James L. Holly, M.D.

Medical Home Series 2 Part XI Continuation of Quality, Coordination and Cost of Care
CMS Medical Home Feedback Report – SETMA's Performance
By James L. Holly, MD
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Last week, we discussed CMS's Medical Home study which analyzed patterns of care, health outcomes, and costs of care for Medicare fee-for-service (FFS) beneficiaries receiving healthcare services from clinical practices that are National Committee for Quality Assurance (NCQA)-recognized medical homes. In particular, the study was interested in determining if there are particular attributes of medical homes that are more favorably related to better outcomes of care.

The data we examined last week showed SETMA contrasted with benchmarks. The results we will review this week include the mean (average) results from 312 practices which have earned recognition by NCQA as Patient-Centered Medical Homes. It is noteworthy that SETMA has 3,682 patients in the study and the total of 312 practices is 146,410, which means that the average practice has 470 patients in the study.

Table 1 below under the heading "Quality of Care," shows that SETMA II out performs both the benchmarks and the mean of the 312 Medical Home practices. You will remember the discussion of the low influenza immunization rates being due to the methodology of this study which depends upon charges sent to CMS. In that many patients get their flu shots from a source other than SETMA, thus the methodology of the CMS study will skew the influenza results.

Coordination and Continuity of Care

The next category of results on Table 1 addresses how often the patient is seen by their primary care provider or his/her representative. And, indirectly, this category addresses the effectiveness of that care by looking at hospital admissions, readmissions, emergency room visits, primary care visits, medical specialty visits (cardiology, etc.), and specialty care visits (orthopedists, general surgery, etc.).

The Medical Home mean outperforms the benchmarks for every measure and SETMA has a statistically significance variance only with the mean of Medical Homes in regard to the number of ER visits. However, even in that measure, SETMA still out performs the benchmarks significantly. Table 2 shows SETMA's performance over time. Three time periods are measured and shows that SEMTA is improving in the area of ER visits. Table 1 also shows that at present SETMA's cost of emergency department care is only 50% of the benchmarks.

Table 1

Measure	Your Practice (N benes=3682)	Benchmark (N benes= 124,210)	Your Practice versus Benchmark	Average across all study NCQA Medical Homes (N benes =146,410 N practices=312)
Quality of Care (% of beneficiaries)				
LDL-C Screening (n=233)	93 %	86 %		85 %
HbA1c Testing (n=180)	97 %	86 %		90 %
Influenza Vaccination	51 %	39 %		50 %
Coordination and Continuity of Care				
Hospitalization (rate per 100 beneficiaries)	24.5	47.4		16.9
Follow-up within 2 weeks of hospital discharge (rate per 100 hospital discharges, n=114)	56.5	40.4		57.3
30-day hospital readmission (rate per 100 hospital discharges, n=114)	17.5	30.9		13.2
ER Visits (rate per 100 beneficiaries)	47.4	80.5		32.3
Primary Care Visits (rate per beneficiary)	4.3	4.5		4.3
Medical Specialist Visits (rate per beneficiary)	3.3	3.9		3.0
Surgical Specialist Visits (rate per beneficiary)	0.6	0.8		0.5
Annual Payments (Average $ per beneficiary)				
Durable Medical Equipment (DME) Payments	$336	$359		$238
Hospice Payments	$328	$297		$148
Home Health Payments	$1,253	$1,100		$283
Physician Payments	$2,780	$3,160		$2,033
Outpatient Department Payments	$905	$1,373		$904
Skilled Nursing Facility (SNF) Payments	$43	$710		$299
Acute Care Hospital Payments	$1,947	$4,929		$1,613
Total Medicare Payments	$8,134	$12,919		$5,715
Physician Payments by Type of Service (Average $ per beneficiary)				
Office Visit Physician Payments	$410	$434		$373
Hospital/ER Visit Physician Payments	$203	$415		$119
Specialty Visits & Consultation Physician Payments	$138	$164		$151
Imaging & Laboratory Physician Payments	$727	$806		$453
Other Physician Payments	$965	$933		$710
Potentially Avoidable Payments based on Ambulatory Care Sensitive Conditions (ACSCs)(Average $ per beneficiary)				
Potentially Avoidable Inpatient Hospital Payments	$962	$2,259		$790
Potentially Avoidable ER Payments	$183	$214		$111

Annual Payments

The third group of comparisons on Table I is “Annual Payments”. There are eight categories of payments including DME, Hospice, Hospice and Skilled Nursing, which were discussed last week in comparison to benchmarks. In almost all areas, SETMA out performs the benchmark and collectively equals the performance of other Medical Homes.

The other four categories are Physician payments, Outpatient Department payments, Acute Care Hospital Payments, and Skilled Nursing Facility payments. SETMA’s “total Medicare”

payments" is 37% below that of the benchmarks but is higher than the mean of the Medical Homes.

Table 2

Measures	Your Practice Time Period 1: July 2007 – June 2008 (N benes=390)	Your Practice Time Period 2: July 2008- June 2009 (N benes=421)	Your Practice Time Period 3: July 2009- June 2010 (N benes=446)	Your Practice % Change (July 2007- June 2010)	Average % Change across all study NCQA Medical Homes (N benes=146,410 N practices=312)
Quality Of Care Measures (% of beneficiaries)					
LDL-C Screening	97 %	90 %	93 %	-4.1 %	3.5 %
HbA1c Testing	98 %	95 %	97 %	-1.0 %	1.5 %
Influenza Vaccination	32 %	34 %	51 %	59.4 %	20.2 %
Potentially Avoidable Hospitalizations / ER Visits based on Ambulatory Care Sensitive Conditions (ACSCs)					
Potentially Avoidable Hospitalizations (rate per 100 beneficiaries)	7.4	9.5	6.7	-9.5 %	-2.2 %
Potentially Avoidable ER Visits (rate per 100 beneficiaries)	13.6	17.6	11.9	-12.5 %	-5.2 %
Average Annual Payments ($ per beneficiary)					
Average Total Medicare FFS Payments	$6,430	$7,464	$8,703	35.4 %	12.0 %

SETMA's average total Medicare FFS increased by 13.4 percent from the first measurement to the second period and then by 14% from the second period to the third. This was significantly higher than the average across all of the Medical Home practices.

Conclusions for SETMA from the CMS Study

We are pleased with the study's results as to "**quality."** SETMA's Model of Care is discussed on our website (www.setma.com) at the following links: *SETMA Model of Ca*re http://jameslhollymd.com/the-setma-way/setma-model-of-care-pc-mh-healthcare-innovation-the-future-of-healthcare and *The Future of Healthcare - SETMA's View* (08.14.2010, Your Life Your Health) http://jameslhollymd.com/your-life-your-health/The-Future-of-Healthcare-SETMAs-View.
SETMA's tracking, auditing and analyzing of quality metrics performance and our public reporting by provider name are bearing fruit. There are places where we can improve but we are moving in the right direction and we are following the right steps.

As to "**Coordination and Continuity of care**," we are doing a good job. We need to decrease the utilization of the emergency department by our patients, although our costs are very low. Most of the lower cost results from the fact that the overwhelming majority of SETMA's patients that go to the emergency room do so because they require admission. SETMA's "transitions of care" is working well. That is discussed in many places, most recently in this series part VI entitled, "Care Transitions" http://jameslhollymd.com/your-life-your-health/medical-home-series-two-part-vi-care-transitionswhich contributes to our decreasing avoidable readmission rates.

While the CMS study measures the patient "follow-up within two weeks of discharge" and while SETMA performs better than the benchmarks and equally to the mean of Medical Homes, the study did not measure other elements of SETMA's care transition such as the completion of the

"Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan" (this was originally called the "Discharge Summary," but that name was changed to reflect the documents function.) The CMS Study did not address the "passing of The Baton," which is the critical part of the Care Transitions from inpatient to outpatient care and from a clinic visit to continuing care of the patient by patent at home. (http://jameslhollymd.com/transforming-your-practice/tcpi-care-coordination is the link to a detailed explanation of "the baton.") And, the CMS Study did not measure the Hospital Following-up Telephone Call which is the first step in SETMA's Department of Care Coordination's "healthcare coaching" for SETMA's healthcare team.

Coupled with "coordination of care" the CMS Study looked at "Continuity of care." SETMA's approach is discussed in Medical Home Series 2 Part V and is found at http://jameslhollymd.com/your-life-your-health/medical-home-series-two-part-vi-care-transitions In this article the elements of continuity of care are discussed and they are:

1. Data connection and data sharing over the entire healthcare experience of the patient whether that involves different visits with the same provider, care by multiple providers, multiple locations of care, or multiple disciplines of care such as physicians, nurse practitioners, physical therapist, social workers, nutritionists, hospices, home health, case managers, pharmacists, etc.
2. Uninterrupted care of and attention to an acute or chronic problem until it is resolved or stabilized. This means that follow-up care always includes review, evaluation of and needed adjustments to previous care.
3. All care givers having adequate knowledge of a patient's overall health and of all conditions requiring attention. The association of continuity of care with the patient being seen by the same healthcare provider assumes that the same provider can and does know more about the patient than a new or different provider, depending upon the quality and granularity of the patients health record that may or may not be the case.
4. The foundation of the patient's care is a record which is longitudinal, cumulative, granular, accurate, accessible, available, confidential and thorough. Electronic patient records is the only method of medical-record keeping which can build on previous examinations and evaluations, continually transforming the "picture" of the patient from a silhouette, longitudinally into a true, granular portrait of the patients health and person.
5. All members of the healthcare team know the patient and have a personal interest in the patient's health and welfare. While the concept of medical home currently depends heavily upon a patient's identification of a "personal healthcare provider" as the principle conduit of continuity of care, the concept also recognizes the healthcare team as an essential foundation for the improved care given in the medical home. An essential part of the development of the medical-home model will be the clarification of the tension between care by a personal provider and care by a healthcare team.
6. Effective transitions of care are established and they function to transfer care from one point of care or provider to another provider or point of care. Transitions of care will be dealt with later in this series but they are critical to the maintaining of the continuity of care when the patient moves from one venue of care, i.e., inpatient hospital, to another, i.e., outpatient or ambulatory care. Like the universal joint in an automobile power train, the transition of care allows for the power, the standard of care and the content of care,

created by and in one venue of care to be incorporated into and to be maintained in another venue.

7. The patient is included as a critical member of the medical home team. All other members of the team respect and support the autonomy, confidentiality and priority of the patient in decision making and in executing the medical home's plan of care and treatment plan. This requires that enhanced communication be present between the patient and provider including secure web portals, health information exchanges, telephone communication and after-hours access to care.

There is a tension between the current concepts of continuity of care and the concepts of a healthcare team and the contribution that a continuity-of-care record (electronic health records) makes to the overall coordination and continuity of care. While a personal relationship with a primary provider is currently the standard of Medical Home, it cannot compete with a robust, longitudinal health record which is available at all points of care. SETMA's electronic health record is used in the clinic, nursing home, emergency department, inpatient, home health, hospice, physical therapy and providers' homes. At every point of care, the patient's care is documented in the same data base contributing to a continuity of care which is otherwise not possible. SETMA has referred to this as morphing a patient's record from its current status as a silhouette by which the patient can be recognized albeit without detail into a portrait which is a granular representation of the details of a patient's condition, care and needs.

CMS Study, SETMA and Cost

There are bright spots in the CMS data for SETMA as to the cost of the care which we deliver. Analytically, it must be understood that there are inverse relationships between elements of cost, i.e., as one element goes up, another will come down. It should be expected that as Home Health and Hospice costs go up, inpatient cost will come down. Also as Home Health and Hospice go up, DME cost will go up. The decreasing of Specialty referrals, both Medical and Surgical, should be associated with a direct decrease in cost of care. The balance is that quality and patient satisfaction must be attended to so that cost control is not achieved at the expense of either or both.

Similarly, there are interactions between "coordination" and "continuity" of care and cost of that care. As the former two become more robust and significant in the Medical Home care model, the cost of care will be expected to decrease. One of the results of this CMS Study is that it demonstrates that these expected results with Medical-Home care actually exist.

This cost analysis also suggests that a collaborative effort between a Patient-Centered Medical Home and coordinated-specialty care can contribute to an increase in quality and simultaneously to a decrease in cost. This requires intense coordination and real continuity of care and it actually expands the Medical-Home Model into a Medical-Neighborhood Model, which sometimes is referred to as an Accountable Care Organization.

Without doubt this is a process in the midst of which we find ourselves! With perseverance and attentiveness, the result will be ever increasing quality and safety while increasing patient satisfaction and decreasing cost.