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SETMA: A portrait versus a silhouette

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For the 35 years of my medical career, I have had a frustration about the nature of medical records. In 1999, after SETMA adopted electronic medical records (EMR) I wrote a paper which SETMA published and distributed as a pamphlet to our patients. It was entitled "More Than a Transcription Service – Transforming Healthcare through Electronic Patient Management." It is posted on our website at www.jameslhollymd.com under Your Life Your Health (Medical Records). In that paper, I lamented that at best, even with dictation and transcription; a medical record offered only a silhouette of a patient and not a granular portrait. You can recognize a person from a silhouette, but you can't tell very much about them.

I would like to offer the following to provide some detail to the silhouette others have of Southeast Texas Medical Associates, LLP (SETMA, LLP). I will do this in an outline form for quick review.

1. Founded in 1995 by four physicians each of whom had been in solo practice for many years. Today, only one of those founding partners remains. SETMA has grown from those four providers and 18 employees to 38 providers and over 250 employees. SETMA is a private-practice, multispecialty, medium size group which has no public or grant funding.
2. In 1995, SETMA built a **reference laboratory within our practice**. All laboratory results are ordered, completed and reported through our EMR/Laboratory interface. For any tests we do not do in house, we have interface connectivity to Quest and LabCorp. All tests results are tracked for completion and reported electronically to the patient's personal healthcare provider. This applies to lab work ordered in the clinic, hospice, home health, nursing home or any other point of care. This has operated for 15 years.
3. In 1995, SETMA built a **referral department**, after 1999, all referrals are generated and completed electronically. Since 2004, the completion and the results of referrals are tracked electronically. With **CHS** and **NextMD** (see below) this process has only improved.
4. **EMR** purchased in 1998 and began to be used in entire clinic in January 1999.
5. In May of 1999, it became obvious to us that EMR was not our goal. EMR was too hard and too expensive if all we were to gain was an electronic means of producing a patient encounter record.
6. In May of 1999, SETMA set a course for "**electronic patient management**," which would leverage the power of electronics into improved care for our patients. To date, SETMA has spent over $5,000,000 on this project. None of that has been reimbursed

by anyone. None of that was paid for by grants or gifts. All of it was paid for out of the income of the practice, and SETMA is currently debt free, which is indirectly a great advantage to our patients.

7. Electronic patient management (**EPM**) has resulted in:
   a. Multiple disease management tools being developed. All of these are posted on our website with tutorials which not only explain how to use our EMR but which are state-of-the-art, evidenced-based treatment courses. For over twelve years, through these tools, we have provided our patients with plans of care, treatment plans, goal setting and evaluation of treatment to goal strategies.
   b. **The LESS Initiative** – a direct result of "a" was that we discovered that no matter what illness or condition a patient had, there were three life-style changes we wanted every patient to make: lose weight, exercise and stop smoking. We designed the LESS, which is explained on our website under EPM and Your Life Your Health. Every patient seen at SETMA for the past eight years has had this evaluation done with a seventeen page, personalized document given them which explains their BMI, BMR, cardiovascular status, exercise goals and how to stop smoking if they do and how to avoid second-hand and now third-hand tobacco smoke if they don't smoke..
   c. For the past ten years, **Disease Risk Assessment** for all of our patients has extended beyond The Less to where it now includes all Twelve Risk Calculators published by the Framingham Heart Study. It takes ONE SECOND for SETMA providers to assess any patient's cardiovascular or cerebrovascular risk. This information is reported to and interpreted for the patient in a plan of care and treatment plan document which is personalized and given to the patient.
   d. The formation of **The SETMA Foundation** through which we not only access the barriers to care for our patients but we provide funds to help pay for mediations, testing or other healthcare needs which our patients would otherwise not obtain. In 2009,. The partners of SETMA contributed $500,000 of their personal money to the foundation for the care of our patients. The transformative benefits to our patients of these resources are heart warming. In addition, SETMA initiated the move by our principle HMO partner to remove primary care co-pays to eliminate another bearer to our patients' access to care. We were warned that that would be disastrous with patients making appointments for inappropriate reasons. It has not resulted not been a problem and has been in place for five years.
   e. The **Diabetes Center of Excellence** was formed with an ADA approved DSME program. Our education efforts include nutritional counseling for weight reduction, hypertension, dyslipideemia, renal disease and diabetes. Most often, because insurance does not pay for these services, SETMA waives the cost so that our patients can receive the information they need. We follow, the founder of the Joslin Center at Harvard's dictum, "The person who knows the most about diabetes will live the longest." SETMA has demonstrated ten consecutive years of improvement in diabetes care.

   f. The **SETMA Hospital Care Team** was formed eleven years ago to make sure that our patients have personal, SETMA-based after-hours care and continuous round the clock care. We use our EMR in the hospital so that the continuity of care is absolute. No matter what time the patient shows up in the

ER or calls for help, they are talked to or seen by a SETMA provider. Every patient discharged from the hospital has all 14 data points and all 4 actions dictated by the Physician Consortium for Performance Improvement (PCPI) Transition of Care completed. Every patient receives a follow- up call from SETMA the day after discharge to make sure they have their medications or their appointments, and that their condition is improved. The results of that call are reported directly to their personal healthcare provider.

g. SETMA has operated a **Hospice** since 1995. Our patients benefit from the personal, timely and excellent care provided by a hospice which is electronically connected by EMR, telephone and management to SETMA
h. SETMA has operated an **HMO Home Health** since 1995 through which our patients can be assured of continuity of care, of instruction and in support of the care they need. All frail patients receive a home visit for assessment of patient safety.
i. For our nursing home care, SETMA has a full-time **long-term residential care group** which uses the same EMR, telephone system, connectivity and continuity of care as all of our systems. This has been in place for 15 years. In that everyone is documenting the same medical record, whether the patient is in hospital, clinic, home, nursing home or other place of service, their healthcare information is available and their care is consistent.
j. SETMA has an **extensive provider and staff education programs**. Monthly, we take all primary-care providers out of clinic for one half of a day for training and education for the past year, those sessions have focused on PC-MH.

8. **SETMA's website** (www.jameslhollymd.com) has been in place for fifteen years. It has provided a secure connection for our patients to request test results, appointments, pay bills or ask questions of their healthcare provider. The website also provides education materials.
9. Now through **NextMD** and **CHS (Community Health Services)** SETMA provides our patients the ability to fill out parts of their acute medical history which after review goes directly into their chart. It allows them to maintain a personal health record including their medications**. CHS** allows other providers and organizations including the hospitals to exchange patient information in a HIPPA-compliant environment to further accelerate and improve patient care.
10. Through **SETMA's COGNOS Project** (for more details see www.jameslhollymd.com Your Life Your Health COGNOS Project), we have eliminated all uncertainty about whether or not we are meeting national quality standards. Before a patient is seen, their chart is searched to determine if all HEDIS, AQA, PCPI, NQF or NCQA standards have been met. At the time of the patient's visit, nurses independently initiate the completion of preventive and screening services according to age requirements. COGNOS allows every provider to personally examine their performance at the point-of-service on over 200 quality metrics including age-appropriate screening and preventive care needs.

These and other SETMA efforts have won the HIMSS Davies Award, Microsoft Clinic of the Year Award, Physician Practice Magazine's National Practice of the Year Runner-up, multiple reviews in *Health Leaders Magazine* in which the February, 2010 cover story was

about SSETMA and EMR Meaningful Use and numerous other recognitions of our efforts toward excellence.

When SETMA began the process of learning about and thinking about patient-centered medical home in February of 2009, it seemed to us that PC-MH was a logical extension and culmination of everything we had been doing since 1995. Yet, PC-MH presented us with a number of challenges. The following are changes which we have made in order to extend the benefit of PC- MH to our patients:

1. We re-tooled many of our patient management materials to precisely fulfill PC-MH requirements. We involved our entire clinic and all of our providers and staff in this process to where, now, everyone is engaged. We made sure that our processes meet the intent and requirements of PC-MH.
2. We built the Medical Home Coordination Review which aggregates in one place many of the functions of medical home including:

    a. Advance planning, medical power of attorney, code status, etc.
    b. Barriers to care evaluation including social, financial and assistive devices.
    c. Preventive care and screening care

3. We built and deployed **Hospital and Clinic Follow-up calls**. The content of these calls differ. We hired nurses who do nothing all day but make calls based on the personal providers' direction. The results are reported back to the provider. All hospital discharged patients are called. Patients whom the provider designates will benefit from a call following a clinic visit are called. In addition the electronic tickler file which is created for smoking cessation results in a follow-up call for encouragement and accountability.
4. We have launched the **COGNOS** project at a cost of over $500,000.
5. We have launched **NextMD** and **CHS**.
6. We refined **The SETMA Model of Care** which includes:

    a. The **tracking** by each provider on each patient of their performance on preventive care, screening care and quality standards for acute an chronic care. SETMA's design is such that tracking occurs simultaneously with the performing of these services by the entire healthcare team, including the personal provider, nurse, clerk, management, etc.
    b. The **auditing** of performance on the same standards either of the entire practice, of each individual clinic, and of each provider on a population, or of a panel of patients. SETMA believes that this is the piece missing from most healthcare programs.
    c. The **statistical analyzing** of the above audit-performance in order to measure improvement by practice, by clinic or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, payer class, socio-economic groupings, education, frequency of visit, frequency of testing, etc. This allows SETMA to look for leverage points through which SETMA can improve the care we provider.

d. The **public reporting** by provider of performance on hundreds of quality measures. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease management tool plans of care and the medical home coordination document summaries a patient's state of care and encourages them to ask their provider for any preventive or screening care which has not been provided. Any such services which are not completed are clearly identified for the patient. We believe this is the best way to overcome provider and patient "treatment inertia."

e. The design of **Quality Assessment and Permanence Improvement** (QAPI) **Initiatives** – this year SETMA's initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital. We have completed a COGNOS Report which allows us to analyze our hospital care carefully.

There are many other things which we have done. We believe that these efforts, our success at deploying them and in sustaining them qualify SETMA as a PC-MH.