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Quality Improvement – Webinar on Bridges to Excellence & PCMH
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3:40-5:24

Thank you, I am delighted to be here. SETMA is a multi-specialty group with 40 providers. We have been using electronic patient records since 1998 and currently hold accreditation as medical home and for ambulatory care from:

1. NCQA a tier 3 (2010-2016)
2. Accreditation Association for Ambulatory Health Care (2010-2017)
3. URAC (2014-2017)
4. The Joint Commission (2014-2017)

which represents all four of the medical home accrediting organizations. To my knowledge we are the only practice in America that has all four. We also have diabetes recognition, heart stroke recognition and the distinction in patient experience reporting from NCQA.

We are also pleased that the Texas Medical Foundation awarded us in 2012 their Texas Physician Quality Improvement Award and we've just submitted our application for the 2013 and 2014.

SETMA is heavily involved in in-patient, out-patient, long-term residual care and quality improvement. We publicly report on our website at jameslhollymd.com on over 300 quality metrics by provider name and this is our 6th year to do that. We are a Joslin Diabetes affiliate and we are involved in research projects with Robert Wood Johnson Foundation, the MacColl Institute in Seattle, Washington and with the American Board of Family Medicine.

I am delighted to be here today to talk about all the subjects that we are discussing. We are involved with Bridges to Excellence and have benefited financially from that relationship; and as I said we have been pleased to be associated with the Texas Medical Foundation and their quality improvements projects. I look forward to participating with you guys.

13:52 - 19:56

I would be delighted to and I appreciate Jessica's presentation. We have been involved with

Bridges to Excellence and appreciate their very much and appreciate what they provide as far as incentive and encouragement. The work of quality improvement is difficult. Nationally, we know that the literature tells us that it takes 17 years from evidence-based standards being established before those standards are generally incorporated into practice. We must shorten that time. We can't take half a generation's careers in order to incorporate new quality standards.

The other issue about quality is that you can't improve that which you don't measure, because you don't know whether you need improvement or not. The standard response I get from physicians around the nation when I have an opportunity to speak to them is, "I'm doing a better job than the data shows." Well, when you analyze the data and you look at the data and you verify the data, you discover that we just think that we are doing a good job, because while we know where we want to go, we don't really know where we are.

If you use a GPS service and you want to go to Detroit and you are in San Francisco, it's a different trip than if you are in Jacksonville, Florida. You have got to know not only where you want to go, you must know where you are. The thing that's missing mostly in health care today is not where we want to go but where we are. We don't really know because we are not measuring our performance.

We realized that at SETMA a long time ago. We started using the EMR in 1998 and we very quickly realized that we need to measure our performance by populations and by panels of patients, and by providers the performance we're delivering in order to know where we need to improve and how we can improve. Once you know where you are and where you want to go, you can take steps to improve. We have been tracking our mean, mode and median on hemoglobin A1C's for the last 16 years. Also we have tracked our standard deviation. We achieved our goal for the mean -- the average hemoglobin A1C -- 8 years ago, but we have not yet completely achieved the standard deviation and so we know we still have a larger population than we want who are not treated to goal. Therefore, we designed projects and goals to improve the standard deviation as well as the mean, the mode and the median.

We use data for a number of different reasons, not only to see where we are but how we can get to where we want to be. In 2009, we first got really serious about public reporting. We are now in our sixth year of public reporting by provider name on our website for over 300 quality metrics. You can go on our website right now how I treat diabetes, congestive heart failure, hypertension and so on. You can see my performance measures.

Though analytics, we realized that when we began to look at data, that many of our patient's who were treated to goal for diabetes were losing that control in October, November and December. W surmised that perhaps that was because of holidays and there was food indiscretion. There was also decreased exercise and so we measured to see if the patients were seen less often and they were. So in September, 2010 , we wrote all of our patient's who had diabetes -- over 8,000 -- and we alerted them to the hazard they faced in that last quarter of the year. We asked them to sign a contract to come see us twice during October, November and December, to be tested them twice and the majority of them agreed to do so. In 2011 we went back and measured to see if there had been any improvement and we found that the pattern we recognized in 2009 had

disappeared. Now, each year, we contact all our patient's with diabetes in September. We ask them to redouble their commitment to being seen, being tested, maintaining their exercise and their dietary discretion. With the simple analysis of data and information, we were able to institute a rather simple plan to improve the patients' care.

We think this is going to be the future because if you can design a program where a provider can measure their performance at the point of care and they can communicate to the patient in both a verbal and written form with a plan of care and a treatment plan, how the patient is doing and some supposition about they can improve their, you can actually do quality improvement as an active on-going process.

In 2008 the AMA, 2006 I think actually, published a project they called Performance Improvement CME. There are three steps: you measure where you are, you do studying to help improve your gaps and then you remeasure where you are. We have participated in several PI CME projects as a practice and we believe that's a really good program. However, we think there is a fourth step and that's having clinical decision support that helps you sustain your improvement over a long period of time. Because of this, SETMA has initiatives we started 14 years ago that we are still performing at a 98-99% standard 14 years later, but only because we have:

1. quality clinical decision support and we have
2. auditing and
3. measurement and we
4. meet once a month as an organization to discuss how we can continue to improve.

The issue with quality improvement is not only to do it but to sustain it and I think that is one of the great challenges we have today.

30:19 – 37:00

Thank you. One of the things Jeff mentioned is that physicians feel some degree of frustration and fatigue at the demands being placed upon them, and that's an understatement. It has gone to what some of us would call as a "sense of futility". In the *New England Journal of Medicine (*August 12, 2010) was an article by an internist who said "My quality metrics a year ago were bad, they are bad this year and they will be bad next year." (see http://www.jameslhollymd.com/Letters/pdfs/response-to-new-england-journal-of-medicine-on-quality- metrics-by-james-l-holly-md.pdf) She had basically given up and felt that it was futile to try to change her performance. That's not a rare or uncommon experience.

Three months after we started using the EMR, I told our staff. "This is too hard and it's too expensive, if all we gain is the ability to document a patient encounter electronically. If we can't leverage the power of electronics to improve the care that our patient's are receiving by auditing, analyzing, reporting and then design and improvement quality improvement programs, and if we cannot measure provider performance and help them improve, then EMR is not worth it."

We immediately changed our goal from documenting patient encounters electronically, though we did continue to do that, and we began to design disease management tools, measurement tools, and clinical decision support. We began to do auditing and tracking of numerous quality metrics. We did not track them "intentionally", i.e., as the purpose of the visit, but we tracked then "incidental" to excellent care. It wasn't that we started seeing our patient's saying that I am going to intend to meet this quality metric, but that it was incidental to excellent care. We determined to treat the patient excellently and incidentally to that excellent care, we were able to aggregate in the background, with no effort on the part of the provider to demonstrate that we were meeting the quality metrics. The aggregation was incidental not intentional. As a result we then determined to begin "to make it easier to do it right than not do it all."

We designed 10 principles in May 1999 which dictated and directed how we designed the EMR:

1. Pursue Electronic Patient Management rather than Electronic Patient Records.
2. Bring to bear upon every patient encounter what is known rather than what a particular provider knows.
3. Make it easier to do it right than not to do it at all.
4. Continually challenge providers to improve their performance.
5. Infuse new knowledge and decision-making tools throughout an organization instantly.
6. Establish and 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 the Consortium for Physician Performance Improvement Data Sets.
10. Create multiple disease-management tools which are integrated in an intuitive and interchangeable fashion giving patients the benefit of expert knowledge about specific conditions while they get the benefit of a global approach to their total health.

These principles just turned out to be coincidentally the principles of Patient Centered Medical Home that we learned almost 10 years later when we began to seek NCQA, AAAHC and then URAC and finally Joint Commission accreditation as a medical home.

This is what is really imperative: the EMR being fitted to the provider. Many providers are being asked to squeeze themselves into a predesigned mold of an EMR that is designed by people who have never practiced medicine, or if they did their first goal was to stop practicing medicine and have a clerical or administrative or an industrial job, because they didn't seem really to enjoy seeing patients. But when you have people that are actually seeing patients every day that are designing the content and also designing the display and deployment of EMR's, they can make it easier to do it right than not do it at all.

One of the things that was said which is so right and that is "If you're going to ask people to make a change, they must make a difference." In 1993, IBM was really in serious trouble as a company, they were losing market share, they were losing profitability. They hired a new CEO and he hired some people called "change agents" and one of the principles of "change agency," if you will, was if you are going to make change, it must make a difference.

That is what we want our patient's to do and here's the problem. It's very complex. If we asked them to make a change today that will make a difference 30 years from now, how do we get them to sustain that change? We can do it by showing them in an analytic fashion, either with things like the Framingham Cardiovascular and Stroke Risk scores, or with other methodologies, that if they make a change this is how it will change their risks and will change their future.

When you begin to get dependent upon that and you use electronics, for instances, we do all 12 Framingham Cardiovascular Risk scores. We added 5 "what if scenarios," i.e., what if you improve this measure to goal and so on. With 12 risk scores and with five "what if scenarios" for each, we now have 72 computations. It would take you all day to do those by hand. It would take you an hour to do them by going on to the web and 15 minutes to do them by hand calculator. With data analytics and EMR, it takes us less than 1 second to do them. As a consequence we can do all 12 every time we see a patient rather than one score every 5 years as the American Academy of Family Practice recommends. And, we can given them to our patients in their plan of care and treatment plan so they can know exactly what will happen if they make this change. It will make a difference and they are able to sustain the change over a long period of time, because it is renewed every time they are seen.

Electronics are powerful tools. For instance, there are 78 conditions that we are asked to report on to the Texas Department of Health in Texas. I have amused myself the last few years by asking every physician I see, would you just name those for me, well nobody can do that. I can't do it either. SETMA deployed all 78 conditions in the EMR so that when a doctor makes a diagnose, it automatically populates the reportable-conditions template. It then automatically sends a note to Care Coordination Department which automatically reports the condition to the state and sends a note back to the doctor. It takes the doctor no more time than making a diagnosis in this complex, difficult, imperatively important task is accomplished.

That's what we have got to do. We have got to redesign EMR's to where they meet the needs of patient's and providers. Making it easier to do it right than not do it at all. We believe we can reduce the time, effort and energy expended by primary care physicians by 30% with simple redesign of the EMR so that providers can accomplish tasks efficiently, excellently and allow us to do all the work we need to be doing while still being patient centric, doing the patient activation, the patient engagement, the shared-decision making and all the things that are beautiful described in our patient centered medical home deployments.

Patient's love it, providers love it and we are improving. We are reaching the triple aim. Patient satisfaction is going up. We are decreasing cost and we in fact are making it sustainable by decreasing that cost and the outcomes are improving. And, if they are provably improving performance and outcomes, which you can examine by going on our website when this webinar is over, www.jameslhollymd.com, look under Public Reporting and you can see for the past six years how we are performing. As I like to say, *"Once you open the books on your performance to public scrutiny there is only one place to hide and that is in excellence."*

41:32 - 45:45

Let me make a comment. I agree with what Jessica has said. I have a personal prejudice if you will, you know that we are not suppose to discuss our prejudices. I find it far more satisfying and far more potentially beneficial to work on transformation than reform. Reform comes from external pressure, external rules, external regulations and/or external incentives. Transformation comes from an internal idea. Peter Senge's book *The Fifth Discipline*, talks about the difference between your vision of what you want to be and the reality of what you are. Senge addresses the difference between your vision and your reality as being what creates your creative tension, i.e., the generative power of becoming what you envision.

SETMA started in 1998, until 2005, we never received a nickel, a dime, or a dollar for the use of EMR, for quality improvement. We have yet to every receive a nickel, a dime or a dollar for patients that are treated in a medical home. Yet, we have totally transformed our practice based on our vision, our ideal, that thing that drives us to get up early in the morning and work hard all day. We have put far more money back into our practice, I would tell you what it is but nobody would believe it so I will spare you the incredulity and not tell you, but it is far more money than I ever imagined existed in the world. This is the money we could take home and use for buying nice cars or whatever else people buy with that kind of money, but we are talking about millions of dollars that we put back into the practice and use for improving and transforming the healthcare.

I think we would be better off rather than trying to incentivize people with dollars, try to challenge them and inspire them with a vision of what healthcare can be, which is really what it once was. Because when you really look at patient centered medical home largely what we are trying to accomplish is to reform healthcare in a technologically advanced age to be what it was when I was a child in the 40's and 50's, and yes I'm that old, where there was that patient centric-ness. That was about all that the doctor could do. He or she really couldn't do much for you. They could do a few things but largely it was that relationship, that empathy, that compassion which we want to rediscover.

While practicing technologically sound healthcare,

1. which you can't do with pencil and paper which is a 19th century methodology such as it was or
2. 20th century methodology of healthcare which was dictation and transcription.

we want the "personal touch" in care. If you are going to do 21st century medicine, it is going to have to be done electronically but not with electronics that simply document a patient encounter but with electronics that empower you to do things which you would not otherwise do and that enables you to do incredible things quickly, efficiently, and at the same time give great personal attention to your patients.

I think the design of many EMR's, even ones that are functioning are very awkward and they are not facilitating what we want to accomplish and it's not the, I am sold out a long time ago to EMR's. SETMA has spent $8,000,000 of our money, there is no foundation money, there is no government money, out of our pockets building the tools that we use every day. Those tools

make it possible for us to do really incredible things. Anybody can do it; it's all on our website. It's free, we don't sell any thing. Go on our website, anything there you can borrow. You don't have to attribute it. You don't have to tell us you've used it, just take it and use and improve your life and improve the care that you give.

46:38 - 47:47

I agree with your point of view Jessica. We were four physicians when we started. We lost two almost immediately, so there were two of us. When we signed our first EMR contract for $650,000 and our accountant said, you've lost your mind you are going to go bankrupt. That was the encouragement we had. I'm not saying that the incentives are bad, I'm just saying ultimately incentives can't do the, can't lift the whole weigh. Heart, vision, passion, personal drive -- that internal critical tension, that critical mass -- it can. And so it's not an either/or it's really both/and.

But ultimately the real work is going to be done when physicians, nurse practitioners and physician assistants get the vision and they have that personal passion and you don't have to pat them on the back. They are going to drive forward and you just have to get out of their way and they are going to move forward. But Bridges to Excellence, which we participate in. we promote it, laud it. We think it's wonderful and it should continue. But the ultimate transformation is going to have to be because of that internalization of the professional drive which is why people became physicians, nurse practitioners and PA's to begin with.

48:38 - 51:13

I don't want to dominate but we do have a patient portal and we do use it. I think that the patient portal has more to do with the patient-centric, shared-decision making process than really fulfilling quality metrics. Though I could foresee how it could be utilized to accomplish several things, particularly when you start talking about NCQA. or one of the other accrediting agencies for medical home, there are some metrics that relate to your communicating with your patient's other than by telephone and where they can contact you electronically such as getting a copy of their record. So these are important things. I would foresee that could be a benefit. It currently has not been, other than as I said increasing the connectivity and the discussion, because now healthcare is at an age where we have to be thinking about our patients and communicating with them when they are not in our presence. In fact more of our thinking about them and more of our connection with them is going to be outside of an office setting where they are paying a fee for the benefit than it's going to be actually in our office.

If you remember the most important number in healthcare today is a 8,760 and I know you all know what that is, so I won't tell you, okay I'll tell you. It's the number of hours in a year. If a patient is getting a great deal of care, a lot of care, they are in a providers presence 20 or 30 hours a year and that's a lot care, so that means there are still 8,730 or 8,740 hours a year that they are not in your presence. So you have to have not only contact with them, they have to have a plan of care and treatment plan, if you will a baton they can grasp, take hold of and comprehend where they can become response, activated and engaged so they can become responsible for their care in that interim time. You can have continuing contact with them

without them having to make an appointment, without them having to disrupt their lives. These are the critical issues we are dealing with, not only in patient centered medical home but in those non-coordinates practices we still need to have that contact with patients and patient portals, secure e-mail, telephone and other means have to be used in order to secured texting is important to be able to contact our patients and do the kind of intervention and interaction that is going to make a difference.

52:20 - 52:57

We are heavily involved in HCAPS and CHAPS as far as patient satisfaction and patient interaction. They have been dramatic. We also have a patient, a community council where there are more patients that vote on that than anybody else so they can out vote us. We are really engaged in finding out what do our patient's think, what do they want to know, not only in a patient centric conversation in the clinic but also in these external organizations, caps, H caps and caps, and those have been very beneficial to us and continue to transverse what we do.

53:21 - 53:46

May I ask a question? I would like to ask Jessica and she and I have had this off-line conversation so but I would like to give a chance to comment about this. What is the potential Jessica in the near term to have an insurance company or an organization that is going to pay for patient centered medical home capacity within a practice or within a group of organizations?