Medical Home 2010
A New Day in Healthcare for You and for Us
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A New Day in Healthcare for You and for Us Part I – NextMD By James L. Holly, MD
Your Life Your Health
The Examiner
July 29, 2010

Over the next few months, SETMA will be deploying a number of new functions for the benefit of our patients and of the Southeast Texas community. You will be hearing more about:

1. SETMA's recognition by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home. At present only 3/10ths of 1 percent (0.3%) of practices in America are so designated and as of March, 2010, there was only one other in Texas.
2. SETMA's submission of an application for NCQA's Diabetes Recognition award. SETMA's performance data, which is published on our website, shows that all three of SETMA's clinics meet the high standards for the care of diabetes required for this designation.
3. SETMA's becoming an affiliate of Joslin Diabetes Center at Harvard University. The designation will officially be "Joslin Diabetes Center affiliate at Southeast Texas Medical Associates, LLP." SETMA is the first primary care/multi-specialty practice in the United States to be so designated. A ribbon cutting to officially announce this will be held in September.
4. SETMA's results from the Accreditation Association for Ambulatory Health Care (AAAHC) survey in August, 2010, for SETMA being a Patient-Centered Medical Home. To our knowledge, SETMA will be the first to seek patient-centered medical home review from both NCQA and AAAHC.

In addition, you will be hearing about:

- The Center for Medicare and Medicaid Services" (CMS) publication of its 865-page Final Rule for "**Meaningful Use of Certified Electronic Health Records Technology**." Over the next few years, practices will be rewarded for adopting electronic patient records.(EMR). Starting in 2015 practices which do not, will be penalized. There are 24 functions required for a practice to demonstrate "Stage I Meaningful Use" of an EMR. SETMA does all 24.
- CMS' new **preventive health initiatives** where Medicare will catch up with Medicare Advantage and begin paying for preventive health care which they have previously expected but refused to pay. SETMA already provides these services but will expand our scope in order to meet the standards established in CMS's 1250-page proposal for 2011 changes in Medicare and Medicaid.
- **Phytel** which is a function by which SETMA will be able to communicate extensively with our patients about their healthcare needs with opportunities for them to improve their health.
- The **Physician Quality Reporting Initiative** (PQRI) which has been voluntary from 2007 to 2014, but starting in 2015 will be mandatory. Healthcare providers who do not

report quality performance standards by 2015 will have their reimbursements decreased. SETMA has participated in PQRI for the past two years and currently reports on more than 200 quality standards.

- **NextMD** which is a secure web portal through which SETMA's patients can communicate with their heath care provider, complete portions of their own medical record, request appointments and medication refills, see their laboratory results, maintain their own "personal health record," and participate in self-guided health education programs.
- **CHS** (Community Health Services) which is NextGen's community health solution whereby the entire medical community can communicate and share health data through a secure connection. While SETMA is making this available, SETMA will not own the function and SETMA will not own the data. Any and all healthcare entities hospitals, physicians, clinics. County and other health departments and offices can participate and share health information in a HIPPA-compliant and secure environment. This will be a not-for-profit means of improving the quality of healthcare available to all of our community.

Piece by piece, I want to introduce these subjects and also to alert any of our healthcare colleagues who are unaware of the challenges which we will all face in the next five years.

Using NextMD

NextMD requires that SETMA enroll you. There is no cost to the patient for using NextMD. There are two requirements for enrollment:

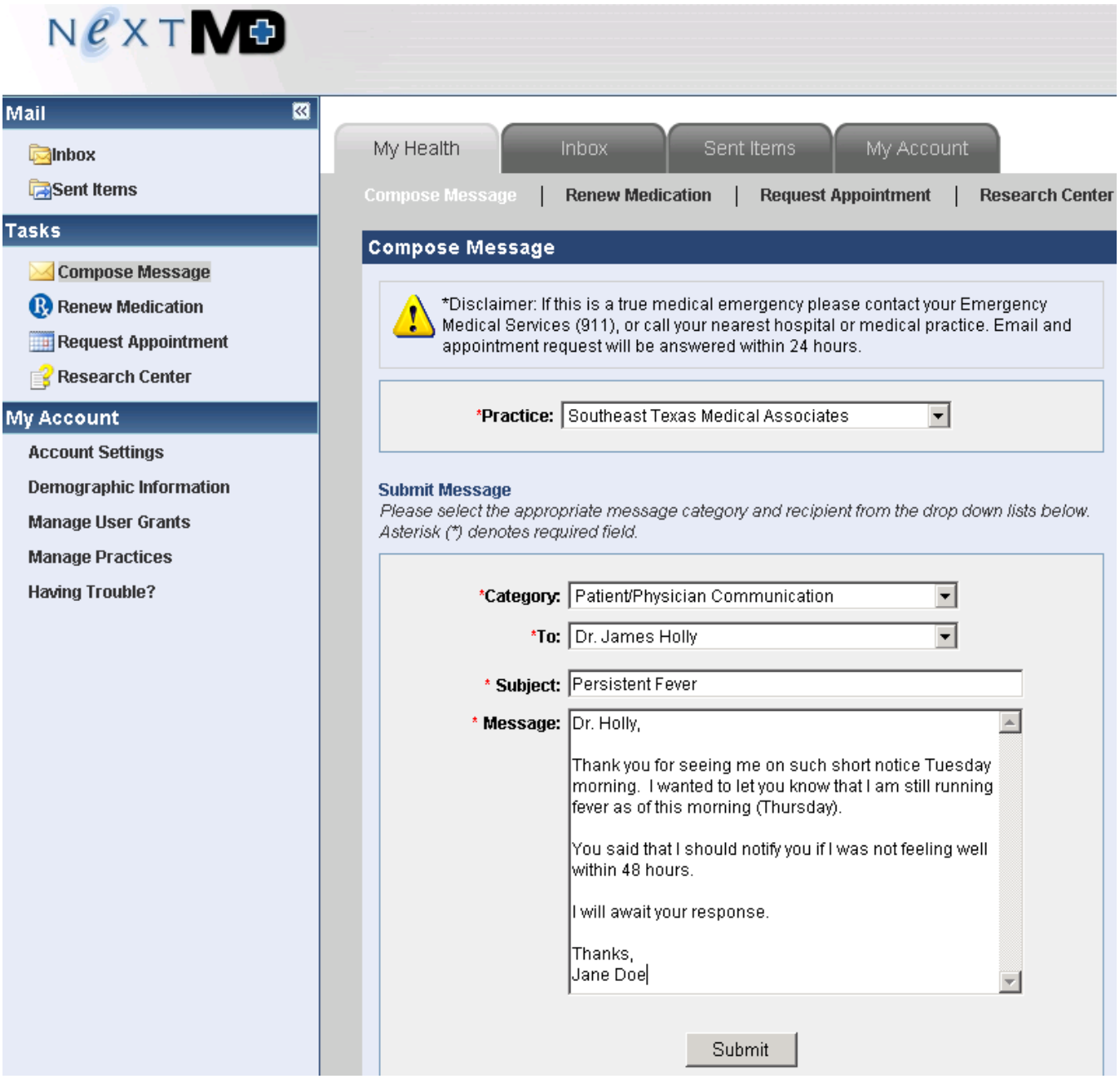
- You must have an email address and
- You must request that we give you access

When you request enrollment, SETMA will give you a code. An e-mail will be sent to you which will detail how to use the token to set-up your NextMD account. Your NextMD account becomes your own personal health record which is accessible only by you. Your NextMD personal health record is automatically linked to your SETMA-based electronic-medical-record (EMR) chart. The following are some of the things you can do on your account.

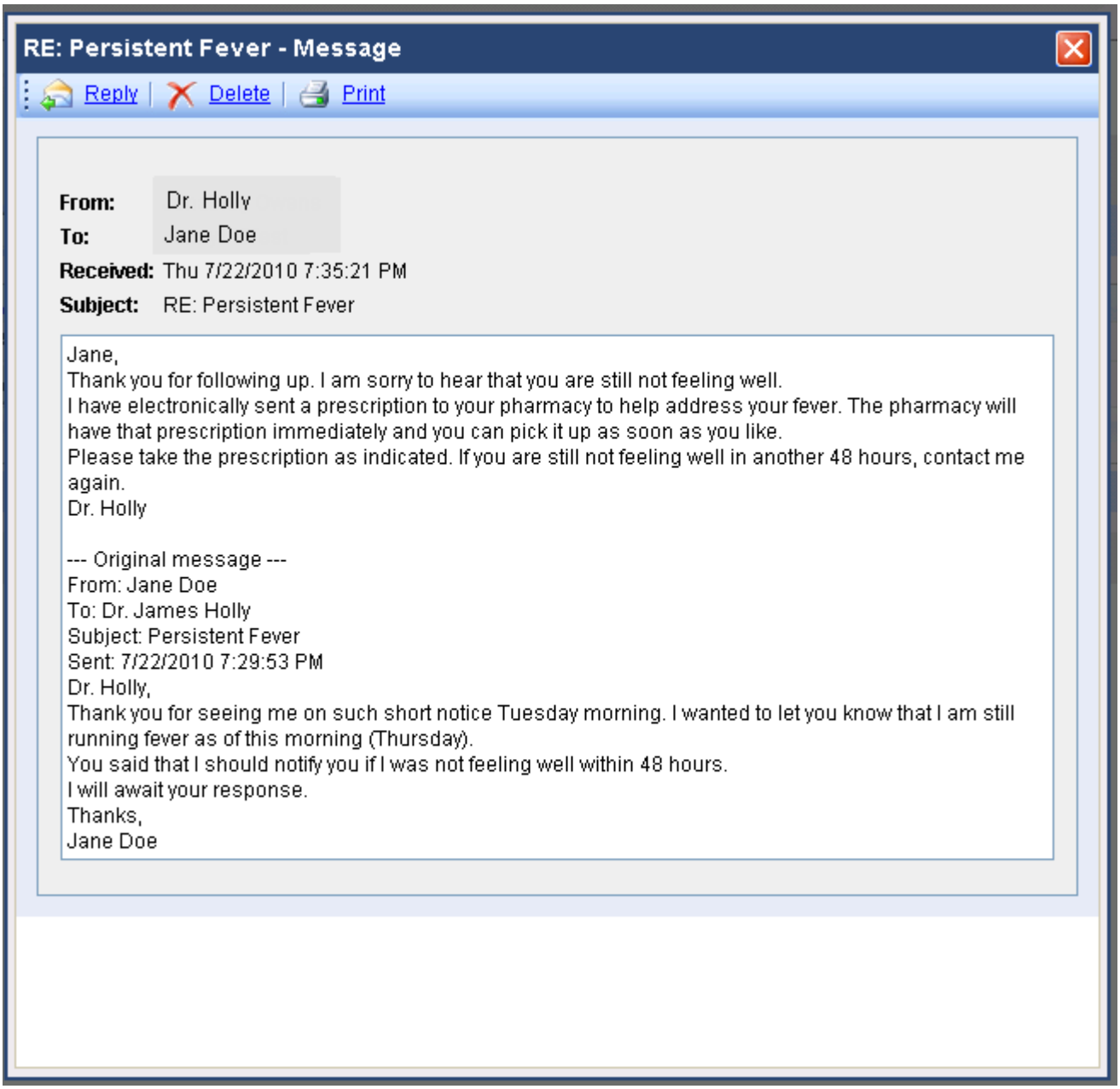
Communicating with your healthcare provider

NextMD allows secure, protected and private communication between you and your healthcare provider. You simply log into NextMD and follow the simple instructions to send a message. Because this message is not e-mailed to anyone, but is placed on a secure, password-protected website, it cannot be viewed by anyone but you. Your message will be delivered directly to your healthcare provider's workflow for review.

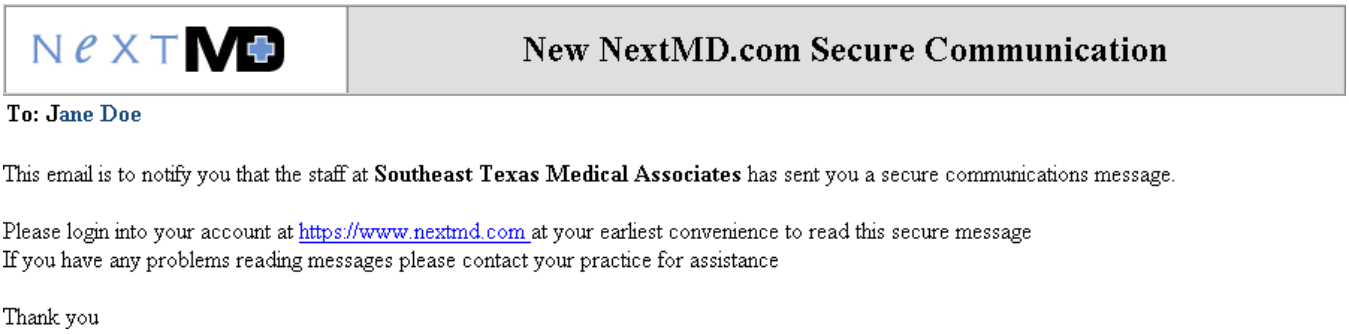
The following is an example of what a message from a patient in NextGen would look like. This may look complex but it is really easy.



This note will be delivered to your healthcare provider's EMR workflow. He/she will know that the message is an e-mail communication and that it is from you. Your healthcare provider will respond to your message. The following is what the message would look like.



SETMA's standard will be that every patient e-mail note will be responded to every day. Once the provider responds, you will be sent an e-mail notifying you that you have a response. That message is HIPPA compliant and reveals nothing about your healthcare or health condition. That e-mail will look like this:



You will then log on and read your healthcare providers response. If you have additional questions you just send another note.

The NextMD account is much like a credit card account. Your credit card company will often send you an e-mail to let you know that something is ready for your review but you must then log into the credit-card secure site to view the information. This is a security measure so that un-encrypted information about the patient's healthcare is not being sent thru email.

Medication Refills and Appointments

NextMD will also allow you to make online requests for appointments and prescription refills. After logging into their NextMD account, you can view your current medication list and select the medications for which you would like to request a refill. The request is then delivered to workflow just as if a pharmacy sent an electronic prescription request. SETMA can approve or deny the refill and a message indicating our response will be sent back to your NextMD account. You will then receive a notification via email that you have received a response to your refill request.

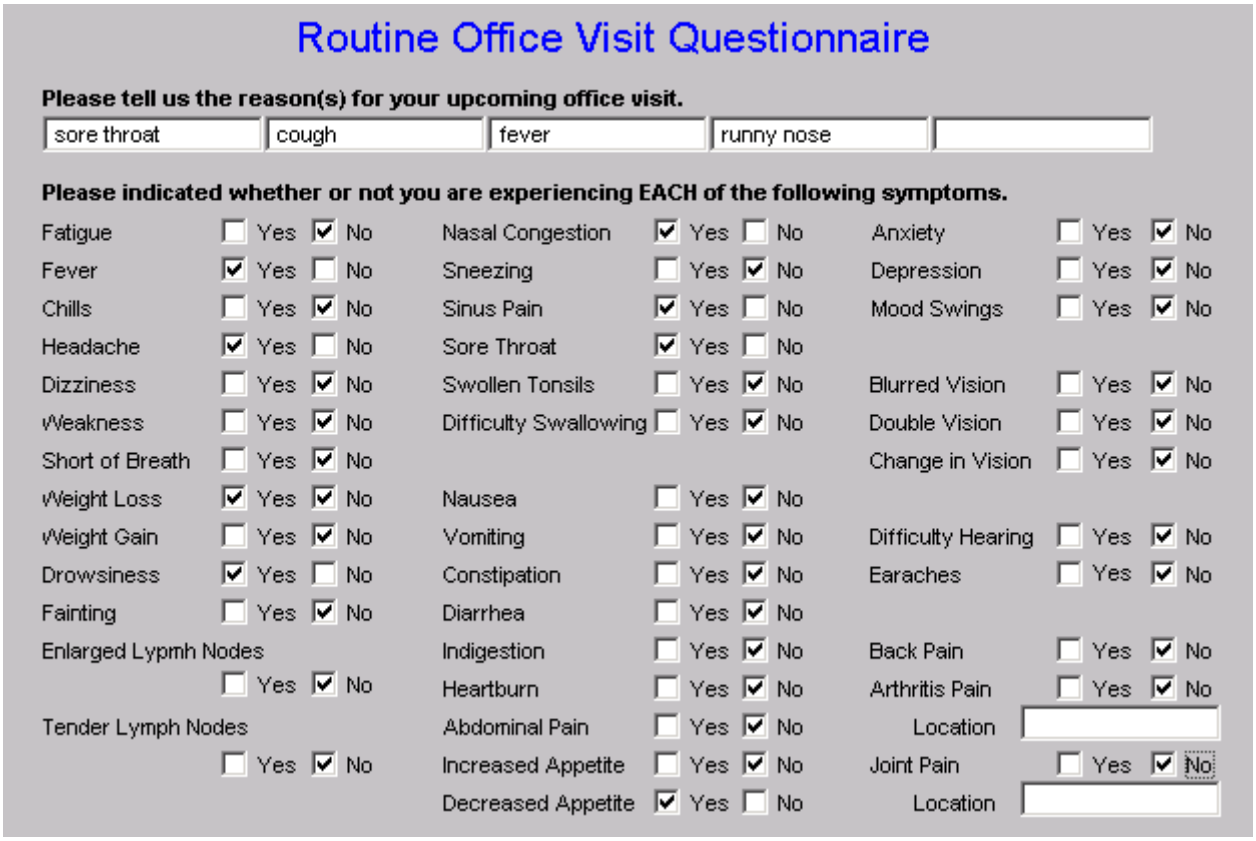
Appointments work very similarly. You can login into NextMD and request an appointment with a provider at a given time or range of time. The request is then sent to the appointments workflow group for scheduling and the patient is notified once the appointment is scheduled.

In the future, we will actually post your healthcare providers appointment schedule which will show his/her availability and you will be able to request a specific appointment. When that request is acceptable, you will receive an e-mail stating that you have an appointment at the time you selected.

Your Personal Health Record

NextMD will allow you to complete questionnaires and fill out templates online before coming to the clinic. SETMA can put EMR templates on your personal health record that we create.

You can document the reasons for your upcoming visit or any symptoms you may be experiencing. Our clinical staff can then review that template in the exam room with you and make changes to it if necessary and then add it to your medical record for that visit. The following is an example of a template which you could fill out.



Routine Office Visit Questionnaire

Please tell us the reason(s) for your upcoming office visit.

sore throat	cough	fever	runny nose	

Please indicated whether or not you are experiencing EACH of the following symptoms.

Fatigue	☐ Yes	☑ No	Nasal Congestion	☑ Yes	☐ No	Anxiety	☐ Yes	☑ No
Fever	☑ Yes	☐ No	Sneezing	☐ Yes	☑ No	Depression	☐ Yes	☑ No
Chills	☐ Yes	☑ No	Sinus Pain	☑ Yes	☐ No	Mood Swings	☐ Yes	☑ No
Headache	☑ Yes	☐ No	Sore Throat	☑ Yes	☐ No			
Dizziness	☐ Yes	☑ No	Swollen Tonsils	☐ Yes	☑ No	Blurred Vision	☐ Yes	☑ No
Weakness	☐ Yes	☑ No	Difficulty Swallowing	☐ Yes	☑ No	Double Vision	☐ Yes	☑ No
Short of Breath	☐ Yes	☑ No				Change in Vision	☐ Yes	☑ No
Weight Loss	☑ Yes	☑ No	Nausea	☐ Yes	☑ No			
Weight Gain	☐ Yes	☑ No	Vomiting	☐ Yes	☑ No	Difficulty Hearing	☐ Yes	☑ No
Drowsiness	☑ Yes	☐ No	Constipation	☐ Yes	☑ No	Earaches	☐ Yes	☑ No
Fainting	☐ Yes	☑ No	Diarrhea	☐ Yes	☑ No			
Enlarged Lymph Nodes			Indigestion	☐ Yes	☑ No	Back Pain	☐ Yes	☑ No
	☐ Yes	☑ No	Heartburn	☐ Yes	☑ No	Arthritis Pain	☐ Yes	☑ No
Tender Lymph Nodes			Abdominal Pain	☐ Yes	☑ No	Location		
	☐ Yes	☑ No	Increased Appetite	☐ Yes	☑ No	Joint Pain	☐ Yes	☑ No
			Decreased Appetite	☑ Yes	☐ No	Location		

Filling Records Request Electronically

NextMD will allow us to provide information from your EMR record to your NextMD account. For example, if you call to request an immunization record, a nurse can log into your chart, open the immunization record and tell the EMR to "push" the immunization record to your NextMD account. The next time you access your NextMD account, you will have the document available to view or print if you desire.

We can do this with any document that is generated in the EMR, chart notes, discharge summaries, prescription sheets, transfer of care documents, disease management follow-up notes, etc.

Lab Work, Medication Lists

Your personal health record will make available to you:

- Your current medication list

- Your drug-drug allergies, your personal drug allergies
- Your Preventive Health Log of what you need and what you've had
- Your Screening Health Log of what you need and what you've had

As you become more familiar with this tool, you will be able to study about how to help yourself with your health, what the terms used by healthcare providers mean and what you should do to improve your health. Health resources will be made available to you and alerts will be sent out to you about new opportunities for learning about your health.

This is a new day in healthcare; you are in charge which means you have to be informed, involved and interested. Get your NextMD account set up today. Call SETMA and ask for your access code. We are looking forward to this new opportunity for you and for us.

A New Day in Healthcare for You and for Us
Part II – NextGen Health Information@ Exchange (HIE@)
By James L. Holly, MD
Your Life Your Health
The Examiner
August 5, 2010

Last week, we described SETMA's launching of NextMD@, a secure web portal published by NextGen@. This portal has been adopted by SETMA to provide our patients with a secure means through which to maintain their own "personal health record," to communicate with their personal healthcare provider about their personal health, and to access resources which will help patients take charge of and participate in the management of their own healthcare. Access to this service costs SETMA's patients nothing, except they must have a personal e-mail account through which to access the web portal.

Challenges to Healthcare Providers – EHR and Meaningful Use

Today, healthcare providers face a number of challenges. One of them is the imperative to adopt electronic health records (EHR) by 2014. The American Recovery and Reinvestment Act (ARRA), which was signed into law in 2009, provided $19 Billion for financial initiatives to be paid for the encouragement of the adoption of EHR. On March 23, 2010, the Patient Protection and Affordable Care Act became law. This sweeping health reform legislation required the U.S. Department of Health & Human Services (HHS) to develop programs to promote the implementation of health information technology (HIT).

Based on the requirements of these two laws, in July, 2010, the Centers for Medicare and Medicaid Services (CMS) published the final rule for "Meaningful Use" of a Certified EHR system. All 865 pages of this rule details the functions a medical practice must perform with an EHR in order to be eligible for incentive payments in 2011, 2012, 2013 and 2014. In 2015, no further incentives will be paid but if a practice is not using an EHR and fulfilling "meaningful use" standards, they will be penalized by having their reimbursements decreased. In a future article, we will discuss "meaningful use." SETMA currently performs all functions required for "meaningful sue."

Challenges to Healthcare Providers – Medical Home

From February 16, 2009 until April 12, 2010, SETMA worked on transforming into a Patient-Centered Medical Home@ (PC-MH). This pilgrimage is detailed in dozens of articles and numerous electronic tools all if which are posted on our website at www.jameslhollymd.com. Many of the functions needed for the transformation of healthcare are common to medical home and to "meaningful use." The principle concepts of medical home are the coordination of care in order

to increase patient safety and patient access to care, and the placing of the focus upon the patient in order to have them as the central focus of all care. Both of these are gauged to increase the patient's control over and participation in their own care.

SETMA has been awarded PC-MH recognition by the National Committee for Quality Assurance (NCQA) and is seeking certification from the Accreditation Associations of Ambulatory Health Care for medical home as well. Yet, even as we are successful in these efforts, we continue to expand our services and to transform our model of care to bring 21st Century health knowledge to our patients in a 21st Century method and means.

The ideal of medical home is that all patient information would be shared in a HIPPA-compliant, secure means to all providers and organizations who treat that patient. SETMA has had a security firm thoroughly analyze our systems to make sure that they are secure and that all appropriate and necessary steps have been taken to guarantee that level of security.

Challenges to Healthcare Providers – Information Exchange

One element of medical home, meaningful use and of transformation of a medical practice is the ability to exchange information between healthcare organizations and healthcare providers. Because SETMA has already invested over $6,000,000 in health information technology and because we know how important information exchange is, we have determined to make this available to Southeast Texas as our contribution to the increasing of safety, efficiency and excellence of the healthcare an the health of our friends and neighbors whether or not they are patients of SETMA.

With the health information exchange in place, a patient who is seen at Baptist Emergency room one night and who goes to Christus emergency room the next night will not have to have the same tests repeated. Also, a patient who is getting narcotics at multiple locations would be immediately known to all who had appropriate access to their health record.

Patient safety due to accurate medication and problem lists will be enhanced no matter where the patient seeks care.

Challenges to Healthcare Providers – Cost of Transformation

Transformation is a process which begins and which is sustained from within the core of an organization and of an individual. External pressures whether of circumstances or of legislation cannot produce transformation. However, whether reformation or transformation, expense is a major issue.

There are financial incentives available for the next few years in order to help healthcare providers make this transition. Presently, there are three programs: Physician Quality Reporting Initiative (PQRI), ePrescribing and "meaningful use."

The cost of getting an information exchange up and running in Southeast Texas will include:

1. Software costs
2. Hardware costs
3. Management
4. Security

The first year's cost will be over $500,000. SETMA is prepared to make this initial investment for the benefit of our community. After the first year, the Board of Directors of the Information Exchange, which will include a majority of non-SETMA providers and organizations, will assess a non-profit-based users' fee, based on the on-going cost of operating and expanding the HIE. . The cost will be levied based on the size of the participating organizations. No cost will be levied for SETMA for years 2-6. This will be a small accommodation for SETMA's original contribution. After the sixth year, SETMA will be accessed a pro-rata share of the ongoing costs like everyone else. It is expected that the cost to an individual provider would be in the hundreds of dollars rather than thousands of dollars and that the cost to the largest organization would be in the thousands rather than in multiple tens of thousands. But, whatever the cost it will be transparent to all participants and no participant will make a profit except as we all realize cost savings while the quality of our care increases. .

NextGen Health Information Exchange@

The next step in the "new day in healthcare" is the launching of NextGen Health Information Exchange@ (HIE@). HIE is a secure data repository that stores, displays and electronically exchanges complete patient records to members of a patient's medical-home team, i.e., hospital, home health, specialists, hospice, physical therapy, etc. NextGen's experience in connecting dozens of regional medical communities through HIE, it is clear that here is no cookie-cutter approach to implementing a connectivity solution. Each communities HIE will look different.

SETMA's deployment of NextGen's HIE@ will provide:

- Easy exchange of data for all community participants, including practices with non-NextGen EHRs or none at all.
- A single-point connection, eliminating the need for point-to-point interfaces, to share lab or test results, ER visits, referrals, medications, allergies, and more, in real time.
- The ability to access – within workflow – only the patient information needed or new to the record.
- A foundation to help ensure eligibility of American Recovery and Reinvestment Act (ARRA) incentives under 'meaningful use' criteria.

SETMA's deployment on NextGen's HIE@ will also provide:

- Ease of data exchange with practices using 3rd party or no EHRs
- Secure, content-rich, and transparent to end-user
- Single-point connection to share clinical information in real time
- True interoperability among disparate systems
- Easier documentation and reporting (health quality and disease management)

Other Benefits for HIE@ users, particularly hospitals, emergency rooms and other outpatient care facilities are:

- Faster access to reliable patient information at the point of care
- Reduced drug-to-drug and drug-to-allergy interactions
- Ability to alert providers to 'drug-seekers'
- Decreased redundant test and administrative costs

Cast History of a Hospital's Use of HIE

(Editorial Note: This case study is based on the use of NextGen; however, the intent is to show how valuable the sharing of information is, regardless of the system which is used.)

"The course toward interoperability and Health Information Exchange (HIE) sometimes starts on an unlikely path. Just ask Doylestown Hospital, a community-focused 209-bed facility located in the Doylestown, Pennsylvania, suburbs just north of Philadelphia. Their course began with the Y2K scare —when community physicians came to them with fears their billing systems for their practices couldn't handle the transition. The hospital responded by establishing an applications services provider (ASP) organization to assist them with the purchase of a new practice management system at cost. A few years later, when the practices wanted an electronic health record (EHR) system, they again turned to Doylestown Hospital to help negotiate licenses.

"Then in 2006, the idea for interoperability and the exchange of patient data as a way to improve patient care and safety became a feasible option— and one that the community was interested in pursuing. It was then that the hospital founded the Doylestown Clinical Network (DCN)—a partnership with independent physicians in their community dedicated to providing high-quality, community-based health care through the use of HIE…

"Now, DCN practices are able to access critical information (demographic data, allergies, medications, histories and problems, lab and test results) within workflow, in real time, through a single-point connection with NextGen HIE – resulting in greater overall patient care, efficiency, and quality, as well as:

"According to Richard Lang, vice president and CIO for Doylestown Hospital, "The DCN — through the use of NextGen HIE—represents a model of genuine interoperability that helps us lead the national HIE conversation with proof that connectivity with other healthcare providers leads to improved patient care."

"... Doylestown Hospital is one of only 53 hospitals nationwide with 5-star ratings for both patient safety and satisfaction. Plus, they were the only Philadelphia-area hospital to receive all 3 cardiac specialty excellence awards from HealthGrades® in 2009 (for cardiac care, cardiac surgery and coronary intervention). Thus, it seems their ultimate goal of more efficient; better quality patient care has been achieved.

"However, that doesn't mean their work is finished. Now that a solid HIE framework has been laid, their efforts are focused on expanding the network so they can help more patients in the future."

Southeast Texas and the Future

The future of healthcare in Southeast Texas will depend upon innovation and collaboration. It is SETMA's hope that this effort will result in our own "Doylestown story," As all area hospitals, including south and mid county participate and has more and more health care providers determine to increase the quality of care all of our patients receive by participating in the information exchange, we will see improvement in care, increase in safety, decrease in cost and a realization on the part of our entire community that we all care much more about our patients than about anything else.

A New Day in Healthcare for You and for Us
Part III – Medical Home
By James L. Holly, MD
Your Life Your Health
The Examiner
August 12, 2010

"You're 'one in a million,'"" Few things qualify for this statement and most often it is an exaggeration. So it would be if anyone claimed that in being a patient-centered medical home, they are "one in a million." Nevertheless, they are in a special group. Currently, there are two organizations who offer a medical practice the opportunity to be examined for whether or not they qualify as a "medical home": National Committee for Quality Assurance (NCQA) which was founded in 1990 and the Accreditation Association for Ambulatory Healthcare (AAAHC) which was founded in 1979.

There are approximately 230,000 medical groups in the United States. As of March, 2010, fewer than 500, have achieved the status of "medical home." No figures exist for how many practices have received medical home designation in the past four months, but assuming that it is 50 a month, there are now 700 recognized medical homes in the United States. This means that .3 of 1% of physician groups have achieved patient-centered medical home status. That is far from being one in a million but it is the exception rather than the rule at present to be a "medical home". As of March, 2010, there was only one medical home group in Texas.

NCQA and AAAHC

This is the context of Southeast Texas Medical Associates, LLP (SETMA) achieving of medical home status by both NCQA and AAAHC. To our knowledge no other medical practice has sought review by both organizations. The two processes are different and the outcomes differ also. NCQA awards "recognition" as a patient-centered medical home after the review of an extensive application which can be hundreds of pages long. NCQA identifies 9 Standards, 30 Elements and 183 data points as the standard for medical home. AAAHC awards "accreditation" as a medical home after the review of a briefer application and an on-site survey of the practice by a team of physicians and administrators. AAAHC's definition of medical home is found in seventeen "core chapters," which address concerns common to all ambulatory health care organizations, and a comprehensive chapter on medical home. Further analysis of the similarities and differences between these two processes will be addressed in a subsequent article.

In AAAHC's recent exit conference at SETMA, the following statements were made about SETMA:

1. "SETMA is an exquisite organization."

2. "Clearly your passion has achieved a level of clinical care based on evidenced-based medicine which is inspirational and is found in very few practices. Your results approach those of the best practices in the country."
3. "You are one of few practices in this rare atmosphere."
4. "I haven't seen an electronic patient record which facilitates chronic and preventive care like yours anywhere. This is the best I have every seen."

AAAHC pointed out areas where SETMA needs to create written polices and procedures for what we are doing. Over the next year, we have plans to write down the policies and procedures which will document what we are already doing. We learned many things in this survey about how important it is to "write down" what we do in provider education, risk management, peer review and an area which we have never thought about, which is that in addition to responding to hospital credentialing and privileging requirements, the need for us doing our own practice credentialing of our providers and of delineating their privileges. We are confident that after responding to AAAHC's survey results, we will be a stronger and better organization.

SETMA's response to the AAAHC survey, both their affirmation of the quality of SETMA's work and their challenging of us to complete and to document the administrative processes which we have neglected, is for SETMA to move farther down the road toward excellence. We have established a one-year plan for to achieve this.

What is unique about a medical home?

Coordinated Care

One of the "catch phrases" to medical home is that the care is "coordinated." While this process traditionally has referred to scheduling, i.e., that visits to multiple providers with different areas of responsibility are "scheduled" on the same day for patient convenience, it has come to mean much more to SETMA. Because many of our patients are elderly and some have limited resources, the quality of care they receive very often depends upon this "coordination." It is hard for the frail elderly to make multiple trips to the clinic. It is impossible for those who live at a distance on limited resources to afford the fuel for multiple visits to the clinic.

"Coordination" has come to mean to SETMA, scheduling which translates into:

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

As with the structure of quality metrics in tracking, auditing, analyzing and public reporting process and outcomes measures, coordination requires intentional efforts to identify opportunities to:

- Schedule visits with multiple providers on the same day, based on auditing the schedule for the next 30-60 days to see when a patient is scheduled with multiple providers and then to determent if it is medically feasible to coordinate those visits on the same day.
- Schedule multiple procedures, based on auditing of referrals and/or based on auditing the schedule for the next 30-60 days to see when a patient is scheduled for multiple providers or tests, and then to determine if it is medically feasible to coordinate those visits on the same day.
- Scheduling procedures or other tests spontaneously on that same day when a patient is seen and a need is discovered.
- Recognizing when patients will benefit from case management, or disease management, or other ancillary services and working to resources those needs.
- Connecting patients who need help with medications or other health expenses to be connected with the resources to provide those needs such as The SETMA Foundation, or sources.

Time, energy, and expense are conserved with these efforts in addition to increasing compliance thus improving outcomes. In order to accomplish this and to gain the leverage, synergism and advantage of coordination, a system is necessary which brings us to a new position designed by SEMTA entitled, Director of Coordinated Care..

Director of Coordinated Care (DCC)

The Director of Coordinated Care is responsible for building a department of Care Coordination. In many ways this could be called the "Marcus Welby Department," as it recognizes the value of each patient as an individual and has as its fundamental mission the meeting of their healthcare needs and helping them achieving the degree of health which each person has determined to have. The driving force is to make each patient feel as if they are SETMA's ONLY patient, just like Dr. Welby.

Initially, the DCC will work as a department of one but will have others assigned to the department as the demands of the mission expand. The DCC will establish protocols and methods for facilitating the care of patients with: special needs, complex-care needs, disease management and case management needs.

An illustration of this new function will be that of a patient who is seen at SETMA's Wilson clinic on the West End of Beaumont. The provider determines that the patient needs an echocardiogram. The nurse will call the Care Coordination Department, which will determine if the patient can be sent to the Ultrasound Department immediately to have the test done that day. We believe that this will increase patient satisfaction as well as compliance which will improve the quality of care the patient will receive.

Integration of Care

The medical home sees the patient as a whole and not as a collection of isolated and disconnect disease processes. While this is not new and has always been the ideal of health care, it becomes a significant focus of the patient-centered medical home. Not only is the patient the major focus of the attention given, but all elements of the patient's needs are attended to and future needs are anticipated and addressed. No longer is a patient encounter simply used to address current needs but potential future needs are identified and addressed. For instance, the young person who is seen for an upper respiratory condition but who is moderately obese, and who has a family history of diabetes, has his disease-risk addressed. In addition, recommendations are made for diabetes prevention and wellness including exercise, weight reduction, avoiding tobacco and others. Future contacts are scheduled, with our without a clinic visit, for assessing whether the patient has made the changes necessary to maintain their health.

Furthermore, through NextMD, SETMA's secure web portal, the patient is referred to education material for achieving the desired results and a follow-up contact via e-mail is scheduled to remind the patient, without a clinic visit and without cost, to pay attention to their health.

Quality of Care and Patient Safety

A medical home measures the quality of care which patients are receiving both through process analysis and outcomes measurement through quality metrics. Quality Improvement Initiatives are planned for the improvement of care across an entire population of patients. For instance, while it is anticipated that the new Director of Coordination of Care will result in improved care, that must be measured and analyzed before it will become obvious that the anticipated improvement has occurred.

As the Director of Coordinated Care works with SETMA's Call-Center staff to address preventive health needs of our patients, it will be important to see if more people are getting their mammograms, bone densities, immunizations, etc. If they are, then the position will have proved value. If they aren't then new ways will have to be used to improve those outcomes.

If the Director of Coordinated Care is responsible for scheduling multiple visits or studies on the same day, it will be necessary to measure whether or not that has improved compliance and consequently quality of care.

If the Director of Coordinated Care is responsible for evaluating whether the post-hospital follow-up call program and the post-clinic-visit follow-up call program is having the desired result, it will be necessary to measure those outcomes. If the desired result does not occur new or additional initiatives will have to be designed.

Continuity of Care

To be a medical home, a practice must provide communication with a personal physician who accepts primary responsibility for the patient's care. This is more than a friendly affect when the patient is seen in the clinic. It means answering inquires about health from the patient at times other than when they are seen in the clinic. It means providing telephone access with same-day response; e-mail contact through a secure web portal with same day access; it mean eliminating a patient's anxiety about whether or not their healthcare provider cares about them by the provider being available to the patient. It may mean in some cases that the patient has the provider's home telephone number or cell phone number. It means doing whatever is necessary for making sure the patient knows how to access care when it is needed. The reality is that the more confident a patient is that they can reach their provider when needed; the less likely the patient is to pester the provider over trivial or unimportant matters.

Continuity of care in the modern electronic age means not only personal contact but it means the availability of the patient's record at every point-of-care. One of the AAAHC surveyors said that his standard for judging medical records is, "Could I pick up this chart and provider excellent care for a patient whom I had never seen?" His answer after reviewing dozens of SETMA charts is, "I could easily treat any of these patients as the records are legible, complete and well organized." Because all of the patient's health needs are clearly documented; because all preventive and screening health needs are constantly and automatically audited; because every patient's laboratory results, medications and diagnoses are interactive; every patent can be confident that all of their health needs are being addressed, can be addressed and will be addressed, no matter who the provider is that they see..

Another issue of continuity of care is communication among all providers and institutions that are providing care for each patient. The Health Information Exchange which SETMA is launching will provide the confidence that care given by hospitals, emergency rooms, specialists, other primary care providers, etc., will be accessible to all providers and will be integrated into the patient's health record. In addition the secure web portal, NextMD, will allow the patient to maintain and periodically review their own personal health record. This places the patient at the center of their healthcare decision-making process, which is the ideal of patient-centered medical home.

Conclusion:

NextMD, HIE (Health Information Exchange) and now medical home are elements of the "new day" in health care for patient and provide alike. Other elements will be discussed in coming days.

A New Day in Health Care for You and for Us
Part IV: Are Quality Metrics a Good Part of the Future of Healthcare?
By James L. Holly, MD
The Examiner
August 19, 2010

(Editorial Note: This article is a response to a "physician perspective" published by the *New England Journal of Medicine* August 12, 2010. The article was written by a physician who is frustrated that her performance on quality measures is being measured and that it is being reported by insurance companies.)

An article from the August 12, 2010, *New England Journal of Medicine* was sent to me by a friend who is an outstanding physician and a leader in quality improvement in medicine. A brief note was attached which stated, "This is more my bias." As I read this "perspective piece," I felt the angst of the physician whose clinical support and treatment resources are limited. I was not concerned that the physician's quality metrics were not good, none of us can claim not to have been surprised with the objective evidence that we are not doing as well as we hoped and as we wanted in the treatment of our patients. The disturbing thing about the "perspective" is that with the quality outcomes not improving from year to year, the physician expressed no alarm, and apparently rather than looking for ways to improve, chose to attack the quality-metric process.

The poor "report card" which the physician received is not nearly as important as the fact that treatable disease processes continue to ravage her patients without any expressed plans by the physician to improve her performance, and thereby improve patients' health.

Treatment Inertia

Treatment, or clinical inertia is well documented in the medical literature. Practice administrations struggle with methods for overcoming this barrier to effective care. The tendency of physicians not to change a treatment plan when a patient is not moving toward or reaching a treatment goal is a problem for large medical organizations, for healthcare centers and for small group or solo practicing physicians. Nevertheless, the audacious declaration by this physician that her documented, continuing poor treatment outcomes only makes this physician hold those who design quality measures in contempt is a new twist in treatment inertia, a twist for which there is no obvious solution.

Healthcare delivery in America must change and the attitude reflected in this perspective is one illustration of why that change may have to come from political pressure, if the medical profession does not effect real change internally. When I started my medical career in 1969, there was no effective way of measuring quality other than by tedious chart reviews which were expensive and time consuming. Now, due to technology, we can measure performance in real time. To ignore that measurement is not an acceptable alternative.

Quality Metrics

No one would argue that quality metrics are the only solution to healthcare improvement. Those who grapple with the design of quality metrics do not sit around thinking up new ways to aggravate healthcare providers. Using scientific methodology and a growing body of medical literature on quality metrics, these pioneers look for leverage points in identifying potential for real change in healthcare-delivery processes, which will reflect real change in the quality of patient health. Unfortunately, quality metrics are not static such that once you identify one metric that it will have permanent relevance to quality improvement. Once processes are in place, such that the outcomes are virtually totally dependent upon the process, rather than healthcare provider performance, new metrics must be found to move the system further toward excellence.

A single quality metric for a complex disease process will have little if any impact upon patient safety and health. And, all quality metrics of value should point to treatment change which will improve patient health. Though a single metric is of extremely limited value, a "cluster," or a "galaxy" of quality metrics can effect real change in healthcare quality and in patient health. A "cluster" is defined as a group of quality metrics (seven or more) which define quality treatment standards in both process and outcomes for a single disease process. "Comprehensive quality measures" for diabetes are a good illustration. Unfortunately, PCPI, NQA, NCQA Diabetes Recognition, AQA, PQRI, HEDIS and Joslin Diabetes Center, all have comprehensive quality measures for diabetes; and, they are all different.

A "galaxy" of quality measures is a group of "clusters" which relate to the health of a single patient. When "comprehensive quality measures" for diabetes, hypertension, dyslipidemia, CHF, Chronic Stable Angina, Cardiometabolic Risk Syndrome, Chronic Renal Disease Stage 1-III and then Stages IV-ESRD are identified and measured for a single patient, the successful meeting of those metrics, which may exceed 50 in number, WILL reflect quality treatment and WILL result in improved health.. Quickly, physicians will say, "But, that will take a two-hour visit for each patient." That would be the case if we were using paper records; if fact, two hours by paper may not be enough time to accomplish all of this. However, with electronic patient management via a well-designed electronic patient record, and with a well-trained and highly functioning healthcare team, this "galaxy" of metrics can be met within in the time and economic constraints currently existent in healthcare in the United States.

How Can Quality Metrics Effect Quality Care?

While quality metrics will always reflect quality, they will not always effect quality unless they are transparent to the healthcare provider at the time and point of a patient encounter. A "report card" delivered retrospectively, six months to two years after the care event which was

measured, will have absolutely no impact on provider behavior. But, if the provider is able to "see" his/her performance at the time of the patient encounter, behavior will begin to change. And, if the panel or population a single provider manages, or participates in managing, has data aggregated daily, monthly, quarterly and annually, treatment inertia can be overcome. And, finally, when that provider's performance is publicly published by provider name, treatment inertia will disappear.

Limitations of Quality Metrics

In a June 3, 2010, article entitled "The SETMA Model of Care – Diabetes Precision Medicine, Quality Performance," (see www.jameslhollymd.com)**,** the limitations of quality metrics were address**.** That article stated in part:

> "Even as we want to talk about 'precision medicine' and even as we want to measure quality using quantifiable processes and outcomes, we still have to admit that there are limitations to quality metrics. Because healthcare does not deal with machines but with people, there will always be subjective, poorly quantifiable elements to quality in healthcare. This question of the balance between technology and humanity was the subject of Your Life Your Health, May 6, 2010. It can me read at www.jameslhollymd.com under Your Life Your Health.
>
> "There are several critical steps which can help bridge the gap between quality metrics and true quality in healthcare. These were discussed in the April 22, 2010, Your Life Your Health. Part of that discussion addressed the place of patient-centered medial home, Medicare Advantage health plans, and Evidenced-based medicine.
>
> **"…**At the foundation of quality healthcare, there is an emotional bond – a trust bond – between the healthcare provider and the patient. It is possible to fulfill all quality metrics without this bond; it is not possible to provide quality healthcare without it. That is why the patient-centered medical home (PC-MH), coupled with the fulfilling of quality metrics is the solution to the need for quality healthcare.
>
> "The genius of PC-MH is to discover the true implications of SETMA's motto which was adopted in August, 1995, which is, 'Healthcare Where Your Health is the Only Care'" It is to put the patient and their needs first. And, it is to include the patient as a member of the healthcare team. There are 8,760 hours in a year. If responsibility for a patient's healthcare is seen as a 'baton,' the patient carries that 'baton' for over 8,700 hours a year. PC-MH promotes methods for effectively 'passing the baton' to the patient so that the patient's healthcare does not suffer under the patient's own supervision. SETMA has placed the patient's healthcare at the center of our healthcare delivery in many ways. One way is that we developed The SETMA Foundation, through which we help provide

funding for the care of our patients who cannot afford it. Our resources are meager in comparison with the need, but it is a start.

"The following is one example of how PC-MH and the SETMA Foundation have worked together to produce quality healthcare. A patient came to the clinic angry, hostile and bitter and was found not to be a bad person but to be depressed because he could not work, could not afford his medication and was losing his eye sight. He left the clinic with The Foundation paying for his medications, giving him a gas card to get to our ADA certified DSME program, waiving the fees for the classes, helping him apply for disability, and getting him an appointment to an experimental program for preserving his eyesight. He returned in six weeks with something we could not prescribe. He had hope and joy. By the way, his diabetes was treated to goal for the first time in years. This is PC-MH; it is caring and it is humanitarianism.

"…As the Patient-Centered Medical Home is restoring the personal aspect of healthcare, the Medicare Advantage (MA) program and/or the Accountability of Care Organizations (ACO) are modifying the 'piece' payment system of healthcare. While the President has been convinced that Medicare Advantage is the problem; it is the solution. The supposed increase in the cost of Medicare Advantage is because it is being compared to traditional Medicare costs where the administrative cost of Medicare is not calculated in the formulae. There are bright examples of success with Medicare Advantage, success marked by quality outcomes and high patient satisfaction. That success also is marked by a dramatic change in the trajectory of health care cost while maintaining its quality.

"The third piece to true healthcare transformation is including quality process and quality outcomes in the payment formula. There are fledgling programs such as the Physician Quality Reporting Initiative (PQRI) where healthcare providers are being paid for the demonstration of quality outcomes rather than just for piece work. The accountability of the pubic reporting of provider performance on quality measures completes this picture. This is why SETMA has begun quarterly reporting on our website of our providers' performance on multiple quality metrics. Included in that reporting is the examination of whether disparities of care in ethnic and socio-economic groups have been eliminated.

"…Quality healthcare is a complex problem. Measureable processes and outcomes are only one part of that complexity. Communication, collaboration and collegiality between healthcare provider and patient, between healthcare provider and healthcare provider, between healthcare providers and other healthcare organizations are important aspects of that complexity also. Data and information sharing within the constraints of confidentiality add another layer of complexity. All of these aspects of healthcare quality can be addressed by technology but only when that technology is balanced by humanitarianism. .

> "The good news is that the right questions are being asked and historically in that setting .the right answers have been found."

Conclusion

Physician hubris or stubbornness may reject quality metrics for a while, but patient and societal demands will rightly press for change. I am confident that the author of the attached perspective piece is a "good doctor" and cares about her patients. Unfortunately, caring in the 21st Century will no longer be measured by personality or friendliness, it will be measured by competence which will increasingly be an objective measurement. To reject that reality is to prepare oneself for obsolescence when that is not necessary.

A New Day in Healthcare for You and For us
Part V: Certified Electronic Health Records (EHRs)
By James L. Holly, MD
Your Life Your Health
The Examiner
August 26, 2010

Are you ready for a headache? Then continue reading. Don't want a headache? Then read on. As a part of our discussion of what is new in healthcare, it is important, whether a healthcare provider or a healthcare consumer to be aware of some of the changes which are being mandated. The use of the word "mandate" is not pejorative, i.e., it is not to imply a negative response to the changes coming to healthcare. The intent of the changes is to improve the quality and safety of the care we all receive. Whether the changes in the law will result in the intended progress, or not is yet to be seen but it may.

Here is the summary. If you know all of this, you don't need to read any further; if you don't, you stop reading at your own peril. **In meeting the HITECH requirements, as defined in the ARRA, and published by the ONC through the ACTIB with final standards to be announced from the NIST, which are not yet available (got a headache yet? Read on), you may use the CCHIT or maybe not, and what you must report to HHS through CMS cannot yet be done, and in order to do this you must have a certified EHR and at present none exist and all of this must be done in 2011.**

What Does this All Mean?

Your first response may be, "I don't care and I don't want to know," but you must remember that contrary to popular wisdom, the only thing which can hurt you is what you don't know.

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA0 of 2009. The HITECH (Health Information Technology for Economic and Clinical Health) Act is part of this legislation and is designed to encourage physicians and other healthcare organizations to adopt and use (in a meaningful way) Electronic Health Records (EHR).

The HITECH Act will be administered by the Office of the National Coordinator for Health Information Technology (ONC) and appropriates $19.2 Billion dollars, most of which will be used as incentive money for hospitals and physicians who adopt EHRs.. The incentive payments are structured in a way to reward early adopters and ultimately penalize those physicians who have not implemented an EHR by reducing their Medicare payments beginning in 2015.

The Final Rule including the final HHS certification criteria and standards were published on July 13, 2010 and becomes effective on September 28, 2010. However all final test procedures are not yet available from the National Institute of Standards and Technology (NIST), nor has

Certification Commission for Health Information Technology (CCHIT) been accredited yet by ONC as an Authorized Certification and Testing Body (ONC-ACTB). When those events occur, CCHIT will replace the Preliminary ARRA program with a final, ONC-accredited ARRA certification program.

Obviously, the framers of this law had heard of the "carrot and stick" method of motivation. In the short run there will be "carrots" for using a certified EHR in a meaningful way, but in the long run (2015), if you are not doing so, your payments will be cut.

A Certified EHR -- History

The first step in the HITECH Act is to insure that health care providers are using "certified EHRs." The twelve-year history of SETMA's use of EHR is well documented. The term "early adapter" has been applied to organizations like SETMA, and now it appears that we were prescient in migrating to EHR in 1998. When SETMA purchased NextGen's EHR, the electronic record market was volatile to say the least. When we purchased NextGen in March, 1998, it had been only four months since we had reviewed dozens of products at the MGMA meeting in Washington, D.C. Fifty percent of the products we reviewed in October, 1997, were no longer available in March, 1998.

CCHIT (Certification Commission for Health Information Technology)

It has long been believed that widespread adoption of health information technology (Health IT) can bring improvements in quality, safety, efficiency and access to healthcare delivery. It also is aapparent that the number and varying quality of EHRs required the adoption of a standardized measure so that healthcare providers could effectively compare products and so that insurance companies could begin planning for adjusting payments to providers on the basis of their using a high quality EHR. Thus a new industry was birthed: Certification of EHRs.

The first organization to be recognized by the Federal Government as an EHR certifier was the CCHIT®, a nonprofit, 501(c)3 organization with the public mission of accelerating the adoption of health IT. CCHIT was founded in 2004, and began certifying electronic health records (EHRs) in 2006. The Commission established the first comprehensive, practical definition of what capabilities were needed in these systems. The certification criteria were developed through a voluntary, consensus-based process engaging diverse stakeholders, and the Certification Commission was officially recognized by the federal government as a certifying body.

NextGen, SETMA's vendor, was among the first EHRs to be certified. CCHIT's website indicates that 200 EHRs have been certified. Currently, there are over 400 EHR vendors in North

American alone. There are a number of "open source," or free; EHRs none of those are, or ever will be certified due to the cost of the process.

HIECH Act an EHR Certification

It would have seen logical, in that the Federal Government endorsed CCHIT, that CCHIT would be accepted as the certifier of EHRS for "meaningful use" (more about this later) and that those who had achieved CCHIT certification would thereby be certified for "meaningful use." Not so.

The Final Rule for Meaningful Use, including the final Heath and Human Services (HHS) certification criteria and standards were published on July 13, 2010 and become effective on September 28, 2010. However all final test procedures are not yet available from the National Institute of Standards and Technology (NIST). The Office of National Coordinator (OINC) certification process is and will be separate from CCHIT. CCHIT may become one of the certifying bodies used by the ONC, but this has not yet been established. All EMR vendors must reapply for certification with the ONC.

The organization that will do the certifying has not yet been confirmed, but they will be known as the Office of National Coordinator Authorized Testing and Certifying Body (ONC- ATCB). EHRs are not able to use previous certifications to prove they have been certified by the ONC. The ONC will be listing ATCB organization on their website when they become qualified. They expect to have some qualified organizations later this summer.

The HITECH Act specifically states that the following conditions for meaningful use must be met.

1. The EHR must use certified technology;
2. The EHR must include ePrescribing;
3. The EHR must allow for the "electronic exchange of health information to improve the quality of health care".
4. The EHR must be able to submit clinical quality measures to HHS.

The Process

In healthcare, the Federal process is tortuous, which means that it has twists and turns which sometimes cause pain. First, the law is passed; then, to know what the law means for the healthcare provider, we have to await the "final rule." which is a detailed explanation about what compliance with the requirements of the law means. Then there are technical specifications which have to be published, interpreted and fulfilled.

The facts are:

1. Healthcare providers can elect not to participate in the incentive program which begins next year, but in 2015, those providers will experience targeted reductions in their reimbursement, thus the carrot and the stick.

2. To participate in the incentive program, a provider must use a certified EHR. At present, there are no certified EHRs as no agency or organization as been selected by the government to do the certification.

3. Once the Federal government designates a certification agency, all vendors will rush to become certified. If the EHR vendor for a particular healthcare provider or medical group does not apply for certification or fails certification, then those healthcare providers will not be able to participate in the program.

4. One of the key elements of a certified EHR is the ability electronically to report quality metrics data to the Federal government. However, the Federal government has already announced that it will not be able t receive that quality data, yet.

5. There are still only a very small percentage of physicians using an EHR or system which will potentially meet certification standards. The National Ambulatory Medical Care Survey (NAMCS) which was conducted by the National Center for Health Statistics (NCHS) for 2009 reported that only 4.4 percent of physicians reported using an EHR which was described as being a "fully functional system"

Now you can understand the summary statement given above. For those within the healthcare system who determined to transform themselves, like SETMA, this process, while not easy, is done; for those who are only responding to the pressure of reform, this process is going to be painful and perhaps impossible within the time frame given.

Next week, we'll talk about "meaningful use," that's when the cluster headache which you now have becomes a migraine.

SETMA Recognized as Tier 3
Patient-Centered Medical Home by
National Committee for Quality Assurance
By James L. Holly, MD
Your Life Your Health
The Examiner
September 16, 2010

Recently, SETMA has achieved:

1. **NCQA PCMH* Tier III Recognition for all three clinics**
2. **NCQA Diabetes Recognition for all three clinics**
3. **Joslin Diabetes Center Affiliation**

On September 2, 2010, SETMA was notified that we had received the National Committee for Quality Assurance's (NCQA) recognition as a Patient-Centered Medical Home Level III, which is their highest recognition.

"The patient-centered medical home promises to improve health and health care," said NCQA President Margaret E. O'Kane. "The active, ongoing relationship between a patient and a physician in medical homes fosters an all-too-rare goal in care: staying healthy and preventing illness in the first place. PPC-PCMH Recognition shows that SETMA has tools, systems and resources to provide SETMA's patients with the right care at the right time." (*PCMH™ is a registered trademark of the National Committee for Quality Assurance).

SETMA's Growth and Progress

SETMA has worked for 15 years to develop the systems, processes and goals in order to provide state-of-the-art care to our patients and to Southeast Texas. Suddenly, seemingly at one time but based on years of work, all of the planning and development have come together with these relationships and recognitions That this has been a process can be seen by reviewing our website. Under the heading "About Us," there now appears the following sections:

- **The SETMA Way** – a description of our business philosophy
- **The SETMA Approach** – a description of our use of health informatics in the improvement of healthcare
- **The SETMA Model of Care** – SETMA's five steps of excellence in healthcare delivery
- **Letters** – important correspondence SETMA has sent to health agencies, journals and others about the process of health care improvement.
- **In-The-News** – a collection of 27 articles published in national magazines and journals about SETMA's growth and development
- **Links to SETMA** – hyperlinks to materials about SETMA published on the web.

While these sections of our website are incomplete, this is a beginning of our documenting SETMA's history.

Patient-Centered Medical Home (PCMH) SETMA's Journey

The history of our recipient of NCQA's recognition as a PCMH began almost 19 months ago. The following are key points in that history

1. February 16, 2009, several SETMA staff attended a lecture in Houston on PCMH.
2. February 17, 2009, SETMA began an internal examination of processes and functionalities to see if we fulfilled the principles of PCMH. This resulted in an initial ten-article series, all of which are posted on our website.
3. In March, 2009 SEMTA began tracking HEDIS and other quality standards.
4. March, 2009, we completed a 400-page evaluation of SETMA based on CMS's published but not official 25 principles of medical home.
5. April, 2009, SETMA began building electronic health record functions by which to fulfill medical home requirements.
6. April, 2009, SETMA continued to learn about PCMH and began evaluating ourselves by NCQA's Patient-Centered Medical Home's 9 standards, 30 elements and 183 data points.
7. September, 2009, SETMA began the COGNOS Project for auditing provider performance.
8. April 12, 2010, SEMTA submitted our application and medical home survey to NCQA.
9. July 2, 2010, SETMA received a Tier 1 (the lowest) recognition from NCQA as a

medical home.

10. July 13, 2010, SETMA had a conference call with NCQA to discuss the result and determine why the result was so dramatically different than what we expected.
11. July 16, 2010, submitted an "add-on" survey to clarify the deficiencies which resulted from our not completing the original application correctly.
12. August 5-6, 2010, SETMA was surveyed by Accreditation Association for Ambulatory Care (AAAHC), an independent organization which also accredits medical home. The results of that survey and of that distinctive from NCQA accreditation is expected to be received by September 18, 2010.
13. August 20, 2010, SETMA received notice from NCQA that two required elements for PCMH Tier 3 were incomplete.
14. August 24, 2010, SETMA submitted the missing material to NCQA.
15. September 2, 2010, SETMA received Tier 3 NCQA Recognition as a PCMH.

This almost 19-month-long process stretched SETMA's endurance, creativity and resolve. SETMA's entire practice and team members were involved in this transformative process. While a few have led the way, all have provided the foundation for creating and sustaining a medical home and all have demonstrated the flexibility and wiliness to change in order to fulfill the demands and promises of patient-centered medical home.

Now that this part of the process is over, we are moving rapidly ahead with:

- SETMA's relationship with Joslin,
- Meaningful use of electronic health records,
- NextMD,
- NextGen's CHS now called Health Information Exchange (HIE)
- Further transformation of our healthcare delivery to fulfill all of the hope, promise and challenges of Patient-Centered Medial Home.
- Opening a Department of Care Coordination within SETMA.

In three years, we will reapply for recognition of medical home as the term of our current recognition is September 2, 2010 to June 12, 2013. The requirements will be different by then. SETMA will have adapted to those changing expectations and will have adopted new methodologies based on sound principles to fulfill these new challenges. While we are enjoying a moment of celebration, we are moving ahead rapidly with growth and development as a Patient-Centered Medical Home.

NCQA Website and SETMA

SETMA is featured in a "fact sheet" bout PC-MH on NCQA's website at www.NCQA.org. If you go to NCQA's home page, at the top of the right-hand column, you will see a link to a document entitled "HIMSS/NCQA PCMH Fact Sheet". The article is entitled, "Leveraging Health IT to Achieve Ambulatory Quality". This fourteen-page paper features six medical practices which had either received Tier 3 recognition (5 of them) or who were expected to receive Tier 3 (SETMA.)

The content of this paper came from interviews and the following are pages 10-14 which relates to SETMA. The following are a reproduction of those four pages:.

Southeast Texas Medical Association (SETMA)

Southeast Texas Medical Association (SETMA) is a multi-specialty clinic located in Beaumont. SETMA has three clinical locations that are connected with a secure electronic medical record (EMR) system to store and access patients' records. Patient records are also available to providers at area hospitals, so that during inpatient care, providers can make accurate decisions based on all of a patient's historical data. SETMA received the Davies Ambulatory Award in 2005.

Mission: Southeast Texas Medical Associates, LLP, was formed in 1995 by Drs. Holly and Wilson as a practice through which healthcare providers could provide quality, private healthcare to their patients in southeast Texas. SETMA is also intended to allow the practice to align activities with managed care to:

- Maintain the health of our patients;
- Maintain quality of life for our patients; and
- Do it in a cost-effective way.

PPC®– PCMH™ Status: Application submitted for Level 3 recognition.

Patient Demographics: SETMA employs 260 personnel and has a patient base of more than 80,000. In addition, through electronic means, SETMA provides management services to the critical care areas of two local hospitals, Golden Triangle Physicians Alliance (a physician-owned IPA), and Select Care of Texas (a federally approved PSO). SETMA's IT solution is integrated across the entire network, providing HIPAA-compliant access to patient data at all points of service including all emergency rooms, three hospitals, all clinical locations, all providers' residences and nursing homes.

Service Locations: Three clinic locations in Beaumont.

1. What motivated your organization to become a Patient Centered Medical Home?

Even as the concept of PCMH became more and more mainstream, SETMA was as ignorant of what it meant as we were about managed care 13 years ago. After attending a PCMH lecture on Feb. 16, 2009, SETMA decided to take the same approach as we had with managed care. Over a one-month period, we did a thorough analysis of our practice based on CMS' 28 principles of PCMH. SETMA produced a 400-page analysis of our practice, in which we identified areas in our practice that reflected the ideals of PCMH, as well as the PCMH functions we were lacking. By March 2009, our judgment was that PCMH was a logical extension for our practice. SETMA published all of our electronic patient management tools on the SETMA Website, as well as publishing our public reporting of provider performance on quality measures.

2. What are the three key value points from becoming a PCMH?

1) **Creating** "intentionality: about quality, excellence, coordination and integration of our patients' health care rather than "coincidently" achieving parts of each. (For more on this concept see "Medical Home Part IV: Help and Hope in Health care", March 12, 2009 at www.jameslhollymd.com under Your Life Your Health.) In that article, it is stated:

"The most innovative aspect of Medical Home and the thing which distinguishes it from any other well-organized and highly-functioning medical organization is the concept of 'Coordination of Care'. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current NCQA, CMS, NQF, PCPI, AQA, and HEDIS requirements for demonstration of excellence in the providing of care.

.

"The concept of 'intentionality'is critical in this process. This is contrasted with 'incidental.' In health care, most HEDIS compliance and coordination of care are done coincidental to a patient encounter, as opposed to having a purposeful, provable and persistent method of fulfilling of national standards of care. Rather than hoping the result is good, "Coordination of Care' plans and reviews care to make certain that it meets the highest standards.

"The Medical Home intentionally fulfills the highest and best health care needs of all patients. In addition, patients are involved in this coordination by our making them aware of the standards and giving them a periodic review, in writing, of how their care is or is not meeting those standards. Patients are encouraged to learn and pursue preventive care on their own."

2) **Team** – The challenge to create a healthcare team with the patient and all healthcare professionals. It is the realization that if the one in charge of a patient's healthcare is characterized as the one with the "baton", the patient has the baton for the majority of the time. (For more on this concept see "Passing the Baton: Effective Transitions in health care Delivery", March 10, 2010, on our Web site at www.jameslhollymd.com under "Your Life Your Health.")

3) It is to discover the true implications of SETMA's motto, which we adopted in August 1995, that states, "Health Care Where Your Health is the Only Care." It is to put patients and their needs first. SETMA has done that in many ways. We developed The SETMA Foundation through which we help provide funding for the care of our patients who cannot afford it.

3. How has health IT enabled your organization to fulfill the requirements of the PCMH?

Without health IT, SETMA could not address the complex patient-care issues which are required by 21st century, technological healthcare, not to mention the complex needs of patients with multiple diseases. Health IT has allowed us to embed hundreds of quality metrics—both process and outcomes—into our EMR, making it ―easier to do it right than not to do it at all.‖ We daily and individually track all HEDIS measures on every patient. We participate in PQRI tracking for more quality metrics than those required. We measure Ambulatory Care Quality Alliance (AQA) standards. We track the Physician Consortium for Performance Improvement (PCPI) metrics for diabetes, hypertension, CHF, Chronic Stable Angina, Chronic Renal Diseases, etc. And, where no agency, or organization has endorsed quality measures, such as for Lipids and Chronic Renal Disease Stage I-III, SETMA wrote our own. We are able to look at patient populations by practice or provider to see longitudinally whether their treatment is to goal and to compare those who are not at goal with those who are. This allows us to see if patterns of care emerge that allow us to improve everyone's care. We are able to look at populations from socio-economic and ethnic perspectives to make sure we have eliminated disparities in care which traditionally afflict these groups.

4. How has quality been transformed in your organization and what role has health IT played? For instance, the ability to measure, monitor and trend?

Using digital dashboard technology, SETMA analyzes provider and practice performance in order to find patterns that can result in improved outcomes practice-wide for an entire population of patients. We analyze patient populations by:

- Provider panel
- Practice panel
- Financial Class – payer
- Ethic group
- Socio-economic groups

We are able to analyze if there are patterns to explain why one population or one patient is not to goal and others are. We can look at:

- Frequency of visits

- Frequency of testing
- Number of medications
- Change in treatment
- Education level
- Many other metrics

We are able to track over time patient results comparing:

- Provider to practice
- Provider to provider
- Provider current to provider over time
- Trending of results to see seasonal changes, etc.

5. What are your next steps, and how will health IT factor into your success?

We will add to our auditing ability. We will add functions to our patient care. We will participate in the transformation of healthcare and health IT, which in 10 years, will be different than it is now. For instance, with the human genome detailed and with more and more genetic foundations for disease being discovered, we believe that in 10 years or less, it will be necessary to have medical informatics capabilities to store, analyze and use each patient‘s genome in their treatment. That is a huge database task for which we are already discussing and designing solutions. We will all get there one step at a time. At times we will lead the development and at other times we will follow the lead of others.

6. What tips would you provide to others in preparing for and going through the process?

Get started! No matter how daunting the task, the key to success is to start. Compete with yourself, not others! Measure your success by your own advancement, and not by whether someone else is ahead or behind you. In the same way, share your success with others. In helping others succeed, you will find true fulfillment.

7. In addition to the six questions above, if you have any additional materials, guidance and/or knowledge to share.

Our Web site has an 11-part series on PCMH. That series reflects our growth and development. Other materials there (under Your Life Your Health) show how we continue to learn and to grow. Under Medical Home at www.jameslhollymd.com, we display the tools we have developed and will continue to post new tools that we develop. Under EPM, we display all of our electronic patient management tools. Under Public Reporting, we display our providers‘performance on all

of the quality measures we are following.

A New Day in Healthcare for You and For us
Part VI: Meaningful Use
By James L. Holly, MD
Your Life Your Health
The Examiner
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On February 17, 2009, President Obama signed the *American Recovery and Reinvestment Act* **(**ARRA**)**. The HITECH (Health Information Technology for Economic and Clinical Health) Act is part of this legislation and is designed to encourage physicians and other healthcare organizations to adopt and use (in a meaningful way) Electronic Health Records (EHR).

In the August 26, 2010, Your Life Your Health, we discussed the requirement that healthcare providers use a "certified EHR" in order to quality for "meaningful use," which is a description of the use of an EHR which will contribute to patient safety and improved quality of care.

In a February, 2010, *Health Leaders Magazine* published an article on "meaning use" *(the link to this article can be found at www.jameslhollymd.com* under *About Us, "In-the-news"*) the following was stated:

> "Based on the 2011 meaningful use criteria defined by the Centers for Medicare & Medicaid Services on December 30, 2009, for example, providers have to improve quality, safety, efficiency, and reduce health disparities by using computerized physician order entry, e-prescribing, and maintaining an active medication list and up-to-date problem list of current and active diagnoses. Providers will also have to engage patients and families by providing patients with an electronic copy of their health information, including diagnostic test results, medication lists, and problem lists, and to improve care coordination by having the capability to exchange key clinical information among care providers. In addition, providers will have to improve population health management by having the capability to submit electronic data to immunization registries and public health agencies—all while ensuring adequate privacy and security protection for personal health information created or maintained in the EHR.
>
> "That is just a snapshot of the technologies organizations need to have in place for the 2011 guidelines. Each year the thresholds and expectations will increase. The proposed rule only defined the 2011 meaningful use criteria, but it did provide insight into where organizations will need to be by 2015. For instance, organizations should be able to achieve minimum levels of performance on national quality, safety, and efficiency measures; use clinical decision support for national high-priority conditions; give patients access to self-management tools and comprehensive health data; and not only capture data in electronic formats, but also be able to exchange both transmission and receipt of that data in an increasingly structured format. The goal by 2015 is to have a patient-

centric, interoperable health information exchange across provider organizations regardless of providers' business affiliations or EHR platform.

"It's a tall order with a lot of moving parts. But to improve outcomes beyond the meaningful use guidelines, senior leaders can't lose sight of what the technology will have to be capable of years from now. Healthcare providers will need to be able to process in a timely manner all of the data being generated to provide the type of clinical decision support and coordinated care that physicians want and patients and payers will demand."

Meaningful use Core and Menu Objectives

The final rule which has not been published, established the following criteria for a physician or group of physicians to achieve "meaningful use" and to quality for payments from CMS. There are two sets of functions required. The first is called an "core set" and all of these must be met. The second is called "menu set" and only five of those must be met in 2011 but one of those five must be one of the measures marked by an double asterisks.

Core SET Objectives and Measures

1. Record patient demographic, (sex, race, ethnicity, date of birth and preferred language) . More than 50% of patients' demographic data records as structured fields.
2. Record vital signs (height, weight and blood pressure for age 2 and higher. More than 50% of patients 2 years of age or older have height, weight and blood pressure recorded as structured data.
3. Maintain up-to-date problem list of current and active diagnoses. More than 80% of patients have at least one entry recorded as structured data or an indication that they have no problems.
4. Maintain active medication list. More than 80% of patients have at least one entry recorded as structured data or an indication they are on no medications.
5. Maintain active medication allergy list. More than 80% of patients have at least one entry recorded as structured data or an indication that they have no allergies.
6. Record smoking status for patients 13 years of age or older. More than 50% of patients 13 years or older have smoking status recorded as structured data.
7. Provide patients with clinical summary for each office visit. Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.
8. On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and medication allergies. More than 50% of requesting patients receive electronic copy within 3 business days.
9. Generate and transmit permissible prescriptions electronically. Moe than 40% of permissible prescriptions are transmitted electronically using certified EHR technology.

10. Computer provider order entry (CPOE) for medication orders. More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE.
11. Implement drug-drug and drug-allergy interaction checks. Functuality is enabled for these checks for the entire reporting period.
12. Implement capability to electronically exchange key clinical information among providers and patient-authorized entities. Perform at least one test of EHR's capacity to electronically exchange information.
13. Implement one clinical decision support rule and ability to track compliance with the rule. One clinical decision support rule implemented.
14. Implement systems to protect privacy and security of patient's data in the EHR. Conduct or review a security risk analysis, implement security updates as necessary and correctly indentified security deficiencies.
15. Report clinical quality measure to CMS or states. For 2011, provide aggregate numerator and denominator through attestation for 2012 electronically submit measures.

Menu Set Objectives and Measures
(Must select five measures and
one must be one of those identified with a double asterisk.)

1. Implement drug formulary checks. Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period.
2. Incorporate clinical laboratory results into EHRs as structured data. More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data.
3. Generate lists of patients by specific conditions to sue for quality improvement, reduction of disparities, research or outreach. Generate at least one listing of patients with a specific condition.
4. Use EHR technology to identify patient/specific education resources and provide those to the patient as appropriate. More than 10% of patients are provided patient-specific education resources.
5. Perform medication reconciliation between care settings. Medication reconciliation is performed for more than 50% of transitions of care.
6. Provide Summary of care record for patients referred to or transitioned another provider or setting. Summary of care record is provided for more than 50% of patient transitions or referrals.
7. Submit electronic immunization data to immunization registries or immunization information systems.**

8. Submit electronic syndromic surveillance data to public health agencies. Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data.**
9. Send reminds to patients (per patient preference) for preventive and follow-up care. More than 20% or patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders.
10. Provide patients with timely electronic access to their health information (including laboratory results, problem lists, medication lists, medication allergies). More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR.

Intent

If physicians demonstrate "meaningful use" in 2011, 2012, 2013, and 2014, they will receive a payment in the form of increased Medicare or Medicare reimbursement. If physicians ignore EHRs and meaningful use, in 2015, penalties are accessed so that the physicians will be paid less than those who are using an EHR meaningfully. The problem is that the penalties are relatively low and may not be enough to motivate EHR adoption.

The intent of this bill and of the incentive payments is both to encourage the adoption of EHRs and to encourage the expansion of their use in order to improve patient safety and quality outcomes. The Federal Government anticipates that 420,000 physicians will qualify for meaningful use payments in 2010. There is a potential for this not happening. In fact, the number qualifying for meaningful use for 2011 may be significantly lower, maybe by as much as 90% lower.

Potential

None of the core or menu functionalities required for meaningful use are inappropriate. The problem is how many providers will be able to perform at that level in the short term. There is no question that SETMA meets most of these standards and the two that we do not currently meet; we will meet by January 2011. But, SETMA has been implementing an EHR since 1998. It would be frightening to us if we did not presently use an EHR at all, and knew that by the end of 2011, we would have to be using it to the level described in the meaningful use rules..

Furthermore, the cost of implementing an EHR is much higher than the funds being offered in this incentive. SETMA has spend and paid for over $6,000,000 for EHR and related technologies over the past 12 years. Many providers may decide that it is cheaper to accept the penalties

which are relatively small, than to implement the technology. If that happens, then it is possible that this bill, designed to promote the adoption of EHRs, may in fact have the opposite effect.

Solution

Providers can quickly buy an inexpensive EHR, which provides the basic functions required for meaningful use. The problem with this is that it may be a short term solution with longer term limitations on obtaining the maximum patient-care benefit from electronic patient management.

Some solo and small group physicians may seek out medical groups who have already achieved meaningful use and join forces with them. This has benefit for both as long as the new physicians are prepared to learn and use the electronic system to its maximum benefit.

Conclusion

Since the publication of the August article on certified EHRs, two agencies have been granted the authority to review EHR vendors' products for whether they meet meaningful use standards. The only problem is that the specifics of that standard have not yet been published.

There is not doubt that the concept of meaningful use is a good one. The problem will come in both the government's inability to fulfill its part of the process effectively and the time table – a three year phase in – may be too aggressive. The desire to get it done and to get in done right now may slow the process of adoption of EHRs rather than speed it up. We shall see.

It had been my hope that healthcare providers who had qualified as patient-centered medical homes could be granted meaningful use standards without further qualifying requirements. This hope was particularly related to those who had qualified for NCQA's Tier (Level) III PC-MH recognition. Now that SETMA has achieved NCQA Tier III recognition, and as we have revived the requirements for meaningful use, it is obvious that that will not happen. Less than 0.3% of medical practices in the United States have qualified as a medical home and only about 70% of those who qualify do so at the Tier III level. And, while all of the meaningful use requirements of NCQA PC-MH, it is possible to become a Tier III medical home without achieving all of the elements of meaningful use. We will have to qualify for meaningful sue in addition to receiving medical home recognition.

Note: On September 29, 11:00 AM CDT, Dr. Holly will be conducting a national webcast sponsored by IBM. The subject title is "Business Intelligence and Reporting at SETMA: Improving Quality, Outcomes and Clinical Practices." You can get information on how to register at no cost for the presentation by checking SETMA's website or by calling SETMA after Tuesday, September 21, 2010.