James L. Holly, M.D.

Links to the Robert Wood Johnson Document

Introduction

A. Preventive Care Measures

Auditing of Preventive Care

B. Clinical Performance Measures

Diabetes

Auditing of Diabetes Quality Metrics

Lipid

Auditing of Lipid Quality Metrics

Hypertension

Auditing of Hypertension Quality Metrics

C. Organizational Measures 38

Addendum
A

SETMA's Major Initiative to Reduce Preventable Readmissions

The Primary Care Team:
Learning from Effective Ambulatory Practices
(*PCT-LEAP*)
Performance Measures Worksheet
Robert Wood Johnson Foundation

Before discussing SETMA's response to request for information from the Robert Wood Johnson foundation (RWJF), it would be helpful to briefly review the Foundation's history. RWJF states, "The mission of the Robert Wood Johnson Foundation is to improve the health and health care of all Americans. Our goal is clear: To help our society transform itself for the better."

The Foundation is the nation's largest philanthropy which is "devoted solely to the public's health, we have a unique capability and responsibility to confront the most pressing health and health care problems threatening our society. Our efforts focus on improving both the *health* of everyone in America, and their *health care*—how it's delivered, how it's paid for, and how well it does for patients and their families. As we invest in improving systems through which people receive care and in fostering environments that promote health and prevent disease and injury, we expect to achieve comprehensive, meaningful and timely change."

The Foundation states, "We are guided by a fundamental premise: we are stewards of private funds that must be used in the public's interest. Our greatest asset isn't our endowment; it's the way we help create leverage for change." The Foundation works to "create leverage by building evidence and producing, synthesizing and distributing knowledge, new ideas and expertise. We harness the power of partnerships by bringing together key players, collaborating with colleagues, and securing the sustained commitment of other funders and advocates to improve the health and health care of all Americans."

The Foundation was created by the General Robert Wood Johnson, who founded Johnson and Johnson. The Foundation's early history from 1936 to 1975 was crucible for what followed when the General died in 1968, "leaving just about his entire estate to the Foundation. When the will was probated, in 1972, The Robert Wood Johnson Foundation emerged as the nation's second-largest philanthropy." .

Description of:	Southeast Texas Medical Associates, LLP (SETMA)
Prepared by:	James L. Holly, MD, CEO, SETMA Adjunct Professor, Family and Community Medicine School of Medicine, UT Health Science Center San Antonio
Presented to:	Ed Wagner, MD, MPH, National Program Co-Director Margaret Flinter, PhD, APRN, National Program Co-Director Tom Bodenheimer, MD, MPH, National Advisory Committee Director

Project Proposal -- Robert Wood Johnson Foundation national program—the *Primary Care Team: Learning from Effective Ambulatory Practices (PCT-LEAP*

The goal of the program is to identify and study about 30 high functioning primary care practices with interesting team models and use of staff (exemplar practices) in order to create tools and materials to help other primary care practices with transformation and improvement. A description of the program can be found on the RWJF website.

(SETMA)….was one of nearly 400 that were recommended by experts in primary care and your peers. Our National Advisory Committee has begun the work of drilling down to a final group of practices for site visits and to form a learning community aimed at sharing the collective knowledge and experience of the participating practices with others. We seek exemplar sites that have performance measurement programs in place that can help assess the impact of their innovations in the practice.

Our next step is to ask you to help us understand how you are measuring and using data on clinical quality, organizational performance, patient experience, and /or staff experience. From our initial conversation with you, it is likely you already are routinely collecting data in several of these categories. We would appreciate it if you would be willing to share any performance reports such as run charts, dashboards, or quality reports that you already collect for your own improvement work.

Introduction

This is our response to your request that we "help (you) understand how (SETMA is)…measuring and using data on clinical quality, organizational performance, patient experience, and /or staff experience." After this introduction, I will address each of the five categories which you identified in your correspondence.

This presentation does not simply provide lists of numbers for quality metrics. It attempts to provide a context in which it is possible to sustain the measurement of quality metrics as both a "score card" for excellent care and also as a guideline for areas which need improvement. Without this context, it is impossible to understand SETMA's use of quality metrics. It is as if quality metrics are a healthcare GPS, telling us where we are, where we want to go, the path to tale to get to our destination and an alert when we have achieved our goal.
A second overarching comment concerns the only Pay-for-Performance programs in which we participate:

1. PQRS
2. ePrescribing
3. Blue Cross/Blue Shield Diabetes

Currently, we receive no additional payments for performance, although through the Medicare Advantage STARs program, the ACO Quality Metrics performance, Meaningful Use and Medical Home, we will soon be receiving more reimbursement based on quality performance. These comments apply to all five of your questions.

Commitment to Primary Care and to the Future of Primary Care

SETMA's commitment to Primary Care is evidenced by my wife and I, with support from The SETMA Foundation and others, having endowing the Dr. & Mrs. James L. Holly Distinguished Professorship in Patient-Centered Medical Home at my school of medicine. This is an interdepartmental and interdisciplinary effort between the schools of nursing and medicine. My wife and I have also endowed a Distinguished Lectureship in PC-MH and have given the initial endowment for the establishment of The Primary Care Institute at the Health Science Center. It is our hope to establish a one year Post-Graduate Fellowship for Primary Care providers the

year after they complete their residencies. The Fellowship would focus on practice management, healthcare transformation, public policy and the growth and development of primary care in a patient-centered environment. .

While most of the material on our website about SETMA is not peer-reviewed, several pieces are:

1. Agency for Healthcare Research and Quality has published SETMA's LESS Initiative (Lose weight, exercise, stop smoking) on their Innovation Exchange.
2. SETMA received the HIMSS Davies Award in 2005
3. Dr. Holly's multiple presentations at HIMSS
4. SETMA's peer-reviewed Stories of Success was published by HIMSS in 2010.
5. American Medical Association – Care Transitions Quality Metrics Application to Hospital Setting
6. Joslin Diabetes Center PI-CME – Glyco and Cardio PI-CME
7. Joslin Diabetes Center PI-CME -- Eldercare PI-CME
1. Centers for Disease Control – Analyzing Cost Control for Medicare Recipients in the Medical Home Setting

The following is a link to my March 21, 2012 presentation entitled, *The Future of Primary Care* to the inaugural meeting of the University of Texas Health Science Center at San Antonio School of Medicine's Chapter of the Primary Care Progress.

http://www.jameslhollymd.com/Primary-Care-The-Future-Primary-Care-Progress.cfm

A Brief History of SETMA

Southeast Texas Medical Associates, LLP (SETMA) is a medium size multi-specialty practice in Beaumont, Texas which began using electronic health records in March, 1998. Shortly after that we determined that our "real" goal was "electronic patient management," i.e., the leveraging of the power and capabilities of electronics to improve the quality of the care we provided to our patients. That history is well documented on our website at www.jameslhollymd.com where all of our electronic patient management tools are displayed.

In 2000, we began auditing and analyzing data including using statistical analysis to look beyond individual patients to assess the quality of our population wise. For diabetes, our mean HbA1c has improved from 7.54 in 2000 to 6.64 in 2011, and our standard deviation has improved from 1.98 in 2000 to 1.2 in 2011. Gradually, we realized that we wanted to do "real time" auditing and analysis of our care. In 2009, we adapted IBM's Business Intelligence software, COGNOS, to healthcare. In that year, we began Public Reporting on over 200 quality metrics on our website.

SETMA's Model of Care evolved to:

1. Tracking metrics one patient at a time
2. Auditing metrics over panels and populations of patients
3. Analyzing the audited data to find leverage points for improvement
4. Public Reporting provider performance and transparently sharing with our patients that performance.
5. Designing quality improvement initiatives based on these four steps.

A complete description and explanation of this Model of Care can be found at:

http://www.jameslhollymd.com/SETMA-Model-of-Care-PC-MH-Healthcare-Innovation-The-Future-of-Healthcare.pdf

In this process, SETMA, SETMA came to believe that the future of healthcare will be founded on four domains:

1. Method -- The methodology of healthcare must be electronic patient management.
2. Content -- The content and standards of healthcare delivery must be evidenced-based medicine.
3. Structure -- The structure and organization of healthcare delivery must be patient-centered medical home.
4. Compensation – The payment must be capitation with rewards for quality in both process and outcomes. .

In this time, SETMA has become an NCQA Tier-Three Patient Centered Medical Home and a AACH accredited ambulatory care clinic, an AAACH Medical Home and the first multispecialty group to become an affiliate of Josllin Diabetes Center.. We document all patient care in the same data-base whether the patient is in the hospital, home heath, physical therapy, hospice, nursing home, clinic or emergency department and are supporting the development of a regional health information exchange.

Quality Metrics Philosophy

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. We are also participating in the Guidelines Advantage Program which is a collaborative between the American Heart Association, the American Diabetes Association and the American Cancer Society. And we are tracking the metrics associated with the MA STARS, the ACO quality metrics and the Meaning Use metrics.

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 measures publicly, by provider name, at www.jameslhollymd.com.

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 technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

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 being 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.

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.

Team Approach to Healthcare Delivery

The ideal setting in which to deliver and to receive healthcare is one in which all healthcare providers value the participation by all other members of the healthcare-delivery team. In fact, that is the imperative of Medical Home. Without an active team with team-consciousness and team-collegiality, Medical Home is just a name which is imposed upon the current means of caring for the needs of others. And, as we have seen in the past, the lack of a team approach at every level and in every department of medicine creates inefficiency, increased cost, potential for errors and it actually eviscerates the potential strength of the healthcare system.

Why is this? Typically, it is because healthcare providers in one discipline are trained in isolation from healthcare providers of a different discipline. Or, they are in the same buildings and often are seeing the same patients but they rarely interact. Even their medical record documentation is often done in compartmentalized paper records, which are rarely reviewed by anyone but members of their own discipline. This is where the first benefit of technology can help resolve some of this dysfunction. Electronic health records (EHR), or electronic medical records (EMR) help because everyone uses a common data base which is being built by every other member of the team regardless of discipline. While the use of EMR is not universal in academic medical centers, the growth of its use will enable the design and function of records to be more interactive between the various schools of the academic center.

And, why is that important? Principally, because more and more healthcare professionals are discovering that while their training often isolates them from other healthcare professionals, the science of their disciplines is crying for integration and communication. For instance, there was a time when physicians rarely gave much attention to the dental care of their patients, unless they had the most egregious deterioration of teeth. Today, however, in a growing number of clinical situations, such as the care of diabetes, physicians are inquiring as to whether the patient is receiving routine dental care as evidence-based medicine is indicating that the control of disease and the well-being of patients with diabetes is improved by routine dental care. Also, as the science of medicine is proving that more and more heart disease may have an infectious component, or even causation, the avoidance of gingivitis and periodontal disease have become of concern to physicians as well as dentist.

Disruptive Innovation

In addition, Medical Home places major emphasis upon issues which historically have been the concern of nurses. Physicians who use EMRs are discovering that the contribution of nursing staff can make the difference in the excellent and efficient use of this documentation and healthcare-delivery method. No longer is the nurse a "medical-office assistant" ancillary to the care of patients, but the nurse is a healthcare colleague central and essential to the patient's healthcare experience. As evidence-based medicine expands the scope of what *The Innovator's Prescription: A Disruptive Solution for Health Care* By Clayton M. Christensen labels as "empirical medicine" which ultimately leads to "precise medicine," it is possible for physicians and nurses to be a true-healthcare delivery team, as opposed to the nurses only being an aide to the physician.

It is as a result of the need for the integration of healthcare disciplines at the delivery level, that the imperative becomes obvious for the restructuring of the training of the members of this healthcare team. And, the first

change must come in the relationships between the leaders of the training programs who educate and mentor future healthcare scientist, teachers, caregivers and researchers. The educational leaders must model this integration for their disparate student bodies and that modeling will require the investment of the most precious and rare resource: time.

Glue? Adhesion and Cohesion

What is the model for this restructuring of the relationships between schools in the academic healthcare centers? It has been suggested that there is "glue" which unites the members of the various schools in an academic healthcare center, which will ultimately create this team. I would argue with that. Glue is an adherent. "Adherence" is described and simultaneously defined by the following:

- "Two dissimilar parts touching each other but not fused."
- "The union of separate parts; tending to adhere to or be connected by contact."

If propinquity is the principle motivation for the forming of a team, it will not survive the stresses and pressures which tend to make the team fly apart.

On the other hand, "cohesion" is "the bonding together of members of an organization/unit in such a way as to sustain their will and commitment to each other, their unit, and the mission." Synonyms of "cohesion" are "harmony, agreement, rationality." Here is the source of the union of the various elements of the healthcare team in training. It is in the recognition of their commonness and in the acknowledgment of their being part of the same "organism."

Harmonics

The concept of "harmony" is valuable here also. Harmony is not the absence of discord; it is the presence of a common nature. The typical definition for a harmonic is "a sinusoidal component of a periodic wave or quantity having a frequency that is an integral multiple of the fundamental frequency." I smiled and chuckled aloud as I wrote this last sentence. It is a mouthful, but how is it related to our problem of healthcare delivery? If you have a room filled with tuning forks of different frequency and you strike one of the forks, all of the forks which are of the same frequency or a multiple of the same frequency, as the one struck, will begin to sound. Those which are intrinsically different will remain silent.

In a room of educators, some health science, some historians, some vocalists, some archeologists, etc., when the sounding is of excellent in healthcare delivery; when the sounding is of evidence-based medicine; when the sounding is of containing the cost of healthcare while maintaining the quality; when the sounding is of increasing the accessibility of healthcare by removing barriers of affordability, linguistics, literacy, etc; each member of the healthcare-education team, whether nurse, dentist, physician, scientist, physical therapist, laboratory technician or other, will begin to resonate, as they are all coherent, by their nature, to the process of sustained improvement in the delivery of healthcare.

It is as if the healthcare-education team, as the healthcare-delivery team, has become a symphonic orchestra made up of instruments which are different in sounding method but which harmonize to produce an aesthetically satisfying result. Remember, the Greek word "symphonia" means "sounding together." So it is that the members of the healthcare-education and the healthcare-delivery team "resonate together" to produce the results we all desire.

A. Preventive Care Measures (e.g., % screened for breast or cervical cancer)

X We collect this type of data routinely and use it for:

X Quality Improvement
X Reporting
X Practice Management
Pay for Performance
Other

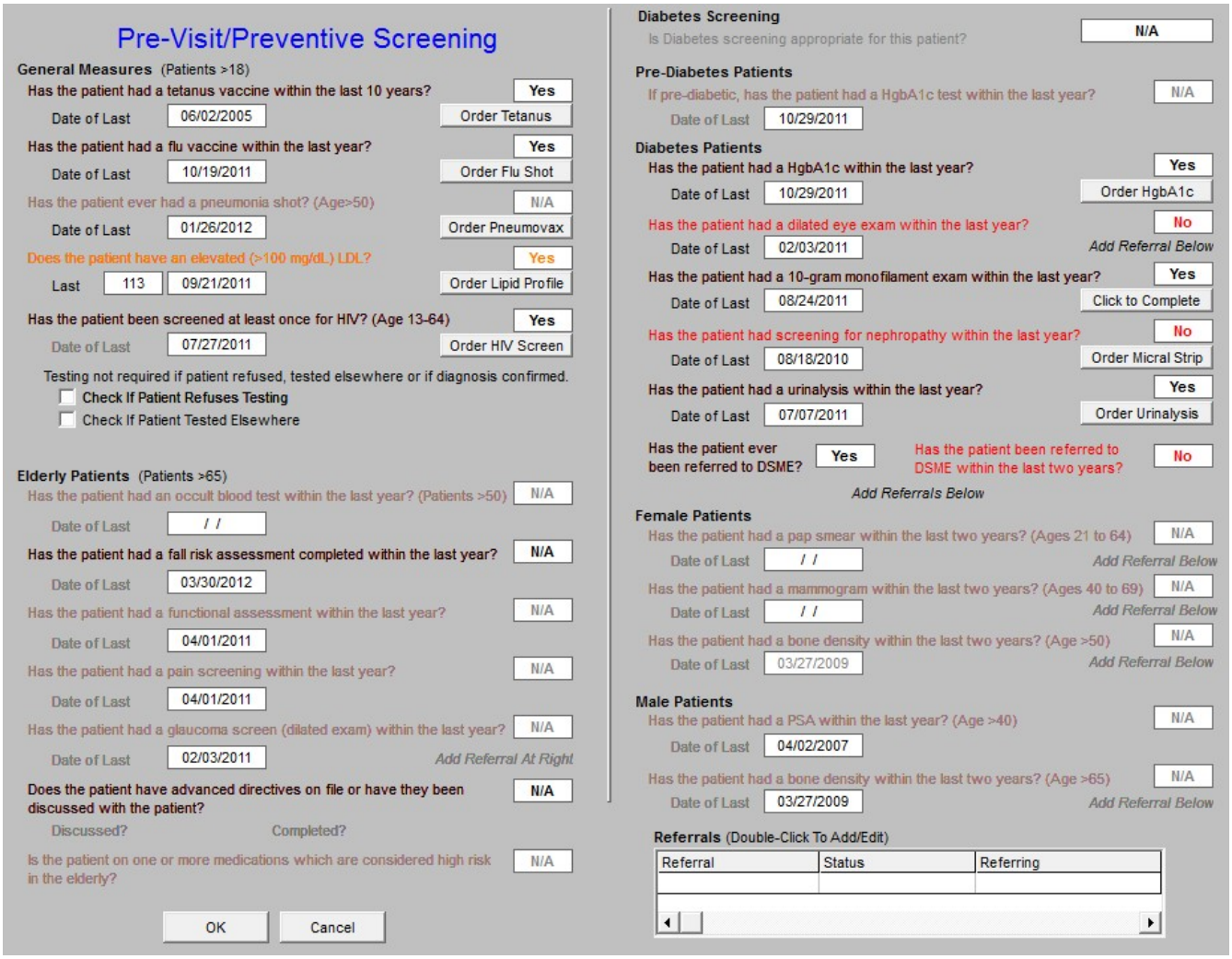
SETMA's Preventive Care Program involves the following:

1. Traditional preventive care such as cancer screening (breast, cervical, prostate, colon)
2. Diabetes prevention and diabetes screening
3. HIV screening for all patients between 13 & 64 years of age
4. Hypertension Prevention
5. Tobacco prevention
6. Obesity prevention
7. Sedentary life style
8. Immunizations (flu, pneumovax, tetanus/diphtheria/acellularpetrussis)
9. Glaucoma Screening
10. Renal Disease Screening

The first step in this preventive program is the following template which address almost all preventive and screening studies done. The first thing the nurse does after completing the patient's weight, blood pressure, body fat, etc., is to open the Pre-Visit/preventive Screening template. The measures which apply to the patient and have been done will appear in black. The measures which apply to the patient and have not been done will appear in red and the measures which do not apply to this patient will be in grey.

Any measures which apply and have not been completed can be fulfilled by clicking the "order" button which appears beside each element. When that button is clicked, three things happen:

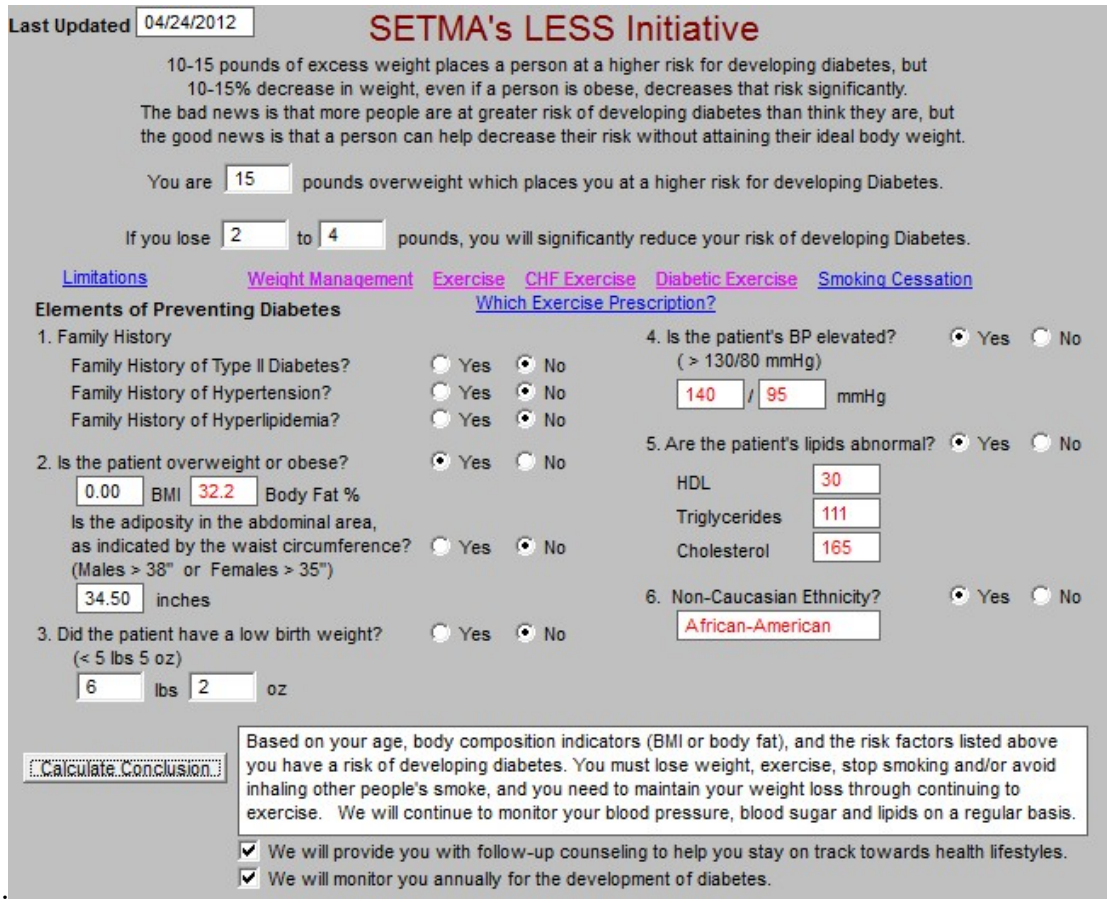
1. The test or procedure is ordered.
2. The charge is sent to billing – but will not be sent to the payer until it has been done.
3. The test is placed on the patient's chart.
4. The metric is marked as done.



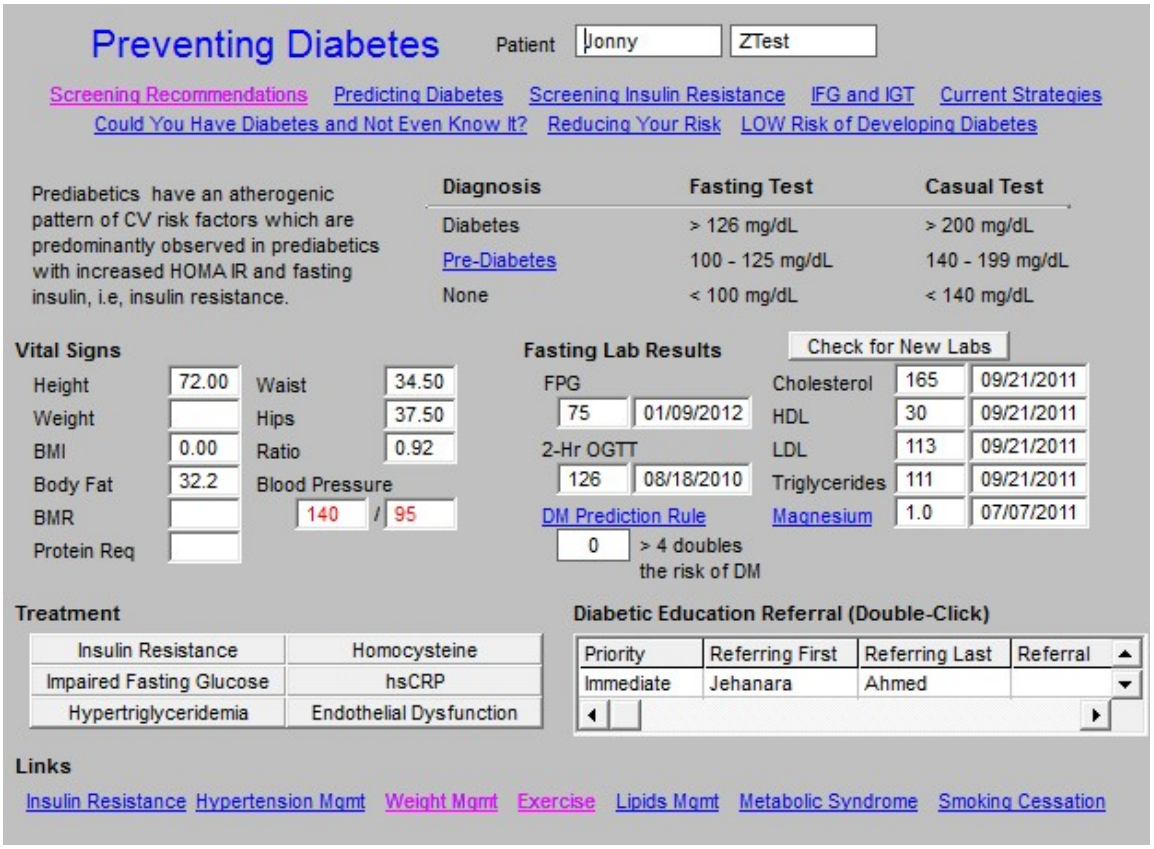
The second thing the nurse does is to complete the LESS Initiative by clicking the following:

1. Weight Management – this shows the disease risk of the patient's weight, the patients BMI, BMR, Body Fat Percent and an explanation of energy metabolism and how to change the BMR.
2. Exercise – this explains to the patient how to get started and provides a personalized exercise program including a walking program. It is scaled to the Cooper Aerobic data. If the patient has exercise limits, i.e., CHF, Diabetes, etc., specialized exercise prescriptions can be completed.
3. Smoking Cessation – this addresses primary, secondary and tertiary tobacco use and strategies for stopping.

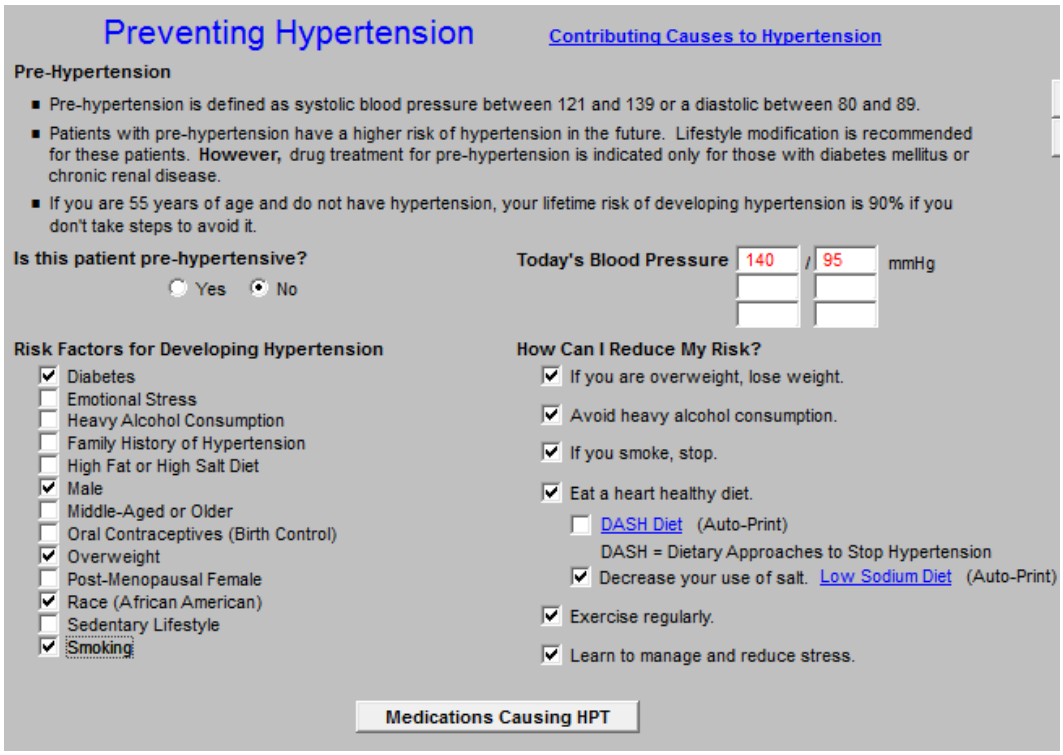
Once this is done, a document is completed which summaries all of the patient's personal data which is given to the patient. SETMA audits nurse and provider performance on The LESS. There is a laser printer in every examination room and the document is printed and given to the patient at that time.



At the time of the Less Initiative being completed the nurse completes the "Screening Recommendations" for diabetes and if the algorithm requires it and the patient is fasting the appropriate screening test is performed. Other tools as seen below are also available for the appropriate patients such as "reducing your risk," "could you have diabetes and not know it," "predicting diabetes," etc. We tell all of our patients who are at risk of developing diabetes, "The best way to treat diabetes is don't get it."



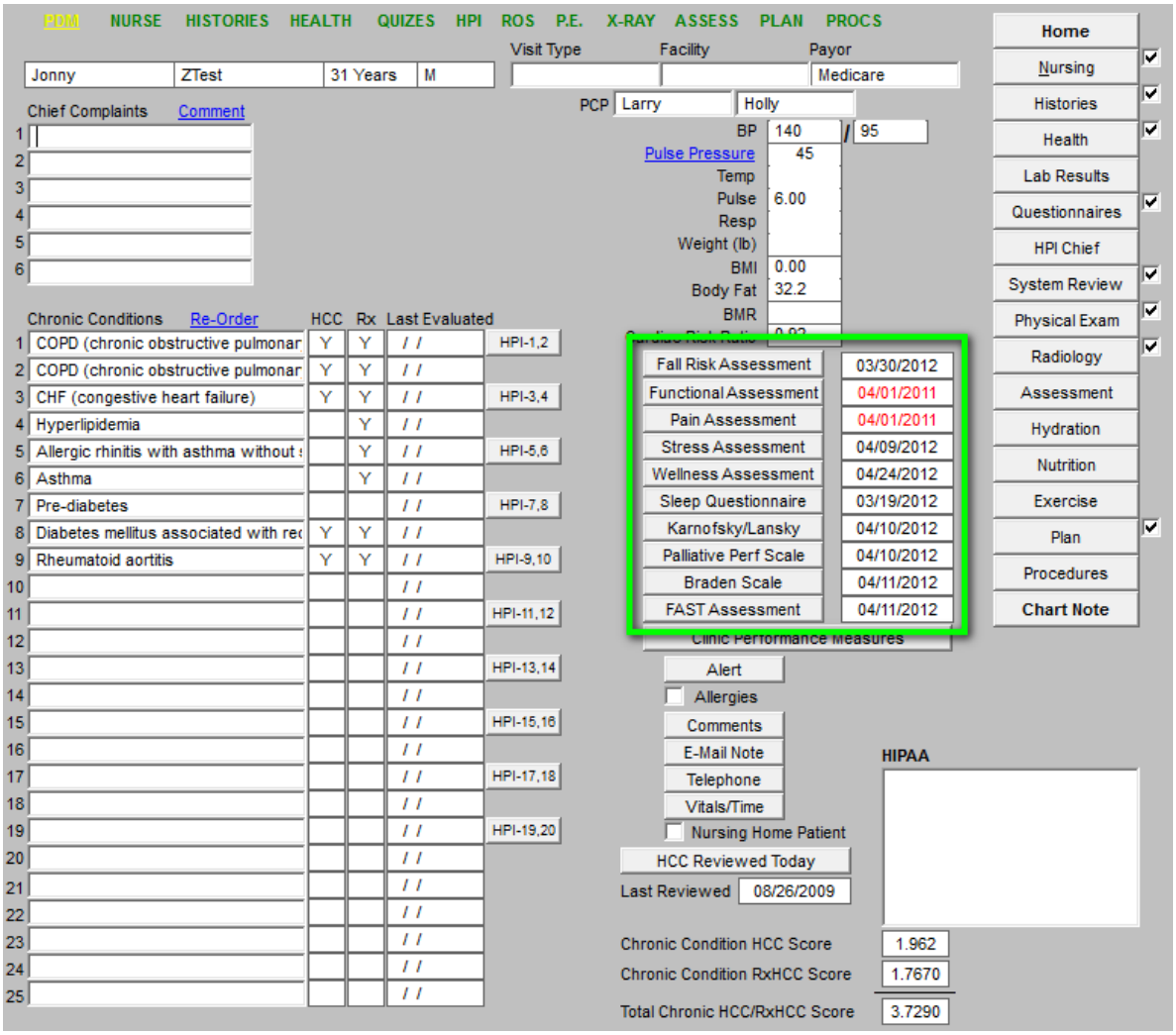
The Preventing Hypertension template is also completed at this time and the materials go on the patients chart. We particularly focus at this point on patients with pre-hypertension.



Part of SETMA's Preventive Health/Wellness Program involves the following questionnaires which are completed once a year on each of our patients. The following his is a link to a tutorial on how to use these materials:

http://www.jameslhollymd.com/Patient-Centered-Medical-Home-Annual-Questionaires.cfm

Those questionnaires are found on the front page of our primary care suite of templates.



Fall Risk Assessment

Last Updated/Reviewed 04/19/2012

☐ Check this box if you are unable to complete this assessment to due medical or other reasons.

Return

Guidelines

1. Level of Consciousness/Mental Status
   - ☐ Alert
   - ☑ **Disoriented**
   - ☐ Intermittent Confusion

2. History of Falls (In past 3 months)
   - ☐ No Falls
   - ☐ 1-2 Falls
   - ☑ **3 or more Falls**

3. Ambulation/Elimination Status
   - ☑ **Ambulatory/Continent**
   - ☐ Chair Bound (Requires restraints and assist with elimination)
   - ☐ Ambulatory/Incontinent

4. Vision Status (With or without glasses)
   - ☐ Adequate
   - ☐ Poor
   - ☑ **Legally Blind**

5. Gait/Balance Instructions
   - ☐ Gait/Balance Normal
   - ☐ Balance problem while standing
   - ☐ **Balance Problem while walking**
   - ☐ Decreased muscular coordination
   - ☑ **Requires usage of assistive devices (i.e. cane, w/c, walker, furniture)**
   - ☐ Jerking or unstable when making turns
   - ☐ Change in gait pattern when walking through the doorway

6. Systolic Blood Pressure (Between lying and standing)
   - ☐ No noted drop
   - ☑ **Drop LESS THAN 20 mm Hg**
   - ☐ Drop MORE THAN 20 mm Hg

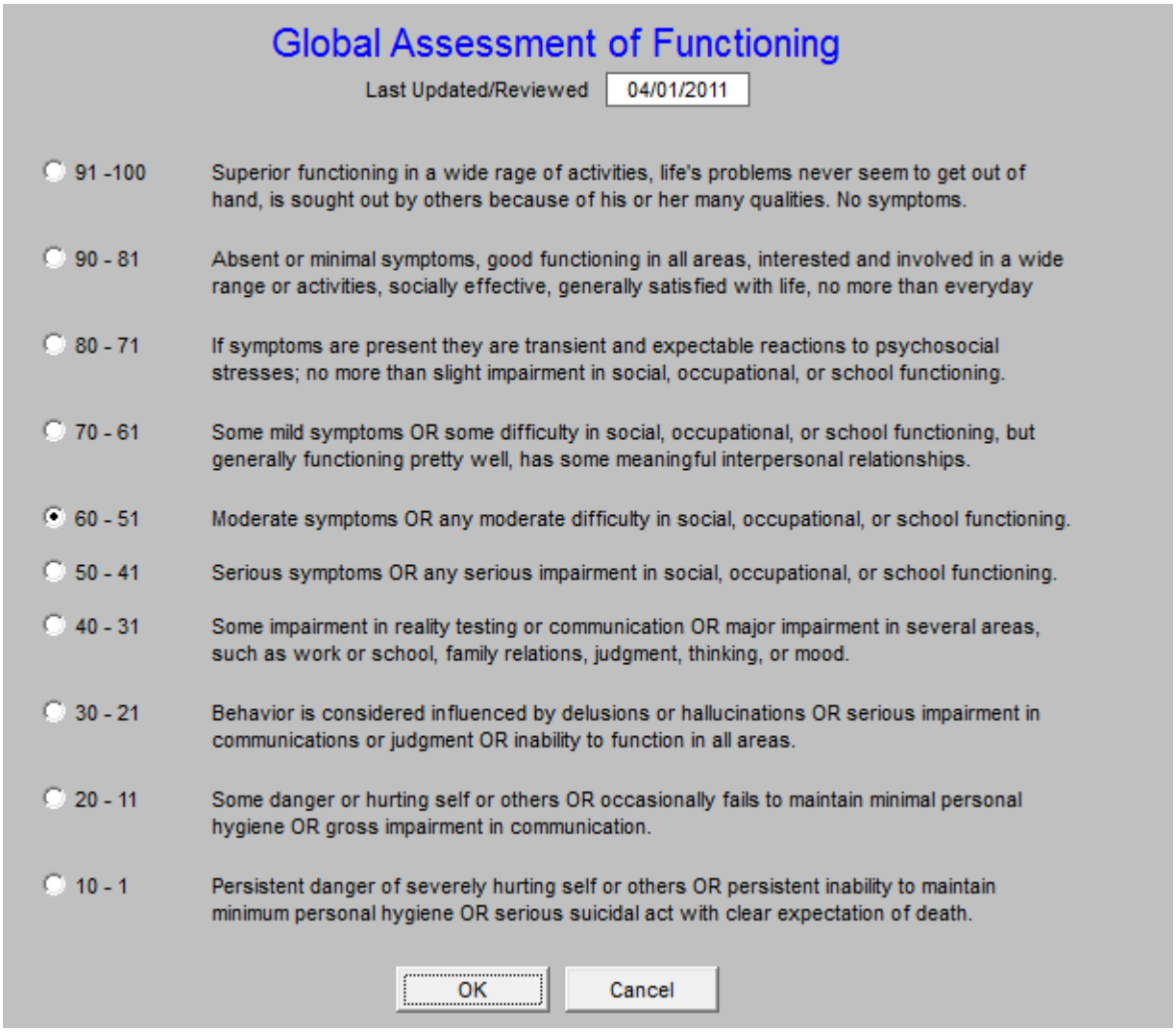
7. Medications Instructions
   - ☑ NONE of thee medication tatken currently or within last 7 days
   - ☐ Takes 1-2 of these medictions currently and/or within last 7 days
   - ☐ Takes 3-4 of these medicatons currently and/or within last 7 days
   - ☐ Change in medication or dosage in last five days

   (Automatically selected based on current med list)

8. Predisposing Diseases Instructions
   - ☐ None present
   - ☑ 1-2 present
   - ☐ 3 or more present

Total Score 15 Past Scores

Total score above 10 indicates HIGH


Global Assessment of Functioning
Last Updated/Reviewed
04/01/2011
91 -100
Superior functioning in a wide rage of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
90 - 81
Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range or activities, socially effective, generally satisfied with life, no more than everyday
80 - 71
If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.
70 - 61
Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
60 - 51
Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
50 - 41
Serious symptoms OR any serious impairment in social, occupational, or school functioning.
40 - 31
Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
30 - 21
Behavior is considered influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
20 - 11
Some danger or hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
10 - 1
Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.
OK
Cancel


Patient Pain Screening
Last Update/Reviewed
04/01/2011
0 1 2 3 4 5 6 7 8 9 10
None
-------Mild-------
-----Moderate-----
----------Severe----------
Click here if the patient is unable to respond.
OK
Cancel

Stress Assessment

Last Updated/Reviewed 04/09/2012

Return

☐ Check here if the patient is unable to complete the assessment today.

Calculate Results >>> Total Points 15 Assessment You are seriously vulnerable to stress.

I eat at least one hot, balanced meal a day.	○ Never	○ Sometimes	○ Always
I get seven to eight hours of sleep at least four nights a week.	○ Never	○ Sometimes	○ Always
I give and receive affection regularly.	○ Never	○ Sometimes	○ Always
I have at least one relative within 50 miles on whom I can rely.	○ None Nearby	○ A Few Nearby	○ Several Nearby
I exercise to the point of perspiration at least twice a week.	○ Never	○ Sometimes	○ Always
I smoke fewer than 10 cigarettes a day.	○ Never	○ Sometimes	◉ Always
I have fewer than 5 alcoholic drinks a week.	○ Never	○ Sometimes	◉ Always
My weight is appropriate for my height.	○ Obese	○ Overweight	◉ Healthy Weight
I have an income adequate to meet basic expenses.	○ Never	○ Sometimes	○ Always
I get strength from my religious beliefs.	○ Never	○ Sometimes	○ Always
I regularly attend club or social activities.	○ Never	○ Sometimes	○ Always
I have a network of friends and acquaintances.	○ No Friends	○ Some Friends	○ Several Friends
I have one or more friends to confide in about personal matters.	○ Never	○ Sometimes	○ Always
I consider myself to be in good health.	○ Poor Health	○ Average Health	○ Good Health
I am able to speak openly about my feelings when angry or worried.	○ Never	○ Sometimes	○ Always
I have regular conversations with the people I live with about domestic problems like chores and money.	○ Never	○ Sometimes	○ Always
I do something fun at least once a week.	○ Never	○ Sometimes	○ Always

Wellness Assessment

Last Updated/Reviewed 04/24/2012

Return

☐ Check here if the patient is unable to complete the assessment today.

Calculate Results >>>

Total Points 9

Assessment Fair

How many days a week do you participate in at least 30 minutes of physical activity?

○ None ◉ 1 to 3 days per week ○ 3 to 4 days per week ○ 5+ days per week

How many days a week do you participate in activities that increase your strength?

○ None ◉ 1 day per week ○ 2 days per week ○ 3+ days per week

How many days a week do you participate in activities that increase your flexibility?

○ None ◉ 1 day per week ○ 2 days per week ○ 3+ days per week

Indicate the type of grain products you usually eat.

○ Only or mostly refined (white) grain products ◉ A mix of refined and whole grain products ○ Only or mostly whole grain products

How many servings of vegetables and fruit do you eat each day?

One serving is equal to one medium or 1/2 cup vegetable or fruit, 1 cup salad, 1/2 cup juice or 1/4 cup dried fruit.

○ None ◉ 1 to 2 servings ○ 3 to 4 servings ○ 5+ servings

How many servings of milk products do you eat daily?

One serving is equal to 1 cup milk, 3/4 cup yogurt or 2 ounces cheese.

◉ None ○ 1 serving ○ 2 servings ○ 3+ servings

How ofen do you eat breakfast (more than just coffee or a roll)?

◉ Never or rarely ○ Most days ○ Every day

What is your smoking status?

◉ Currently smoke ○ Have smoked but quit ○ Never smoked

How often do you feel you get the sleep you need?

◉ Never ○ Most nights ○ Every night

How well are you coping with your current stress load?

◉ Difficult to cope most days ○ Coping fairly well ○ Coping very well

How many alcoholic drinks do you usually have each week?

One drink is equal to 12 ounces beer, 5 ounces wine or 1.5 ounces liquor.

◉ None ○ 1 to 8 drinks ○ 9 to 13 drinks ○ 14+ drinks

Sleep Study Candidate Questionnaire

Last Updated/Reviewed 03/19/2012

Check off each of the following statements that apply.

- [ ] I have been told that I snore.
- [ ] I have been told that I stop breathing when I sleep, although I have no recollection of this.
- [x] I am always sleepy during the day even though I sleep throughout the night.
- [x] I have high blood pressure.
- [ ] I have been told that I sleep restlessly. I am always tossing and turning while I sleep.
- [ ] I frequently awake with headaches.
- [ ] I tend to fall asleep in inappropriate situations.
- [ ] Others and/or I have noticed a recent change in my personality.
- [x] I am overweight.
- [x] I tend to sweat excessively during my sleep.

Conclusion

You have answered 'Yes' to three or more questions and therefore you are a candidate for a sleep study.

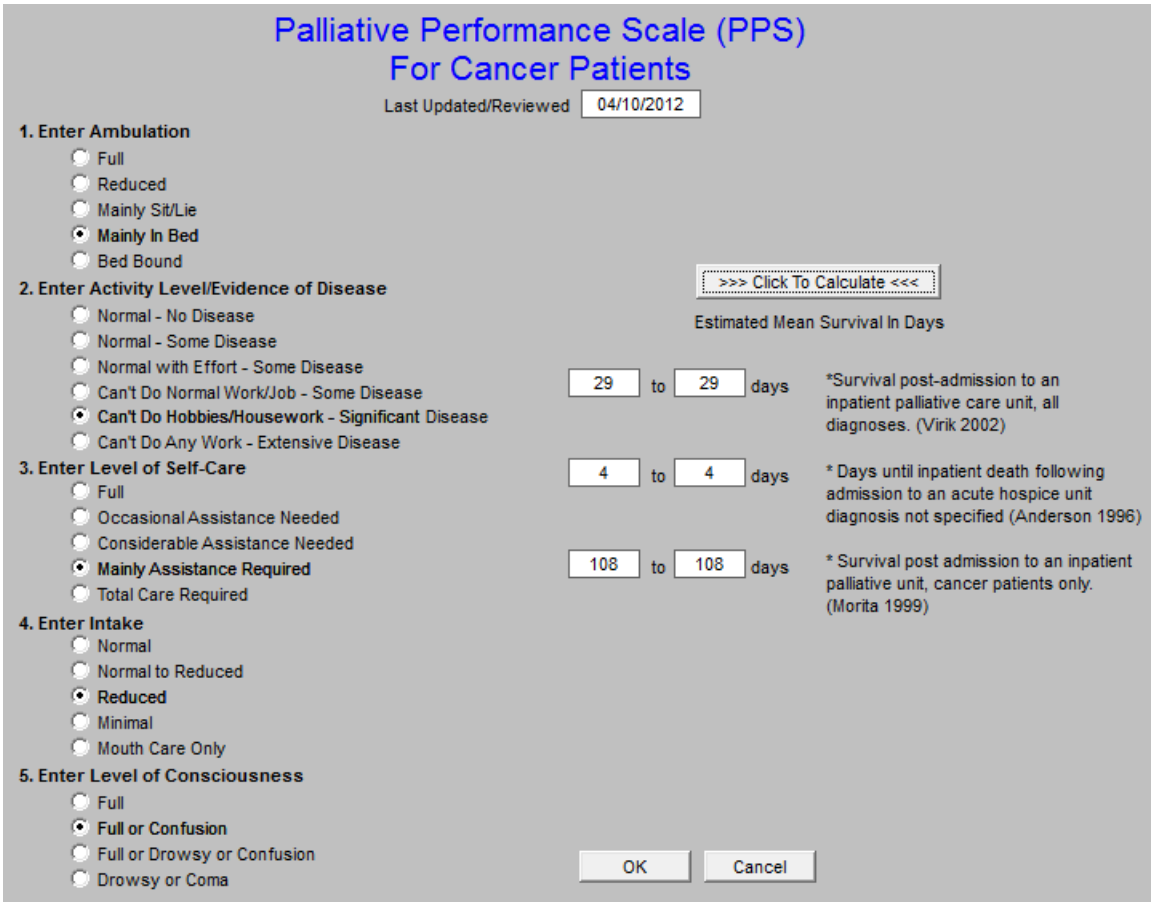
The following four questionnaires are used exclusively for patients who may be eligible for hospice care:

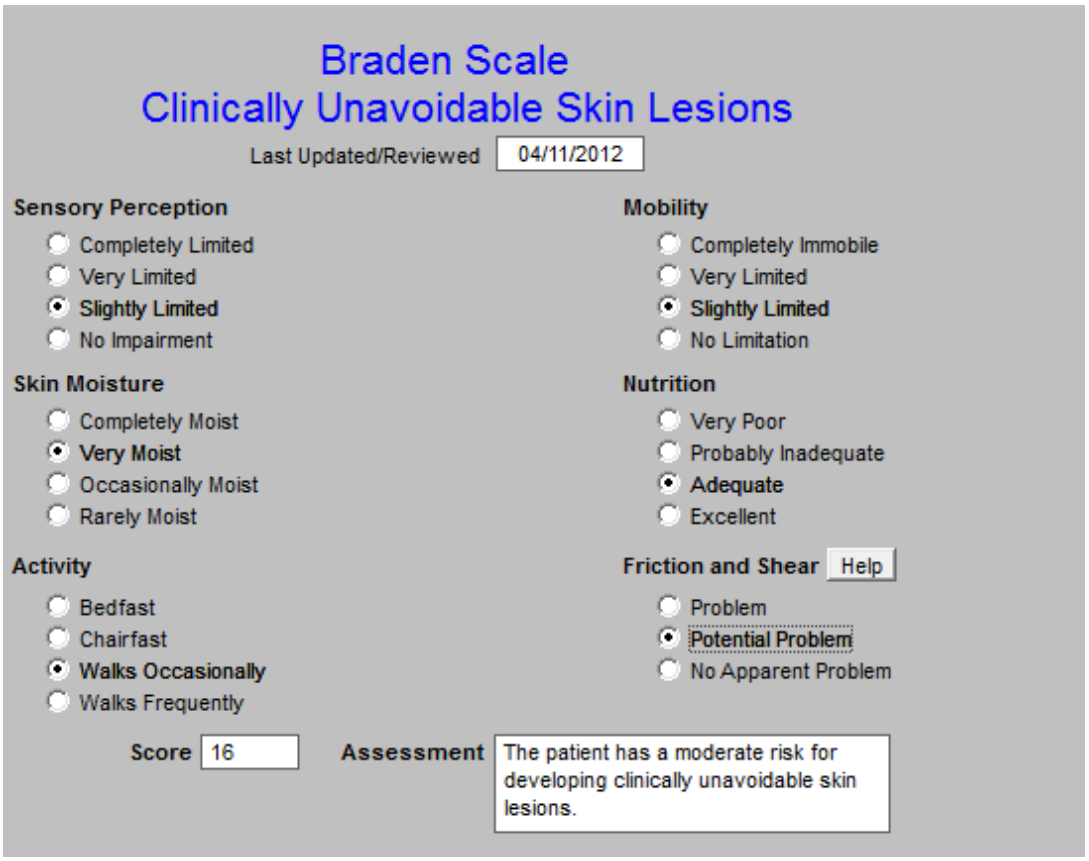
Karnofsky & Lansky Performance Scales

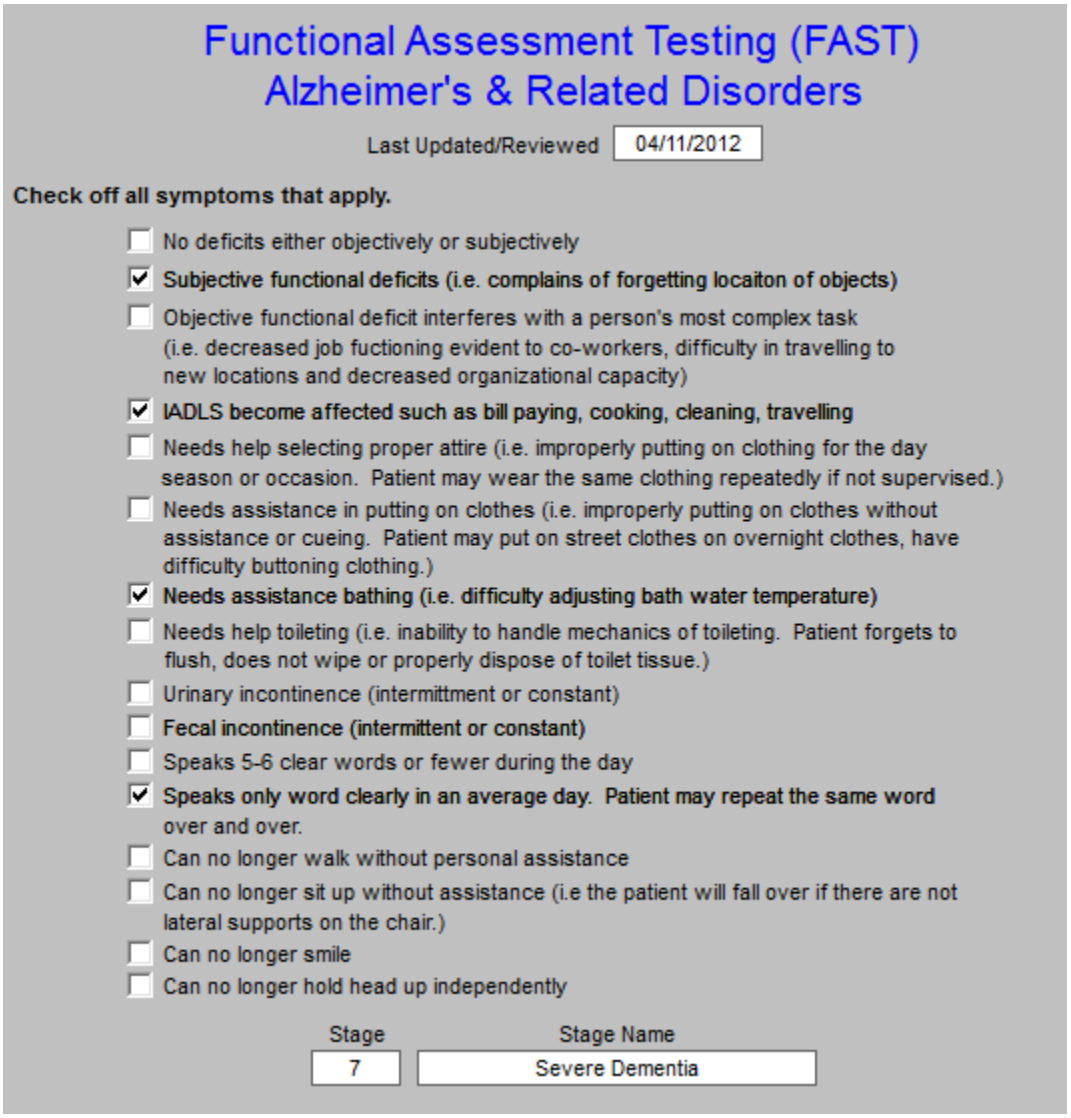
Last Updated/Reviewed 04/10/2012

Karnofsky Scale Patients 16 Years And Older		Lansky Scale Patients Less Than 16 Years
Able to carry on normal activity; no special care needed		Able to carry on normal activity; no special care needed
Normal, no complaints, no evidence of disease	○ 100	Fully active
Able to carry on normal activity	○ 90	Minor restriction in physically strenuous play
Normal activity with effort	○ 80	Restricted in strenuous play, tires more easily, otherwise active
Unable to work, able to live at home, cares for most personal needs, a varying amount of assistance is needed		Mild to moderate restriction
Cares for self, unable to carry on normal activity or to do active work	◉ 70	Both greater restrictions of, and less time spent in play
Requires occasional assistance but is able to care for most needs	○ 60	Ambulatory up to 50% of the time, limited active play with assistance/supervision
Requires considerable assistance and frequent medical care	○ 50	Considerable assistance required for any active play, fully able to engage in quiet play
Unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly		Moderate to severe restriction
Disabled, requires special care and assistance	○ 40	Able to initiate quite activities
Severely disabled, hospitalization indicated, although death not imminent	○ 30	Needs considerable assistance for quiet activity
Very sick, hospitalization necessary	○ 20	Limited to very passive activity initiated by others (e.g., TV)
Moribund, fatal process progressing rapidly	○ 10	Completely disabled, not even passive play

OK Cancel


Palliative Performance Scale (PPS)
For Cancer Patients
Last Updated/Reviewed 04/10/2012
1. Enter Ambulation
Full
Reduced
Mainly Sit/Lie
Mainly In Bed
Bed Bound
2. Enter Activity Level/Evidence of Disease
Normal - No Disease
Normal - Some Disease
Normal with Effort - Some Disease
Can't Do Normal Work/Job - Some Disease
Can't Do Hobbies/Housework - Significant Disease
Can't Do Any Work - Extensive Disease
3. Enter Level of Self-Care
Full
Occasional Assistance Needed
Considerable Assistance Needed
Mainly Assistance Required
Total Care Required
4. Enter Intake
Normal
Normal to Reduced
Reduced
Minimal
Mouth Care Only
5. Enter Level of Consciousness
Full
Full or Confusion
Full or Drowsy or Confusion
Drowsy or Coma
>>> Click To Calculate <<<
Estimated Mean Survival In Days
29 to 29 days
*Survival post-admission to an inpatient palliative care unit, all diagnoses. (Virik 2002)
4 to 4 days
* Days until inpatient death following admission to an acute hospice unit diagnosis not specified (Anderson 1996)
108 to 108 days
* Survival post admission to an inpatient palliative unit, cancer patients only. (Morita 1999)
OK
Cancel


Braden Scale
Clinically Unavoidable Skin Lesions
Last Updated/Reviewed 04/11/2012
Sensory Perception
Completely Limited
Very Limited
Slightly Limited
No Impairment
Mobility
Completely Immobile
Very Limited
Slightly Limited
No Limitation
Skin Moisture
Completely Moist
Very Moist
Occasionally Moist
Rarely Moist
Nutrition
Very Poor
Probably Inadequate
Adequate
Excellent
Activity
Bedfast
Chairfast
Walks Occasionally
Walks Frequently
Friction and Shear
Help
Problem
Potential Problem
No Apparent Problem
Score 16
Assessment
The patient has a moderate risk for developing clinically unavoidable skin lesions.



Functional Assessment Testing (FAST)
Alzheimer's & Related Disorders

Last Updated/Reviewed: 04/11/2012

Check off all symptoms that apply.

- [ ] No deficits either objectively or subjectively
- [x] **Subjective functional deficits (i.e. complains of forgetting locaiton of objects)**
- [ ] Objective functional deficit interferes with a person's most complex task (i.e. decreased job fuctioning evident to co-workers, difficulty in travelling to new locations and decreased organizational capacity)
- [x] **IADLS become affected such as bill paying, cooking, cleaning, travelling**
- [ ] Needs help selecting proper attire (i.e. improperly putting on clothing for the day season or occasion. Patient may wear the same clothing repeatedly if not supervised.)
- [ ] Needs assistance in putting on clothes (i.e. improperly putting on clothes without assistance or cueing. Patient may put on street clothes on overnight clothes, have difficulty buttoning clothing.)
- [x] **Needs assistance bathing (i.e. difficulty adjusting bath water temperature)**
- [ ] Needs help toileting (i.e. inability to handle mechanics of toileting. Patient forgets to flush, does not wipe or properly dispose of toilet tissue.)
- [ ] Urinary incontinence (intermittment or constant)
- [ ] **Fecal incontinence (intermittent or constant)**
- [ ] Speaks 5-6 clear words or fewer during the day
- [x] **Speaks only word clearly in an average day. Patient may repeat the same word** over and over.
- [ ] Can no longer walk without personal assistance
- [ ] Can no longer sit up without assistance (i.e the patient will fall over if there are not lateral supports on the chair.)
- [ ] Can no longer smile
- [ ] Can no longer hold head up independently

Stage	Stage Name
7	Severe Dementia

The following are our audits for preventive services. SETMA Mid County is a brand new clinic and the providers there are new. Their performance will improve quickly. We are only giving you the data for 2011, but on our website all of the data for 2009, 2010, 2011 and the first quarter of 2012 are posted. Each month, SETMA's providers and nurses have a training meeting in which the use of the disease management tools, clinical decision support tools and provider performance audits are reviewed. Opportunities and plans for improvement of our performance on the Triple Aim are discussed.

NQF - Care for Older Adults

E & M Codes: Clinic Only
Encounter Date(s): Jan 1, 2011 Through Dec 30, 2011

Location	Provider	Counseling for Physical Activity	Colorectal Cancer Screening	Fall Risk Assessment	Urinary Incontinence Assessment
SETMA 1	Aziz	52.8%	63.7%	99.0%	95.1%
	Duncan	90.8%	68.2%	94.8%	99.2%
	Henderson	53.1%	65.3%	99.8%	99.7%
	Murphy	69.6%	60.6%	98.6%	98.4%
	Palang	40.3%	37.0%	98.0%	97.3%
	Thomas	31.0%	39.8%	90.6%	98.2%
	SETMA 1 Totals:	59.9%	59.3%	98.0%	97.8%
SETMA 2	Anthony	99.2%	69.5%	99.4%	98.9%
	Anwar	98.6%	78.5%	98.6%	97.2%
	Colbert	--	--	--	--
	Holly	99.1%	77.4%	100.0%	99.6%
	Leifeste	88.9%	81.8%	97.7%	98.3%
	Wheeler	98.9%	74.5%	97.3%	98.7%
	SETMA 2 Totals:	96.8%	76.7%	98.4%	98.1%
SETMA Mid County	Aziz	0.0%	0.0%	50.0%	0.0%
	George	15.3%	20.8%	85.2%	79.0%
	Halbert	--	0.0%	--	--
	Shepherd	0.0%	15.8%	28.6%	97.6%
	Thomas	34.0%	22.7%	87.3%	95.8%
	SETMA Mid County Totals:	25.3%	21.9%	84.0%	89.2%
SETMA West	Curry	86.1%	64.2%	99.8%	89.6%
	Deiparine	52.0%	52.6%	98.6%	98.7%
	Halbert	73.2%	52.4%	98.9%	98.3%
	Horn	94.0%	65.5%	99.7%	99.1%
	Qureshi	47.0%	61.4%	99.6%	97.4%
	Satterwhite	88.1%	56.2%	99.8%	89.9%
	Vardiman	77.1%	56.1%	99.1%	94.1%

We have a major effort going forward to decrease the use of potentially high risk medications.

HEDIS - Effectiveness of Preventive Care - Older Adults

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

Report Criteria: Patients 65 And Older

Location	Provider	Advance Care Planning	Medication Review	Functional Assessment	Pain Screening	At Least 1 High Risk Medication	At Least 2 High Risk Medications	Glaucoma Screening
SETMA 1	Aziz	29.7%	93.3%	99.1%	98.8%	35.8%	18.6%	99.1%
	Duncan	13.4%	100.0%	94.8%	96.5%	48.5%	18.6%	98.8%
	Henderson	23.7%	100.0%	99.8%	99.8%	35.9%	14.8%	99.5%
	Murphy	12.8%	99.9%	98.9%	99.2%	36.1%	11.5%	99.9%
	Palang	10.1%	98.7%	96.5%	98.3%	35.4%	12.2%	99.6%
	Thomas	20.9%	93.3%	94.0%	100.0%	43.3%	17.2%	97.6%
	SETMA 1 Totals:	18.8%	98.1%	98.0%	98.7%	38.2%	15.2%	99.4%
SETMA 2	Anthony	36.7%	100.0%	99.6%	99.7%	32.7%	9.8%	99.6%
	Anwar	71.1%	100.0%	98.8%	98.8%	28.6%	9.7%	99.6%
	Holly	24.5%	100.0%	100.0%	100.0%	25.3%	6.1%	100.0%
	Leifeste	14.8%	100.0%	97.7%	98.0%	29.8%	11.6%	98.7%
	Wheeler	35.2%	94.5%	97.5%	97.5%	42.4%	16.3%	99.4%
	SETMA 2 Totals:	45.3%	99.2%	98.6%	98.6%	31.3%	10.9%	99.4%
SETMA Mid County	George	11.0%	100.0%	95.9%	95.9%	20.5%	0.0%	100.0%
	Thomas	22.9%	94.9%	94.9%	98.3%	39.8%	9.3%	97.3%
	SETMA Mid County Totals:	18.3%	96.9%	95.3%	97.4%	32.5%	5.8%	98.4%
SETMA West	Curry	9.6%	99.8%	99.8%	99.8%	34.4%	14.2%	99.8%
	Deiparine	11.6%	99.5%	98.9%	98.9%	35.5%	13.8%	100.0%
	Halbert	6.9%	100.0%	99.2%	99.2%	32.4%	13.2%	99.4%
	Horn	17.2%	100.0%	99.6%	99.6%	37.4%	13.1%	98.6%
	Qureshi	13.4%	100.0%	100.0%	100.0%	43.5%	16.8%	87.5%
	Satterwhite	17.7%	100.0%	100.0%	100.0%	41.3%	16.0%	98.5%
	Vardiman	11.2%	99.6%	99.4%	99.4%	37.8%	15.4%	94.1%
	SETMA West Totals:	11.5%	99.9%	99.5%	99.5%	36.3%	14.2%	97.4%
	SETMA Totals:	25.6%	99.0%	98.6%	98.9%	35.2%	13.3%	98.8%

HEDIS - Effectiveness of Preventive Care

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

Location	Provider	Adult BMI	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening	Childhood Immuni-zations	Colorectal Cancer Screening	Lead Screening in Children	Child BMI
SETMA 1	Aziz	94.5%	34.6%	75.2%	--	--	94.3%	--	--
	Duncan	97.3%	39.7%	78.9%	--	--	96.8%	--	--
	Henderson	98.9%	60.2%	75.5%	--	--	95.5%	--	--
	Murphy	97.6%	38.7%	71.6%	--	--	96.9%	--	--
	Palang	97.7%	50.0%	63.5%	--	--	98.1%	--	--
	Thomas	100.0%	60.7%	58.8%	--	--	95.2%	--	--
SETMA 1 Totals:		97.4%	45.1%	75.0%	--	--	96.1%	--	--
SETMA 2	Anthony	99.6%	49.4%	66.3%	--	--	98.1%	--	--
	Anwar	99.6%	71.7%	82.5%	--	--	98.2%	--	--
	Cricchio, A	97.4%	43.2%	59.5%	--	--	98.7%	--	--
	Cricchio, M	99.7%	52.2%	65.5%	--	--	98.6%	--	--
	Holly	100.0%	50.0%	72.7%	--	--	100.0%	--	--
	Leifeste	100.0%	74.2%	75.2%	--	--	100.0%	--	--
	Wheeler	98.9%	50.9%	81.9%	--	--	98.2%	--	--
SETMA 2 Totals:		99.4%	59.7%	74.4%	--	--	98.6%	--	--
SETMA West	Curry	100.0%	55.3%	77.3%	--	--	99.0%	--	--
	Deiparine	98.5%	40.7%	59.2%	--	--	97.3%	--	--
	Halbert	99.8%	31.6%	38.8%	--	--	96.1%	--	--
	Horn	99.9%	39.9%	57.3%	--	--	96.9%	--	--
	Qureshi	99.6%	44.8%	57.5%	--	--	97.0%	--	--
	Satterwhite	99.1%	36.8%	50.0%	--	--	97.4%	--	--
	Vardiman	100.0%	44.0%	59.6%	--	--	93.7%	--	--
SETMA West Totals:		99.6%	41.2%	56.8%	--	--	96.9%	--	--
SETMA Totals:		99.0%	48.0%	66.5%	--	--	97.2%	--	--

The following are the auditing results for screening of our Medicare Advantage patients which represent 32% of our patients and 50% of our visits. This data is for January-March, 2012

Provider	Breast Cancer Screening >=80%	Colorectal Cancer Screening >=66%	Cholesterol Management In Patients w/Cardiovascular Disease >=91%	Glaucoma Screening In Older Adults >=78%	Adult Body Mass Index >=73%	Osteoporosis Management In Women w/Fracture >=67%	Diabetes Dilated Eye Exam >=73%
Anthony	77.8	73.3	84.1	100.0	100.0	50.0	79.2
Anwar	65.1	80.5	78.1	100.0	100.0	0.0	69.9
Aziz	33.3	71.7	86.0	100.0	100.0	--	56.6
Curry	56.0	55.4	87.9	100.0	97.1	0.0	70.3
Darden	0.0	72.7	100.0	100.0	100.0	--	100.0
Deiparine	57.1	61.2	76.7	100.0	100.0	--	42.1
Duncan	56.2	72.5	84.8	99.3	98.0	--	67.2
Halbert	66.7	49.3	73.9	98.9	100.0	--	34.3
Henderson	60.0	74.7	77.5	100.0	92.9	100.0	61.0
Holly	66.7	80.4	89.3	100.0	100.0	--	80.5
Horn	45.0	73.5	84.1	96.2	100.0	50.0	41.1
Leifeste	90.9	80.0	88.5	99.0	98.0	--	83.5
Murphy	33.3	69.8	88.9	100.0	95.0	--	47.5
Palang	100.0	66.3	84.6	100.0	90.0	66.7	41.4
Qureshi	56.2	71.6	92.1	96.3	100.0	--	50.6
Read	100.0	82.4	75.0	91.7	100.0	--	75.0
Thomas	0.0	63.4	57.5	100.0	100.0	--	100.0
Vardiman	60.0	66.3	68.8	92.3	100.0	0.0	58.1
Wheeler	81.2	81.6	78.0	98.6	100.0	--	71.3

Provider	Diabetes Nephropathy Screening >=89%	Diabetes HbA1c Control (<= 9.0%) >=88%	Diabetes LDL Control (< 100 mg/dL) >=66	Controlling High Blood Pressure >=71%	Drug Theraphy for Rheumatoid Arthritis >=84%	Annual Flu Vaccine >=76%	Pneumonia Vaccine >=78%
Anthony	98.9	94.0	74.3	82.0	50.0	82.3	86.4
Anwar	94.2	92.7	62.6	94.8	35.3	76.8	96.8
Aziz	94.7	89.5	69.7	76.9	28.6	49.8	86.0
Curry	87.8	95.9	70.3	76.7	50.0	77.6	85.2
Darden	100.0	100.0	100.0	75.0	--	78.6	92.3
Deiparine	81.6	97.4	63.2	84.8	25.0	62.1	81.5
Duncan	90.5	94.8	69.0	93.1	55.6	79.9	90.3
Halbert	90.5	96.1	71.3	72.3	42.1	37.5	57.2
Henderson	94.3	96.2	66.7	91.2	18.2	74.3	89.7
Holly	96.1	93.5	64.9	95.0	16.7	94.6	98.3
Horn	93.2	98.6	63.0	96.4	60.0	55.6	74.4
Leifeste	94.2	97.5	77.7	85.0	80.0	84.4	94.4
Murphy	86.3	96.3	76.7	82.0	45.5	78.3	92.1
Palang	77.6	89.7	67.2	76.8	0.0	60.1	75.8
Qureshi	82.0	87.6	65.2	87.8	20.0	55.0	76.1
Read	100.0	100.0	75.0	61.5	--	73.7	84.2
Thomas	100.0	100.0	66.7	89.4	33.3	30.2	40.7
Vardiman	71.0	96.8	64.5	69.0	--	44.8	76.3
Wheeler	92.0	95.4	66.7	83.7	25.0	75.3	96.1

Provider	Advice for Physical Activity >=80%	Fall Risk Intervention >=76%	High Risk Medications <=9.3%
Anthony	99.7	99.7	20.5
Anwar	99.4	99.6	16.0
Aziz	54.8	99.2	20.7
Curry	44.4	99.4	12.8
Darden	46.2	100.0	28.3
Deiparine	55.5	96.0	11.9
Duncan	84.7	97.2	31.1
Halbert	13.1	88.9	20.5
Henderson	39.0	100.0	19.2
Holly	99.1	100.0	9.5
Horn	81.4	100.0	17.0
Leifeste	92.8	100.0	19.7
Murphy	57.3	98.9	20.1
Palang	21.9	96.9	18.9
Qureshi	31.4	98.1	18.5
Read	89.5	94.7	11.7
Thomas	63.4	95.4	18.2
Vardiman	77.3	99.9	18.5
Wheeler	99.1	100.0	25.9

The following is the 2011 audit for performance on the LESS Initiative. We consider anything above 95% as being acceptable.

Provider	LESS Initiative Compliance (%)
Anthony	95.1
Anwar	96.0
Aziz	95.5
Cricchio, A	98.3
Cricchio, M	87.9
Curry	92.1
Deiparine	90.9
Duncan	90.9
Halbert	83.1
Henderson	89.2
Holly	99.0
Hom	96.7
Leifeste	84.2
Murphy	93.4
Palang	76.2
Qureshi	92.1
Satterwhite	89.7
Thomas	78.2
Vardiman	95.8
Wheeler	94.9

B. Clinical Performance Measures (e.g., % diabetics with HbA1C <9%)

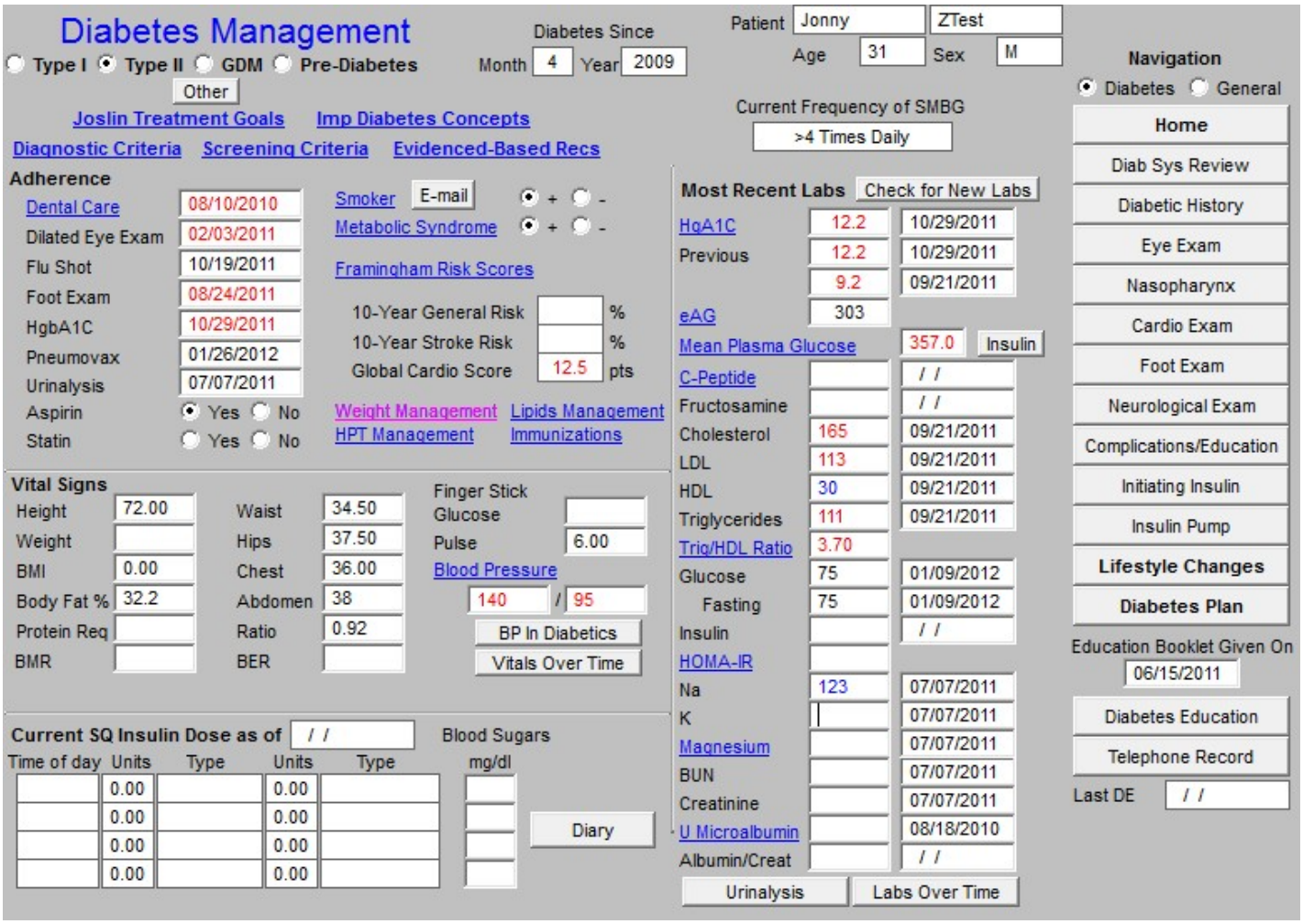
X We collect this type of data routinely and use it for:

X Quality Improvement
X Reporting
X Practice Management
X Pay for Performance
Other

SETMA does extensive clinical performance measures, all of which are found on our website at the following link: http://www.jameslhollymd.com/PublicReporting.cfm I will only illustrate three here:

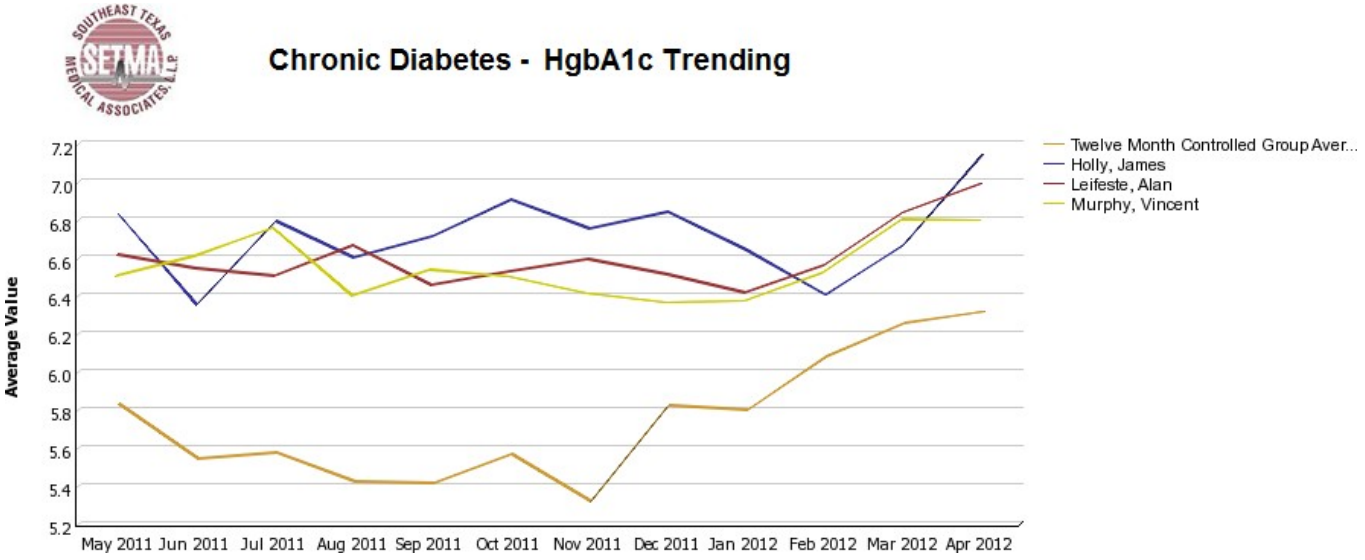
1. Diabetes
2. Hypertension
3. Lipids

The following is the front page of our Diabetes Disease Management tool:

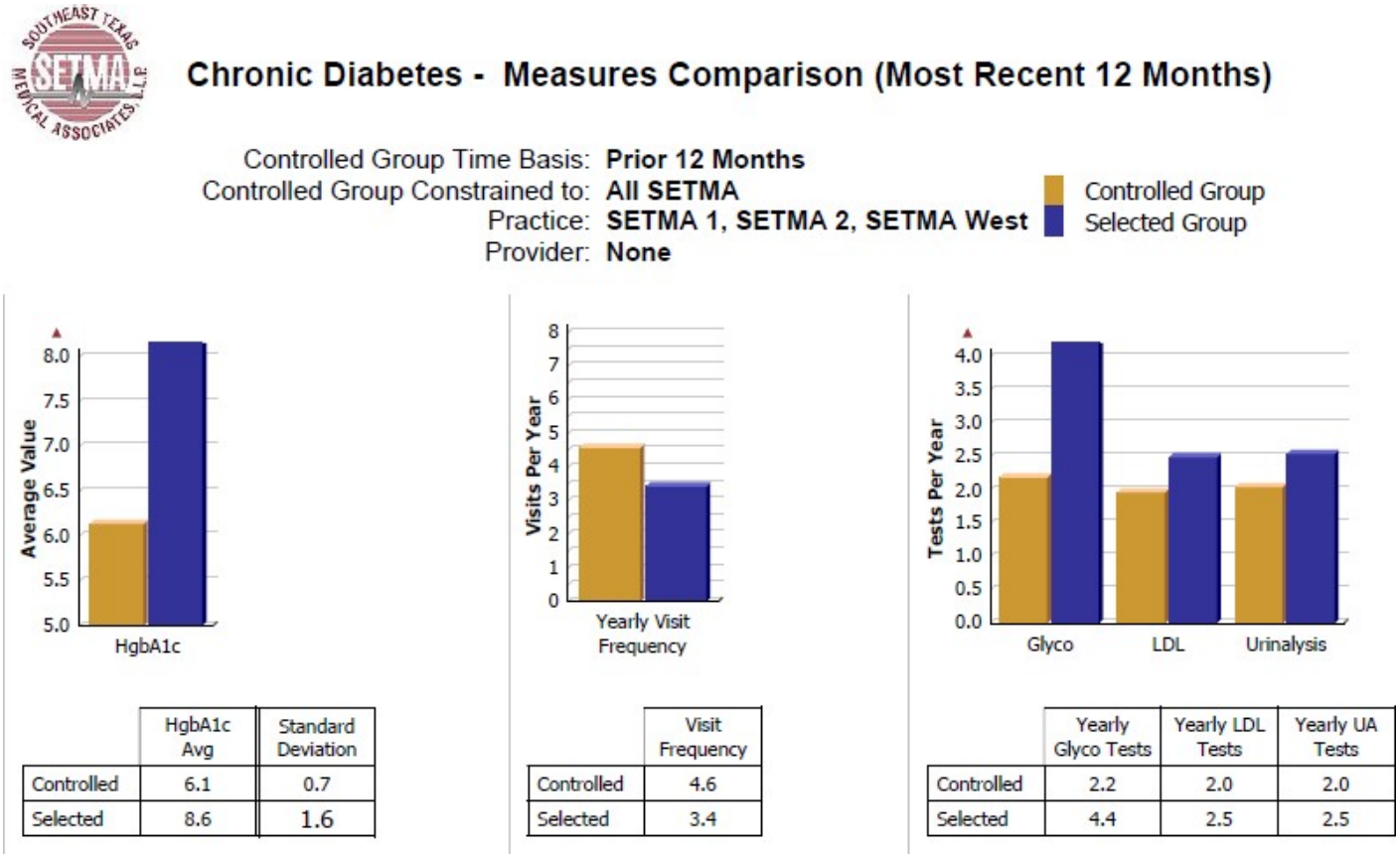


The Diabetes Disease Management tool is interactive with all of the patient's record. The following is a link to the full Diabetes Management Tool tutorial: http://www.jameslhollymd.com/Tutorial_Diabetes.cfm

From the work documented in the Diabetes Disease Management Tool, the following analytics can be done.



Through this longitudinal display, in 2009, we discovered that our patients who were well controlled all year were often losing their control of diabetes in October, November and December. We then did further audits to see if they were being seen less often and being tested less often and they were. In 2010, in September, we sent letters to all 7,000+ patients with diabetes alerting to this fact. We indicated we wanted them to enjoy holiday celebrations but to maintain their exercise and dietary discretion. We had them sign a contract to be seen twice in those three months and to be tested twice. In 2011, our audit showed that this phenomenon had disappeared.

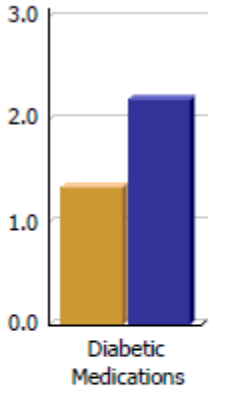


	HgbA1c Avg	Standard Deviation
Controlled	6.1	0.7
Selected	8.6	1.6

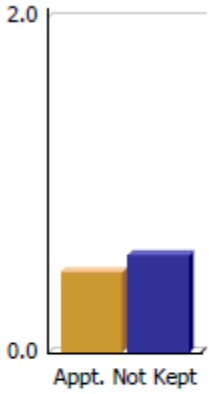
	Visit Frequency
Controlled	4.6
Selected	3.4

	Yearly Glyco Tests	Yearly LDL Tests	Yearly UA Tests
Controlled	2.2	2.0	2.0
Selected	4.4	2.5	2.5

The above compares the standard deviation of our controlled patients with diabetes (gold) and that of the uncontrolled. We established our goal to be .7 for our diabetes populations. We discovered that our controlled patients were seen 1.2 times more often. This is statistically significant and we saw an opportunity to improve the control of all of our patients by making sure that all patients with diabetes had 4-5 visits a year.

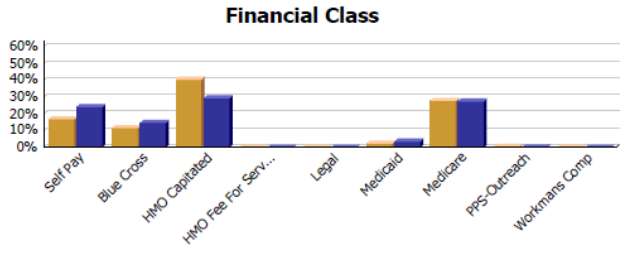


	Diabetic Medications
Controlled	1.3
Selected	2.2

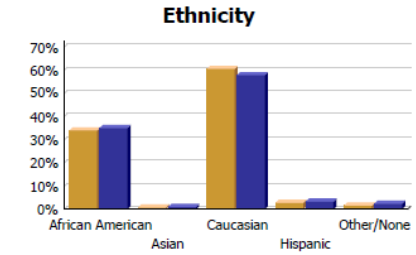


	Appt. Not Kept
Controlled	0.5
Selected	0.6

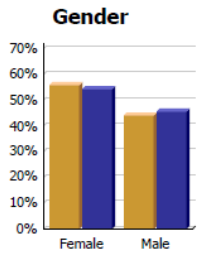
No leverage points for improvement were found in the data above. (the controlled are gold and are patients with diabetes treated to goal and the selected are the uncontrolled patients in purple)



	Self Pay	Blue Cross	HMO Capitated	HMO Fee For Service	Legal	Medicaid	Medicare	PPS-Outreach
Controlled	16.9%	11.6%	40.5%	0.0%	0.0%	2.4%	27.9%	0.6%
Selected	24.2%	14.8%	29.5%	0.0%	0.0%	3.7%	27.6%	0.2%

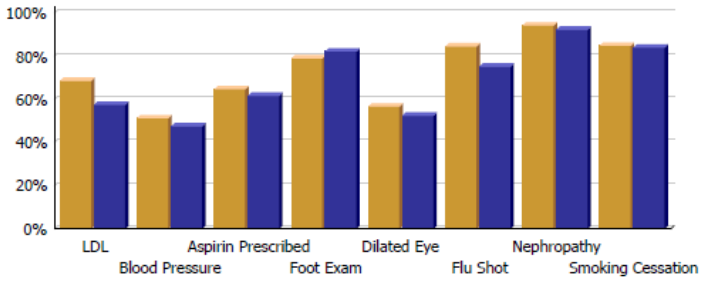


	African American	Ethnicity Asian	Caucasian	Hispanic	Other/ None
Controlled	34.1%	0.8%	60.6%	2.9%	1.6%
Selected	35.1%	1.1%	57.9%	3.4%	2.5%

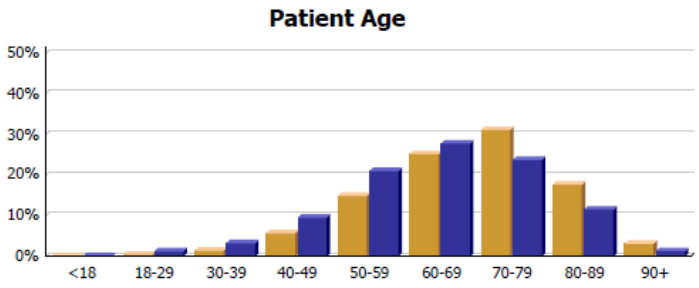


	Female	Male
Controlled	55.9%	44.1%
Selected	54.3%	45.7%

From the above, we found that our HMO capitated patients who have a zero office co-pay are treated more effectively than Fee-for-Service Medicare allowing the inference that the cost of care for the FFS Medicare patients is a barrier to the effectiveness of care in that when that barrier is removed in a similar population that the care improves. We were able to see that for diabetes we had eliminated ethnic disparities of care.



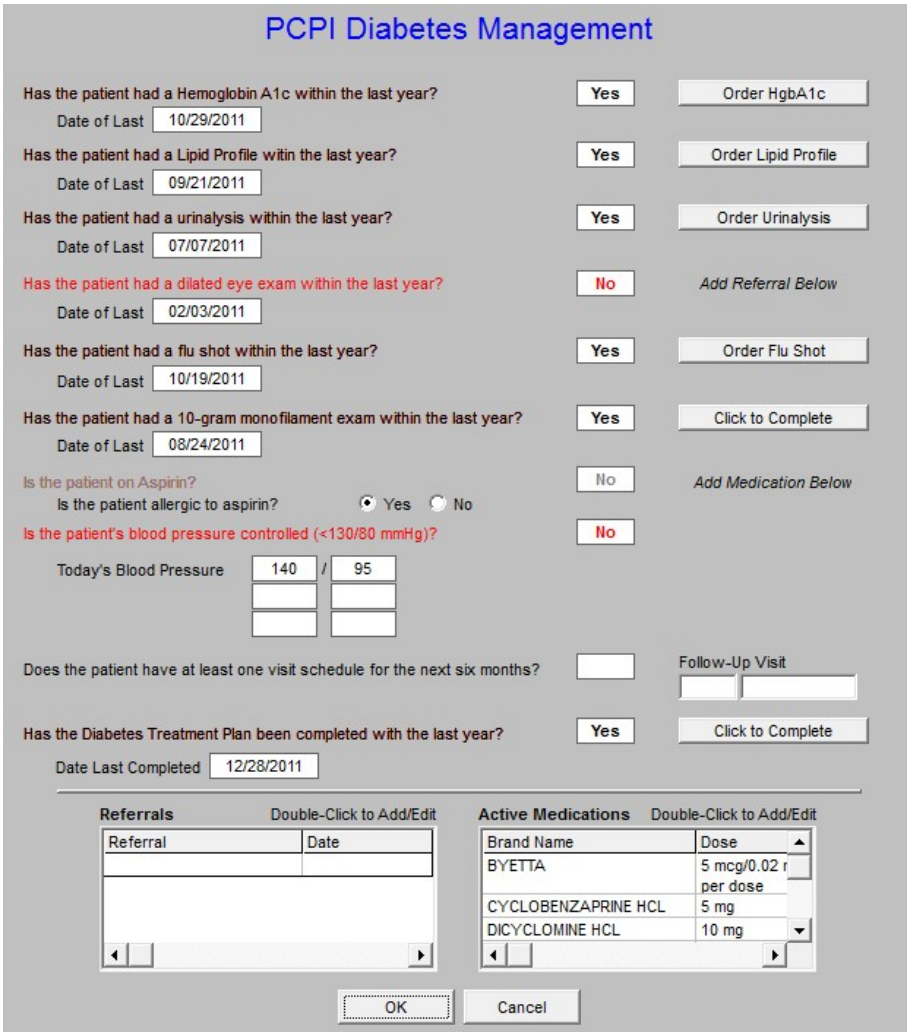
	LDL Controlled, <70	BP Controlled, <130/80	Aspirin Prescribed	Yearly Foot Exam	Yearly Dilated Exam	Yearly Flu Shot	Attention for Nephropathy
Controlled	68.7%	51.4%	64.8%	79.1%	56.8%	84.6%	94.3%
Selected	57.6%	47.6%	61.8%	82.3%	52.6%	75.3%	92.4%



	<18	18-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
Controlled	0.0%	0.5%	1.5%	5.8%	14.9%	25.2%	31.2%	17.8%	3.2%
Selected	0.1%	1.3%	3.3%	9.6%	21.1%	27.8%	23.8%	11.6%	1.4%

From the above profile, we were able to see that our older patients have better control of diabetes than our younger patients. Concerned that this might reflect co-morbidities rather than excellence of care, we tested the patients for malnutrition (pre-albumin), weight loss and appetite and found that they were not malnourished but were responding well to increased attention.

The following is the diabetes quality measurement set of PCPI. The elements are collected automatically without the provider doing anything, but at the point of service, once the provider completes the audit of patent's care can be reviewed by the provider.



The following is the PCPI diabetes audit for 2011. Once again, 2009, 2010, 2011 and the first quarter of 2012 are on our website.

Diabetes Consortium - Blood Pressure Management

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

Report Criteria: Patients 18 to 75 With a Chronic Diagnosis of Diabetes
Specialists Excluded (Dr. Ahmed Included)

		Systolic									Diastolic						
Location	Provider	< 120	120-129	130-139	140-149	150-159	160-169	170-179	>= 180	Not Present	< 75	75-79	80-89	90-99	100-109	>= 110	Not Present
SETMA 1	Aziz	26.6%	31.8%	19.2%	13.6%	5.0%	2.9%	0.3%	0.7%	0.0%	55.0%	13.1%	25.6%	5.5%	0.3%	0.3%	0.1%
	Duncan	35.1%	35.3%	18.4%	8.0%	1.1%	0.8%	0.0%	0.0%	1.3%	50.1%	9.7%	35.1%	3.8%	0.0%	0.0%	1.3%
	Henderson	36.3%	33.1%	18.1%	7.8%	2.9%	1.0%	0.3%	0.3%	0.2%	55.4%	11.8%	28.1%	4.0%	0.2%	0.3%	0.2%
	Murphy	30.5%	29.4%	23.0%	9.5%	3.6%	2.2%	0.8%	0.8%	0.2%	48.5%	8.1%	33.9%	7.2%	1.7%	0.4%	0.2%
	Palang	10.6%	33.2%	29.4%	16.1%	6.5%	2.0%	0.5%	0.0%	1.8%	54.5%	5.0%	32.2%	5.8%	0.8%	0.0%	1.8%
	Thomas	14.0%	41.2%	21.1%	14.9%	6.1%	1.8%	0.9%	0.0%	0.0%	28.1%	14.9%	50.0%	6.1%	0.0%	0.0%	0.9%
SETMA 1 Totals:		28.5%	32.4%	21.3%	10.8%	3.8%	1.9%	0.4%	0.4%	0.5%	51.4%	10.0%	31.6%	5.5%	0.7%	0.2%	0.6%
SETMA 2	Ahmed	36.3%	24.4%	28.1%	8.9%	1.6%	0.3%	0.1%	0.0%	0.2%	63.1%	12.6%	21.6%	2.2%	0.3%	0.0%	0.2%
	Anthony	29.6%	33.1%	19.8%	11.8%	2.7%	1.7%	0.8%	0.5%	0.0%	48.4%	18.1%	29.6%	3.0%	0.7%	0.2%	0.0%
	Anwar	17.0%	48.0%	24.9%	7.0%	2.0%	0.7%	0.0%	0.2%	0.1%	71.2%	14.2%	12.5%	1.5%	0.2%	0.1%	0.2%
	Cricchio, A	25.1%	36.2%	23.0%	9.3%	3.6%	1.7%	0.3%	0.4%	0.4%	56.5%	13.6%	25.0%	4.1%	0.4%	0.1%	0.3%
	Cricchio, M	35.3%	23.5%	20.9%	11.6%	3.5%	2.8%	1.2%	0.5%	0.7%	58.9%	12.4%	20.7%	6.5%	0.8%	0.1%	0.5%
	Deiparine	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
	Holly	28.2%	58.2%	10.0%	1.8%	0.6%	0.6%	0.0%	0.6%	0.0%	70.0%	18.2%	11.2%	0.6%	0.0%	0.0%	0.0%
	Leifeste	37.6%	26.8%	23.2%	7.0%	2.6%	1.1%	0.5%	1.1%	0.1%	54.3%	15.0%	25.3%	4.2%	0.5%	0.5%	0.1%
	Wheeler	22.0%	32.7%	22.8%	11.1%	4.6%	4.4%	1.4%	0.6%	0.2%	57.4%	7.7%	27.7%	6.1%	1.0%	0.0%	0.2%
SETMA 2 Totals:		30.8%	31.2%	24.2%	9.0%	2.5%	1.3%	0.5%	0.4%	0.2%	60.4%	13.4%	22.0%	3.3%	0.5%	0.2%	0.2%
SETMA West	Curry	23.9%	30.5%	24.1%	12.6%	6.3%	1.4%	0.0%	1.1%	0.0%	52.9%	12.9%	27.9%	4.9%	1.4%	0.0%	0.0%
	Deiparine	21.6%	27.4%	22.2%	14.2%	7.0%	4.3%	1.6%	1.5%	0.1%	50.7%	9.1%	24.0%	12.1%	3.0%	0.9%	0.1%
	Halbert	30.6%	24.9%	21.9%	12.0%	6.0%	3.3%	0.7%	0.4%	0.2%	51.6%	13.3%	27.6%	5.4%	1.8%	0.1%	0.1%
	Horn	24.7%	41.5%	31.9%	1.4%	0.2%	0.2%	0.2%	0.0%	0.0%	53.0%	14.8%	31.3%	0.8%	0.2%	0.0%	0.0%
	Qureshi	31.9%	39.6%	17.2%	6.1%	2.4%	1.8%	0.3%	0.3%	0.5%	51.7%	15.6%	28.5%	2.1%	1.6%	0.0%	0.5%
	Satterwhite	17.9%	28.9%	25.2%	11.6%	5.0%	1.3%	1.0%	1.0%	8.0%	42.9%	15.0%	23.6%	7.0%	2.3%	1.3%	8.0%
	Vardiman	26.2%	22.7%	26.5%	17.0%	3.5%	2.2%	0.3%	1.4%	0.3%	51.1%	14.6%	27.8%	4.3%	1.4%	0.5%	0.3%
SETMA West Totals:		25.9%	30.5%	24.2%	10.4%	4.5%	2.3%	0.7%	0.7%	0.8%	51.1%	13.3%	27.4%	5.4%	1.7%	0.4%	0.8%

There are currently twelve different published audit sets for diabetes. We track all of those. The following is the audit set with measures, discriminators and the aggregate score for the NCQA Diabetes Recognition program. That program changed this in February of 2012 and SETMA is updating our audit to reflect the new standards. All of SETMA providers and clinics have NCQA Diabetes Recognition.

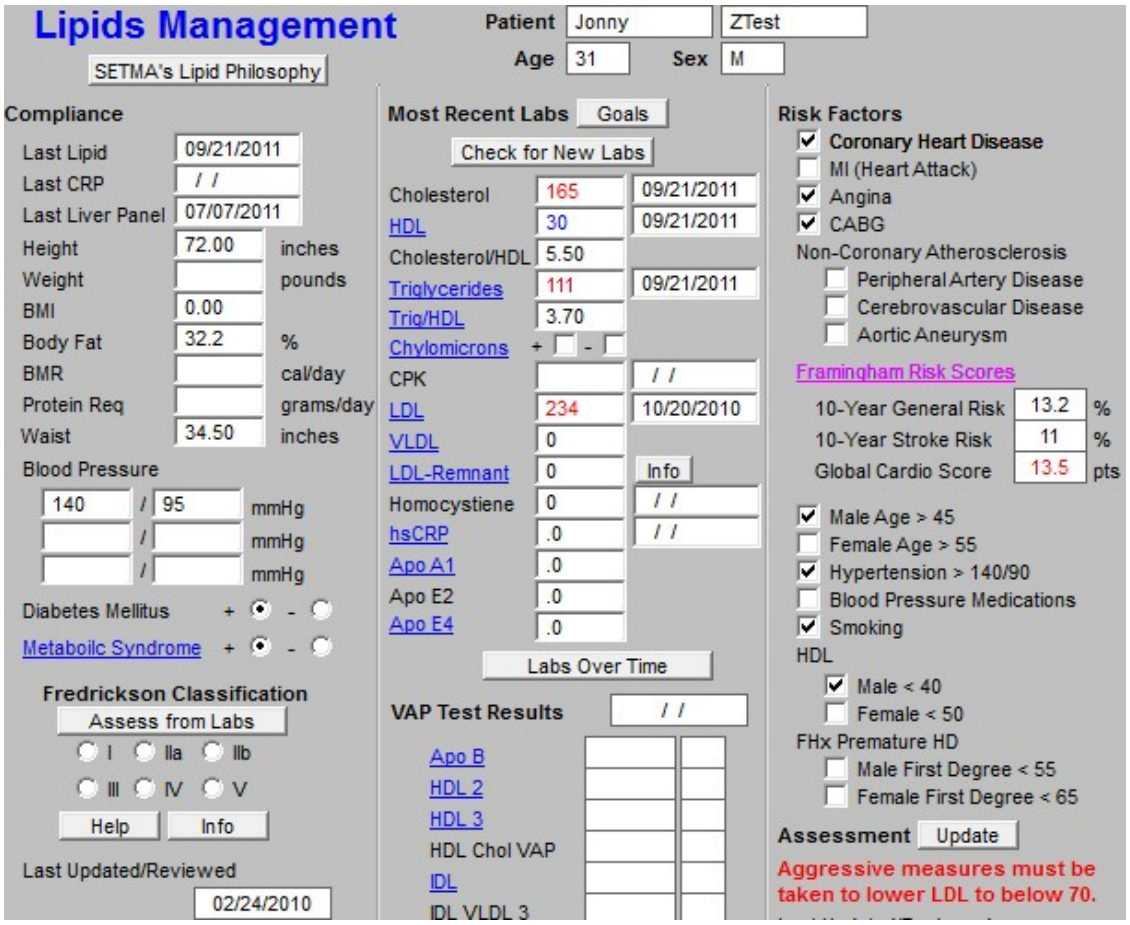
NCQA Diabetes Measures

Encounter Date(s): January 1, 2011 to December 31, 2011

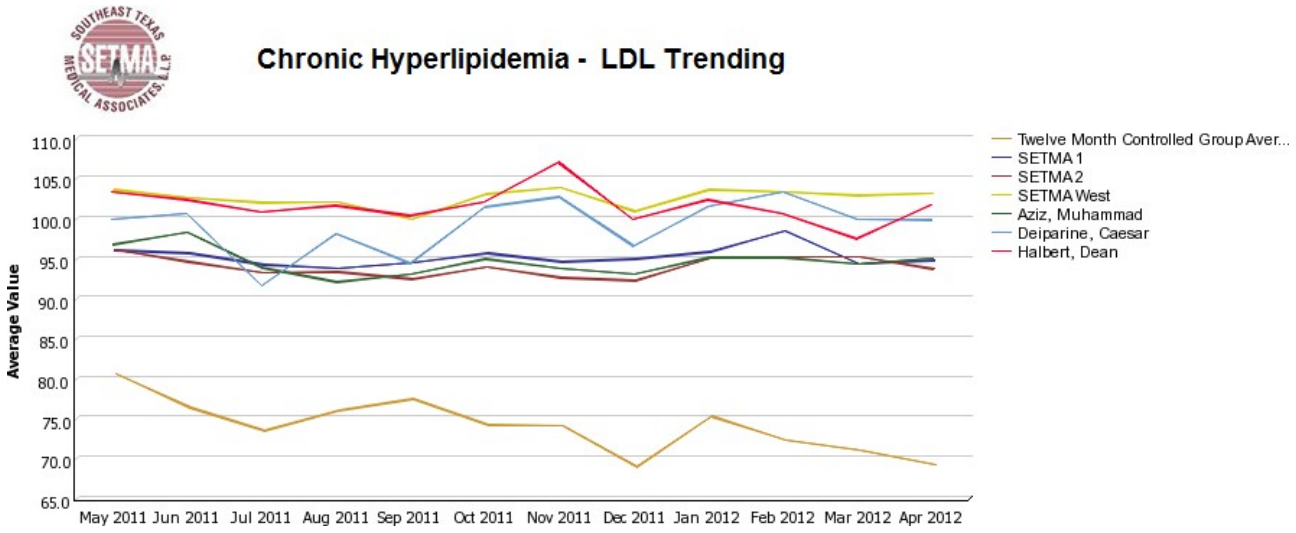
Location Name	Provider	Encounters	A1c >9.0 <= 15%	A1c < 8.0 >= 60%	A1c < 7.0 >= 40%	BP > 140/90 <= 35%	BP < 130/80 >= 25%	Eye Exam >= 60%	Smoking Cessation >= 80%	LDL >= 130 <= 37 %	LDL < 100 >= 36%	Nephropathy >= 80%	Foot Exam >= 80%	Total Points
SETMA 1	Aziz	1,078	10.6%	72.5%	58.3%	18.2%	56.8%	60.2%	95.6%	13.5%	69.6%	83.4%	74.6%	95
	Duncan	766	8.6%	79.5%	67.4%	12.5%	68.7%	57.7%	93.6%	15.4%	65.9%	81.6%	79.9%	85
	Halbert	1	0.0%	100.0%	100.0%	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	100.0%	75
	Henderson	848	10.1%	78.4%	66.5%	9.4%	69.5%	60.4%	95.9%	13.1%	66.4%	84.2%	93.6%	100
	Murphy	1,504	6.0%	84.7%	70.5%	14.3%	57.7%	45.9%	85.1%	10.6%	75.5%	87.8%	82.4%	90
	Palang	675	5.5%	51.6%	42.7%	19.7%	53.0%	22.5%	95.5%	7.7%	50.1%	34.7%	31.0%	72
	Thomas	166	9.6%	70.5%	47.0%	18.1%	56.0%	77.7%	100.0%	11.4%	62.7%	75.9%	82.5%	95
SETMA 2	Ahmed	2,938	14.4%	43.2%	29.0%	8.3%	61.7%	63.9%	73.5%	11.3%	64.2%	71.0%	99.3%	72
	Anthony	843	9.7%	78.9%	66.1%	14.1%	66.5%	66.5%	83.5%	10.3%	69.4%	93.5%	96.1%	100
	Anwar	1,408	8.5%	78.3%	64.0%	5.0%	80.0%	64.8%	96.5%	11.2%	65.8%	92.0%	75.3%	95
	Cricchio, A	884	11.9%	44.9%	29.6%	9.2%	71.7%	64.6%	80.2%	10.1%	69.6%	76.5%	99.3%	82
	Cricchio, M	964	7.0%	76.9%	63.7%	15.5%	60.8%	65.0%	67.6%	9.5%	68.0%	91.6%	86.5%	90
	Deiparine	1	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%		0.0%	100.0%	100.0%	100.0%	52
	Holly	283	6.7%	84.1%	71.4%	3.9%	83.0%	81.6%	71.4%	11.3%	71.4%	97.5%	95.4%	90
	Leifeste	991	6.3%	81.6%	71.0%	13.3%	63.2%	72.4%	58.3%	7.9%	70.0%	89.2%	83.5%	90
	Wheeler	679	6.9%	85.0%	74.1%	21.6%	57.1%	58.8%	81.7%	12.8%	62.7%	90.3%	89.1%	90
SETMA West	Curry	435	9.0%	75.2%	60.2%	16.1%	60.9%	70.8%	88.9%	13.6%	64.1%	87.6%	88.3%	100
	Deiparine	836	9.4%	72.0%	57.2%	23.2%	52.2%	47.8%	95.5%	13.0%	59.1%	72.0%	83.1%	85
	Halbert	1,346	10.1%	73.8%	61.8%	20.1%	55.4%	36.8%	96.3%	14.9%	61.5%	59.6%	81.4%	85
	Horn	802	5.9%	79.6%	66.7%	2.1%	68.8%	47.3%	92.2%	16.2%	55.0%	81.2%	92.6%	90
	Qureshi	484	17.6%	62.8%	52.3%	9.1%	71.1%	51.2%	94.1%	16.3%	58.5%	66.7%	95.5%	73
	Satterwhite	370	16.2%	60.3%	47.3%	24.1%	54.6%	52.7%	95.0%	19.5%	51.1%	76.8%	80.5%	73
	Vardiman	572	9.6%	72.9%	60.0%	21.5%	47.9%	57.7%	96.6%	15.0%	58.2%	64.5%	85.1%	85

This is the master template for the Lipid Disease Management Tool

The following is the master template in the Lipid Disease Management Tool built by SETMA. The is the link to the full tutorial: http://www.jameslhollymd.com/Tutorial_Lipids.cfm



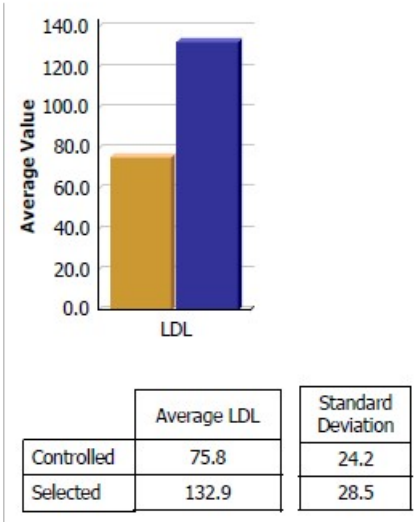
With the use of the disease management tool for Lipids, the following auditing and analytics can be done electronically.



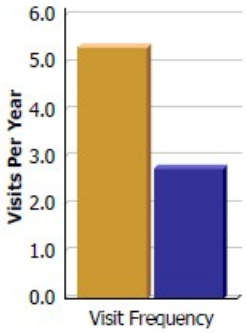
Chronic Hyperlipidemia - Measures Comparison (Most Recent 12 Months)

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

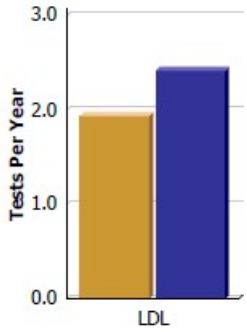
Controlled Group
Selected Group



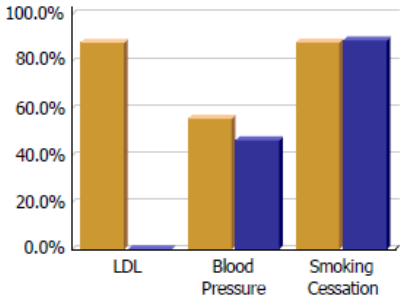
	Average LDL	Standard Deviation
Controlled	75.8	24.2
Selected	132.9	28.5



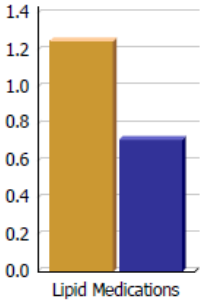
	Visit Frequency
Controlled	5.3
Selected	2.8



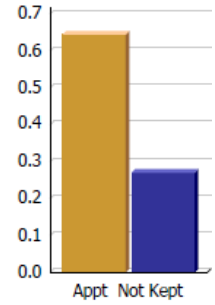
	Yearly LDL Tests
Controlled	1.9
Selected	2.4



	LDL Controlled < 70	BP Controlled < 130/80	Smoking Cessation Provided
Controlled	87.8%	55.7%	88.1%
Selected	0.0%	46.5%	88.9%

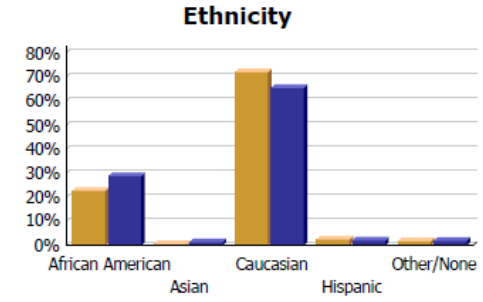


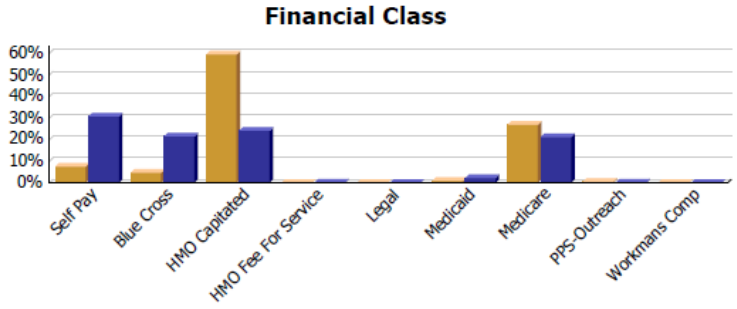
	Lipid Medications
Controlled	1.2
Selected	0.7



	Appt Not Kept
Controlled	0.6
Selected	0.3

The following audit shows that we have not eliminate ethnic disparities in care of patients with dyslipidemia. We believe this is cultural and we are working on it. **We see once again that our Medicare Advantage patients (HMO) are better treated that our Medicare FFS patients.**

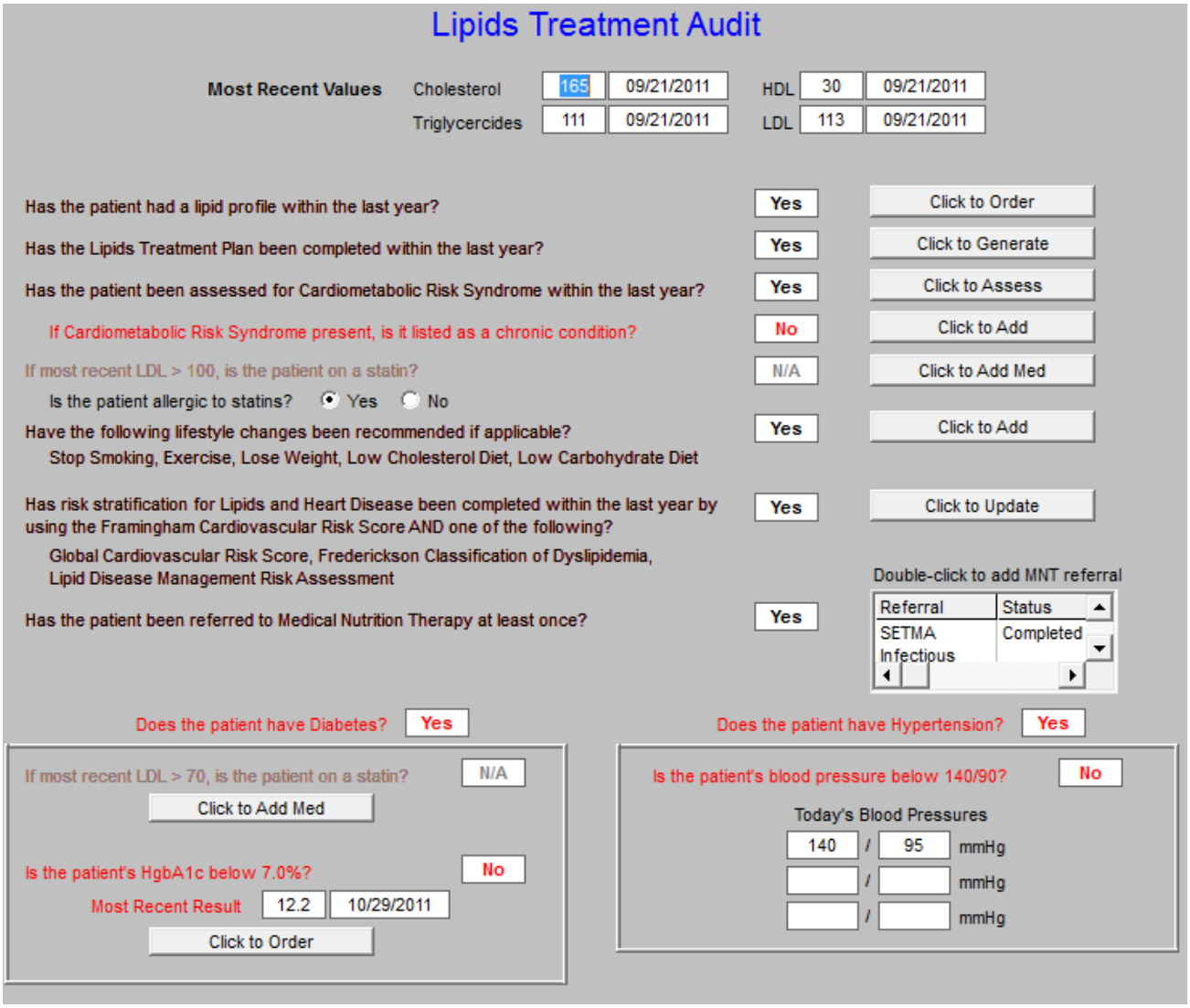




	African American	Asian	Caucasian	Hispanic	Other/ None
Controlled	22.9%	0.6%	72.2%	2.5%	1.8%
Selected	28.9%	1.5%	65.6%	2.1%	2.0%

	Self Pay	Blue Cross	HMO Capitated	HMO Fee For Service	Legal	Medicaid	Medicare	PPS-Outreach	Workmans Comp
Controlled	7.5%	4.7%	59.4%	0.0%	0.0%	0.9%	26.9%	0.5%	0.0%
Selected	30.7%	21.4%	24.1%	0.1%	0.0%	2.3%	21.2%	0.1%	0.0%

There is no nationally endorsed quality metric set for lipids, therefore SETMA design this one and the audit bellows shows our performance.



The following is the audit of the Lipid Quality Metric set which allows us to see leverage points for improvement.

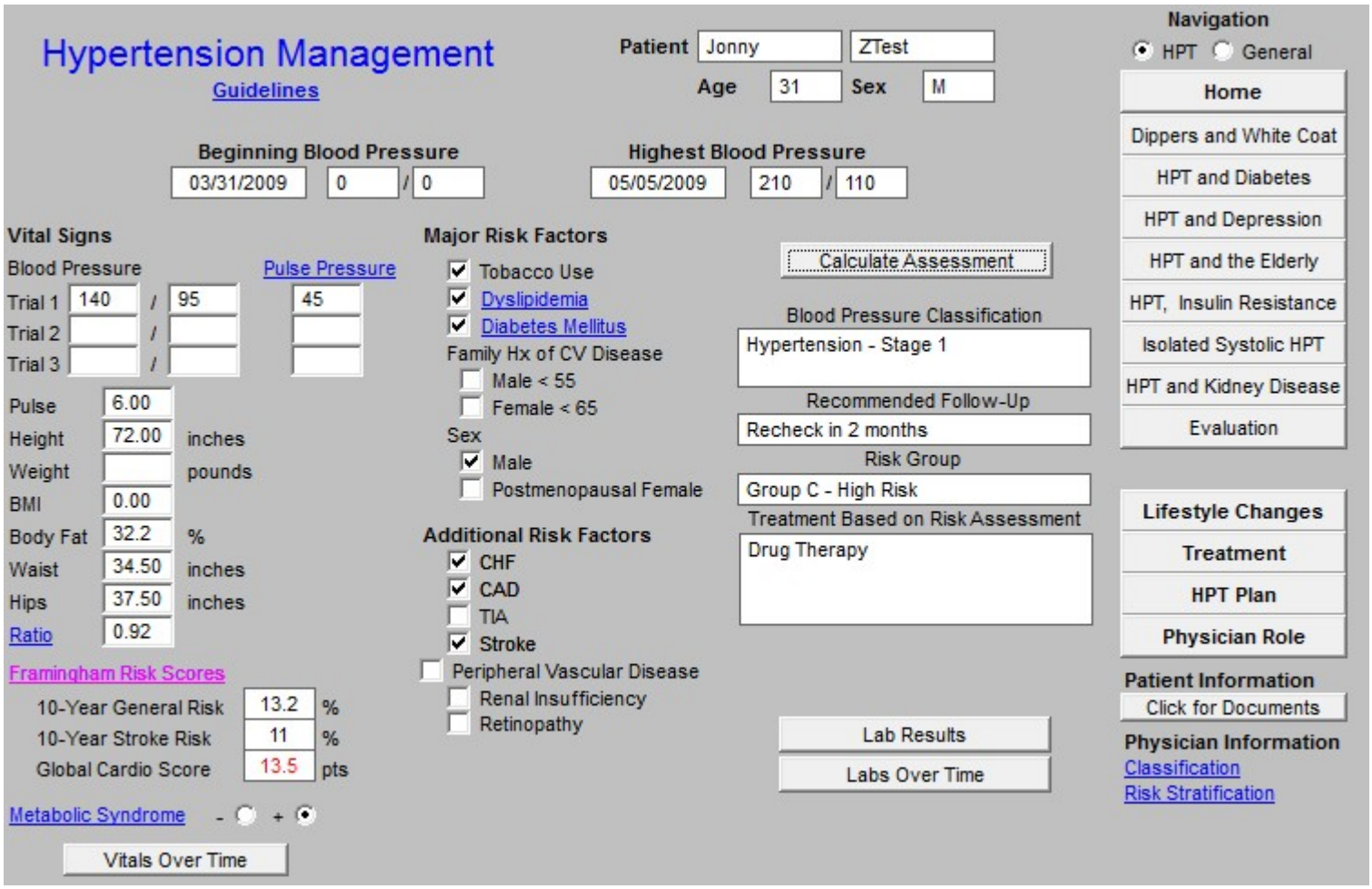
Lipid Audit

E & M Codes: Clinic Only
Encounter Date(s): 01/01/2011 through 12/31/2011

Location	Provider	Frequency of Lipid Profile	Lipids Treatment Plan	Metabolic Syndrome Assessment	Statin Therapy	Lifestyle Changes	Risk Stratification	Medical Nutrition Therapy	Statin Therapy	Hemoglobin A1c	Blood Pressure Control
SETMA 1	Aziz	96.0%	88.3%	51.2%	67.2%	99.9%	22.5%	2.1%	79.9%	57.3%	76.7%
	Duncan	86.9%	96.5%	88.0%	60.9%	99.4%	49.7%	4.0%	77.5%	68.2%	85.9%
	Halbert	100.0%	100.0%	100.0%	--	100.0%	0.0%	0.0%	--	100.0%	--
	Henderson	90.8%	94.5%	84.1%	57.8%	99.9%	40.6%	5.6%	77.5%	66.8%	85.9%
	Murphy	95.3%	95.3%	87.4%	69.0%	99.8%	33.0%	6.7%	81.9%	71.1%	79.5%
	Palang	66.8%	74.2%	87.4%	62.3%	99.3%	12.8%	1.2%	74.9%	43.1%	81.1%
	Thomas	83.6%	94.7%	84.1%	67.1%	99.5%	38.5%	3.8%	79.6%	43.4%	74.8%
SETMA 1 Totals :		89.0%	91.0%	79.0%	63.8%	99.7%	32.6%	4.2%	79.2%	62.8%	81.1%
SETMA 2	Abbas	100.0%	100.0%	100.0%	--	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%
	Anthony	90.5%	95.8%	82.1%	62.0%	100.0%	66.1%	5.8%	79.0%	65.8%	80.2%
	Anwar	95.0%	92.1%	88.6%	65.0%	100.0%	82.2%	3.7%	72.7%	65.2%	88.2%
	Cricchio, A	91.1%	74.9%	51.7%	75.0%	99.9%	1.3%	5.7%	81.8%	29.5%	82.7%
	Cricchio, M	91.7%	96.7%	88.8%	63.1%	100.0%	64.0%	7.0%	81.5%	64.7%	74.8%
	Holly	97.2%	99.0%	96.0%	74.3%	100.0%	95.2%	21.1%	89.0%	72.5%	96.0%
	Leifeste	92.7%	95.4%	90.2%	63.8%	99.7%	85.5%	8.6%	83.7%	72.1%	84.3%
	Murphy	100.0%	100.0%	100.0%	--	100.0%	100.0%	0.0%	--	--	100.0%
	Wheeler	90.8%	96.4%	89.8%	56.1%	99.8%	66.5%	6.6%	71.3%	73.2%	70.5%
SETMA 2 Totals :		92.6%	93.8%	86.0%	63.2%	99.9%	70.4%	6.7%	78.4%	62.6%	81.9%
SETMA West	Curry	91.0%	86.6%	92.2%	51.1%	99.8%	17.7%	20.1%	68.9%	62.0%	74.9%
	Deiparine	84.1%	91.5%	42.1%	55.3%	98.8%	56.3%	2.6%	73.8%	57.9%	65.8%
	Halbert	82.5%	93.2%	74.7%	48.3%	98.6%	62.2%	2.9%	69.5%	63.7%	72.3%
	Horn	85.3%	97.3%	49.4%	54.9%	100.0%	53.1%	5.6%	74.5%	67.9%	96.7%
	Qureshi	80.2%	97.8%	76.7%	53.3%	99.6%	59.0%	6.6%	78.3%	53.5%	87.6%
	Satterwhite	81.1%	91.8%	86.7%	55.9%	98.1%	25.4%	10.5%	74.3%	49.6%	68.5%
	Vardiman	81.0%	94.7%	68.8%	52.2%	99.7%	45.5%	6.6%	72.0%	63.2%	72.1%
SETMA West Totals :		83.6%	93.5%	65.6%	52.5%	99.2%	50.8%	6.2%	72.5%	61.3%	76.9%

The following is the Hypertension Disease management Master Template

This is the link to the full tutorial: http://www.jameslhollymd.com/Tutorial_Hypertension.cfm



The following are the audits and analysis which we perform for hypertension as we look for patterns and points of leverage for improving the care of our patients with hypertension as we see their health improve and for a lower cost.

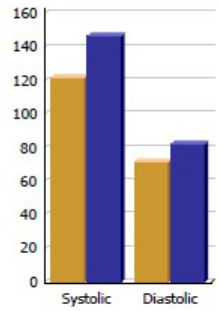
The analytics allow us to compare the patients treated to goal and those who are not to goal in order to discover leverage points for improving the care of all patients. Elements analyzed are frequency of visits, numbers of medication, gender, payer class, ethnicity, age, frequency of testing, etc. In that these analytics are all done electronically, they do not take much time and can be done with increased frequency for increased value. One of the most important elements of analysis is the determining of whether a change was made when a patient is seen who is not to goal. The overcoming of clinical inertia is critical to the improving of patient health or outcomes.

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**

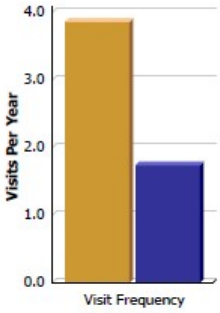
Controlled Group
Selected Group

Average Blood Pressure

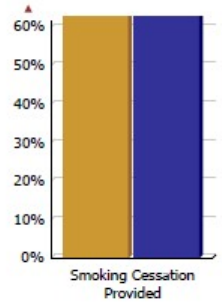


	Systolic
Controlled	122.0
Selected	146.9

	Standard Deviation
	Systolic
Controlled	10.4
Selected	12.6

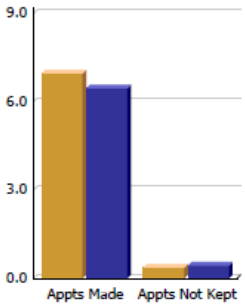


	Visit Frequency
Controlled	3.9
Selected	1.7

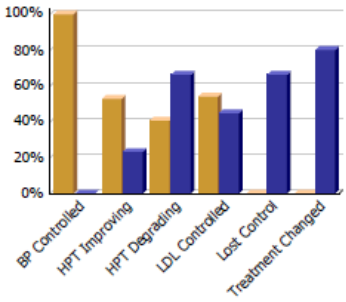


	Smoking Cessation Provided
Controlled	88.5%
Selected	88.2%

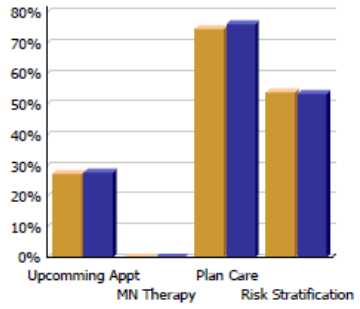
Below, you will see an element entitled "Treatment Changed." In the patients who were not to goal, 80.2% of the time a change was made in the treatment! That is excellent.



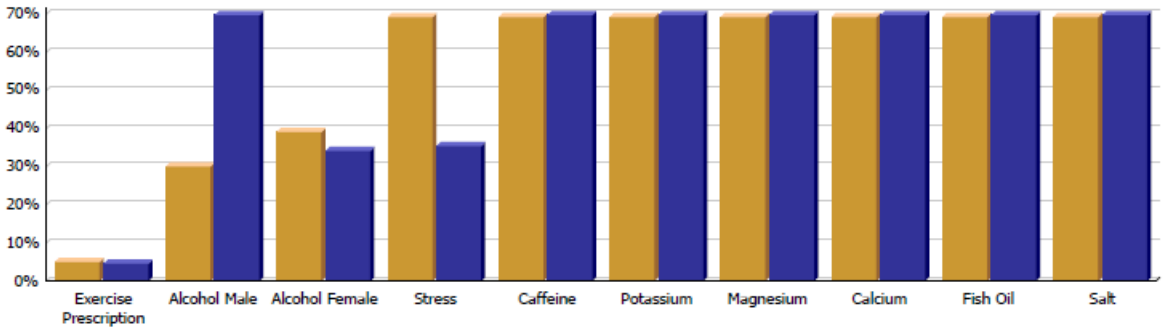
	Appts Made	Appts Not Kept
Controlled	7.0	0.4
Selected	6.4	0.4

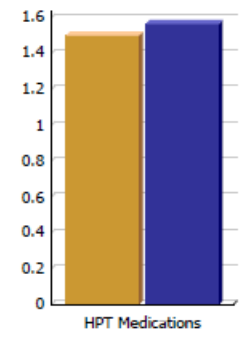


	BP Controlled	HPT Improving	HPT Degrading	LDL Controlled	Lost Control	Treatment Changed
Controlled	100.0%	52.8%	40.8%	54.1%	0.0%	0.0%
Selected	0.0%	23.3%	66.3%	44.9%	66.3%	80.2%



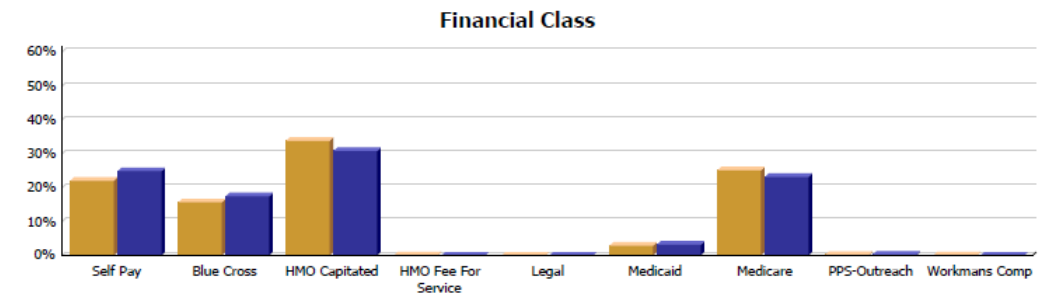
	Upcomming Appt	MN Therapy	Plan Care
Controlled	27.3%	0.0%	74.6%
Selected	27.8%	0.0%	76.1%



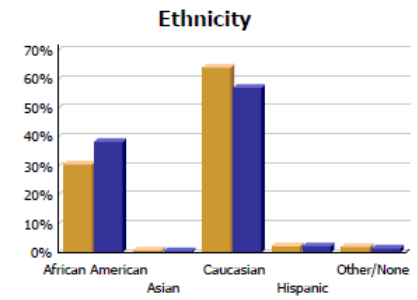


	Exercise Prescription	Alcohol Male	Alcohol Female	Stress	Caffeine	Potassium	Magnesium	Calcium	Fish Oil	Salt	Weight Mgt
Controlled	5.1%	30.1%	39.1%	69.3%	69.3%	69.3%	69.3%	69.3%	69.3%	69.3%	22.1%
Selected	4.6%	69.8%	34.3%	35.5%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	21.3%

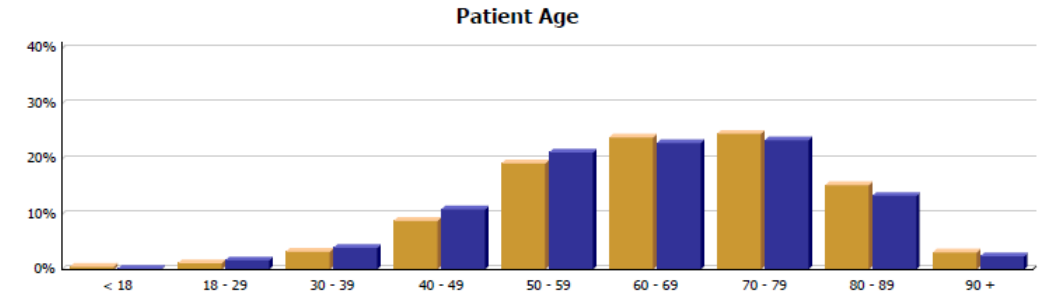
	HPT Medications
Controlled	1.5
Selected	1.6



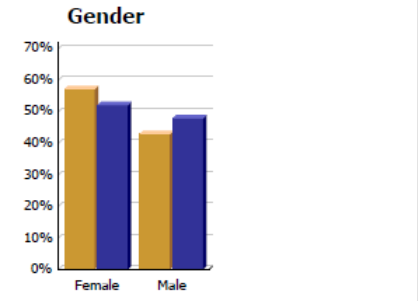
	Self Pay	Blue Cross	HMO Capitated	HMO Fee For Service	Legal	Medicaid	Medicare	PPS-Outreach	Workmans Comp
Controlled	22.1%	15.7%	33.8%	0.0%	0.0%	3.0%	25.1%	0.2%	0.0%
Selected	24.9%	17.5%	30.9%	0.0%	0.0%	3.2%	23.3%	0.3%	0.0%



	African American	Asian	Caucasian	Hispanic	Other/ None
Controlled	30.6%	0.9%	64.1%	2.4%	2.1%
Selected	38.4%	0.6%	57.0%	2.3%	1.6%



	< 18	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90 +
Controlled	0.5%	1.2%	3.2%	8.8%	19.2%	23.9%	24.6%	15.3%	3.1%
Selected	0.1%	1.7%	3.9%	10.9%	21.2%	22.9%	23.4%	13.4%	2.4%



	Female	Male
Controlled	57.1%	42.9%
Selected	52.1%	47.9%

This is the PCPI Quality Metrics SET for hypertension and following that is the audit for hypertension care.

Physician Role in Hypertension Management

- [x] Blood pressure measured at least once this visit
- [ ] Blood pressure measurement repeated if elevated
- [x] Blood pressure classification determined
- [x] Weight reduction discussed/recommended
- [x] Sodium intake discussed/changes recommended
- [x] Alcohol intake discussed/changes recommended
- [x] Exercise discussed/recommended
- [x] Appropriate follow-up scheduled

- [ ] Generate a follow-up document for the patient at least yearly

Date Last Generated 01/09/2012

Physician Role in Hypertension Management

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

Report Criteria: Patients 18 And Older With a Chronic Diagnosis of Hypertension
Specialsits Excluded

Location	Provider	Blood Pressure Measured	Repeat BP (Elevated)	Class Assessed	Weight Reduction Discussed	Sodium Intake Discussed	Alcohol Intake Discussed	Exercise Discussed	Follow-up Scheduled
SETMA 1	Aziz	99.8%	29.3%	31.7%	93.9%	33.4%	24.5%	54.9%	98.7%
	Duncan	99.1%	11.9%	43.6%	92.1%	49.7%	42.8%	91.8%	73.4%
	Henderson	99.8%	76.8%	39.6%	96.1%	52.4%	39.0%	55.9%	66.2%
	Murphy	99.6%	43.3%	46.2%	88.0%	52.1%	46.0%	71.7%	0.5%
	Palang	99.2%	0.3%	34.4%	46.6%	44.7%	35.0%	39.7%	96.5%
	Thomas	99.8%	0.0%	59.8%	67.9%	65.3%	60.9%	35.8%	72.6%
SETMA 1 Totals:		99.5%	32.7%	40.3%	84.1%	47.1%	38.6%	62.6%	61.5%
SETMA 2	Abbas	100.0%	--	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
	Anthony	99.8%	9.4%	47.0%	99.1%	50.0%	42.3%	99.2%	66.5%
	Anwar	99.8%	27.6%	71.4%	83.0%	46.2%	37.6%	98.3%	0.1%
	Colbert	100.0%	--	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%
	Cricchio, A	99.6%	15.0%	2.4%	96.7%	4.0%	2.4%	6.8%	97.9%
	Cricchio, M	99.7%	59.4%	86.6%	98.8%	89.3%	88.0%	97.2%	30.6%
	Deiparine	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
	Holly	100.0%	94.0%	97.5%	99.8%	98.3%	97.5%	99.2%	98.3%
	Leifeste	99.8%	73.9%	83.9%	99.2%	83.6%	81.5%	90.4%	0.0%
	Murphy	100.0%	--	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%
	Wheeler	99.7%	5.2%	84.1%	98.7%	84.0%	81.9%	98.9%	3.8%
SETMA 2 Totals:		99.8%	40.1%	70.5%	94.6%	64.8%	60.4%	90.6%	26.6%
SETMA West	Curry	99.9%	17.4%	19.5%	88.1%	24.1%	15.7%	84.8%	99.7%
	Deiparine	99.9%	20.9%	67.3%	83.5%	65.6%	59.0%	53.2%	99.3%
	Halbert	99.6%	9.5%	31.6%	71.1%	33.7%	29.6%	73.3%	92.6%
	Horn	100.0%	91.6%	36.7%	75.6%	22.3%	16.5%	94.5%	0.2%
	Qureshi	99.8%	46.0%	79.3%	95.8%	82.5%	75.9%	50.2%	98.3%
	Satterwhite	92.6%	11.7%	20.6%	89.0%	22.4%	17.2%	87.9%	86.2%

C. Organizational Measures (e.g., days to 3rd available appointment)

X We collect this type of data routinely and use it for:

X Quality Improvement
X Reporting
X Practice Management
Pay for Performance
Other

Organizational measures which SETMA routinely collects are:

1. **Daily Cash Flow report** – in order to sustain our quality initiatives, we must maintain the fiscal soundness of the practice. The third prong of the Triple Aim is "lower cost," which really addresses the issue of sustainability. SETMA is debt free and maintains careful accounting of our overhead, cash management, over time, timeliness of payments, cash balances and strategic planning which requires financial resources. All of these are measured and reported on daily and quarterly and annually. They are not included in summary because they are confidential, but they are as critical to quality improvement as anything else we do.
2. **Hospital admission and discharge tracking --** SETMA designed the IMRC (Inpatient Medical Record Census) which tracks date of admission and date of when the history and physical examination was completed and date of discharge and date when discharge summary was completed. Nine years ago, we have five different departments trying to keep an accurate hospital census. Now there is a central, electronic one.

Inpatient Medical Record Census Home

Search for Patients

Incomplete | Complete - 6 months only | Complete more than 6 months

Last Name	First Name	DOB	Hospital	Adm Date	Dis Date	Provider	HP Date	DS Date	CBO
[redacted]			005 Baptist	04/27/2012		Leifeste	04/27/2012		
			824 Christus	04/26/2012		Aziz	04/27/2012		
			616 Christus	04/26/2012		Murphy	04/26/2012		
			225 Christus	04/26/2012		Halbert	04/26/2012		
			230 Baptist	04/26/2012		Holly	04/27/2012		
			809 Baptist	04/26/2012		Holly	04/27/2012		
			824 Baptist	04/25/2012		Holly	04/26/2012		
			207 Christus	04/25/2012		Aziz	04/25/2012		
			210 Baptist	04/25/2012		Qureshi	04/25/2012		
			209 Baptist	04/25/2012		Anwar	04/25/2012		
			217 Baptist	04/25/2012		Leifeste	04/26/2012		
			508 Baptist	04/25/2012		Leifeste	04/25/2012		
			408 Baptist	04/25/2012		Holly	04/26/2012		
			412 Baptist	04/25/2012		Holly	04/26/2012		
			814 Baptist	04/25/2012		Holly	04/26/2012		
			218 Baptist	04/25/2012		Qureshi	04/26/2012		
			025 Baptist	04/25/2012		Anwar	04/26/2012		
			712 Baptist	04/25/2012		Holly	04/26/2012		
			327 Baptist	04/25/2012		Holly	04/26/2012		
			025 Baptist	04/25/2012		Deiparine	04/26/2012		
			427 Baptist	04/25/2012		Holly	04/26/2012		
			701 Baptist	04/25/2012		Qureshi	04/26/2012		
			801 Baptist	04/25/2012		Qureshi	04/26/2012		
			018 Christus	04/25/2012		Murphy	04/26/2012		
			225 Christus	04/25/2012		Palang	04/26/2012		
			726 Christus	04/25/2012		Aziz	04/26/2012		
			806 The Medical Center	04/25/2012		Thomas	04/26/2012		
			811 The Medical Center	04/25/2012		Thomas	04/26/2012		
			801 The Medical Center	04/25/2012		Thomas	04/26/2012		
			821 Altus Inpatient Baptist	04/24/2012		Anwar	04/25/2012		
			312 Baptist	04/24/2012		Holly	04/25/2012		
			230 Baptist	04/24/2012		Holly	04/25/2012		

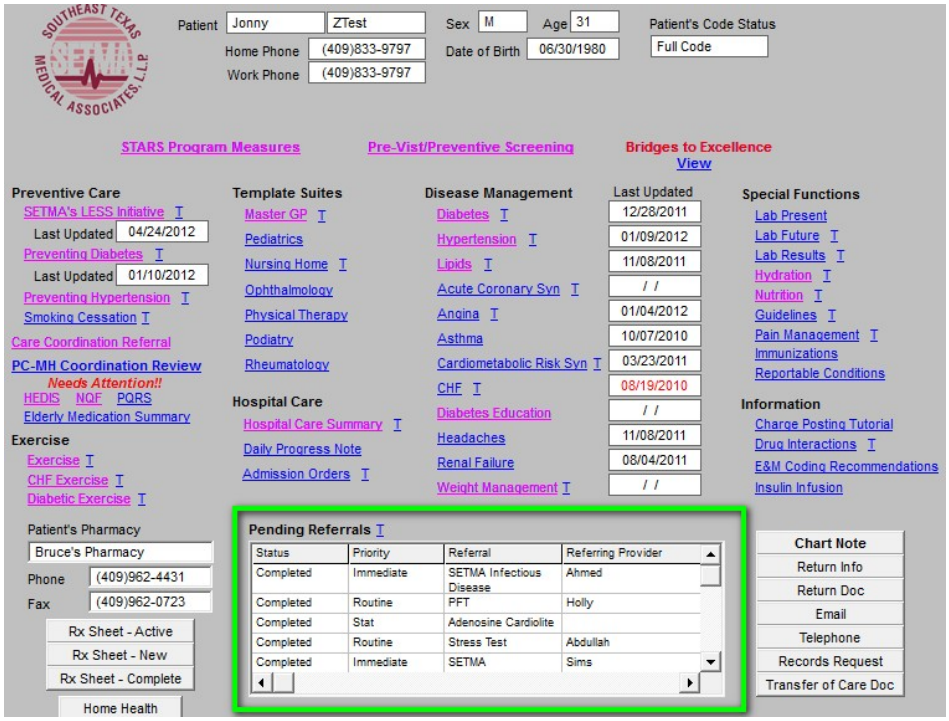
3. **Work Flow completion** – everything we do is electronic. Daily we audit whether providers have completed their work flow where they are alerted to telephone messages, laboratory results, consultations and procedure results.

Provider Workflow Items - Non Telephone

4/25/2012 8:00:06 AM

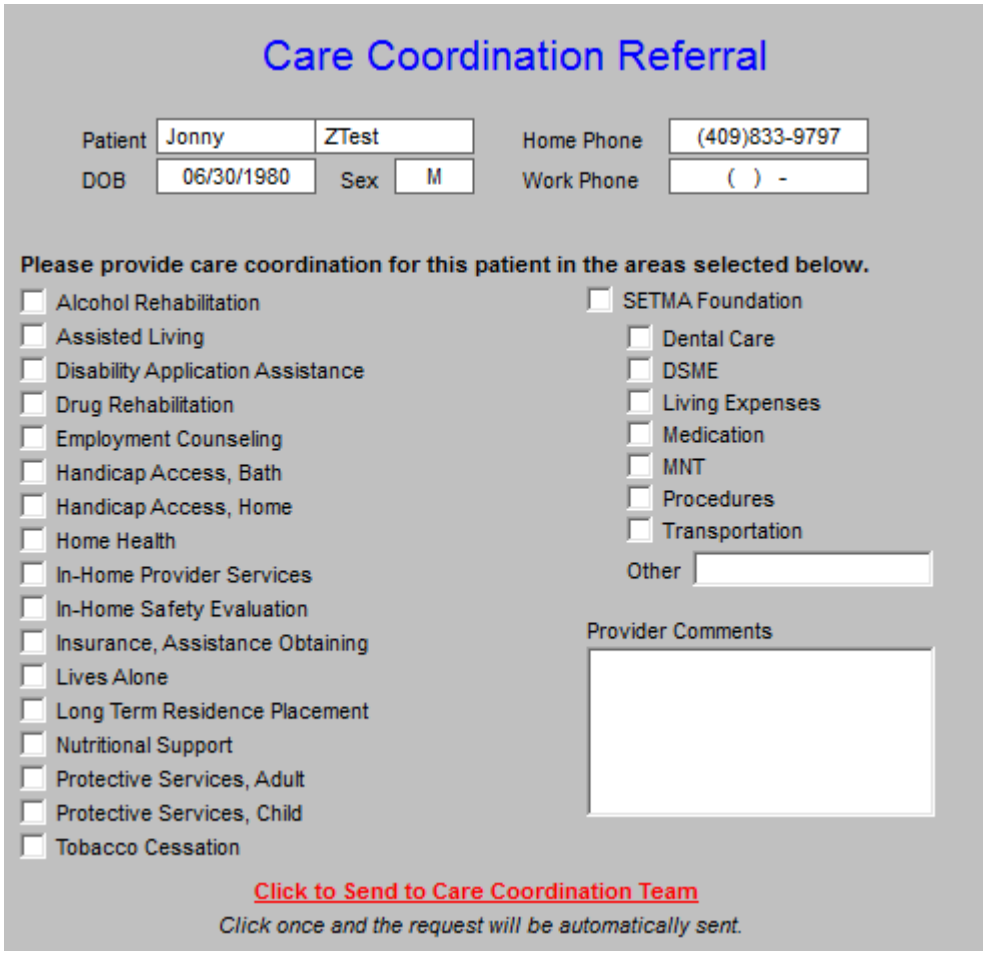
Provider	Total Outstanding Items
Ahmed, J	6
Anthony, S	16
Anwar, S	51
Aziz, M	36
Colbert, B	15
Deiparine, C	1
Duncan, N	5
George, W	1
Halbert, D	6
Holly, J	3
Kusnoor, V	7
Leifeste, A	59
Luviano, D	1
Palang, R	6
Thomas, M	5
Vardiman, J	5
Wheeler, M	16

4. Referral Tracking



SETMA monitors the progress of referrals through the system from their origination, to their approval, to the appointment or procedure being scheduled to the results of the referral request being returned to the order provider.

5. In 2008, SETMA formed a Foundation through which our patients can receive support for needed care. The provider can send a Care Coordination Referral for any of the following causes. They are all processed the day they are received. For each of the last three years, the partners of SETMA have given $500,000 to the foundation. We have seen dramatic changes in patients' lives due to their having access to care they could not otherwise afford. None of the Foundation money can profit SETMA.



6. Number of days until the next appointment is available – Patient experience who requested As Soon As Possible Appointment

- A total of 1919 appointments were made with the type "_Established – ASAP%' from February 15 thru April 15.
- Of the 1919, 990 where scheduled the same day the request was made.
- Of the 1919, 666 were scheduled the next business day (Friday scheduled on Monday) after the request was made.
- Of the 1919, 199 were scheduled within two business days (Friday scheduled on Tuesday) after the request was made.
- Of the 1919, 64 were scheduled within three or more business days (Friday scheduled on Wednesday) after the request was made.

Wait Time in Days

12/19/2011 8:00

	New Patient Spot	Established Patient Spot
Dr. Ahmed	52	52
Mr. Anthony		0
Dr. Anwar	10	10
Dr. Aziz	15	15
Dr. Colbert	0	4
Mr. Cricchio		8
Dr. Curry	9	9
Dr. Deiparine	17	0
Mrs. Duncan		15
Dr. George	1	1
Dr. Halbert	3	3
Mrs. Henderson		15
Dr. Holly	42	42
Mrs. Horn		1
Dr. Kusnoor	0	0
Dr. Leifeste	45	42
Dr. Luviano	0	0
Dr. Murphy	8	8
Dr. Palang	2	1
Dr. Qureshi	1	1
Dr. Spiel	23	37
Dr. Thomas	16	16
Dr. Vardiman	10	8
Mrs. Wheeler		16

Wait Time in Days

4/23/2012 8:00

	New Patient Spot	Established Patient Spot
Dr. Ahmed	44	50
Mr. Anthony		2
Dr. Anwar	7	7
Dr. Aziz	7	7
Ms. Cash		0
Dr. Colbert	1	1
Dr. Curry	70	70
Mr. Davis		0
Ms. Darden		0
Dr. Deiparine	14	2
Mrs. Duncan		0
Dr. George	1	1
Dr. Halbert	2	3
Mrs. Henderson		0
Dr. Holly	30	79
Mrs. Horn		0
Dr. Kumar	36	0
Dr. Kusnoor	1	1
Dr. Leifeste	42	43
Dr. Luviano	2	1
Dr. Murphy	9	10
Dr. Palang	7	1
Dr. Qureshi	2	1
Mr. Read		0
Dr. Shepherd	0	0
Dr. Spiel	23	30
Dr. Thomas	1	1
Dr. Vardiman	16	14
Mrs. Wheeler		9

7. How many patients received their ***Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan*** (previously called "***Discharge Summary***") at the time of leaving the hospital?

    - For 2011, 97.7% of all discharges had documentation completed at the time of discharge.
    - For the past 39 months, SETMA has discharged 12, 236 patients from the hospital, 99.1% of the time, the patient, family and/or care giver has received the Hospital Summary at the time of discharge.

    The receiving of this document is one of the most critical steps in our "reducing preventable readmissions" quality improvement initiative.

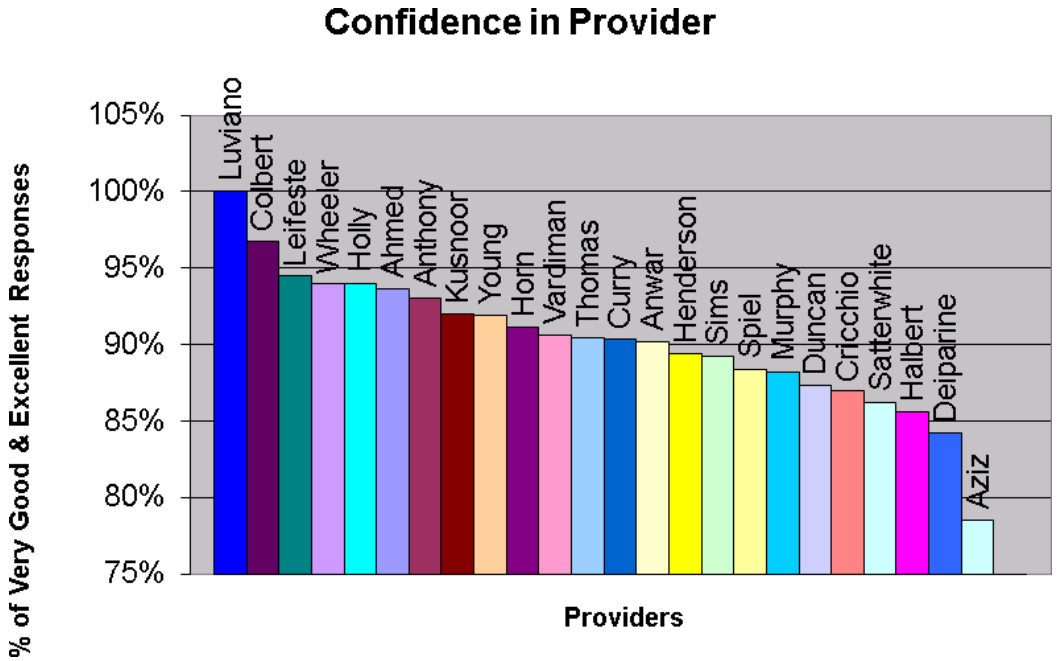
    This same document is completed for patients seen in the emergency department and discharged without having been admitted to inpatient status.

D. Patient Experience Measures (e.g., % reporting doctor explained things clearly)

X We collect this type of data routinely and use it for:

X Quality Improvement
X Reporting
X Practice Management
Pay for Performance
Other

	Total	Poor	Fair	Average	Good	Very Good	Excellent	Comments
1. Call answered quickly?	100%	0%	1%	2%	10%	33%	54%	57.56% Pt. Response
2. Was it easy to obtain an appointment??	100%	1%	1%	2%	9%	32%	55%	
3. Was the front office (check-in) helpful in answering questions and resolving problems?	100%	0%	0%	1%	8%	31%	59%	
4. After check-in, was your wait time appropriate?	100%	0%	1%	2%	10%	31%	56%	
5. Was the nursing staff helpful in answering questions?	100%	0%	0%	1%	8%	32%	59%	
6. Do you feel comfortable following the insrtuctions you received for self care?	100%	0%	0%	2%	9%	31%	57%	
7. Was your call returned in a prompt manner by the nursing staff?	100%	0%	1%	1%	8%	29%	60%	
8. What is your confidence level in your provider?	100%	0%	1%	2%	9%	30%	58%	
9. Your overall opinion of our clinic.	100%	0%	0%	1%	6%	29%	64%	



SETMA is studying the Consumer Assessment of Healthcare Providers and Systems (CAPHS) program to see if we can adopt it to improve our patient satisfaction analysis.

The following are the minutes from the April, 2011 QIO Committee meeting about patient satisfaction results.

The past survey results were analyzed comparing fourth quarter 2008, 2009, and 2010. The most recent 4th quarter data showed a decline from 4th quarter 2009 where results were at their peak. Each clinical coordinator received the data and reviewed this data with the Director of Operations. Provider data was sent individually to each of them for their review. Clinical Coordinators were instructed to share the results with staff and brainstorm ideas and ways to improve results. SII typically has the best scores. The Mark A Wilson SETMA West (MWSW) clinic will rearrange the clinic responsibilities for the desk clerks. SI has recently moved clerks to different pods. This occurred during the 4th quarter of 2010. Staff have adjusted to the transition and are settled now in new positions and time will show if this move was beneficial to patient satisfaction.

The survey results were compared to first quarter 2010 and 4th quarter aggregate 2010. Survey results overall have declined however SI has shown the most dramatic decline. In the two specific areas – speed of nursing staff returning calls and confidence in provider SII maintained above 50% in each of these categories. There was slight improvement in returning calls to 57% and a slight drop in physician confidence to 67%. MWSW did not see improvement with phone calls however the desk clerk change has not taken place. The score for this is 33%. The physician confidence is above the target and did improve to 67%. SI dropped significantly in returning calls to 29% and the physician confidence also dropped to 35%.

MWSW supervisor, by May 2, 2011 follow through and rearrange unit clerks to have an extra devoted to walk in patients and assisting with patient calls in addition to the 5 clerks assigned to providers. This has been done through staff cross training and required no additional hire at this time.

SI supervisor, by April 29, 2011 will meet individually with each staff member and provider to discuss scores and brainstorm ideas for improvement. Director of Operations will discuss weekly with supervisor progress made and initiatives started to monitor progress. Supervisor will seek patient feedback by specifically setting time on Wednesdays to meet with random patients from each pod to ask about their care, response to phone calls etc. Also when the next survey is done, depending on staffing availability, attempt to have non SETMA I employee offer to assist patients with reading and understanding questions as many of the clientele at SI are elderly and may need assistance with seeing the survey questions.

The committee met and recommended having 6 – 10 random friends/family call the main SETMA number to see if there are identified issues with satisfaction related to appointment staff. The callers will complete a survey about each call. They will be looking to see if the staff identified themselves, if they were asked if the call was related to a medical question or an appointment and their overall impression of the call. The survey will be ready for use by Monday May 2 and the identified callers will receive general instructions to use in order to prevent an actual appointment from being made but that can still capture the information needed. Calls will be made Monday and Wednesdays between 8 and 9 am and then either Tuesday or Thursday in the afternoons. Each caller will be asked to make 3 calls on different days. Results will be analyzed and taken back to the subcommittee for recommendations.

E. Staff Satisfaction Measures (e.g., % burnt out)

X We collect this type of data routinely and use it for:

X Quality Improvement
X Reporting
X Practice Management
Pay for Performance
Other

Because turnover is a measure of employee satisfaction, SETMA yearly evaluates the turnover rate for our organization. Since 2007 we have seen significant decrease in turnover. The Human Resource department is responsible for ensuring an employee friendly atmosphere. There have been several initiatives over these years that recognize and reward the employees. These efforts have paid off as evidenced by the turnover, see results below.

Department	# FTE's authorized	#FTE's filled as of 12/31/11	# resigned	# termed	2011 Year end turnover	2010 year end turn over	2009 year end turnover	2008 year end turnover	2007 yr end turnover	2006 yr end turn over
SETMA Wide	225.5	221	14	5	9%	7%	17%	13%	42%	39%

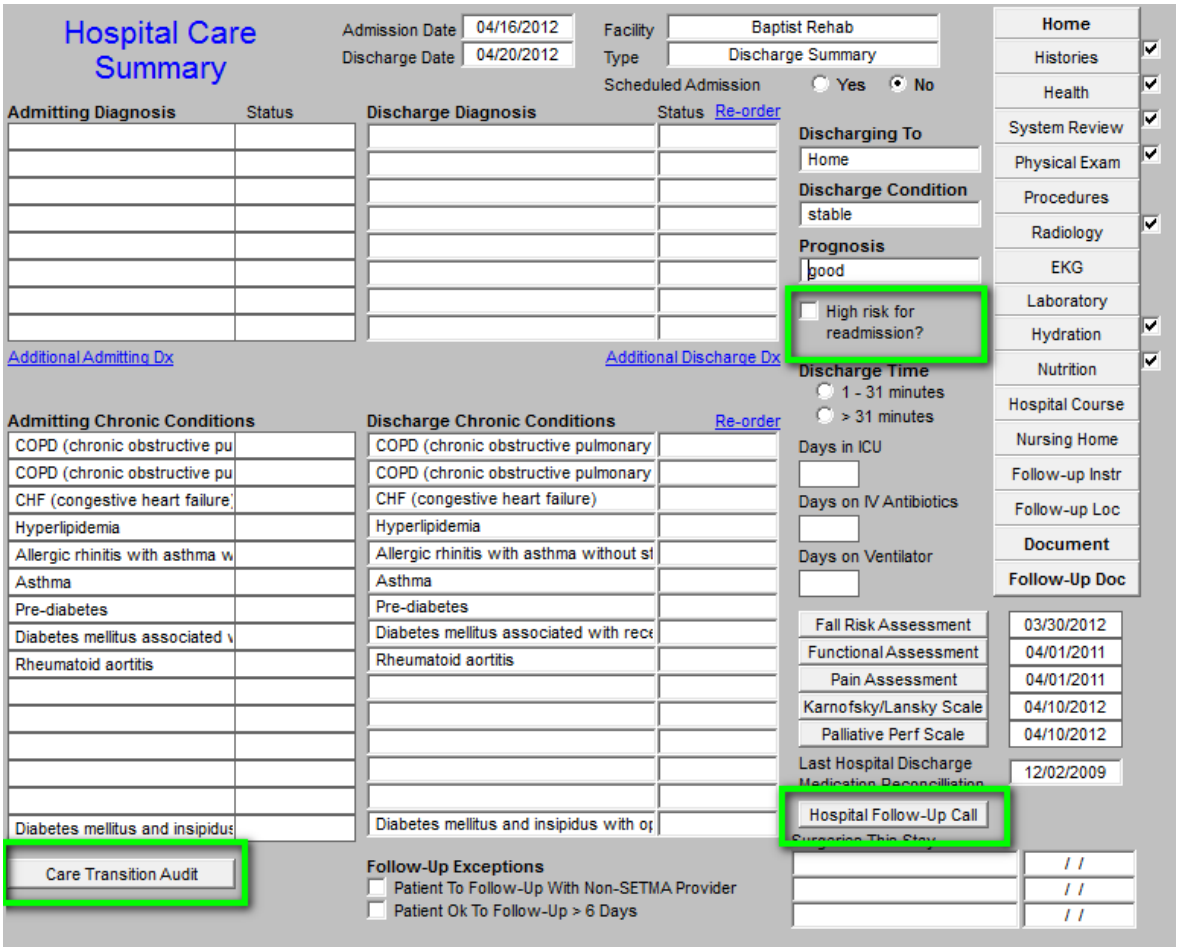
SETMA also does employee focus groups where random employees are chosen to participate. With these focus groups the employees are able to bring up issues they would like to see changed within the organization. The last of our focus groups revealed a very small amount of issues to discuss.

Addendum A
SETMA's Major Initiative to Reduce Preventable Readmissions

The following is a description of the tools, of the audits and the analytics associated with SETMA's major quality improvement initiative to decrease the preventable readmissions. Our program is working as one hospital reported that our 30-day readmission rate at their hospital had dropped to 7.6% for all admissions.

The first step in this process is the completion at the time the patient leaves the hospital of a summary of their hospital stay and of their instructions and schedule for the transition to the ambulatory setting or to other points of care. The following is a link to the tutorial which explains all of our preparation of this document.

http://www.jameslhollymd.com/Tutorial_Discharge_Summary.cfm



The summary of the hospital stay is completed with a suite of templates. As is show in the green outline above, the keys to the Hospital Care Summary and the Post Hospital Plan of Care and Treatment Plan are:

1. Designation of the patient as high risk for re-admission or not. If they are high risk a series of interventions are initiated which are discussed below.
2. Hospital follow-up call is schedule which occurs on day after discharge and is a 12-30 care coaching at which time a third medication reconciliation is done. The first is done at admission, the second at the time the patient leaves the hospital and the third during the care-coaching call. A fourth reconciliation is done at the follow-up clinic visit.
3. PCPI Care Transitions audit is performed.

Nothing is more is more important to the process of successfully decreasing preventable admissions than is an effective Care Transition process. In SETMA's Model of Care -- Care Transition involves:

1. Evaluation at admission -- transition issues: "lives alone," barriers, DME, residential care, or other needs
2. Fulfillment of PCPI Transitions of Care Quality Metric Set
3. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan
4. Post Hospital Follow-up Coaching -- a 12-30 minute call made by members of SETMA's Care Coordination Department and additional support
5. Follow-up visit with primary provider

Focus in care coordination by the NPP are the links between:

- **Care Transitions -** …continually strive to improve care by … considering feedback from all patients and their families… regarding coordination of their care during transitions between healthcare systems and services, and…communities.
- **Preventable Readmissions -** …work collaboratively with patients to reduce preventable 30-day readmission rates.
- Once the **Care Transition** issues are completed, The **Hospital Care-Summary-and-Post- Hospital-Plan-of Care-and Treatment-Plan** document is generated and printed. It is given to the patient and/or to the patient's family and to the hospital.

The following is a link to my presentation on SETMA's 14-year history of developing the tools and capacities to do effective Care transitions. It is entitled, *Care Transitions: The Heart of Patient-Centered Medical Home*.

http://www.jameslhollymd.com/Care-Transitions-The-Heart-of-Patient-Centered-Medical-Home.cfm

The following are examples of SETMA's Care Transitions audit:

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2011 through 12/31/2011

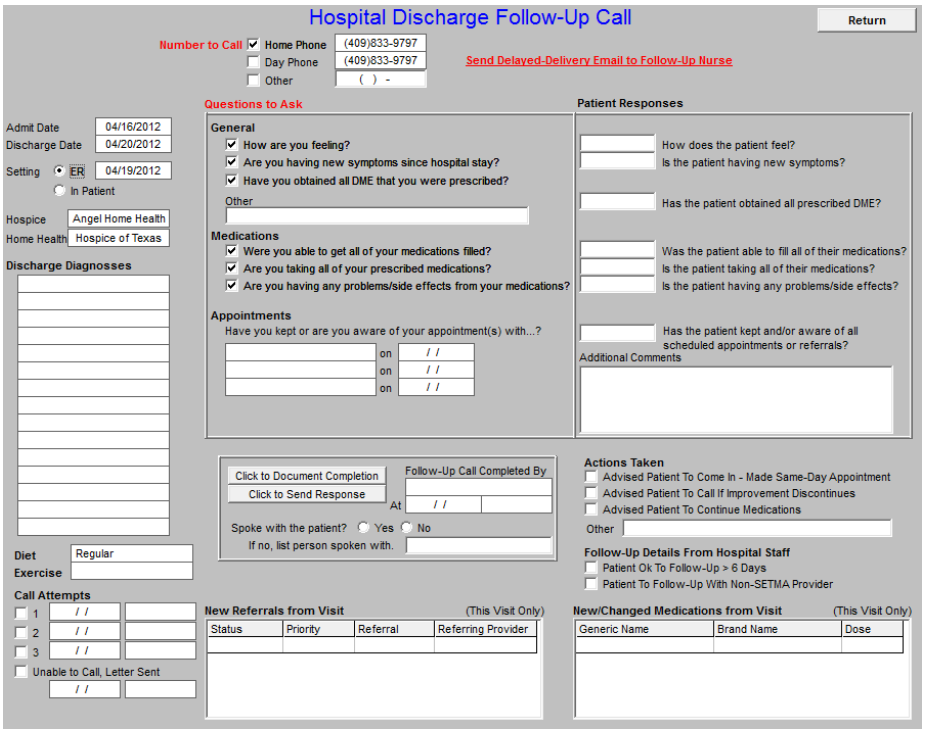
Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	98.3%	99.5%	90.8%	94.3%	94.8%	98.1%	97.4%	94.3%	97.9%
Aziz	99.0%	99.9%	97.1%	97.5%	97.0%	98.7%	97.8%	98.0%	96.8%
Curry	98.6%	100.0%	98.0%	98.0%	98.0%	98.6%	96.6%	95.2%	98.6%
Deiparine	97.9%	99.9%	96.1%	98.0%	98.2%	97.7%	97.7%	97.2%	98.3%
Halbert	100.0%	99.6%	98.7%	97.4%	97.0%	100.0%	97.4%	98.3%	98.3%
Holly	96.5%	99.6%	91.8%	94.7%	94.7%	94.2%	93.9%	92.1%	96.5%
Leifeste	98.1%	99.7%	94.9%	96.9%	96.9%	97.4%	96.5%	96.0%	97.4%
Murphy	98.4%	100.0%	96.7%	96.3%	96.3%	98.0%	96.7%	97.6%	97.2%
Palang	99.0%	100.0%	98.1%	98.1%	97.1%	99.0%	97.6%	98.1%	97.1%
Qureshi	96.9%	99.7%	92.4%	96.2%	97.1%	96.4%	96.4%	95.2%	96.6%
Satterwhite	97.4%	99.1%	97.4%	93.2%	94.9%	97.4%	94.0%	94.0%	95.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.7%	99.8%	89.7%	93.7%	93.2%	97.9%	95.3%	93.2%	97.4%
Vardiman	98.0%	100.0%	95.1%	97.1%	99.0%	98.0%	98.0%	98.0%	97.1%
SETMA Totals :	98.0%	99.8%	94.5%	96.4%	96.4%	97.5%	96.6%	95.8%	97.3%

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2011 through 12/31/2011

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	90.1%	98.3%	95.0%	94.8%	88.4%	88.2%	88.2%	88.2%	88.2%
Aziz	95.6%	98.7%	97.2%	97.8%	84.0%	94.6%	94.6%	94.5%	93.3%
Curry	93.2%	99.3%	98.0%	98.0%	85.0%	93.2%	93.2%	93.2%	93.2%
Deiparine	94.6%	98.0%	98.5%	98.2%	92.3%	92.2%	92.2%	92.1%	92.2%
Halbert	96.6%	99.6%	97.8%	98.7%	84.1%	94.8%	94.8%	94.8%	94.8%
Holly	89.7%	96.3%	95.3%	95.6%	88.4%	87.0%	87.2%	87.2%	87.2%
Leifeste	93.4%	97.8%	98.0%	96.5%	91.4%	91.4%	91.4%	91.4%	91.2%
Murphy	96.3%	98.0%	97.6%	99.2%	85.0%	94.7%	94.7%	94.7%	94.3%
Palang	95.2%	99.0%	97.1%	98.6%	91.4%	96.2%	95.7%	95.7%	95.7%
Qureshi	90.0%	96.9%	97.4%	96.6%	88.3%	89.0%	89.0%	88.6%	88.8%
Satterwhite	95.7%	97.4%	94.9%	97.4%	77.8%	82.9%	83.8%	83.8%	82.9%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	89.2%	97.4%	94.4%	92.3%	88.5%	86.2%	86.2%	86.2%	85.9%
Vardiman	94.1%	97.1%	99.0%	96.1%	92.2%	89.2%	90.2%	90.2%	90.2%
SETMA Totals :	92.9%	97.9%	97.0%	96.7%	88.3%	90.8%	90.9%	90.8%	90.6%

The second most important part of Care Transitions is the scheduling of the hospital follow-up, care-coaching call. The following is the follow-up call scheduling template.



The following BI analytics are done on all patients who leave the hospital. They contrast patients who are readmitted and those who are not looking for leverage points for decreasing readmissions. Thus far, we have found only two variables that really predict readmission probability:

1. Did the patient receive their care coaching call.
2. Were they seen in the clinic in follow-up within three days if they are high risk and within six days if they are not.

Hospital Discharge Analysis

Section I - Admissions and Follow-ups

Prompt Selections		
	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	680	3225

	Selection Group 1	Selection Group 2
Readmission		
Average Days:	11.79	
Mode:	1.00	
Previous Hospitilization		
Average Days:	9.39	10.24
Mode:	2.00	2.00
Follow-up (Clinic Visit)		
Average Days:	6.81	19.11
Follow-up Visit (%):	37.94%	68.40%
Follow-up (Call)		
Call Completed (%):	74.56%	77.55%
Unable to Complete (%):	6.47%	6.91%

Hospital Discharge Analysis

Section II - Patient Measures

Prompt Selections		
	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	680	3225

	Selection Group 1	Selection Group 2
Ancillary Services		
Hospice:	1.62%	1.36%
Home Health:	4.26%	2.82%
Physical Therapy:	0.15%	0.25%
Case Management:	0.00%	0.00%
Assisted Living:	0.44%	0.37%
Nursing Home:	21.32%	16.25%
Living Alone		
Patient Lives Alone:	1.62%	2.39%
Barriers to Care		
Financial Barriers:	5.59%	4.90%
Social Barriers:	5.29%	6.54%
Assistive Device:	12.94%	9.02%
Habits		
Tobacco Use:	21.32%	23.47%
Alcohol Use:	10.15%	12.25%
Illicit Drug Use:	2.50%	1.64%
Disease - Not in Compliance		
Diabetic:	40.95%	39.20%
Hyperlipidemia:	23.78%	28.40%
Hypertension:	22.49%	23.56%
CHF:	89.45%	88.51%
Care Transition Audit		
Transition Audit Completed:	94.85%	94.17%

Hospital Discharge Analysis

Section III - Patient BMI and Changes Made

Prompt Selections		
	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	680	3225

	Selection Group 1	Selection Group 2
Body Mass Index		
Less than 18.5:	6.03%	6.82%
Between 18.5 and 25:	24.56%	23.94%
Between 25 and 30:	28.09%	25.27%
Between 30 and 35:	15.59%	18.05%
Between 35 and 40:	9.41%	8.19%
Greater than 40:	7.79%	8.65%

Hospital Discharge Analysis

Section IV - Readmission Diagnoses

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	680	3225

Selection Group 1

Top 5 Principle Diagnoses of Readmission

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	78097	Altered Mental Status
4	486	Pneumonia organism NOS
5	5789	Hem gi tract

Top 5 Supporting Diagnoses of Readmission

Rank	Readmission Diagnoses	Description
1	4011	Essential hypertension benig
2	4019	Essential hypertension unsp
3	496	Chronic airway obstruction NEC
4	2859	Anemia unsp
5	25040	Diab mellitus ren manif typ II

Selection Group 2

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	7802	Gen symp syncope/collapse
4	78097	Altered Mental Status
5	2859	Anemia unsp

Rank	Readmission Diagnoses	Description
1	4019	Essential hypertension unsp
2	4011	Essential hypertension benig
3	25040	Diab mellitus ren manif typ II
4	2859	Anemia unsp
5	496	Chronic airway obstruction NEC

By analyzing the above data, it is possible to find leverage points for decreasing readmission.

The Hospital Care Summary and the Post Hospital Plan of Care and Treatment Plan document along with a personal explanation of the tool is the method by which responsibility for the patient's care is transferred from the provider and the inpatient to the patient and the ambulatory setting. We call that tool The Baton.

The Baton – the transition of care tool

"The Baton" is a pictorial representation of the patient's "plan of care and the treatment plan," which is the instrument through which responsibility for a patient's health care is transferred to the patient. Framed copies hang in all pubic places throughout SETMA's clinics. A poster copy hangs in every examination room. The poster declares:

Firmly in the providers 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 the following seven key principles:

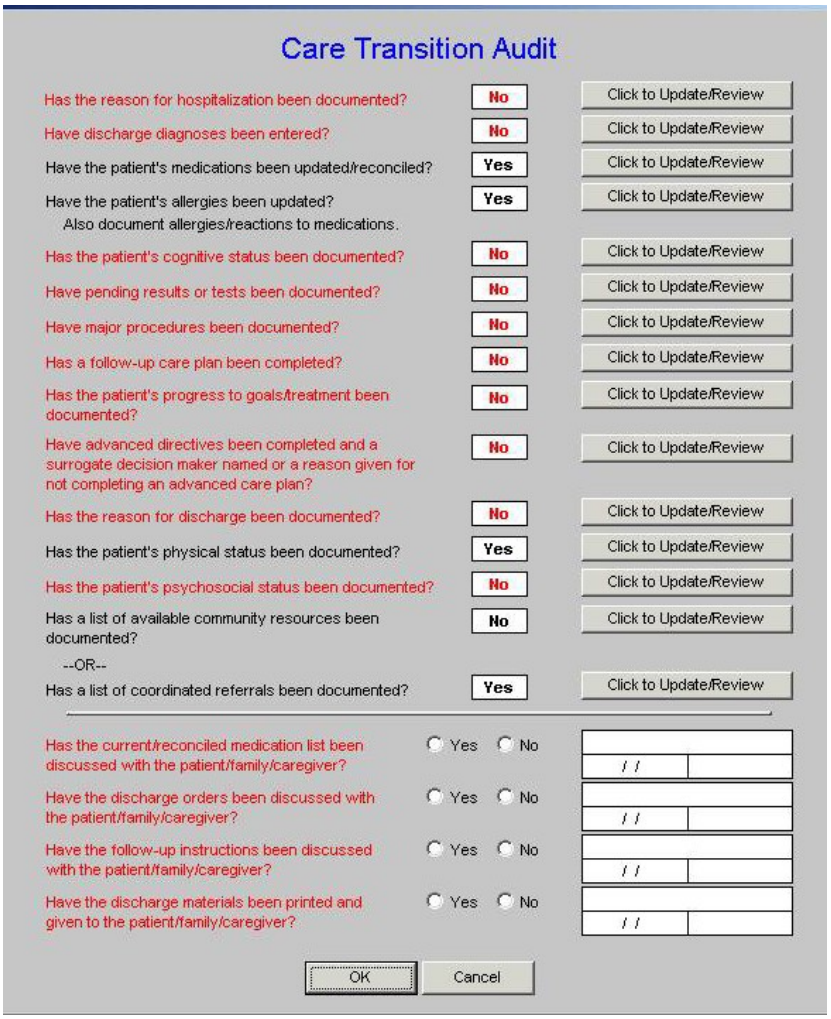
1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan – the "baton" – is that it 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. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That 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.

It must be remembered that when a patient leaves the hospital, until they are seen in the office or home, the provider team member who is in charge of the patient's care is the patient or a family member. Therefore the baton must be successfully passed to the patient, if the coordination, integration, and continuity of care are to be maintained.

The Analytics

To successfully achieve and sustain reductions in readmissions, healthcare organizations must track, audit, and analyze the data.

Care Transition - in June, 2009 the AMA released the "PCPI Care Transitions measurement set". This transition audit is one of the tools used to "build" the "baton" and then to make sure that the complete "baton" has been transferred to the next team member.



Preventing Readmissions: Lessons to Date

What we have learned so far about decreasing readmission rates is:

- **The disease-management model-of-care will not solve this problem**. Healthcare providers can't see patients often enough, give them enough medications, or do enough procedures on them, to effectively reduce readmissions and/or to sustain any reductions which are achieved.
- **Care, even within the same organization or system, is still too fragmented to effectively achieve reductions in readmissions**. Team building and learning how to effectively use teams are key to this process. SETMA's current, active effort is to create a "team spirit and collaboration" between four SETMA departments which are working extraordinarily well individually but which are experiencing barriers to a full, integrated, team approach between departments.
- **Analytics will be an important part of discovering leverage points for the improving of readmission rates**. SETMA has deployed Business Intelligence analytics for that purpose. Because health deteriorates, and on an individual basis and on organizational level, methods must change to respond to that deterioration; it is imperative to continue to redesign the readmissions-reduction effort to keep pace with new realities.

- **There is no "silver bullet" for solving the problem of readmissions**. A multi-pronged effort will gradually improve readmission rates, until it is suddenly apparent that the system is working. Research will be required to determine the percentage contribution of each element to the success of the effort.

Readmissions rates will always be a challenge. They can be managed effectively with a system such as the one used at SETMA. More details on this system are available at www.jameslhollymd.com under *Your Life Your Health* by accessing the icons entitled *Care Transitions* and *Care Coordination* Here are additional lessons we have learned in this process.

1. The problem of readmissions will not be solved by more care: more medicines, more tests, more visits, etc.
2. The problem will be solved by redirecting the patient's attention for a safety net away from the emergency department.
3. The problem will be solved by our having more proactive contact with the patient.
4. The problem will be solved by more contact with the patient and/or care giver in the home: home health, social worker, provider house calls.
5. The problem will be solved by the patient and/or care giver having more contact electronically (telephone, e-mail, web portal, cell phone) with the patient giving immediate if not instantaneous access.

Readmission rate will be reduced with a Seamless Collaboration Between these members of SETMA's healthcare team:

- Hospital Care Team
- Care Coordination Department
- I-Care (Nursing Home) Team
- Healthcare Providers
- Clinic Staff
- Hospital In-Patient Staff

SETMA's most recent development in this quality initiative is that when a person is identified as a high risk for readmission, SETMA's Department of Care Coordination is alerted. The following ten steps are then instituted:

1. ***Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan*** is given to patient, care giver or family member.
2. The post hospital, care coaching call, which is done the day after discharge, goes to the top of the queue for the call – made the day after discharge by SETMA's Care Coordination Department. It is a 12-30 minute call.
3. Medication reconciliation is done at the time of discharge, is repeated in the care coordination call the day after discharge and is repeated at the follow-up visit in the clinic.
4. MSW makes a home visit for need evaluation, including barriers and social needs for those who are socially isolated.
5. A clinic follow-up visit within three days for those at high risk for readmission.
6. A second care coordination call in four days.
7. Plan of care and treatment plan discussed with patient, family and/or care giver at EVERY visit and a written copy with the patient's reconciled medication list, follow-up instructions, state of health, and how to access further care needs.
8. MSW documents barriers to care and care coordination department designs a solution for each.
9. The patient's end of life choices and code status are discussed and when appropriate hospice is recommended.
10. Referral to disease management is done when appropriate, along with tetehealth monitoring measures.

Currently, SETMA's determination of whether patients are high risk for readmissions is intuitively determined, i.e., at discharged based on experience and judgment, a patient is designated as potentially high risk for readmission. SETMA is designing a "predictive model" for identifying patients at high risk for readmissions and instituting the above plan for interdicting a readmission. This is an attempt to quantify the most effective opportunities for decreasing preventable readmissions.

There is a significant body of science associated with "**predictive modeling**." It is clear that tradition models of care delivery will not "work" in a sustainable program for decreasing readmissions. Traditional disease management will not result in changing the patterns of care. In a January/February, 2012 *Professional Care Management* Journal article, the following abstract addressed changes needed to affect a decrease in preventable readmissions: