$299
Acute Care Hospital Payments	\$1,947	\$4,929		\$1,613
<b>Total Medicare Payments</b>	<b>\$8,134</b>	<b>\$12,919</b>		<b>\$5,715</b>
<b>Physician Payments by Type of Service (Average \$ per beneficiary)</b>				
Office Visit Physician Payments	\$410	\$434		\$373
Hospital/ER Visit Physician Payments	\$203	\$415		\$119
Specialty Visits & Consultation Physician Payments	\$138	\$164		\$151
Imaging & Laboratory Physician Payments	\$727	\$806		\$453
Other Physician Payments	\$965	\$933		\$710
<b>Potentially Avoidable Payments based on Ambulatory Care Sensitive Conditions (ACSCs)(Average \$ per beneficiary)</b>				
Potentially Avoidable Inpatient Hospital Payments	\$962	\$2,259		\$790
Potentially Avoidable ER Payments	\$183	\$214		\$111

SETMA’s results are excellent. Our quality is superior to all. Our coordination results are superior to the benchmarks and comparable with the mean of the 312 Medical Homes. Our costs are superior to the benchmarks. Our total annual medical cost per capita for Fee-for-Service Medicare beneficiaries is 37.5% below the benchmarks. While our goal is always to improve, these CMS-generated results show that our model works.

### 3. Commitment to Transparency

SETMA's "commitment to transparency" is demonstrated by:

1. Our Clinic's "Treatment Plans and Plans of Care," which detail each patient's personal care and the provider's fulfillment of national standards of care in their treatment.
2. Published newspaper articles with specifics of provider performance by provider name.
3. The Public Reporting Section on SETMA's website [www.setma.com](http://www.setma.com) where over 200 quality metrics are publicly reported by provider name.
4. SETMA's participation in PQRS and in Bridges To Excellence quality reporting.

SETMA's first step toward transparency with our patients began in 1999 when we published the "Diabetes Standard of Care," which was included on each patient's Diabetes Follow-up Care Note. It was described as, "This is your healthcare provider's 'Report Card,' if your provider is not completing these evaluations during your visit; ask him/her to do so." Subsequently, the disease management tools for diabetes, hypertension, hypercholesterolemia and other conditions, included the compliance standards for each condition and the patient's adherence to the standards. This was noted as the responsibility of the patient/provider alliance in maintaining quality of care.

The first Quality Metric sets SETMA learned were published by the Physician Consortium for Performance Improvement (PCPI). In 2004, SETMA deployed the PCPI Diabetes Measures Set, so that each provider could measure their own performance at the point-of-care. The provider's performance on these metrics was given to the patient on their Follow-up Note for each disease management tool. In February, 2009, when SETMA began learning about Patient-Centered Medical Home, we added a number of quality metric sets to our performance standards. We created a PC-MH Coordination Review template on which we deployed all of the quality metric sets which applied to the patient being treated. These included NQF, HEDIS, PCPI Diabetes, PCPI Hypertension, PCPI CHF, and PCPI Chronic Stable Angina, BTE and PQRS.

In 2010, the following NQF measures were added to our tracking and auditing: Comprehensive Diabetes Measures, General Health Measures, Medication Measures, Chronic Condition Measures, and Care for Older Adults, Female Specific Measures, and Pediatric Measures. In all more than 40, NQF measures are tracked. SETMA began tracking metrics for the Physician Quality Reporting Initiative (PQRI now PQRS). Our reporting included the following Measures Groups: Diabetes, Fall Risk, Back Pain, Preventive, and Chronic Kidney Disease. There are approximately 30 individual metrics in this reporting. Because no nationally endorsed quality measure sets exist, SETMA developed measurement sets for Stage 1-3 Chronic Renal Disease and for Lipids.

#### **Transparency: Public Reporting SETMA Providers' Performance on Quality Metrics**

In that NCQA PC-MH Tier III recognition required that a practice report at least ten NQF-endorsed quality metrics to an external group, SETMA decided not only to report the metrics to an HMO with which SETMA works, but also to report them to our patients. We report them in several ways:

First, the PC-MH Coordination Review document, which is given to our patients at clinic visits, summarizes the current status of the care required by over 200 quality metrics. The note concludes with the following statements: “Please review this document. Identify the information which is missing from your chart, such as medical power-of-attorney, living will, etc. Please bring that with you to your next visit, e-mail your provider via our secure web portal with the information, or call your health care provider and give him/her this information...Also, please review the quality measures listed. If any apply to you and are NOT completed, please ask your provider to address these issues the next time you come to the office.”

Second, health education pieces in the newspaper with provider-specific performance metrics. For the past fifteen years, SETMA has written a weekly health column for a local newspaper. (All articles can be found at [www.setma.com](http://www.setma.com) under *Your Life Your Health*) The articles average 2,000 words each and include information about healthcare policy, transformation, and detail SETMA’s progress in improving healthcare. The articles often included SETMA’s providers’ quality performance. The following are examples of this transparency. In 2008, SETMA published the following information in an article about diabetes care. The following data was for SETMA’s HbA<sub>1c</sub> for 2008.

Patients with Diabetes Only						All Patients	
Provider	Instances	Average (Mean)	Std Dev	Median	Mode	Latest Value Average (Mean)	Average (Mean)
Ahmed	2611	7.36	1.9081	6.8	6	7.25	7.36
Anthony	1912	6.87	1.4698	6.5	5.8	6.72	6.88
Anwar	3086	7.31	1.83	6.8	6.2	6.92	7.29
Aziz	1772	7.41	1.7623	6.9	6.9	7.29	7.36
Cricchio	18	6.97	2.0353	6.1	5.6	7.05	6.79
Curry	42	7.05	2.3711	6	6	6.76	6.92
Duncan	1860	7.08	1.5776	6.6	6.4	6.71	7.02
Fowler	1281	6.34	0.0495	6.3	6.3	6.03	6.12
Halbert	2491	6.98	1.654	6.5	6	6.8	6.85
Henderson	1099	6.91	1.6533	6.4	6.2	6.8	6.85
Holly	1701	6.99	1.6471	6.5	6.2	6.71	6.89
Leifeste	533	6.44	1.2941	6.1	5.7	6.41	6.33
McClure	1042	6.36	1.0143	6.1	5.6	6.21	6.36
Murphy	1388	6.67	1.5915	6.2	5.8	6.67	6.6
Satterwhite	41	7.14	2.3175	6.2	5.6	6.67	7.12
Sims	60	6.87	1.8085	6.3	5.5	6.66	6.84
Vardiman	1195	6.94	1.457	6.6	6.2	6.58	6.76
Wheeler	1173	6.9	1.7408	6.5	6.2	6.68	6.79
Wilson	2092	6.97	1.4146	6.6	6.3	6.92	6.91
Young	124	6.55	1.2147	6.2	6	6.51	6.2

Overall	25521	6.99	1.6496	6.5	6	6.78	
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SETMA is a multi-ethnic, multi-cultural, multi-faith practice. This is true of the partners, the providers, the patients, and the management of SETMA. As a result, we are particularly sensitive to disparities in access to care, or in the outcomes of care for any group. There is no place this is truer than in the case of ethnicity. While nationally significant disparities of care are reported between various racial groups, SETMA has worked hard to eliminate such disparities. In a May 13, 2009 article, SETMA’s efforts to eliminate Ethnic Disparities of care in diabetes were detailed. The following were SETMA’s results comparing Caucasian patients with African-American Patients for 2009:

	Controlled Caucasian	Controlled African American	Uncontrolled Caucasian	Uncontrolled African American
Average HbA1c	5.76%	5.82%	7.48%	8.71%
Std Dev	0.377	0.376	2.234	2.427
Mode	5.80%	5.70%	7.70%	7.30%
Median	5.80%	5.80%	7.70%	7.80%

	Controlled	Uncontrolled
Caucasian	69%	31%
African- American	59%	41%

The above data was for all Caucasians (4104 discrete individuals) and all African Americans (2134 discrete individuals) with the diagnosis of diabetes seen by SETMA during 2009. The standard deviations, mode and median for both groups were essentially identical with the African-American group having a lower mode in the uncontrolled population and also having a lower standard deviation and mode in the controlled groups.

The only discrepancy was between the average (mean) between uncontrolled Caucasians and uncontrolled African-Americans. Rather than lament this, SETMA designed an aggressive plan for intervening in the care of the 31% of Caucasians and the 41% of African-Americans who were not controlled. Our goal was to:

- decrease the number and percentage of uncontrolled in both groups,
- decrease the standard deviations in both groups which will mean that a lower percentage of our patients will have poor diabetes control, and
- eliminate the differences between the average (mean) between the two groups and to eliminate the difference between the percentage of uncontrolled in the two groups

In 2010, we successfully eliminated ethnic disparities in care for patients with diabetes.

**The following provider-specific performance data was published in a March 13, 2010 article.** The statistical analysis of SETMA's HbA1C data for the period March 2009 through March 2010 shows the following provider specific information.

Third, in 2009, SETMA realized that our reporting was too involved and that the display of our reports was not easily understandable. Therefore, we undertook what we referred to as SETMA's COGNOS Project. With the help of a consultant firm, we designed reporting modules which allowed the efficient, frequent and accurate analysis of our performance on all of the quality metrics listed above. By comparing the details of the patients treated to goal and those who weren't, we have been able to look for leverage points for care improvement.

In a major project to identify opportunities for decreasing preventable readmissions to the hospital through BI analytics, we discovered that the most consistent issue, once care transitions issues were resolved, was how quickly the patient was seen after discharge from the hospital. Decreasing that time and increasing contact with the patient and family has resulted in a 22% decrease in preventable readmissions.

With SETMA's COGNOS Reports, we are now able to understand the processes and outcomes of the care we deliver to all of our patients and to compare those processes and outcomes by ethnic groups, gender groups, socio-economic groups and others. COGNOS will allow SETMA to continue to move healthcare delivery forward and to improve the care for our patients.

	Average	Std Dev	Median	Mode	Count
Ahmed	7.4	1.6	7	6.7	2121
Anthony	6.87	1.55	6.4	5.9	407
Anwar	6.7	1.24	6.4	6.1	652
Aziz	6.95	1.68	6.5	6.4	285
Cricchio	6.38	1.19	6.1	5.9	369
Curry	7.12	1.77	6.6	6.1	185
Duncan	6.63	1.45	6.2	5.8	277
Groff	7.22	1.45	6.9	6.2	31
Halbert	6.79	1.75	6.3	5.9	616
Henderson	6.72	1.5	6.2	5.9	269
Holly	6.47	1.38	6.1	5.9	542
Horn	6.67	1.36	6.3	5.8	300
Leifeste	6.56	1.47	6.2	5.9	638
Murphy	6.51	1.21	6.2	6	900
Satterwhite	6.94	1.61	6.4	6.1	169
Thomas	6.48	1.47	6.1	5.8	343
Vardiman	6.74	1.7	6.4	6.5	155
Wheeler	6.54	1.23	6.2	5.9	288
Young	6.68	1.65	6.2	5.7	144
SETMA	6.82	1.52	6.4	5.9	8935

## **Public Reporting Goals**

First, we wanted to know what we were doing. Without auditing our performance, we could never know how we were performing. The COGNOS Project allowed us to objectify our performance. We no longer would just "think" we were doing well; we could know if we were. Second, we wanted to improve what we were doing. Evidence-based medicine with the treatment targets established by science, tells us where we want to be. If we know where we are and if we know where we want to go, we can design a way to get there.

Third, when we knew that a patient was not treated to goal, we wanted to know why. COGNOS allowed us to know if evidence-based standards of care were being employed. If they were, and if the patients were still not to goal, it allowed us to address obstacles to the patient getting to goal. Fourth, we wanted to change provider behavior. The medical literature is replete with reports of "clinical inertia." Change requires that there be more discomfort in staying the same as is required to make a change. SETMA believed that comparing provider performance and publishing that performance internally by patient name, and externally as an aggregate practice performance by provider name but without the patient identifier would motivate providers to change. The data given above shows that this is true.

Fifth, we wanted to change patient behavior. Like the frog dropped into a kettle of cool water which is then placed on the fire, changes in a patient's health are often so subtle and so slow that devastation overtakes them before they realize they are sick. SETMA expanded the use of patient data through the COGNOS Project to create discomfort in patients to make them "jump out of the heating kettle" of deteriorating health before it is too late. Sixth, we wanted to examine through statistical methodology and epidemiologic-principles patterns of care and outcomes. We wanted to be able to ask questions and analyze our data to get answers both retrospectively and then prospectively to those questions.

## **Care Transitions**

SETMA has used EHR for completion of Hospital History and Physical Examinations since 2000. In 2002, we began using the EHR for completing Hospital Discharge Summaries. During an NQF Conference on Care Transitions In September 2010, SETMA changed the name of the "discharge summary" to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." While long, this name is functional and addresses the imperatives of transitions of care which are critical for patient safety and for excellence of care. In June, 2009, SETMA adopted the PCPI Care Transitions Audit as a standard of care. Since then, SETMA has discharged 25,456 patients from the hospital with a 99.1% efficiency of giving the patients the Post Hospital Plan of Care and Treatment Plan with reconciled medication lists, follow-up appointments scheduled and a Care Coordination follow-up telephone call scheduled the following day. This call is a 12-30 minute call which is the first step in care coaching for the patient and is a third point of medication reconciliation.

SETMA's care transition is not considered complete until the patient is seen by the primary care provider at which time a fourth medication reconciliation is completed. SETMA providers, in collaboration with SETMA's Hospital Care team and SETMA's Department of Care Coordination, work together to make sure that all issues of quality care, patient safety and follow-up care are completed. The complexity of care transitions is seen in the realization that there are eight different places a patient can go when being discharged from the inpatient setting. Each of these is discussed in articles found at [www.setma.com](http://www.setma.com) under *Your Life Your Health* at the icons *Care Coordination* and *Care Transitions*.

The following COGNOS audits, which are publicly reported, reflect SETMA's provider performance on care transition metrics.



**Care Transition Audit (Section A)**

Discharge Date(s): 01/01/2011 through 10/31/2011

Provider	Reason for Hospitalization	Discharge Diagnosis	Medications Updated/Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals/Response to Treatment
Anwar	95.5%	100.0%	93.9%	97.0%	98.5%	95.2%	100.0%	99.2%	98.5%
Acc	99.6%	100.0%	97.7%	99.2%	98.1%	95.6%	98.0%	99.2%	98.9%
Curry	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%
Dequaine	97.7%	100.0%	96.1%	98.8%	98.8%	97.7%	98.8%	97.7%	97.7%
Hallbert	100.0%	100.0%	100.0%	98.9%	98.9%	100.0%	98.9%	100.0%	98.9%
Holly	97.9%	100.0%	95.7%	98.9%	98.9%	97.9%	97.9%	96.8%	97.9%
Larfeke	98.0%	100.0%	96.2%	98.0%	98.4%	98.0%	98.0%	98.0%	98.4%
Murphy	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	100.0%	99.0%	99.0%
Pakung	98.3%	100.0%	98.3%	99.1%	99.1%	98.3%	98.3%	98.3%	97.4%
Qureshi	96.0%	100.0%	93.0%	95.9%	98.9%	96.0%	98.9%	96.0%	96.0%
Saberswhite	97.6%	97.6%	100.0%	96.1%	97.6%	97.6%	96.1%	96.1%	96.1%
Spal	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	98.4%	100.0%	93.0%	98.9%	97.0%	98.4%	96.2%	97.3%	98.4%
Vardman	97.0%	100.0%	93.2%	100.0%	100.0%	97.0%	97.0%	97.0%	97.0%
<b>SETMA Totals :</b>	<b>98.2%</b>	<b>99.9%</b>	<b>96.2%</b>	<b>98.7%</b>	<b>98.0%</b>	<b>96.4%</b>	<b>98.4%</b>	<b>98.0%</b>	<b>98.1%</b>



**Care Transition Audit (Section B)**

Discharge Date(s): 01/01/2011 through 10/31/2011

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources/Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	93.9%	98.5%	98.5%	97.7%	93.9%	92.4%	92.4%	92.4%	92.4%
Acc	98.6%	98.9%	98.1%	98.9%	93.5%	97.3%	97.3%	96.6%	93.9%
Curry	91.7%	100.0%	100.0%	100.0%	89.8%	97.9%	97.9%	97.9%	97.9%
Dequaine	95.2%	97.2%	99.6%	98.7%	94.6%	93.4%	93.4%	93.4%	93.4%
Hallbert	100.0%	100.0%	98.9%	100.0%	95.7%	97.9%	97.9%	97.9%	97.9%
Holly	94.1%	97.3%	98.9%	97.9%	94.1%	91.4%	91.4%	91.4%	91.4%
Larfeke	95.1%	98.4%	98.4%	98.4%	94.7%	93.0%	93.0%	93.0%	93.0%
Murphy	100.0%	100.0%	99.0%	100.0%	95.1%	98.0%	98.0%	98.0%	97.1%
Pakung	96.6%	98.2%	98.1%	99.1%	91.5%	96.7%	96.7%	96.7%	96.7%
Qureshi	89.8%	94.8%	100.0%	96.8%	91.4%	88.2%	88.2%	87.7%	88.2%
Saberswhite	97.6%	95.1%	97.6%	100.0%	92.7%	92.7%	95.1%	95.1%	95.1%
Spal	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	93.0%	97.0%	98.5%	98.7%	94.1%	87.0%	87.0%	87.0%	86.0%
Vardman	93.3%	97.0%	100.0%	98.6%	91.1%	91.1%	91.1%	91.1%	91.1%
<b>SETMA Totals :</b>	<b>95.0%</b>	<b>98.1%</b>	<b>99.0%</b>	<b>98.1%</b>	<b>93.2%</b>	<b>93.2%</b>	<b>93.2%</b>	<b>93.1%</b>	<b>93.6%</b>

#### 4. Data-Driven Improvement in the National Quality Strategy Priority Goal Areas

SETMA's PC-MH provides twenty-four-hours-a-day, seven-days-a-week access to care for our patients. This is the first and the minimal level of safety and quality for patients' safety and continuity of care. The second level of safety and quality is that each patient's EHR is available at all points-of-care: clinic, providers' homes, nursing homes, emergency departments (ED), hospitals, hospice, home health, physical therapy, etc. The EHR provides a longitudinal health record which is an increasingly granular "health portrait," rather than the traditional static "silhouette," or "snapshot" of a patient's health and healthcare.

The third level of continuity and safety is that admission histories and physicals and/or emergency-department records are completed in the same data base in which all care is documented. Therefore, these episodes of care are built upon the patient's global health record including medications, allergies, histories, laboratory and procedure results, as well as preventive health and screening health standards. And, the patient's personal plan of care and treatment plan is always available at all points of care. The hazards of medication errors are decreased, as all medications – over-the-counter, nutraceuticals (herbal) and pharmaceuticals – are available and reconciled at all points-of-care. With every hospital-care encounter the patient receives four medication reconciliations: admission, discharge, post-hospital follow-up call the day after discharge, and provider follow-up visit from the hospital.

The fourth level of safety and continuity of care occurs with the multiple functions of SETMA's Department of Care Coordination. The following is the Care Coordination Referral template. When the button displayed in "red" and entitled "Click to send to Care Coordination Team" is deployed, an e-mail is sent to the Department. The SETMA Foundation, seen in the second column, allows for SETMA providers to request financial assistance for patients who cannot afford care.

**Care Coordination Referral**

Patient: Jimmy L ZTest Home Phone: (409)835-0797  
DCB: 08/17/1940 Sex: M Work Phone: ( ) - ( )

[Return](#)

Please provide care coordination for this patient in the areas selected below.

<input type="checkbox"/> Alcohol Rehabilitation	<input type="checkbox"/> SETMA Foundation
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Dental Care
<input type="checkbox"/> Disability Application Assistance	<input type="checkbox"/> DSME
<input type="checkbox"/> Drug Rehabilitation	<input type="checkbox"/> Living Expenses
<input type="checkbox"/> Employment Counseling	<input type="checkbox"/> Medication
<input type="checkbox"/> Handicap Access, Bath	<input type="checkbox"/> MNT
<input type="checkbox"/> Handicap Access, Home	<input type="checkbox"/> Procedures
<input type="checkbox"/> Home Health	<input type="checkbox"/> Transportation
<input type="checkbox"/> In-Home Provider Services	Other: <input type="text"/>
<input type="checkbox"/> In-Home Safety Evaluation	Comments: <input type="text"/>
<input type="checkbox"/> Insurance Assistance Obtaining	
<input type="checkbox"/> Lives Alone	
<input type="checkbox"/> Long Term Residence Placement	
<input type="checkbox"/> Nutritional Support	
<input type="checkbox"/> Protective Services, Adult	
<input type="checkbox"/> Protective Services, Child	
<input type="checkbox"/> Tobacco Cessation	

[Click to Send to Care Coordination Team](#)  
Click once and the request will be automatically sent.

In November, 2011, in a HIMSS Leaders and Innovators Conference, the Chairman, CEO & President of AETNA said, "Convenience is the new word for quality." Previously, SETMA established the link between "convenience" and "quality and safety," in working through

whether patient convenience is a worthy, high priority for a PC-MH. SETMA’s analysis linked the two through the following steps: “**coordination**” has come to mean scheduling which translates into **convenience** for the patient; which results in increased patient **satisfaction** which contributes to the patient having **confidence** that the healthcare provider **cares** personally; which increases the **trust** the patient has in the provider; all of which increases **compliance (adherence)** in obtaining healthcare services recommended; which promotes **cost** savings in travel, time and expense of care; which results in increased patient **safety and quality** of care.

The fifth level of safety and continuity of care occurs with the post-hospital and/or post-clinic follow-up call. In SETMA’s effort to decrease preventable readmissions to the hospital, we have found two leverage points: a care-coaching follow-up call the day following hospital discharge; a follow-up by the primary care provider within five days of the discharge. The following is SETMA’s Post-Hospital Follow-up Call template. This is a 12-30 minute call, which upon occasion, with the frail-elderly, has lasted for 97 minutes, or more.

The next level of safety and quality is a clinic follow-up call which the provider can schedule at any time he/she chooses; that schedule can be two days, or two months, or any time in between or after. This additional telephone contact with the patient reinforces the treatment plan and strengthens the patient’s follow-up care. The sixth level of safety and quality is SETMA’s electronic tickler file. Follow-up care must be initiated by the practice when a patient fails to keep scheduled visits, or fails to obtain prescribed care. Through the power of electronics and the integration of Microsoft Outlook into the EHR, it is possible to create a pre-populated e-mail and delay its delivery to remind the provider to make sure the patient received scheduled care.

In one dramatic instance, a patient was seen and diagnosed with new-onset diabetes. The day following her visit, her provider explained her tests, new treatments, diabetes education, eye-care, and dental-care referrals. The patient agreed to and embraced the plan, but as the provider disconnected, he thought, “I think she is not going to follow-up”. An electronic-tickler file was created for a call three days later. On that day, an e-mail appeared in the Care Coordination queue and a follow-up call was made. The patient indicated that she appreciated the attention

but was not ready to accept the fact that she has diabetes and did not intend to follow-up with the care prescribed. Continuing efforts are being made to help her accept her diagnosis and treatment. In SETMA's Smoking Cessation Program, patients are called one month after their visit in order to follow-up cessation efforts. The follow-up clerk is reminded to make this call with an electronic tickler file which generates a pre-populated e-mail on the date the call is to be made. In addition, the previous day's schedule of patients is audited to find patients who missed appointments for important conditions such as diabetes, hypertension, elevated cholesterol, etc. Those patients are then called to make sure they rescheduled another appointment and that they keep that appointment.

The seventh level of safety and quality is the plan-of-care and treatment plan – “the Baton” – which is discussed with the patient and family at the time of care. The personalized plan is written with the patient's lab results and the patient's name on each page. The plan is updated at each visit and it can be reviewed at: <http://www.setma.com/article.cfm?ID=571>. The eighth level of safety and quality is SETMA's auditing which involves the above mentioned “missed appointments” and includes an audit of provider work flow where notices of laboratory results, procedure reports, or patient contacts are posted. The goal is “every call from every patient answered every day,” and that every laboratory result is reviewed and analyzed every day. Auditing is also done on referrals to make sure that they were completed and that the referral report was received and reviewed.

The ninth level of safety and quality is **communication**. Follow-up calls are initiated by the practice. And, SETMA's HIE coordinates the sharing of information with all providers participating in the care of patients. SETMA's secure web portal allows additional patient and provider communication. It also allows the patient to receive electronic copies of medications, lab results and treatment plans. In SETMA's Joslin Diabetes Affiliate and in the entrance to all SETMA clinics, *Seven Stations for Success* in diabetes care are displayed in framed posters. Station 5 addresses the physician/patient collaboration, declaring:

- TOGETHER, set goals of blood glucose, blood pressure and cholesterol.
- TOGETHER, determine your risk of complications.
- TOGETHER, plan for preventing complications.
- TOGETHER, review and agree on treatment plan.

The tenth level of safety and quality is SETMA's EHR, declared by AHRQ to be one of thirty exemplary deployments of Clinical Decision Support. Care coordination is seamless through the EHR and continuity of care is maintained by it.

Patients are involved in the care coordination process by the completion of “patient satisfaction surveys” at the end of each visit. These surveys have been collected for more than ten years and the results have been posted on our website at [www.setma.com](http://www.setma.com) for the past two years. The patient satisfaction survey results are publicly reported as an aggregate of each clinic and not by provider name. In 2012, SETMA is will adopt the NQF-endorsed, *Clinician-Group -- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)*. Patient-satisfaction results are distributed to all healthcare providers and executive management staff.

The patient's personal plan of care and treatment plan, along with their PC-MH Care Coordination Review document are given to the patient and reviewed with them. They are asked to continue their review at home and to bring the documents to their next visit for discussion. When serious issues are involved, the Care Coordination Department will call the patient to discuss specific patient needs. At all points of care, patient feedback is invited. With the plan of care and treatment plan, the patient is given a summary of the compliance standards and of the patient's adherence to those standards.

The most creative care coordination and patient involvement is when the patient returns for the follow-up visit with the plan of care in hand and announces, "This information is wrong!" The creative aspect is generated by the fact that the patient is engaged in their own analysis of their care. Over 99% of the time, the information is correct, but even when it is not, we are happy to make sure that our data and that our "portrait" of our patients are correct. As the patient's concerns are addressed, they learn and our relationship is strengthened, as is their control of their care.

A public member is on the Diabetes Self-Management Education Program oversight committee. The non-healthcare-provider member meets with the team and is invited to comment on the care given. Significant process alterations have been made through this method, particularly in what information is available to the patient through the secure web portal. Patient complaints are an important part of care coordination. When a patient files a complaint with SETMA's staff, it is investigated by the Care Coordination Director, reviewed with the CEO and Managing Partner, and a formal and personal response is made to the patient filing the complaint. When the complaint involves a process, modifications are made to the process as appropriate.

All of SETMA's team – nurses, nurse managers, unit clerks, healthcare providers, management and other staff – are involved in the care of patients. Feedback is given to multiple personnel about patients' responses to their care. This information is shared via secure e-mail to all providers involved and an analysis is made as to how we can improve our communication and interaction with patients outside of the examination room.

### **Laser Printers**

One of the most effective changes in SETMA's processes came from simply putting a laser printer in each examination room. Because our plans of care are personalized, before the laser printers, providers had to leave the exam room to retrieve documents. Sometimes, they forgot and sometimes the patient felt that the provider was a jack-in-the-box, popping in and out of the exam room. With multiple providers using the same printer, it was a task to hunt through several documents to find your patient's materials. After the laser printers were placed in the exam room, the provider did not have to leave the room until the visit was over and could easily give the patient their plan of care and treatment plan. This left ample time to discuss the plan of care with them in the context of the visit rather than as an "add on" in the hallway.

## **Tele-monitoring**

One of the most effective means of engaging patients in their care is in assigning specific tasks for them to perform and then to follow-up to make sure the tasks were performed, such as, daily weights for patients with congestive heart failure; blood glucose logs for patients with diabetes; blood pressure measurements for patients with hypertension; exercise and dietary logs for inactive and/or overweight patients. Tele-monitoring of patients offers effective, real-time potential for these tasks. The deployment of methodologies for capturing this data in real-time, longitudinal and structured data fields gives the patient an indication of how important their participation is.

## **Best Practices – eAG versus Mean Plasma Glucose**

Best Practices are identified via evidence-based literature and published and endorsed quality standards. For example, annually the American Diabetes Association publishes a monograph on the standard of care in diabetes. SETMA's staff reads this and updates our Diabetes-Disease-Management tool with any new developments. Even when all providers do not read the monograph, new knowledge can be infused into their practice as if they had read it.

A recent improvement in our diabetes disease management tool was the adoption of the "estimated average glucose" (eAG) for Self-Monitoring of Blood Glucose (SMBG) by the patient. Previously, SETMA used the "mean plasma glucose" (MPG), but the formula for interpreting the MPG relationship to hemoglobin A1c (HbA1c) understates the severity of the patient's risk. For instance, if a patient does his/her blood glucose monitoring and has a result of 165 mg/dl, the MPG formula would suggest that the HbA1c is 6.8%, while the eAG computation would correlate with a HbA1c of 7.5% for the same glucose value. For the MPG to correlate with a HbA1c of 7.5%, the blood glucose reading would have to be 190 mg/dl; the eAG for a glucose of 190mg/dl would correlate with a HbA1c of 8.5%. Using the MPG makes the patient think they are "doing better" than they are. Teaching the patient to use the eAG allows him/her to accurately estimate their HbA1c, which accurately reflects their cardiovascular risk.

With the patient understanding that their treatment goal is a HbA1c of 7.0%, or below, and with a glucometer result of 190 mg/dl, the patient can know that they are not at, or near their goal. With the knowledge gained from Diabetes Self Management Education (DSME) classes and refresher courses, patients are able to determine when they need to exercise more, eat less and monitor their blood glucose more carefully.

With glucometers which automatically report results to a web portal, patients will be able to see the graphic display of their blood glucose over time. This will allow patients to see if their blood glucose is always high, only high in the morning or high after meals. Each pattern will allow an adjustment of medication based on a treatment algorithm, which can be taught to the patient. Communicating through a secure web portal, it is possible to do this in real-time between visits which both enhances quality, safety and controls cost.

## **SETMA's Medical Home and Care Coordination "Poster Child"**

In February, 2009, SETMA saw a patient in the hospital for the first time. He was angry, hostile, bitter and depressed, and it was impossible to coax him out of his mood. When he left the hospital, he was given an appointment to the clinic. In his follow-up visit, his affect had not changed, but we discovered he was only taking four of nine medications because of expense. He could not afford gas to get the diabetes education he needed. He was disabled and could not work. He was losing his eyesight and could not afford to see an ophthalmologist. He did not know how to apply for disability. His diabetes had never been treated to goal. When he left that clinic visit, he had: an appointment to SETMA's DSME program, with the fees waived; a gas card for the fuel to get to education classes; all medications paid for by the SETMA Foundation; assistance in applying for Social Security disability. He had a visit that day with SETMA's ophthalmologist who arranged a referral to an experimental eye-preservation program in Houston, which is free.

Six weeks later, he returned with something which could not be prescribed for him; he had hope. He was smiling and happy. Without anti-depressants, he was no longer depressed. He now believed there was life after a ten-year diagnosis of diabetes. For the first time, his diabetes was treated to goal. Eighteen months later, he was in for a scheduled visit and he was sad. Asked why; he said that he was afraid that SETMA would get tired of helping him. He had applied for and had received disability but he would not be eligible for Medicare for two years. In two years, without care, he would be blind, in kidney failure, or dead. He asked if we would stop helping him. The answer was, "Yes, we will. Absolutely, the day after we go bankrupt."

## **SETMA's Less Initiative**

In 2011, AHRQ accepted SETMA's LESS Initiative for display on their Innovation Exchange (<http://www.innovations.ahrq.gov/content.aspx?id=3223>). In 2001, after developing several disease management tools – Diabetes, Hypertension, CHF, Chronic Stable Angina, Lipids, Cardiometabolic Risk Syndrome and others – SETMA realized there were three life-style changes which were common to the treatment of all illnesses and which were important even to those who did not have chronic disease. They are: Weight Loss, Exercise, Smoking cessation; from this came the name, LESS Initiative. The LESS includes: a weight management assessment, with a BMI, BMR, protein requirement, assessment of weight class and disease risk, which was built on the AMA's Adult Weight Management program; a personalized exercise program based on the patient's age and gender with explanations of stretching, aerobics and strength training, which was built on the Cooper Clinic Model, and an assessment of tobacco use.

In 2002, a mother brought her five-year-old son to SETMA's pediatric clinic and The LESS evaluation was completed on the child. When the mother returned home, she inadvertently left the LESS document on the truck seat. Shortly, the father left home to buy cigarettes and saw the document. What attracted him to it was that his son's name was on it. The father began reading, seeing firsthand the very specific risks and damage that he was causing by exposing his son on a regular basis to secondhand smoke in the home. He sat in the truck and cried for 45-minutes. Still in the driveway, he returned to the house and discarded all the cigarettes in his possession. He hasn't smoked since that day.

## 5. Demonstration of Readiness to Assume Responsibility of an ACO

After reading the November, 2011, 695-page *Final Rule for Accountable Care Organizations (ACO)*, SETMA is prepared to move forward to participate in a physician-led ACO, which will be formed around an established Medical-Services-Organization (MSO) partner, an Independent Physician Association (IPA) and a Health Maintenance Organization (HMO). SETMA has worked closely and collaboratively with these organizations for sixteen years. Because most of patients covered by the HMO had not had insurance, and/or could not access care even when insured, it was important to SETMA for the HMO to succeed. The only way many of our patients could afford healthcare was through an HMO, most of which had come and gone in Southeast Texas; often leaving the most vulnerable patients without access to care. SETMA saw the HMO model of care as a solution to healthcare for these members of our community and our practice.

SETMA assumed medical leadership of the IPA in October 1997, with SETMA's CEO serving as the Medical Director. At that time, the IPA was losing \$500,000 a month and the MSO, which was liable for the losses, was considering leaving the market. By eliminating waste, in ninety days, the IPA stopped losing money and in six months had monthly reserves. The process of eliminating waste included: rounding in the hospital on all covered patients every day; consulting with the attending physicians; insuring proper follow-up, and, establishing pre-authorization for major procedures and surgeries.

The high cost of care was not only the result of a high case mix index but also of utilization patterns in the medical community. How those problems were addressed is illustrated by a case study from October 27, 1997, the first day the new Medical Director made hospital rounds. A covered patient had been in the hospital for five days. After reviewing the chart, the Medical Director called the attending physician and asked why the patient was in the hospital. The attending responded, "Patient very sick (sic) and needs careful management." The Director asked, "Then why isn't there a history and physical, or a plan of care on the chart. And, why haven't you written a progress note since the patient was hospitalized and you haven't written an order in four days?" The attending said, "That is not true!" To which the Director rejoined, "I have the chart in my hand and I am at the hospital. It is true." The patient was discharged by the attending thirty minutes later.

Two other examples address waste and its elimination. Two surgeons had supported partial colectomy for a patient with chronic constipation. There was no other indication. The Medical Director denied the surgery. The surgeons appealed to the Federal Quality Improvement Organization (QIO) for Texas. The QIO upheld the denial and everyone began to understand that unnecessary and dangerous surgeries and procedures were not going to be allowed. In another case, a patient was hospitalized with a "hot gallbladder." Surgery was going to be delayed for four days to allow the gallbladder to "cool off." Fortunately, the surgeon told the truth when he wrote in his progress note that he was going to be out of town playing golf. The patient's condition was normal except for a solitary gall bladder stone. The white blood cell count was normal; the patient had no temperature, no pain, no abdominal tenderness and no liver inflammation. The additional days in hospital were denied and the patient had surgery the same day. The quality of care began to increase and simultaneously the cost of care began to decrease. This has been successfully

done for the past fourteen years in the patient population covered by the IPA. The CMS study done by RTI International, referenced earlier in this application, reflects the same performance by SETMA for fee-for-service Medicare beneficiaries.

### **Vision for the Value and Power of ACOs**

In addition to medical management issues, there were other sources of waste in the care being delivered. One of SETMA's former partners was the Chairman of the Board of the above mentioned IPA. In November, 1997, two other SETMA partners told the Chairman that if the IPA was to be successful, laboratory services had to capitated. The Chairman correctly concluded, "If we do that, it will cost SETMA \$50,000 a month," as SETMA operated a profitable reference laboratory. His two partners agreed with his assessment, but affirmed that the future of the IPA, MSO and PSO demanded this change, which was made under duress. SETMA lost income but the financial problems of the IPA and PSO improved. The long term affects of this change have been positive for SETMA, even though the short term outcome was costly. The transformation of healthcare into ACO's will affect other practices in the same way but the long term results will be equally good for them.

In 1997, SETMA began to engage other physicians, particularly specialists in dialogue about the future of healthcare. Because we had data on quality and cost through the MSO and the PSO, we were able to have these conversations based on facts. We knew the outcomes of patient care because we were caring for the same patients as the specialist, but now we also knew the cost of that care. We knew which specialists utilized more resources to provide the same services. Everyone did not want to be a part of the future we saw. One cardiology group wanted pre-authorization at every visit for laboratory test (to be done in their office), echocardiograms, EKGs, X-rays and other procedures. We declined and they resigned. Other cardiologists, equally excellent, agreed to work with us. Based on utilization and quality outcomes, they were able to qualify for incentive payments.

In this process, authorizations were not used to limit care but to manage its quality which resulted in decreased cost of care, with patient safety and health, and national standards as the guiding principles of decision making. Over the past sixteen years, denial rates for authorizations have been less than one percent, but even with that, patterns of care changed. Patients began to understand that the coordination and authorization processes added a layer of safety to their health care, particularly when they saw their friends and/or family members have negative results in following through on care we recommended that they not have. An example was a 94-year-old who wanted coronary by-pass surgery because he could not walk and play a round of golf. We told him that his life-expectancy was greater without surgery than with, and that all he had to do in order to control his angina was use a golf cart. He left the HMO, had the by-pass surgery, and died on the operating table.

In addition to building a multi-specialty clinic, SETMA built relationships with other providers who answered consults in a timely fashion and who opted for cost-effect, efficient care. They did not always default to expensive technology which added no value to the patient's care. SETMA developed a philosophy which supports the premise: ***Excellence and Expensive are not***

**Synonyms.** These relationships have sustained a successful IPA for sixteen years. The same management, infrastructure, relationships, quality, and cost controls will be utilized to build a successful ACO.

### **Managed Care, Medical Home, ACO**

An ACO is a logical extension both of our experience in Medicare Advantage and our functioning as a medical home which provides the patient-centric, coordination functions needed for success in the new model of care. SETMA's experiences, innovations and philosophy of practice enabled us to succeed in managed care and in medical home, both of which are the foundation from which success in an ACO will flow. Except in the case of existing staff-model HMOs and/or functioning IPAs, the infrastructure costs of forming and sustaining an ACO may be much higher than most people think. And, that cost is going to be incurred without any guarantee of recovery. As a result, we recommend that those who wish to pursue the formation of an ACO, partner with those who have a significant existing infrastructure, therefore avoiding the need for duplication.

If an organization is starting to become an ACO *de novo*, SETMA would judge it as being virtually impossible. The foundation required for success, in addition to a sixteen-year history of practicing in an accountable-care environment, in making tough decisions for the good of the group, and in building the tools for success, are:

1. A robust EHR with disease management and screening and preventive care tools in place and functioning.
2. The additional IT requirement of a secure web portal through which to communicate with patients and to engage them in their own care is essential.
3. An HIE which promotes the continuity of care through effective communication and sharing of patient-care information.
4. Experience with global risk for healthcare such as was gained by managed care in general and Medicare Advantage and its predecessors in particular.
5. Experience with quality metrics in tracking, auditing and analyzing data through which to design quality improvement initiatives, after finding leverage points for improvement.
6. The integration of data aggregation over a large network of providers, facilities and practice types. SETMA has this capacity internally and the MSO and HMO partner add to that capacity.
7. Proved ability to provide high quality, low cost care which is valued by patients. This has been proved by our success with HMO patients and by RTI International's cost, coordination and quality analysis of Medicare Fee-for-Service experience at SETMA for 2007, 2008, 2009 and 2010.
8. Experience with patient-centric care in a coordinated setting and with Patient-Centered Medical Home functionalities.
9. Administrative, financial and coordination capabilities which include risk stratification, care management and direction, referral mapping, case management, etc.
10. A willingness on the part of healthcare providers to build a future for their patients and for themselves which in the short run will cost them but which in the long run will benefit all who participate.

## **Revenue-Sharing Model**

The highest probability of ACO success is in an integrated delivery network such as staff-model HMOs or IPAs such as the one in which SETMA participates. These organizations already have an electronic infrastructure, which can be adapted to the accountability and accounting functions needed for success in an ACO. In the same way, non-staff model HMOs with strong relationships with IPAs may also provide an increased probability of success. When the staff model has an ownership interest in hospitals, the potential for success is enhanced significantly. The principle reason for the higher potential of success in these instances is that they already have a model for the sharing of revenue and the participants have already accepted the details of that revenue-sharing model.

When the participants in an ACO do not have an integrated financial relationship, it will be very difficult to hold the group together once the division of profits begins to take place. The USA health care system has placed high value on facility and procedure services and has placed little value on comprehensive and coordinated care. There is nothing structurally within the ACO model which addresses that dichotomy in anything but a *Laissez-faire* manner. The division of the financial benefits of the ACO may be its Achilles heel.

Finding a venue which equitably shares revenue, valuing elements of care which are pivotal to ACO success but which have traditionally been undervalued, or unvalued is critical. SETMA, our IPA, MSO and HMO have a revenue-sharing model which will operate seamlessly but separately in the ACO setting. The model respects all members of the healthcare value equation including CMS. The revenue-sharing model is based on measurable quality metrics, participation in care coordination and in patient satisfaction survey results.

## **Tension in the ACO Model**

One of the principle means of ACOs creating financial savings will be in the using of lower levels of care, i.e., outpatient rather than inpatient services. If hospitals are partners in the ACO, they will recognize that the increased savings often result from decreased utilization of their services. In their own defense, hospitals will increase their competition with ambulatory-care providers, both by owning medical practices and by opening their own ambulatory-care centers. The perverse result could be not only increasing competition, which in this unique case might drive up cost, but also make appropriate and beneficial collaboration between hospitals and independent healthcare providers more difficult. Increasing cost savings at the expense of the hospital could also create the situation where essential and expensive care could be limited due to increasing financial pressure on the hospitals.

SETMA believes that this perverse effect can be avoided by dialogue between the ambulatory providers and the hospital. Each must recognize and respect the role of the other. With ambulatory care providers working with hospitals to improve lengths of stay and thus the effective return on DRGs; to decrease preventable readmissions; to prevent redundant and expensive care, a true collaboration between inpatient and outpatient care can be achieved. This partnership between hospital and healthcare provider can go a long way to avoiding the perverse effect of conflicting interests.

The ACO model in which SETMA will participate does not engage the hospital as a partner. The hospital is not asked to participate in the risk and is paid standard DRGs for their services. The hospital's interests are addressed through excellence of care with excellent and timely documentation of all reasons for admission and co-morbidities, with the utilization of hospital services for important ambulatory services where possible and appropriate. This is why, SETMA has been a good partner with hospitals with whom they have not shared risk but which hospitals have valued SETMA's participation on their staff.

### **Avoiding the Hazard of Involuntary Enrollment**

Patients who understand the benefits of restricted-access healthcare (managed care) have already elected to join Medicare Advantage programs. One trade-off is that for agreeing to see only certain healthcare providers, the patient receives increased benefits and reduced cost. This methodology has increased access to healthcare for many. Others, either because of excellent insurance, or personal resources, have rejected that model of care, even though it can be demonstrated that Medicare Advantage is providing improved care. To involuntarily enroll those who have previously rejected a "managed care" model creates an ethical dilemma.

SETMA will transparently notify all whose care is to be managed in an ACO. The ACO will enroll only those who give prior consent to do so. As with patient-centered medical home, the best solution for the future of healthcare is engaging the patient as a partner in preserving their health with improved quality by cost savings. This process begins with the methods of patient enrollment (engagement). Patients recruited for participation in an ACO must be engaged actively in learning how to access care efficiently and at the appropriate level. Being patient-centric; this care will also be patient driven.

In an age where most patients have more confidence and trust in technology – procedures, tests, etc. – than they do in a personal relationship with a healthcare provider, it may seem that the principle way to decrease the cost of care is to ration care by structurally decreasing access to care. However, in an environment where healthcare providers are functioning as a team with the patient as part of the team, the best way to change the healthcare-cost curve is to restore patient trust in their healthcare providers, where the provider's counsel is sought before a test is ordered. This is the reason why any ACO which has the potential for success must be built upon healthcare providers who not only have the designation but who are also actually functioning in a patient-centered medical home. ***It is only with compassionate, comprehensive, coordinated and collaborative care that the relationship with provider and patient can recreate the trust bond which supersedes technology in the healthcare-decision-making equation.*** In that trusting relationship, wise decisions can be made about watchful waiting, appropriate end-of-life care and a balance between life expectancy with and without expensive but unhelpful care.

Recently, Mark Bertolini, Chairman, CEO & President of AETNA said, "Convenience is the new word for quality." The statement on its face seems an oversimplification. However, as SETMA became a PC-MH, we came to see that "Coordination" translates into:

1. Convenience for the patient, which,

2. Results in increased patient satisfaction, which contributes to,
3. The patient having confidence that the healthcare provider cares personally which,
4. Increases the trust the patient has in the provider, all of which,
5. Increases compliance (adherence) in obtaining healthcare services recommended which,
6. Promotes cost savings in travel, time and expense of care which,
7. Results in patient safety and quality of care with cost savings.

It was only through this analysis that we accepted "convenience" as a worthy goal of quality care as opposed to it only being a means of "humoring" patients. This fulfilled SETMA's goal of ceasing to be the constable, attempting to impose healthcare on our patients; and, to our functionally becoming the consultant, the collaborator, the colleague to our patients, empowering them to achieve the health they have determined to have.

In addition to continuing to function in the Medicare Advantage practice model – 25% of our patients have chosen to get their healthcare through this method – and in addition to continuing to transform our practice into a patient-centered medical home – all of our patients are treated in a coordinated fashion -- SETMA is ready to and will participate in an ACO. We expect this to add one more dimension to our growing into a full-fledged, 21<sup>st</sup>-century multi-specialty practice.

## 6. Demonstrated Results on Publicly Reported Performance Measures

SETMA's approach to quality metrics and public reporting is driven by these assumptions:

1. Quality metrics are not an end in themselves. Optimal health at optimal cost is the goal of quality care. Quality metrics are simply "sign posts along the way." They give directions to health. And the metrics are like a healthcare "Global Positioning Service": it tells you where you want to be; where you are, and how to get from here to there.
2. The auditing of quality metrics gives providers a coordinate of where they are in the care of a patient or a population of patients.
3. Statistical analytics are like coordinates along the way to the destination of optimal health at optimal cost. Ultimately, the goal will be measured by the well-being of patients, but the guide posts to that destination are given by the analysis of patient and patient-population data.
4. There are different classes of quality metrics. No metric alone provides a granular portrait of the quality of care a patient receives, but all together, multiple sets of metrics can give an indication of whether the patient's care is going in the right direction or not. Some of the categories of quality metrics are: access, outcome, patient experience, process, structure and costs of care.
5. The collection of quality metrics should be incidental to the care patients are receiving and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible. Notwithstanding, the very act of collecting, aggregating and reporting data will tend to create a Hawthorne effect.
6. The power of quality metrics, like the benefit of the GPS, is enhanced if the healthcare provider and the patient are able to know the coordinates while care is being received.
7. Public reporting of quality metrics by provider name must not be a novelty in healthcare but must be the standard. Even with the acknowledgment of the Hawthorne effect, the improvement in healthcare outcomes achieved with public reporting is real.
8. Quality metrics are not static. New research and improved models of care will require updating and modifying metrics.

SETMA currently tracks the following: 34 NCQA HEDIS measures; 14 NCQA Diabetes Recognition Metrics; 35 NQF-endorsed measures; 27 PQRS measures; 9 PCPI measures related to the physician role in hypertension management; 43 measures of the Bridges to Excellence program for Asthma, Chronic Stable Angina, Congestive Heart Failure, COPD, Diabetes and Hypertension; 10 PCPI related to Diabetes; 6 PCPI for Stages 4 and 5 of Chronic Kidney Disease; 5 PCPI for Chronic Stable Angina; 7 PCPI for Congestive Heart Failure; 20 PCPI Transition of Care measures.

In addition to endorsed-measurement sets, SETMA tracks these self-designed quality measures: 10 measures related to hyperlipidemia; 12 measures related to Chronic Kidney Disease Stages 1-III. Also, in the hospital setting, SETMA has designed an internal study to identify patterns in hospital readmissions, such as lengths of stay, morbidities and co-morbidities, socio-economic status, ethnicity, gender, age, follow-up calls, follow-up visits in clinic, etc.. The purpose is to control cost and increase safety by reducing preventable readmissions to the hospital.

## Population Management and Quality Improvement Metrics

SETMA tracks a number of key data points for diabetes, hypertension and hyperlipidemia for its entire patient population. These measures are compared between patients who are controlled against patients who are not controlled. Secondly, the results for the controlled and uncontrolled populations are further analyzed by gender, age, ethnicity, numbers of medications, frequency of visits, frequency of test, income and other measures in an effort of to reduce disparities in patient care across all demographics.

To ensure timely compliance by providers, SETMA has designed functions with its EHR to alert providers to patient conditions which must be reported to local or state agencies for infectious disease control. SETMA reports the results of all of the measures listed here publicly, by provider name on the organization's website at [www.setma.com](http://www.setma.com). The results of each of the measures are updated and republished each quarter with the most recently available data.

### Gaps in Reporting

Through quality reporting, SETMA has been able to identify deficiencies not only in our work but also in reporting programs endorsed at the national level. For example, SETMA tracks nine different quality metric sets for Diabetes (NQF, NCQA Diabetes Recognition, NCQA HEDIS, PCPI, Joslin, PQRS, BTE, AQA) and each one differs from the next. While the sets are not contradictory, they are not complimentary either. Harmonization of diabetes measurement sets across the entire quality-metric community would be valuable for population management and comparing of practice outcomes.

In addition to the lack of standardization of diabetes measures, there are two important disease processes that presently lack standardized quality metrics. Those two diseases are Stages 1-3 of Chronic Kidney Disease and Hyperlipidemia. SETMA recommends the adoption of standardized, published quality metrics for these two important disease processes.

### Changing Quality Metrics

Diabetes is a target of quality measures for several reasons:

- Process Quality Measures, i.e., was a hemoglobin A1c (HbA1c) done, and Outcomes Quality Measures, i.e., what was the HbA1c value, are easy to determine and to report.
- The treatment goals for the elements of diabetes are generally known and accepted.
- Standardization of methods for laboratory testing is generally accepted.
- These three make diabetes a model for the idea of "precision medicine" presented in *The Innovator's Prescription: A Disruptive Solution for Health Care*. Precision medicine, exists "Only when diseases are diagnosed precisely...therapy that is predictably effective ...be developed and standardized. We term this domain *precision medicine*." The care of diabetes calls for little intuitive judgment or guess work.
- Diabetes is a devastating disease but evidence-based medicine demonstrates that aggressive and successful treatment dramatically changes the outcome of the disease.

- Diabetes is a major public health problem in that the increasing prevalence of diabetes is almost on the scale of a pandemic.
- The cost of caring for diabetes and its complications is enormous making the potential benefit of treating the illness large for both the individual and the society.

While the above points are true, new research is suggesting that if a patient has had diabetes for more than twenty years, and if the patient does not have certain complications, it is probable that the patient may develop those complications. Therefore, research will modify our understanding of quality metrics and their value. New research will not eliminate the use of quality metrics, but it will make us stay “up to date” in our understanding of how to apply quality metrics.

Additionally, quality metrics groups published by different organizations can have different goals. Some of the greatest points of leverage for improving outcomes come from the examination of complex processes which are not easily reduced to simple process metrics. Diabetes metrics illustrate this point. Because excellence in diabetes care requires a team, it is possible to identify complex quality metrics to assess the functioning of the team. These complex-process metrics are often not easily audited. For instance, if a primary care provider is caring for a patient with diabetes, it is possible to establish a standard that if after a pre-determined interval the patient is not progressing toward the treatment goal, the patient should be referred to an endocrinologist. Business Intelligence software solutions can measure this process, audit it and report it. Without the auditing of this metric, a significant opportunity for improving care can be missed.

These complexities of quality metrics are in mind as SETMA is reading the National Quality Forums 171-page “Measures Under Consideration for Calendar Year 2012.” It is for these reasons that quality metrics, even ones which are quantifiable, must always be being reviewed and re-evaluated.

### **The Limitations of Quality Metrics**

*The New York Times Magazine* of May 2, 2010, published an article entitled, "The Data-Driven Life," which asked the question, "Technology has made it feasible not only to measure our most basic habits but also to evaluate them. Does measuring what we eat or how much we sleep or how often we do the dishes change how we think about ourselves?" Further, the article asked, "What happens when technology can calculate and analyze every quotidian thing that happened to you today?" Does this remind you of Einstein's admonition, "Not everything that can be counted counts, and not everything that counts can be counted?"

Technology must never blind us to the human. Bioethicist, Onora O'Neill, commented about our technological obsession with measuring things. In doing so, she echoes the Einstein dictum that not everything that is counted counts. She said, "In theory again the new culture of accountability and audit makes professionals and institutions more accountable for good performance. This is manifest in the rhetoric of improvement and rising standards, of efficiency gains and best practices, of respect for patients and pupils and employees. But beneath this admirable rhetoric the real focus is on performance indicators chosen for ease of measurement and control rather than because they measure accurately what the quality of performance is."

## **Technology Can Deal with Disease but Cannot Produce Health**

In our quest for excellence, we must not be seduced by technology with its numbers and tables. This is particularly the case in healthcare. In the future of medicine, the tension - not a conflict but a dynamic balance - must be properly maintained between humanity and technology. Technology can contribute to the solving of many of our disease problems but ultimately cannot solve the "health problems" we face. The entire focus and energy of "health home" is to rediscover the trusting bond between patient and provider. In the "health home," technology becomes a tool to be used and not an end to be pursued. The outcomes of pure technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

As we move deeper into the 21st Century, we do so knowing that the technological advances are astounding. Our grandchildren's generation will experience healthcare methods and possibilities which seem like science fiction to us today. Yet, that technology risks decreasing the value of our lives, if we do not in the midst of technology retain our humanity. As we celebrate science, we must not fail to embrace the minister, the ethicist, the humanist, the theologian, indeed the ones who remind us that being the bionic man or women will not make us more human, but it seriously risks causing us to be dehumanized. And in doing so, we may just find the right balance between technology and trust and thereby find the solution to the cost of healthcare.

### **Conclusion**

It is in this context that SETMA whole-heartedly embraces technology and science, while retaining the sense of person in our daily responsibilities of caring for persons. Quality metrics have made us better healthcare providers. The public reporting of our performance of those metrics has made us better clinician/scientist. But what makes us better healthcare providers is our caring for people.

The following pages summarize SETMA's performance on over 200 quality metrics. By provider name, provider performance is measured. Each year, we add new metrics to measure and each year, we make sure that our denominators and numerators are properly defined and that the benchmarks against which we measure ourselves are valid, but the "real benchmark" against which we measure ourselves is our prior performance. Like Mikhail Baryshnikov, "we never try to dance better than someone else, we try to dance better than ourselves."

Quality Metrics Publicly Reported By Southeast Texas Medical Associates, LLP for 2009, 2010, 2011 (Jan - Oct)  
 ("Public Reporting" at www.setma.com)

Sponsor Organization	Measurement Set	Measure	Benchmark	2009		2010		2011 (Thru Oct)	
				Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented
NQF	Care for Older Adults	Counseling for Physical Activity	UNP*	86.3	7123	78.0	7349	76.9	8818
		Colorectal Cancer Screening	UNP	61.7	10484	64.6	10858	63.6	12012
		Fall Risk Assessment	UNP	63.5	7123	98.9	7123	92.3	8818
		Urinary Incontinence Assessment	UNP	32.8	7123	93.1	7349	97.3	8818
NQF	Congestive Heart Failure	Weight Assessment	UNP	96.6	1407	97.6	1381	94.0	1621
		Activity Assessment	UNP	90.6	1407	98.0	1381	93.3	1621
		Assessed for Volume Overload	UNP	1.2	1407	8.6	1381	11.1	1621
		LV Function Assessment	UNP	4.5	1407	37.0	1381	50.3	1621
		ACE/ARB Therapy	UNP	88.7	1407	80.0	1381	80.5	1621
		Warfarin Therapy	UNP	61.8	1407	62.1	1381	61.8	1621
NQF	Diabetes	Blood Pressure Control	UNP	75.9	7123	85.9	4727	87.2	5267
		HgbA1c Frequency	UNP	88.3	4258	91.4	4727	82.4	5267
		HgbA1c Level	UNP	45.5	4258	30.8	4727	39.2	5267
		LDL Frequency	UNP	84.1	4258	88.9	4727	89.7	5267
		LDL Level	UNP	76.5	4258	79.8	4727	80.7	5267
		Smoking Cessation	UNP	18.2	4258	65.6	4727	85.8	5267
		Dilated Eye Exam	UNP	51.8	4258	60.3	4727	58.0	5267
		Nephropathy Screening	UNP	41.2	4258	65.3	4727	77.9	5267
		Foot Exam	UNP	85.0	4258	86.7	4727	87.6	5267
NQF	Female Measures	Breast Cancer Screening	UNP	65.3	3333	52.1	3458	42.1	5938
		Cervical Cancer Screening	UNP	8.3	4315	38.9	4479	67.8	6706
		Chlamydia Screening	UNP	29.4	460	22.3	683	13.0	914
		Osteoporosis Management in Women Who Had Fracture	UNP	13.2	12	15.2	13	8.2	8
NQF	General Health Measures	Body Mass	UNP	97.4	19175	98.2	19627	97.7	21216
		Measurement of Oxygen Saturation in COPD	UNP	40.5	1779	85.8	1868	95.6	2134
		Influenza Immunization	UNP	50.6	12371	65.2	12848	59.4	14724
		Pneumonia Immunization	UNP	67.3	12371	81.2	12848	80.6	14724
		Blood Pressure Measured	UNP	99.0	19175	99.2	19627	99.4	21217
		Blood Pressure Repeated (If Elevated)	UNP	80.9	19175	89.2	19627	90.4	21217
		Blood Pressure Plan of Care (If Elevated)	UNP	7.4	19175	46.9	19627	43.2	21217
		Smoking Cessation - Advised to Quit	UNP	11.9	3083	80.0	3336	97.3	3298
		Smoking Cessation - Prescribed Pharmacotherapy	UNP	5.2	3083	21.5	3336	23.0	3298
		Smoking Cessation - Counseling Provided	UNP	9.3	3083	55.7	3336	70.8	3298
		Persistent Medication Monitoring - Digoxin	UNP	90.0	457	93.2	429	91.7	534
		Persistent Medication Monitoring - Diuretics	UNP	85.6	10405	88.8	10982	89.7	12194
		Persistent Medication Monitoring - ACE/ARB	UNP	86.2	5826	89.3	6208	90.4	6942
		Persistent Medication Monitoring - Phenobarbital	UNP	71.9	143	75.0	128	75.6	114
		Persistent Medication Monitoring - Carbamazepine	UNP	26.8	610	29.4	560	41.0	554
		Persistent Medication Monitoring - Phenytoin	UNP	70.5	687	76.8	637	73.3	618
		Persistent Medication Monitoring - Valproic Acid	UNP	20.0	20	34.5	26	39.5	39
NQF	Medication Measures	Documentation of Allergies/Reactions	UNP	91.5	23634	96.2	24495	96.1	24236
		Appropriate Medications for People with Asthma	UNP	79.6	1577	81.4	1621	79.0	1605
		Avoidance of Antibiotics in Adults with Acute Bronchitis	UNP	25.4	1890	32.7	1429	26.2	1564
		LDL Drug Therapy for Patients with CAD	UNP	76.8	1839	58.4	1988	77.7	2350
		High Risk Medications in Older Patients (1)	UNP	42.4	7123	39.1	7349	33.3	8818
		High Risk Medications in Older Patients (2)	UNP	20.0	7123	17.4	7349	12.7	8818
		Patient Given Current Medication List	UNP	96.0	23634	91.9	24495	95.6	24236
		Warfarin Therapy for Patients with Atrial Fibrillation	UNP	60.4	619	59.6	686	60.7	1605
NQF	Pediatric Measures	Appropriate Treatment for Children with Pharyngitis	UNP	36.2	601	48.7	549	52.6	987
AMA/PCPI	Care Transition	Reason for Hospitalization	UNP	88.1	6488**	96.9	9419**	98.5	12449**

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 ("Public Reporting" at www.setma.com)

Sponsor Organization	Measurement Set	Measure	Benchmark	2009		2010		2011 (Thru Oct)	
				Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented
		Discharge Diagnoses	UNP	99.2	6488**	99.9	9419**	99.9	12449**
		Medication Reconciliation	UNP	32.8	6488**	89.4	9419**	96.2	12449**
		Allergy Documentation	UNP	62.0	6488**	94.0	9419**	98.7	12449**
		Cognitive Status	UNP	94.1	6488**	96.5	9419**	98.6	12449**
		Pending Test Results	UNP	67.5	6488**	95.2	9419**	98.4	12449**
		Major Procedures	UNP	60.3	6488**	93.9	9419**	98.4	12449**
		Follow-Up Care Plan	UNP	90.4	6488**	94.8	9419**	98.0	12449**
		Response to Treatment	UNP	86.8	6488**	95.5	9419**	98.1	12449**
		Advanced Directives	UNP	19.4	6488**	83.7	9419**	95.0	12449**
		Reason for Discharge	UNP	28.7	6488**	96.0	9419**	98.1	12449**
		Physical Status	UNP	95.4	6488**	97.0	9419**	99.0	12449**
		Psychosocial Status	UNP	60.4	6488**	92.7	9419**	98.1	12449**
		Community Resources/Referrals	UNP	10.1	6488**	64.2	9419**	93.5	12449**
		Medication List	UNP	20.9	6488**	82.1	9419**	93.2	12449**
		Discharge Orders	UNP	20.8	6488**	82.8	9419**	93.2	12449**
		Follow-Up Instructions	UNP	20.9	6488**	82.2	9419**	93.1	12449**
		Discharge Materials	UNP	20.8	6488**	82.0	9419**	92.6	12449**
AMA/PCPI	Diabetes Consortium	Systolic Blood Pressure	UNP	86.5	4258	92.7	4727	93.9	5267
		Diastolic Blood Pressure	UNP	90.5	4258	93.8	4727	94.3	5267
		HgbA1c Level	UNP	61.3	4258	54.7	4727	55.3	5267
		HgbA1c Frequency	UNP	82.4	4258	85.8	4727	76.6	5267
		Lipids Frequency	UNP	74.4	4258	80.7	4727	77.9	5267
		Cholesterol Level	UNP	83.7	4258	86.6	4727	87.4	5267
		HDL Level	UNP	68.2	4258	69.9	4727	72.2	5267
		LDL Level	UNP	91.0	4258	88.3	4727	89.0	5267
		Triglyceride Level	UNP	82.1	4258	84.0	4727	82.4	5267
		Smoking Cessation	UNP	18.3	4258	65.5	4727	85.8	5267
		Dilated Eye Exam	UNP	52.1	4258	60.6	4727	58.0	5267
		Aspirin Use	UNP	59.9	4258	67.8	4727	67.3	5267
		Flu Shot	UNP	62.8	4258	73.5	4727	62.7	5267
		Foot Exam	UNP	69.9	4258	73.8	4727	71.5	5267
		Nephropathy Screening	UNP	41.5	4258	65.7	4727	77.9	5267
AMA/PCPI	Lower Urinary Tract Symptoms Eval	Medical History	UNP	98.4	1109	98.1	1190	98.2	1192
		Physical Exam with Digital Rectal Exam	UNP	25.7	1109	23.5	1190	20.9	1192
		IPSS Questionnaire	UNP	1.1	1109	0.9	1190	0.0	1192
		PSA within One Year	UNP	61.2	1109	69.3	1190	74.4	1192
		Creatinine with One Year	UNP	82.4	1109	85.0	1190	87.6	1192
		Urinalysis with One Year	UNP	0.0	1109	6.1	1190	75.1	1192
		Referral for Uroflowmetry	UNP	0.4	1109	1.6	1190	0.0	1192
		Referral for Postvoidal Residual Volume	UNP	0.4	1109	0.5	1190	0.0	1192
AMA/PCPI	CKD, Stages 4-5	Laboratory Testing	UNP	4.3	143	10.0	209	8.7	215
		Blood Pressure Control	UNP	41.9	143	44.7	209	49.3	215
		Blood Pressure Plan	UNP	12.5	143	88.8	209	95.5	215
		Influenza Immunization	UNP	78.9	143	83.6	209	76.5	215
		AV Fistula Referral	UNP	0.0	143	0.3	209	0.0	215
AMA/PCPI	Physician Role in HTN Management	Blood Pressure Measured	UNP	99.1	10247	99.3	10919	99.5	12277
		Blood Pressure Repeated (If Elevated)	UNP	17.0	10247	34.3	10919	33.6	12277
		Stage/Classification Assessed	UNP	55.9	10247	69.9	10919	52.7	12277
		Weight Reduction Discussed	UNP	83.1	10247	94.0	10919	88.7	12277
		Sodium Intake Discussed	UNP	18.2	10247	62.2	10919	52.9	12277
		Alcohol Intake Discussed	UNP	10.6	10247	58.4	10919	46.9	12277

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Sponsor Organization	Measurement Set	Measure	Benchmark	2009		2010		2011 (Thru Oct)	
				Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented
		Exercise Discussed	UNP	86.0	10247	78.3	10919	76.9	12277
		Follow-Up Scheduled	UNP	49.0	10247	52.3	10919	55.9	12277
NCQA	Diabetes Recognition	HgbA1c > 9.0	<= 15%	9.7	4258	11.4	4727	10.1	5267
		HgbA1c < 8.0	>= 60%	77.5	4258	74.9	4727	70.0	5267
		HgbA1c < 7.0	>= 40%	63.3	4258	54.6	4727	56.1	5267
		BP > 140/90	<= 35%	24.7	4258	14.3	4727	13.0	5267
		BP < 130/80	>= 25%	51.3	4258	62.5	4727	63.5	5267
		Dilated Eye Exam	>= 60%	52.1	4258	60.9	4727	58.1	5267
		Smoking Cessation	>= 80%	17.3	4258	64.7	4727	85.1	5267
		LDL >= 130	<= 37%	13.6	4258	12.4	4727	12.3	5267
		LDL < 100	>= 36%	58.6	4258	63.9	4727	64.6	5267
		Nephropathy Screening	>= 80%	42.5	4258	67.7	4727	78.5	5267
		Foot Exam	>= 80%	84.6	4258	86.7	4727	86.7	5267
NCQA/HEDIS	Effectiveness of Acute Care	Avoidance of Antibiotics in Adults with Acute Bronchitis	UNP	25.4	1890	24.1	1429	26.2	1564
		Appropriate Testing for Children with Pharyngitis	UNP	36.2	601	48.7	549	52.6	477
		Appropriate Treatment for Children with Upper Respiratory Infection	UNP	7.8	474	12.8	321	12.0	264
NCQA/HEDIS	Effectiveness of Chronic Care	Follow-Up for Children Prescribed ADHD Medications- 30 Days	UNP	93.5	368	86.8	398	73.0	570
		Follow-Up for Children Prescribed ADHD Medications- 270 Days	UNP	0.0	368	0.0	398	0.0	570
		Drug Therapy for Rheumatoid Arthritis	UNP	42.5	414	41.0	369	38.9	414
		Appropriate Medications for People with Asthma	UNP	79.6	1577	81.8	1621	79.0	1605
		Controlling High Blood Pressure	UNP	68.9	10247	83.0	10919	79.7	12277
		Osteoporosis Management	UNP	15.5	2522	7.7	2797	10.2	2982
		Spirometry Testing for COPD	UNP	18.0	1779	19.2	1868	15.9	2134
		Antidepressant Medication Management - 84 Day Prescription	UNP	12.3	4967	6.0	5217	9.6	8230
		Antidepressant Medication Management - 180 Day Prescription	UNP	8.1	4967	4.8	5217	7.0	8230
		LDL Management for Cardiovascular Conditions - Screening	UNP	80.7	1839	57.9	1988	87.9	2350
		LDL Management for Cardiovascular Conditions - Control	UNP	77.0	1839	66.3	1988	81.6	2350
		Management of Acute COPD Exacerbation - Corticosteroid	UNP	23.1	1570	25.0	1723	19.8	2088
		Management of Acute COPD Exacerbation - Bronchodilator	UNP	6.6	1570	6.2	1723	6.5	2088
		Persistent Medication Monitoring - Digoxin	UNP	90.0	457	93.2	429	91.8	534
		Persistent Medication Monitoring - Diuretics	UNP	85.6	10405	88.8	10982	89.7	12194
		Persistent Medication Monitoring - ACE/ARB	UNP	86.2	5826	89.3	6208	90.3	6942
		Persistent Medication Monitoring - Phenobarbital	UNP	71.9	143	75.0	128	77.6	114
		Persistent Medication Monitoring - Carbamazepine	UNP	26.8	610	29.4	560	39.6	554
		Persistent Medication Monitoring - Phenytoin	UNP	70.5	687	76.8	637	73.3	618
		Persistent Medication Monitoring - Valproic	UNP	20.0	20	34.5	26	40.0	39
NCQA/HEDIS	Comprehensive Diabetes Care	Blood Pressure Control	UNP	75.9	4258	85.9	4727	87.2	5267
		HgbA1c Frequency	UNP	88.3	4258	91.4	4727	82.4	5267
		HgbA1c Level	UNP	45.5	4258	30.8	4727	74.8	5267
		LDL Frequency	UNP	84.1	4258	88.9	4727	89.1	5267
		LDL Level	UNP	76.5	4258	79.8	4727	80.7	5267
		Smoking Cessation	UNP	18.2	4258	65.6	4727	85.8	5267
		Dilated Eye Exam	UNP	51.8	4258	60.3	4727	58.0	5267
		Nephropathy Screening	UNP	41.2	4258	65.3	4727	77.9	5267
		Foot Exam	UNP	85.0	4258	86.7	4727	87.6	5267
NCQA/HEDIS	Effectiveness of Preventive Care	Older Adults - Advance Care Planning	UNP	17.3	7123	23.6	7349	92.7	9198
		Older Adults - Medication Review	UNP	75.5	7123	98.5	7349	98.3	9198
		Older Adults - Functional Assessment	UNP	62.1	7123	98.5	7349	98.2	9198
		Older Adults - Pain Screening	UNP	62.8	7123	98.9	7349	98.6	9198
		Older Adults - High Risk Medications (1)	UNP	42.4	7123	39.7	7349	33.3	9198
		Older Adults - High Risk Medications (2)	UNP	20.1	7123	18.3	7349	12.7	9198

Quality Metrics Publicly Reported By Southeast Texas Medical Associates, LLP for 2009, 2010, 2011 (Jan - Oct)  
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Sponsor Organization	Measurement Set	Measure	Benchmark	2009		2010		2011 (Thru Oct)	
				Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented
		Older Adults - Glaucoma Screening	UNP	98.0	7123	99.1	7349	98.4	9198
		Adult BMI Assessment	UNP	98.3	19175	99.2	19627	99.0	21216
		Breast Cancer Screening	UNP	75.9	3333	57.9	3458	47.8	5938
		Cervical Cancer Screening	UNP	7.3	4315	37.4	4479	66.3	6706
		Colorectal Cancer Screening	UNP	98.2	2142	97.8	2264	97.4	12012
PQRS***	Diabetes Measures Group	Systolic Blood Pressure	UNP	57.9	1488	72.9	1699	77.4	1741
		Diastolic Blood Pressure	UNP	87.2	1488	90.9	1699	90.2	1741
		HgbA1c	UNP	43.0	1488	66.5	1699	70.9	1741
		LDL	UNP	31.1	1488	59.8	1699	63.7	1741
		Nephropathy Screening	UNP	82.6	1488	84.8	1699	87.6	1741
		Foot Exam	UNP	65.1	1488	69.5	1699	71.8	1741
		Dilated Eye Exam	UNP	24.3	1488	37.8	1699	37.2	1741
PQRS***	Preventive Measures Group	Influenza Immunization	UNP	57.8	1467	87.8	1672	80.2	1716
		Pneumonia Immunization	UNP	75.8	1467	86.4	1672	90.8	1716
		Urinary Incontinence Assessed	UNP	34.2	1467	85.7	1672	97.0	1716
		Tobacco Use Assessment	UNP	94.4	1467	99.6	1672	99.6	1716
		Smoking Cessation	UNP	20.8	1467	71.2	1672	90.3	1716
		BMI Assessment	UNP	96.7	1467	97.3	1672	97.3	1716
		BMI Follow-Up (If Abnormal)	UNP	96.3	1467	99.0	1672	99.6	1716
		Colorectal Cancer Screening	UNP	61.6	1467	64.6	1672	63.6	1716
		Mammography Screening	UNP	70.4	1467	70.6	1672	61.5	1716
		Osteoporosis Management	UNP	73.7	1467	77.0	1672	81.0	1716
SETMA	CKD, Stages 1-3	Urinary Protein Assessment	UNP	69.3	1846	82.4	2448	83.9	2586
		Renal Disease Stage Assessment	UNP	0.0	1846	8.1	2448	6.9	2586
		Referral for Renal Ultrasound	UNP	0.9	1846	9.0	2448	11.8	2586
		Referral to Nephrologist	UNP	0.7	1846	6.0	2448	20.1	2586
		Lipid Panel	UNP	86.4	1846	93.7	2448	94.4	2586
		Prealbumin	UNP	0.0	1846	0.0	2448	0.0	2586
		Blood Pressure Control	UNP	61.8	1846	74.0	2448	74.7	2586
		Exercise Prescription	UNP	0.0	1846	92.7	2448	88.8	2586
		Weight Assessment	UNP	92.4	1846	98.7	2448	99.4	2586
		Smoking Cessation	UNP	19.0	1846	72.4	2448	90.7	2586
		Flu Vaccine	UNP	70.3	1846	78.9	2448	73.9	2586
		Pneumonia Vaccine	UNP	82.0	1846	87.7	2448	85.3	2586
		Hepatitis B Vaccine	UNP	0.2	1846	0.0	2448	0.0	2586
		Anemia Screening	UNP	0.0	1846	2.4	2448	0.0	2586
		Renal Treatment Plan	UNP	0.0	1846	14.9	2448	17.3	2586
SETMA	Lipid Audit	Frequency of Lipid Panel	UNP	81.8	10006	87.1	10940	88.3	11916
		Lipids Treatment Plan	UNP	12.9	10006	82.4	10940	93.0	11916
		Metabolic Syndrome Assessment	UNP	0.0	10006	5.8	10940	79.6	11916
		Statin Therapy	UNP	56.1	10006	60.5	10940	59.5	11916
		Lifestyle Changes	UNP	88.3	10006	98.6	10940	99.6	11916
		Risk Stratification	UNP	8.1	10006	56.0	10940	53.2	11916
		Medical Nutrition Therapy	UNP	0.4	10006	3.7	10940	5.6	11916
		Statin Therapy	UNP	70.0	10006	76.0	10940	76.9	11916
		Hemoglobin A1c	UNP	69.3	10006	59.4	10940	61.7	11916
		Blood Pressure Control	UNP	64.1	10006	78.0	10940	80.7	11916
				TOTAL PATIENTS SEEN	23634		24495		24236
				TOTAL ENCOUNTERS	99364		110343		105403****

7/1/2009 to 6/30/2010

Quality Metrics Publicly Reported By Southeast Texas Medical Associates, LLP for 2009, 2010, 2011 (Jan - Oct)  
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Sponsor Organization	Measurement Set	Measure	Benchmark	2009		2010		2011 (Thru Oct)	
				Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented	Performance Score (%)	Number of Patients Represented
				SETMA 1 Clinic		SETMA 2 Clinic		SETMA Mark Wilson Clinic	
			Benchmark	Performance Score (%)		Performance Score (%)		Performance Score (%)	Performance Score (%)
CMS	Selected Clinical Quality Measures	LDL Screening		82.0	81.0	86	93	89.0	85
		HgbA1c Testing		92.0	82.0	86	97	93.0	94
		Influenza Vaccination		39.0	38.0	39	51	51.0	55
	Hospitalization Measures	Hospitalization Rate		41.9	64.2	47.7	24.5	20.6	11.9
		Follow-Up Within 2 Weeks of Hospitalization		57.8	47.7	40.4	56.5	56.9	62
		Thirty Day Hospital Readmission		25.7	42.5	30.9	17.5	20.0	14.4
		ER Visits		77.2	108.3	80.5	47.4	32.2	34.7
	Coordination and Continuity of Care	Percent with Primary Care Visit		3.4	4.7	4.5	4.3	3.6	5
		Percent with Medical Specialist Visit		2.4	4.2	3.9	3.3	3.6	3.7
		Percent with Surgical Specialist Visit		0.4	0.9	0.8	0.6	0.7	0.7
	Reimbursement	Average Annual Medicare Payment Per Beneficiary (\$)		\$ 13,072	\$ 17,394	\$ 12,919	\$ 8,314	\$ 6,444	\$ 5,147
		Durable Medical Equipment		\$ 3,697	\$ 478	\$ 359	\$ 336	\$ 265	\$ 262
		Hospice		\$ 515	\$ 546	\$ 297	\$ 328	\$ 168	\$ 82
		Home Health		\$ 1,258	\$ 1,547	\$ 1,100	\$ 1,253	\$ 890	\$ 254
		Skilled Nursing Facility		\$ 2,367	\$ 1,445	\$ 710	\$ 43	\$ 41	\$ 1
		Physician		\$ 3,149	\$ 4,021	\$ 3,160	\$ 2,700	\$ 2,310	\$ 2,485
		Outpatient Department		\$ 1,784	\$ 1,610	\$ 1,373	\$ 905	\$ 818	\$ 868
		Acute Care Hospital		\$ 2,884	\$ 6,342	\$ 4,929	\$ 1,947	\$ 1,711	\$ 1,061
		Office Visit		\$ 321	\$ 513	\$ 434	\$ 410	\$ 379	\$ 485
		Hospital ER/Visit		\$ 344	\$ 643	\$ 415	\$ 203	\$ 146	\$ 95
		Specialty Visits and Consultation		\$ 243	\$ 219	\$ 164	\$ 138	\$ 112	\$ 159
		Imaging and Laboratory		\$ 868	\$ 910	\$ 806	\$ 727	\$ 640	\$ 601
		Other Physician Payments		\$ 1,127	\$ 1,251	\$ 933	\$ 965	\$ 684	\$ 857
		Average Annual Potentially Avoidable Hospitalization		\$ 1,766	\$ 3,290	\$ 2,259	\$ 962	\$ 731	\$ 300
		Average Annual Potentially Avoidable ER		\$ 317	\$ 309	\$ 214	\$ 183	\$ 138	\$ 152

**Legend**

- \*UNP = Unpublished
- \*\* The AMA Care Transition measurement set represents distinct hospital discharges, not distinct patients.
- \*\*\* PQRS measures are electronically submitted via claims form to CMS.
- \*\*\*\* This figure represents the first ten months of 2011. SETMA anticipates 126,000 encounters for all of 2011.

**Comments**

SETMA also tracks (but does not yet publicly report) all of the measures for the six disease processes in the Bridges to Excellence program: Asthma, Congestive Heart Failure, Coronary Artery Disease, COPD, Diabetes and Hypertension.  
 SETMA also tracks (but does not yet publicly report) two measurements sets for the Physician Consortium for Performance Improvement program: Chronic Stable Angina, Congestive Heart Failure and Weight Management.

# Quality Metrics Internally Tracked By Southeast Texas Medical Associates, LLP

Sponsor Organization	Measurement Set	Measure
PQRS	Fall Risk	Assessment for History of Falls
		Fall Risk Assessment
		Fall Risk Plan of Care
PQRS	Back Pain	Comprehensive Initial Assessment
		Physical Examination
		Advice for Normal Activities
		Advice Against Bed Rest
PQRS	Chronic Kidney Disease (Stage 4-5)	Appropriate Laboratory Testing
		Blood Pressure Monitoring
		Blood Pressure Plan/Control
		Influenza Immunization
		Referral for AV Fistula
		Plan of Care for Elevated Hemoglobin w/ESA Therapy
BTE	Asthma	Assessment of Symptoms
		Lung Function Testing
		Medication Therapy
		Influenza Immunization
		Patient Self-Management Plan
		Smoking Cessation
BTE	Congestive Heart Failure	ACE/ARB Therapy
		Beta Blocker Therapy
		LVF Assessment
		Weight Measurement
		Assessment of Symptoms of Volume Overload
		Activity Level
		Patient Education
BTE	Coronary Artery Disease	Blood Pressure Control
		LDL Control
		Annual Lipid Profile
		Evaluation of Activity and Anginal Symptoms

# Quality Metrics Internally Tracked By Southeast Texas Medical Associates, LLP

Sponsor Organization	Measurement Set	Measure
		Smoking Cessation
		Antiplatelet Therapy
		LDL Drug Therapy
		ACE/ARB Therapy
		Beta Blocker Therapy
BTE	COPD	Lung Function Testing
		Assessment of Oxygen Saturation
		Medication Therapy - Bronchodilator
		Medication Therapy - Corticosteroid
		Influenza Immunization
		Pneumonia Immunization
		Smoking Cessation
BTE	Diabetes	HgbA1c Control
		LDL Control
		Blood Pressure Control
		Dilated Eye Exam
		Foot Exam
		Nephropathy Assessment
		Smoking Cessation
BTE	Hypertension	Blood Pressure Control
		LDL Control
		Annual Lipid Profile
		Smoking Cessation
		Use of Aspirin
		Urine Protein Test
		Annual Creatinine Test
		Diabetes Screening Test
		Diet and Exercise Counseling
AMA/PCPI	Chronic Stable Angina	Antiplatelet Therapy
		Statin Therapy

# Quality Metrics Internally Tracked By Southeast Texas Medical Associates, LLP

Sponsor Organization	Measurement Set	Measure
		Beta Blocker Therapy
		Smoking Cessation
		Use of Standardized Assessment Tool
AMA/PCPI	Congestive Heart Failure	Assessment of Symptoms of Volume Overload
		Activity Level
		Patient Education
		Beta Blocker Therapy
		ACE/ARB Therapy
		Warfarin Therapy
AMA/PCPI	Weight Management	Body Mass Index
		Body Fat Percentage
		Basal Metabolic Rate
		Disease Risk Level
		Class of Obesity
		Activity Level
		Risk Stratification
		Treatment Recommendation
Joslin	PI CME Cardiovascular Risk	Weight/BMI Assessment
		Smoking Cessation
		Diabetes Assessment
		Dyslipidemia Assessment
		Hypertension Assessment
		HgbA1c Measurement (If Diabetes)
		Lipids Measurement
		Blood Pressure Measurement
Joslin	PI CME Advancing Diabetes Therapy	Weight/BMI Assessment
		HgbA1c Measurement
		Nutritional Education/Counseling
		Exercise Education/Counseling
		Self Monitoring of Blood Glucose

# Quality Metrics Internally Tracked By Southeast Texas Medical Associates, LLP

Sponsor Organization	Measurement Set	Measure
		Medication Management