
QIN-QIO SHARING CALL
QIN-QUALITY IMPROVEMENT ORGANIZATIONS (QIOS)
QUALITY IMPROVEMENT NETWORK –
NATIONAL COORDINATING CENTER (QIN-NCC, TELLIGEN)
CMS I ITH SCOPE OF WORK

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**SETMA's Development: Automation and Model of Care
Which Prepared For
Medicare Access and CHIPS Reauthorization Act (MACRA)
and the Merit-Based Incentive Payment System (MIPS)**

CONFLICTS OF INTEREST

- James L. Holly, MD has no conflicts of interest to report in relationship to this presentation.

GOALS AND OBJECTIVES

1. Principles of Practice and EMR Development
2. Recognizing and Benefiting from Seminal Moments in Practice Transformation
3. How to address provider fatigue and/or burn-out
4. The Progression from Clinical Decision Support and Disease Management Tools to Process Automation
5. Improving Provider Performance and Satisfaction with Automation
6. Developing Tools for Provider and Patient Collaboration
7. The relationship between MACRA and MIPS and SETMA's Standards of Care

FOUR SEMINAL EVENTS – MAY, 1999

- The first event was the announcement that the electronic health records (EHR) was too hard and too expensive if we only gained the ability to document a patient encounter electronically.
- EHR was only “worth it,” if we could leverage electronics:
 1. to improve care for each patient;
 2. to eliminate errors which were dangerous to the health of patients; and,
 3. to improve the care and health of all patients and of population groups.
- **This was our transition from EMR to electronic patient management (EPM).**

FOUR SEMINAL EVENTS – MAY, 1999

- The second event was the application of Peter Senge's *The Fifth Discipline* as we defined ten principles which guided SETMA's EMR development and SETMA's transformation, ten years later, into a Patient-Centered Medical Home (PC-MH). The principles are:
 1. Pursue Electronic Patient Management rather than EMR
 2. Bring what is known to every patient encounter, not just what a particular provider knows
 3. **Make it easier “to do it right than not to do it at all”**
 4. Continually challenge providers to improve their performance
 5. Infuse new knowledge and decision-making tools throughout an organization instantly

FOUR SEMINAL EVENTS – MAY, 1999

6. Promote continuity of care with patient education, information and plans of care
7. Enlist patients as partners and collaborators in their own health improvement
8. Evaluate the care of patients and populations of patients longitudinally
9. Audit provider performance based on endorsed quality measurement sets
10. Integrate electronic tools in an intuitive fashion giving patients the benefit of expert knowledge about specific conditions

FOUR SEMINAL EVENTS – MAY, 1999

Cortez - Fahrenheit 451 - Maginot Line

- The third seminal event was the preparation of a philosophical base for our future; written in May, 1999 and published in booklet form in October, 1999, this blueprint was entitled, “More Than a Transcription Service: Revolutionizing the Practice of Medicine: And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) which Evolves into Electronic Patient Management.”
- This booklet was distributed to our practice and our community. It became our declaration that we were going to succeed at this process at any cost and at any effort.
- **We called that our "Cortez Project". Like Cortez, we scuttled our ships; there was no going back. We had to succeed.**

FOUR SEMINAL EVENTS – MAY, 1999

- The fourth seminal event was that we determined to adopt a celebratory attitude toward our progress in EMR.
- In May, 1999, my cofounding partner was lamenting that we were not crawling yet with our use of the EMR. I agreed and asked him, “When your son first turned over in bed, did you lament that he could not walk, or did you celebrate this first milestone of muscular coordination of turning over in bed?” He smiled and I said, “We may not be crawling yet, but we have begun. If in a year, we are doing only what we are currently doing, I will join your lamentation, but today I am celebrating that we have begun.”

FOUR SEMINAL EVENTS – MAY, 1999

- SETMA's celebratory spirit has allowed us to focus on the future through many lamentable circumstances and has allowed us to press forward through many disappointments. Focusing on our successes kept us moving forward and the cumulative effect was always success.

TRANSFORMATION OF PRIMARY CARE

- The future of primary care is providers with internalized ideals and personal passion for excellence. Transformation is the goal, as it is self-sustaining and generative (creative tension).

- SETMA believes that the strategies which must be employed in this transformative effort are:
 1. The **methodology** of healthcare must be electronic patient management.
 2. The **content and standards** of healthcare delivery must be evidenced-based medicine.
 3. The **structure and organization** of healthcare delivery must be patient-centered medical home.
 4. The **payment methodology** of healthcare delivery must be that of capitation with additional reimbursement for proved quality performance and cost savings.

SETMA'S PAST ALIGNS WITH MACRA/MIPS

- The four categories defined by MIPS in 2015 correlate with the four strategies SETMA defined in 2000-2005 for the transformation of our practice. In 2000-2005, SETMA established the belief that the key to the future of healthcare transformation was an internalized ideal and a personal passion for excellence rather than reform which comes from external pressure. Transformation is self-sustaining, generative and creative. In this context, SETMA believes that efforts to transform healthcare may fail unless four strategies are employed, upon which SETMA depends in its transformative efforts.

SETMA'S PAST ALIGNS WITH MACRA/MIPS

- SETMA's Strategies for Healthcare Transformation - **MIPS Categories of Scoring System**
 1. The methodology of healthcare must be **electronic patient management** - **MIPS Advancing Care Information** (an extension of Meaningful Use with a certified EMR)
 2. The content and standards of healthcare delivery must be **evidenced-based medicine** - **MIPS Quality** (This is the extension of PQRI which in 2011 became PQRS and which in 2019 will become MIPS -- evidence-based medicine has the best potential for legitimately effecting cost savings in healthcare while maintaining quality of care)

SETMA'S PAST ALIGNS WITH MACRA/MIPS

- SETMA's Strategies for Healthcare Transformation - **MIPS Categories of Scoring System**
- 3. The structure and organization of healthcare delivery must be **patient-centered medical home** - **MIPS Clinical Practice Improvement Activities** (This MIPS category is met fully by Level 3 NCQA PC-MH Recognition).
- 4. The payment methodology of healthcare delivery must be that of **capitation with additional reimbursement for proved quality performance and cost savings** - **MIPS Cost** (measured by risk adjusted expectations of cost of care and the actual cost of care per fee-for-service Medicare and Medicaid beneficiary)

SETMA'S PAST ALIGNS WITH MACRA/MIPS

- This is remarkable both in affirming our work over the past twenty years and affirming the rationale behind MACRA and MIPS. This realization came as the result of the writing of this article and twelve other articles about MACRA and MIPS.
- Personally, I approve of MACRA and MIPS and think it is a step in the right direction, however, I think there are potential problems with the design of MIPS. Some of the rationale for my concerns are present in at the following link: <http://www.jameslhollymd.com/the-setma-way/setma-model-of-care-pc-mh-healthcare-innovation-the-future-of-healthcare>.
- The following is an explanation of this concern.

HOW MANY TASKS WILL A PROVIDER DO?

- In May, 2012, at a Massachusetts Medical Society Conference, this question was asked. After a lengthy discussion, the speaker who asked the question answered it by saying, “You can get a provider to do one thing at every visit.”
- The last speaker said, “You can’t answer that question until you answer three other questions:
 1. How important is the task you are asking providers to do?
 2. How much time does it take?
 3. How much energy does it take?

HOW MANY TASKS CAN YOU GET A PROVIDER TO DO?

- If you were to create a formula to represent this process, there would be a direct correlation between how many tasks a provider can or will do and how important the tasks are; the more important the tasks, the more tasks a provider will do.
- There would be an inverse relationship between how much time it takes and how many tasks will be done; the more time it takes, the fewer tasks will be done.
- There would also be an inverse relationship between how much energy it takes and how many tasks will be done; the more energy it takes, the fewer tasks will be done.
- The key to getting more done is to determine what is important and only to do that, and then to make the completion of the important tasks require less energy and less time.

COMPLEXITY DEMANDS SYSTEMIC SOLUTIONS

- The Texas State Health Department's Reportable Conditions illustrates the standardization and the automation of parts of healthcare processes. Remember, "The more complex a problem is, the more systemic the solution must be."
- Today, SETMA providers make a diagnosis, and when that diagnoses is one of the seventy-eight reportable conditions, automatically, the condition is reported to the state with the provider doing nothing more than making the diagnosis.
- If an important task is not being done either because the provider is resistant to doing it, or because the provider has "too much" to do, automate it. (Remember the Maginot Line)

COMPLEXITY DEMANDS SYSTEMIC SOLUTIONS

- In August, 2010, the *American Academy of Family Practice Journal* recommended that every family physician calculate one Framingham Risk Score for each of their patients every five years.
 1. There are 12 Framingham Risk Scores
 2. To turn these scores into a tool for challenging patients with the premise “If you make a change, it will make a difference.”
 3. You can add “What If Scenarios” to each
 4. But now you have 72 computations
 5. Can you get a provider to do all of these scores at every visit?

HOW CAN WE CHANGE THE FUTURE OF PRIMARY CARE?

- Make it easier to do it right than not do it at all!
- With automation, imitate Henry Ford, who automated the manufacturing of automobiles with assembly lines and in so doing made it possible for those who made cars to afford to drive them.
- There are many aspects of patient care which can be automated.
- Classically, SETMA has used clinical decision support as reminders to providers, but now we are realizing that many of the tasks which were the object of CDS, actually could and should be automated, requiring no input from the provider.
- For instance, the value of the flu immunization is not enhanced by it being ordered by a healthcare provider, or by it being given by a registered nurse.
- And, the process of a flu immunization can be automated.

THE IDEA OF AUTOMATION GROWS

- In June, 2013, the *American Medical News* published an article entitled, “Serious work put into making primary care fun again.”
- With an anticipated serious shortage of primary care physicians over the next twenty years, the article addressed how to improve the lot of primary care providers, stating in part:

“Amid alarming rates of physician burnout, hundreds of clinics nationwide are redesigning their practices with a goal in mind beyond improving the quality of care. They are aiming to make life as a primary care doctor enjoyable once more. Twenty-three of these clinics...describe practice innovations that can ease the chaos, administrative overload, miscommunication and computerized busy work that too often characterize primary care.”

GENESIS OF AN IDEA

- In 1993, John Patrick set IBM on another course and changed the company's future.
- Reading his story made me wonder, is it possible for SETMA to set medicine on another course and to change the future.
- John did not want people to work “collaterally,” side by side, maybe going in the same direction, maybe even having the same goal, but working independently and at best in a cooperative manner; he wanted people to work “collaboratively,” synergistically, leveraging the generative power of a team in creating a new future which they partially envision but which even they could not control.

GENESIS OF AN IDEA

- What can we do today in healthcare which would mirror the changes IBM experienced? How can we change “**collateralists**” into “**collaborativists**”?
- How can we use the power of electronics, analytics, and informatics principles to energize radical change to create a new future in healthcare?
- Testing and measurement is a science. In most industries, quality is determined by testing performance.

GENESIS OF AN IDEA

- **But, in healthcare we are involved in a new kind of “testing.”** The tests used to measure the performance of healthcare providers are unique. Therefore:
 1. If we are going to measure the quality of care given by healthcare providers:
 2. If we are going to give a test to healthcare providers, and
 3. If we are going to give them the test questions before hand, and
 4. If the test is open-book, and
 5. If there is no time limit for taking the test

GENESIS OF AN IDEA

- Why not “cheat?” Look up the answers before the test so providers can know their performance before they get the test results.
- Don’t wait until an insurer, an ACO, or an agency measures your HEDIS performance. Know your performance by measuring your performance yourself.
- In fact, know your performance at the time you see a patient. The ultimate “game changer” in healthcare is when the provider knows how he/she is doing in the care of an individual patient, or in the care of a panel or population of patients and then when the provider turns around and shares this information with patients and with the public at large.
- The game is changed because the motivation to improve is maximized.

THERE IS NO CHEATING!

- Of course, ethically there is no “cheating” in this context.
- Unlike traditional medical-education tests, this test is not measuring what you know; **it is measuring what you have access to and it is measuring to what you pay attention.**
- It is measuring how efficiently and excellently you are applying what you know.
- The test is not measuring what you remember; **it is measuring what you are reminded of.**
- If you have Clinical Decision Support (CDS) which remind you of what needs to be done and if you have CDS tools which allow you to measure your own performance at the point of care, you can consistently improve your performance.

ABRAHAM LINCOLN

- This is the power of data analysis in the quality improvement of healthcare; it is the power of a provider knowing his/her own performance at the point of care.
- This is the application of Abraham Lincoln's 1858 statement in which he said:

“If we can first know where we are and whither we are tending; we can better judge what to do and how to do it.”

THE MAGINOT LINE

- In April, 2013, after a three and a half hours presentation of SETMA's system to eight Medicare Advantage executives, they asked how they could get other providers to perform as well as SETMA.
- They were told to develop leaders who will help improve the processes and outcomes of care, but that they must recognize also that some times physician leaders use their positions to resist, or to obstruct change rather than to facilitate it.
- This is not unlike the French Government after World War I.

THE MAGINOT LINE

- Determined never to be invaded by Germany again, in the 1930s the French constructed a fixed, defensive fortification between France and Germany called the Maginot Line.
- The French did not know what General George Patton intuitively knew. In an era of mechanized warfare, fixed fortifications could be and were easily ignored.
- The enemy went around the Maginot Line. Similarly, when the barrier to healthcare improvement is created by the refusal of healthcare providers to accept new realities and new standards of care, health systems will simply go around them.
- The intent is to make the obstructing providers irrelevant to the process. The reality is if healthcare providers become fixed fortifications against the future, the process and the system will go around them.

VALUE EQUALS QUALITY DIVIDED BY COST

- The lessons of the industrial revolution give us guidance here. Rather than handmade tools and machines made by artisans who were creative geniuses, machines were made by other machines and they were reproduced in mass.
- Costs went down and quality went up, so the value escalated geometrically.
- **Applying these lessons of standardization, automation and reproducibility to healthcare, we can get to our goals much faster.**
- Henry Ford made a new machine on an assembly line which was nothing more than a standardized, automated method for producing a product which also required human input.

VALUE EQUALS QUALITY DIVIDED BY COST

- If healthcare providers look at every process and outcome in healthcare as a sum of that which can be automated and standardized, and of that which still requires human input, healthcare quality can improve predictably.
- The cost can be reduced consistently, and provider and patient satisfaction can improve.
- Some things in healthcare cannot yet be standardized and automated but the satisfaction of receiving the care that can be, will be increased by determining what can be automated and standardized and then by doing so.

HOW CAN WE CHANGE THE FUTURE?

1. When a patient is given an appointment and the system determines that the patient has not had a current flu immunization and the appointment time is in the appropriate time frame to receive the vaccine, the system should order the flu immunization, and send the order to the nurse, to the chart and to charge posting. The provider is not involved which increases the probability that it will be done.
2. Additionally, the system should be programmed so that every patient who has not made an appointment in the time frame for a flu immunization should be notified electronically at the beginning of the flu-immunization season that they need to have a flu shot and toward the end of the immunization season, the system should check again to see who has not had the shot.

HOW CAN WE CHANGE THE FUTURE?

- This principle can be expanded to all chronic conditions for which the patient is being treated and/or for all screening and preventive care the patient requires.
- In the future, all healthcare process will be evaluated for:
 1. That which can and should be automated, all based on evidence-based medicine
 2. That which requires human input based on patient-centered care
- This will give the healthcare provider more time to focus on the patient while fulfilling the processes (care) which we believe will improve the health (outcomes) and which will decrease the cost of excellent care.
- Automation of care can help healthcare providers fulfill the “triple aim” and it can reduce or even eliminate “burn out.”

THE EXPLANATION AND THE EXECUTION – THE VISION

- As we learn more about how to improve our health and as we are able to change the future of our health more, excellence in healthcare increasingly is dependent upon two things:
 1. a team approach and
 2. the automation of those standardized tasks,
- Which while they are critical to excellent care, can be completed without requiring the time and attention of team members. This gives the team more time to interact with one another personally.
- This standardization and automation of care brings us one step closer to the ultimate promise of electronic patient management which is the ultimate goal of electronic patient records.

The Automated Team is the logical extension of clinical decision support.

THE EXPLANATION AND THE EXECUTION – THE TEAM

- The majority of healthcare is delivered and received in the ambulatory setting in a clinician's office.
- While the healthcare team is much broader, in the ambulatory setting, the principle members of the team are the patient, the nursing staff and the healthcare provider.
- Ultimately, while the standardization and automation of this team's functions will spread across all areas of care, Southeast Texas Medical Associates' efforts begin with diabetes.
- Each member of the team - patient, nurse, and provider -- contribute to the excellence of ambulatory care for diabetes.

THE EXPLANATION AND THE EXECUTION – THE PLAN

- When a patient who has diabetes makes an appointment, based on evidenced-based medicine and national standards of care, the electronic record will immediately:
 1. Search the patient’s entire medical record to determine what tests, procedures, consultations or interventions are required and
 2. Which have not been performed.
- Interventions will be directed at the prevention of the complications of diabetes and/or at the improvement of the care of the patient with diabetes.
- Because diabetes is a progressive disease, excellence of care at one point in time may not reflect excellence of care at another time, thus the reason why the “automated team” needs an updated, current and complete plan of care and treatment plan at each visit.

THE EXPLANATION AND THE EXECUTION – THE AUTOMATION

When the patient presents for their appointment, three documents will have been prepared:

- I. For the nurse, a document will have been prepared which lets the nurse know what elements of his/her contribution to the team's effort are not up to date and need to be addressed, such as The LESS Initiative, the 10-gram monofilament sensory examination, immunizations, medication reconciliation, etc.

THE EXPLANATION AND THE EXECUTION – THE AUTOMATION

When the patient presents for their appointment, three documents will have been prepared:

2. For the patient, a patient engagement and activation document will have been prepared which tells the patient what tests, procedures or referrals have been scheduled. An explanation will be provided to the patient as to why he/she is being asked to have these tests, procedures, or appointments. As stated above, all interventions will be directed toward the improvement of the patient's care and the avoidance of the complications of diabetes. With this document, the patient will know what his/her responsibility is to support the efforts of the team.

THE EXPLANATION AND THE EXECUTION – THE AUTOMATION

When the patient presents for their appointment, three documents will have been prepared:

3. For the provider, a document will have been prepared which explains the information which has been given to the nurse and the patient. The provider will be alerted to whether or not the patient has been treated to goal for diabetes and if they are not, the provider will be encouraged to change medication, life-styles, education, etc., in order to achieve control.

THE TEAM'S ACTIVATION - TRUE PATIENT-CENTERED CARE

- Each team member will have access to the documents given to other members of the team. Each team member will know what is expected of the team and each team member will know the goals are for the entire team.
- **Because the team will be spending less time on the tasks of ordering and scheduling tests, procedures and referrals, there will be more time for the building of relationships and for the activation and engagement of each member of the team.**
- This will leave more time for the provider to listen to the patient's healthcare concerns and desires, to modify the patient's plan of care and treatment plan to improve outcomes and to make certain that he grasps the "baton" through which the patient will accept responsibility for their care.


PRE-VISIT/PREVENTIVE SCREENING

- Every ambulatory visit at SETMA starts with the Pre-Visit/Preventive Screening template which is seen below. The illustration below shows the template after it has been deployed, which means that the notations created by The Automated Team functions are already present on the template.
- The legend for this template is that all elements in black apply to the patient and have been done. All elements in grey, do not apply to the patient and all items which apply to the patient and which have not been done appear in red. When the template is opened, all elements of diabetes are automatically searched by the computer and the elements of diabetes care which have not been done are automatically completed. The completed items are noted in green on this template. Eventually, all items on this template will be automated but SETMA has started with diabetes.

PRE-VISIT/PREVENTIVE SCREENING

- Once any non-automated measures have been dealt with, the nurse and/or provider will click the button entitled “Return.” At that time, three documents will be automatically created. They are discussed and illustrated below. There is a document for the nurse, for the patient and for the healthcare provider. All members of the ambulatory healthcare team will receive all information given to the other members of the team:
 1. The information given to the nurse will also appear on the document prepared for the patient and for the provider.
 2. The information given to the patient will also appear on the document provided for the nurse and the provider.
 3. The information given to the provider will also appear on the document provided to the patient and the nurse.

PRE-VISIT/PREVENTIVE SCREENING



Patient Sex Age Patient's Code Status
 Home Phone Date of Birth
 Work Phone **Patient has one or more alerts!** [Click Here to View Alerts](#)
 Cell Phone

[Pre-Vist/Preventive Screening](#)

Patient Eligible For Medicare Preventive Exam
Urine Drug Screening Suggested - [Click Here](#)

[Intensive Behavioral Therapy Transtheoretical Model](#)
[Bridges to Excellence View](#)

<p>Preventive Care</p> <p>SETMA's LESS Initiative I Last Updated <input type="text" value="01/20/2015"/></p> <p>Preventing Diabetes I Last Updated <input type="text" value="//"/></p> <p>Preventing Hypertension I</p> <p>Smoking Cessation I</p> <p>Care Coordination Referral</p> <p>PC-MH Coordination Review</p> <p>Needs Attention!!</p> <p>HEDIS NQF ACO</p> <p>Elderly Medication Summary</p> <p>STARS Program Measures</p> <p>Exercise Exercise I</p> <p>CHF Exercise I</p> <p>Diabetic Exercise I</p>	<p>Template Suites</p> <p>Master GP I</p> <p>Pediatrics</p> <p>Nursing Home I</p> <p>Ophthalmology</p> <p>Physical Therapy</p> <p>Podiatry</p> <p>Rheumatology</p> <p>Hospital Care</p> <p>Hospital Care Summary I</p> <p>Daily Progress Note</p> <p>Admission Orders I</p>	<p>Disease Management</p> <p>Diabetes I</p> <p>Hypertension I</p> <p>Lipids I</p> <p>Acute Coronary Syn I</p> <p>Angina I</p> <p>Asthma</p> <p>Cardiometabolic Risk Syn I</p> <p>CHF I</p> <p>Diabetes Education</p> <p>Headaches</p> <p>Renal Failure</p> <p>Weight Management I</p>	<p>Last Updated</p> <table border="1"> <tr><td>01/20/2015</td></tr> <tr><td>05/21/2013</td></tr> <tr><td>04/08/2015</td></tr> <tr><td>//</td></tr> <tr><td>//</td></tr> <tr><td>//</td></tr> <tr><td>09/23/2013</td></tr> <tr><td>//</td></tr> <tr><td>//</td></tr> <tr><td>//</td></tr> <tr><td>//</td></tr> </table>	01/20/2015	05/21/2013	04/08/2015	//	//	//	09/23/2013	//	//	//	//	<p>Special Functions</p> <p>Lab Present I</p> <p>Lab Future I</p> <p>Lab Results I</p> <p>Hydration I</p> <p>Nutrition I</p> <p>Guidelines I</p> <p>Pain Management</p> <p>Immunizations Print</p> <p>Reportable Conditions</p> <p>Information</p> <p>Charge Posting Tutorial</p> <p>E&M Coding Recommendations</p> <p>Drug Interactions I</p> <p>Infusion Flowsheet</p> <p>Insulin Infusion</p>
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PRE-VISIT/PREVENTIVE SCREENING

Pre-Visit/Preventive Screening

General Measures (Patients >18)

Has the patient had a tetanus vaccine within the last 10 years?

Date of Last

Has the patient had a flu vaccine within the last year?

Date of Last

Allergic? Y N

Has the patient ever had a pneumonia shot? (Age>50)

Date of Last

Does the patient have an elevated (>100 mg/dL) LDL?

Last

Has the patient been screened at least once for HIV? (Age 13-64)

Date of Last

Testing not required if patient refused, tested elsewhere or diagnosis confirmed.

Check If Patient Refuses Testing

Check If Patient Tested Elsewhere

Elderly Patients (Patients >65)

Has the patient had an occult blood test within the last year? (Patients >50)

Date of Last

Has the patient had a fall risk assessment completed within the last year?

Date of Last

Has the patient had a functional assessment within the last year?

Date of Last

Has the patient had a pain screening within the last year?

Date of Last

Has the patient had a glaucoma screen (dilated exam) within the last year?

Date of Last *Add Referral At Right*

Does the patient have advanced directives on file or have they been discussed with the patient?

Discussed? Completed?

Is the patient on one or more medications which are considered high risk in the elderly?

Male Patients

Has the patient had a PSA within the last year? (Age >40)

Date of Last

Has the patient had a bone density within the last two years? (Age >65)

Date of Last *Add Referral Below*

Diabetes Screening

Is Diabetes screening appropriate for this patient?

Pre-Diabetes Patients

If pre-diabetic, has the patient had a HgbA1c test within the last year?

Date of Last

Diabetes Patients

Has the patient had a HgbA1c within the last year?

Date of Last

Has the patient had a dilated eye exam within the last year?

Date of Last Referral Sent Today *Add Referral Below*

Has the patient had a 10-gram monofilament exam within the last year?

Date of Last

Has the patient had screening for nephropathy within the last year?

Date of Last Ordered Today

Has the patient had a urinalysis within the last year?

Date of Last Ordered Today

Has the patient had a cholesterol screen within the last year?

Date of Last

Has the patient had a flu vaccine within the last year?

Date of Last

Is the patient on aspirin?

Is the patient allergic to aspirin? Yes No

Has the patient ever been referred to DSME? Has the patient been referred to DSME within the last year?

Add Referrals Below

Female Patients

Has the patient had a pap smear within the last two years? (Ages 21 to 64)

Date of Last *Add Referral Below*

Has the patient had a mammogram within the last two years? (Ages 40 to 69)

Date of Last *Add Referral Below*

Has the patient had a bone density within the last two years? (Age >50)

Date of Last Treatment *Add Referral Below*

Referrals Diagnostic/Referral Orders

Status	Ordered	Priority	Order
completed	02/10/2015	Routine	Colonoscopy
ordered	02/03/2016		Referrals: Holly, James. Consult

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.

HOW CAN MACRA AND MIPS BE IMPROVED?

- MIPS could be improved by the establishment of an absolute standard against which providers and practices will be measured, rather than a comparison with others. Competitiveness among providers can improve performance on objective standards but if the idea is to improve the quality of care, an established standard which everyone can meet would be better than the current design of MIPS.

HOW CAN MACRA AND MIPS BE IMPROVED?

- **Additionally, the artificial assumption that performance on nine, or six, or any number of isolated, unconnected, arbitrarily metrics chosen by a practice, often on the basis of how easy it is to perform the requirements of the metric, is not going to change the quality element of practice. This was always the flaw of PQRI and subsequently PQRS, although “comprehensive metric sets” for a particular condition were an option in both programs. **The design flaw was that the comprehensive metric sets were not required. Now the same mistake is being made in MIPS.****

THE ULTIMATE HOPE OF THE FUTURE OF HEALTHCARE IS TRANSFORMATION

- **To be successful, the implementation of new policies and initiatives which will produce the future we imagine, must be transformative which comes from within.** Transformation results in change which is not simply reflected in shape, structure, dimension or appearance, but **transformation results in change which is part of the nature of the organization being transformed.** The process itself creates a dynamic which is generative, i.e., it not only changes that which is being transformed but it creates within the object of transformation the energy, the will and the necessity to sustain and expand that change and improvement. Transformation is not dependent upon external pressure (rules, regulations, requirements) but is sustained by an internal drive which is energized by the evolving nature of the organization.

THE ULTIMATE HOPE OF THE FUTURE OF HEALTHCARE IS TRANSFORMATION

- This transformation will require the patient and the provider to rethink their common prejudice that technology - tests, procedures, and studies - are superior methods of maintaining health and avoiding illness than self discipline, communication, vigilance and "watchful waiting." In this setting, both provider and patient must be committed to evidence-based medicine which has a proven scientific basis for medical-decision making. This transformation will require a community of patients and providers who are committed to science. This will eliminate "provider shopping" by patients who did not get what they want from one provider so they go to another.

SEMTA'S MIPS QUALITY METRIC TOOL

MACRAMIPS Quality Measures

Click to Complete	Measure 068 - Medication Reconciliation Patients 18 and older at every encounter.	Return
Click to Complete	Measure 139 - Fall Risk Screening Patients 65 and older at least once during the year.	
Click to Complete	Measure 069 - BMI Screening and Follow-Up Patients 18 and older at least every six months.	
Click to Address	Measure 165 - Controlling High Blood Pressure Patients 18 and older with hypertension should have blood pressure controlled to below 140/90 mmHg.	
Click to Address	Measure 126 - Use of High Risk Medications in the Elderly Medications deemed high risk should be avoided in patients over 65 years of age.	
Click to Order	Measure 127 - Pneumonia Vaccination Patients 65 and older should have had the pneumonia vaccine at least once.	
Click to Add Med	Measure 128 - Antidepressant Medication Management Patients diagnosed with depression should have an active prescription for an antidepressant for a continuous 180 days.	
Click to Address Order HbA1c	Measure 122 - HbA1c Control for Patients with Diabetes Patients with diabetes should have a HbA1c test at least once during the year and should be controlled to less than 7.0%.	Last HbA1c <input type="text" value="9.4"/> <input type="text" value="07/15/2016"/>
Click to Add Med Order Micral Strip	Measure 134 - Urine Protein Assessment for Patients with Diabetes Patients should have a nephropathy screening at least annually and/or have an active prescription for an ACE or ARB. **Patients with Stage 4 or higher CKD are excluded.	
Calculate Risk Order Lipid	Measure 061 - Heart Disease and Cholesterol Screening Patients 20-79 years of age should have their heart disease risk assessed and a fasting lipid panel at least annually if high risk or every four years if low risk.	Risk Level <input type="text" value="high"/> Last Lipid <input type="text" value="04/08/2015"/>
Click to Add Med	Measure 164 - IVD Use of Aspirin or Another Antithrombotic Patients with ischemic vascular disease should have an active prescription for aspirin or another antithrombotic.	

SEMTA'S MIPS QUALITY METRIC TOOL

- Clicking the link next to the quality measure will take you right to the place in the EHR so you can complete the steps and fulfill the metric. There is no need to go elsewhere to fulfill quality.
- This is making it easier to do it right than to not do it at all!

Medication Review

How to conduct a medication review: ⓘ

Panel Control: Toggle Cycle

Reconciliation Type

Manual reconciliation: Manual medication reconciliation completed

Electronic reconciliation: **Electronic Reconciliation**

Medication Module

Double click grid to add/edit Medication Module.

Medication Name	Sig Desc	Last Refilled
Abilify 2 mg tablet	take 2.5 by oral route once	02/25/2016
aspirin 81 mg tablet, delayed release	inject by Subcutaneous route once daily DM250.50	//
Celebrex 50 mg capsule	take 2 capsule by oral route 2 times every day	//
Celebrex 50 mg capsule	take 2 capsule by oral route 2 times every day	//
Celebrex 50 mg capsule	take 2 capsule by oral route 2 times every day	09/15/2014
hydrocodone 10 mg-acetaminophen 300	take 1 tablet by oral route every 8 hours as needed	12/01/2015

Medication Review

Save & Close Cancel

SEMTA'S MIPS QUALITY METRIC TOOL

MACRAMIPS Quality Measures

Return

Click to Complete	<p>Measure 068 - Medication Reconciliation Patients 18 and older at every encounter.</p> <p>Measure 139 - Fall Risk Screening Patients 65 and older at least once during the year.</p>	
Click to Complete	<p>Measure 069 - BMI Screening and Follow-Up Patients 18 and older at least every six months.</p>	
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Click to Address	<p>Measure 126 - Use of High Risk Medications in the Elderly Medications deemed high risk should be avoided in patients over 65 years of age.</p>	
Click to Order	<p>Measure 127 - Pneumonia Vaccination <i>Ordered</i> Patients 65 and older should have had the pneumonia vaccine at least once.</p>	
Click to Add Med	<p>Measure 128 - Antidepressant Medication Management Patients diagnosed with depression should have an active prescription for an antidepressant for a continuous 180 days.</p>	
Click to Address	<p>Measure 122 - HbA1c Control for Patients with Diabetes Patients with diabetes should have a HbA1c test at least once during the year and should be controlled to less than 7.0%.</p>	<p>Last HbA1c 9.4 07/15/2016</p>
Order HbA1c	<i>Ordered</i>	
Click to Add Med	<p>Measure 134 - Urine Protein Assessment for Patients with Diabetes Patients should have a nephropathy screening at least annually and/or have an active prescription for an ACE or ARB. **Patients with Stage 4 or higher CKD are excluded.</p>	
Order Micral Strip	<i>Ordered</i>	
Calculate Risk	<p>Measure 061 - Heart Disease and Cholesterol Screening Patients 20-79 years of age should have their heart disease risk assessed and a fasting lipid panel at least annually if high risk or every four years if low risk.</p>	<p>Risk Level high</p>
Order Lipid	<i>Ordered</i>	<p>Last Lipid 04/08/2015</p>
Click to Add Med	<p>Measure 164 - IVD Use of Aspirin or Another Antithrombotic Patients with ischemic vascular disease should have an active prescription for aspirin or another antithrombotic.</p>	

AUDITING OUR PERFORMANCE

- Each day we run a report for the previous days' encounters.
- The results are grouped by each provider name.
- Two items are shown on the audit.
 - Encounters where the MIPS Quality Measures Template was not accessed at all.
 - Encounters where one or more items on the MIPS Quality Measures template were left out of compliance.

AUDITING OUR PERFORMANCE

MIPS Quality Measures Summary

Listed below are the encounters from the previous day which (1) did not have the MIPS template accessed at all or (2) which had the MIPS template accessed but one or more measures left outstanding or unaddressed.

Provider	MIPS Template Not Accessed (# of encounters)	1+ Measures Left Outstanding/Unaddressed (# of encounters)
Akhter, J	1	0
Anthony, J	1	0
Anwar, S	0	3
Castro, M	0	0
Dao, T	5	1
Darden, K	0	0

AUDITING OUR PERFORMANCE

MIPS Quality Measures Summary

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