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SETMA Recognized as Tier 3 Patient-
Centered Medical Home by
National Committee for Quality Assurance
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Recently, SETMA has achieved:

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

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

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

SETMA's Growth and Progress

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

- **The SETMA Way** – a description of our business philosophy
- **The SETMA Approach** – a description of our use of health informatics in the

improvement of healthcare

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

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

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

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

1. February 16, 2009, several SETMA staff attended a lecture in Houston on PCMH.
2. February 17, 2009, SETMA began an internal examination of processes and functionalities to see if we fulfilled the principles of PCMH. This resulted in an initial ten-article series, all of which are posted on our website.
3. In March, 2009 SEMTA began tracking HEDIS and other quality standards.
4. March, 2009, we completed a 400-page evaluation of SETMA based on CMS's published but not official 25 principles of medical home.
5. April, 2009, SETMA began building electronic health record functions by which to fulfill medical home requirements.
6. April, 2009, SETMA continued to learn about PCMH and began evaluating ourselves by NCQA's Patient-Centered Medical Home's 9 standards, 30 elements and 183 data points.
7. September, 2009, SETMA began the COGNOS Project for auditing provider performance.
8. April 12, 2010, SEMTA submitted our application and medical home survey to NCQA.
9. July 2, 2010, SETMA received a Tier 1 (the lowest) recognition from NCQA as a medical home.
10. July 13, 2010, SETMA had a conference call with NCQA to discuss the result and determine why the result was so dramatically different than what we expected.
11. July 16, 2010, submitted an "add-on" survey to clarify the deficiencies which resulted from our not completing the original application correctly.
12. August 5-6, 2010, SETMA was surveyed by Accreditation Association for Ambulatory Care (AAAHC), an independent organization which also accredits medical home. The results of that survey and of that distinctive from NCQA accreditation is expected to be received by September 18, 2010.
13. August 20, 2010, SETMA received notice from NCQA that two required elements for PCMH Tier 3 were incomplete.
14. August 24, 2010, SETMA submitted the missing material to NCQA.

15. September 2, 2010, SETMA received Tier 3 NCQA Recognition as a PCMH.

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

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

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

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

NCQA Website and SETMA

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

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

Southeast Texas Medical Association (SETMA)

Southeast Texas Medical Association (SETMA) is a multi-specialty clinic located in Beaumont. SETMA has three clinical locations that are connected with a secure electronic medical record (EMR) system to store and access patients' records. Patient records are also available to providers at area hospitals, so that during inpatient care, providers can make accurate decisions

based on all of a patient's historical data. SETMA received the Davies Ambulatory Award in 2005.

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

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

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

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

Service Locations: Three clinic locations in Beaumont.

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

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

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

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

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

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

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

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

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

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

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

and ethnic perspectives to make sure we have eliminated disparities in care which traditionally afflict these groups.

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

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

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

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

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

We are able to track over time patient results comparing:

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

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

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

solutions. We will all get there one step at a time. At times we will lead the development and at other times we will follow the lead of others.

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

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

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

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