James L. Holly, M.D.

SETMA's Response to the Robert Wood Johnson Foundation
Part I The Primary Care Team
Learning from Effective Ambulatory Practices
By James L. Holly, MD
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Before discussing SETMA's response to a request for information from the Robert Wood Johnson foundation (RWJF) and their project to study "The Primary Care Team, Learning from Effective Ambulatory Practices," it would be helpful to briefly review the Foundation's history. RWJF describes its mission as, "to improve the health and health care of all Americans. Our goal is clear: To help our society transform itself for the better."

The Foundation is the nation's largest philanthropy which is "devoted solely to the public's health, we have a unique capability and responsibility to confront the most pressing health and health care problems threatening our society. Our efforts focus on improving both the *health* of everyone in America, and their *health care*—how it's delivered, how it's paid for, and how well it does for patients and their families. As we invest in improving systems through which people receive care and in fostering environments that promote health and prevent disease and injury, we expect to achieve comprehensive, meaningful and timely change."

The Foundation states, "We are guided by a fundamental premise: we are stewards of private funds that must be used in the public's interest. Our greatest asset isn't our endowment; it's the way we help create leverage for change." The Foundation works to "create leverage by building evidence and producing, synthesizing and distributing knowledge, new ideas and expertise. We harness the power of partnerships by bringing together key players, collaborating with colleagues, and securing the sustained commitment of other funders and advocates to improve the health and health care of all Americans."

The Foundation was created by the General Robert Wood Johnson, who founded Johnson and Johnson. The Foundation's early history from 1936 to 1975 was crucible for what followed when the General died in 1968, "leaving just about his entire estate to the Foundation. When the will was probated, in 1972, The Robert Wood Johnson Foundation emerged as the nation's second-largest philanthropy."

In this context, it is an honor for SETMA to be asked to describe our work in order to allow the RWJF to determine if we should be one of the thirty practices which they will chose for this project.

The description of the project: The Primary Care Team: Learning from Effective Ambulatory Practices

"The goal of the program is to identify and study about 30 high functioning primary care practices with interesting team models and use of staff (exemplar practices) in order to create

tools and materials to help other primary care practices with transformation and improvement. A description of the program can be found on the RWJF website.

–(SETMA)….was one of nearly 400 that were recommended by experts in primary care and your peers. Our National Advisory Committee has begun the work of drilling down to a final group of practices for site visits and to form a learning community aimed at sharing the collective knowledge and experience of the participating practices with others. We seek exemplar sites that have performance measurement programs in place that can help assess the impact of their innovations in the practice.

–Our next step is to ask you to help us understand how you are measuring and using data on clinical quality, organizational performance, patient experience, and /or staff experience. From our initial conversation with you, it is likely you already are routinely collecting data in several of these categories. We would appreciate it if you would be willing to share any performance reports such as run charts, dashboards, or quality reports that you already collect for your own improvement work.‖

SETMA's Response

Introduction

This is our response to your request that we –help (you) understand how (SETMA is)…measuring and using data on clinical quality, organizational performance, patient experience, and /or staff experience.‖ After this introduction, I will address each of the five categories which you identified in your correspondence.

This presentation does not simply provide lists of numbers for quality metrics. It attempts to provide a context in which it is possible to sustain the measurement of quality metrics as both a –score card‖ for excellent care and also as a guideline for areas which need improvement. Without this context, it is impossible to understand SETMA's use of quality metrics. It is as if quality metrics are a healthcare GPS, telling us where we are, where we want to go, the path to tale to get to our destination and an alert when we have achieved our goal.
A second overarching comment concerns the only Pay-for-Performance programs in which we participate:

1. PQRS
2. ePrescribing
3. Blue Cross/Blue Shield Diabetes

Currently, we receive no additional payments for performance, although through the Medicare Advantage STARs program, the ACO Quality Metrics performance, Meaningful Use and Medical Home, we will soon be receiving more reimbursement based on quality performance. These comments apply to all five of your questions.

Commitment to Primary Care and to the Future of Primary Care

SETMA's commitment to Primary Care is evidenced by my wife and I, with support from The SETMA Foundation and others, having endowing the Dr. & Mrs. James L. Holly Distinguished Professorship in Patient-Centered Medical Home at my school of medicine. This is an interdepartmental and interdisciplinary effort between the schools of nursing and medicine. My wife and I have also endowed a Distinguished Lectureship in PC-MH and have given the initial endowment for the establishment of The Primary Care Institute at the Health Science Center. It is our hope to establish a one year Post-Graduate Fellowship for Primary Care providers the year after they complete their residencies. The Fellowship would focus on practice management, healthcare transformation, public policy and the growth and development of primary care in a patient-centered environment. .

While most of the material on our website about SETMA is not peer-reviewed, several pieces are:

1. Agency for Healthcare Research and Quality has published SETMA's LESS Initiative (Lose weight, exercise, stop smoking) on their Innovation Exchange.
2. SETMA received the HIMSS Davies Award in 2005
3. Dr. Holly's multiple presentations at HIMSS
4. SETMA's peer-reviewed Stories of Success was published by HIMSS in 2010.
5. American Medical Association – Care Transitions Quality Metrics Application to Hospital Setting
6. Joslin Diabetes Center PI-CME – Glyco and Cardio PI-CME
7. Joslin Diabetes Center PI-CME -- Eldercare PI-CME
8. Centers for Disease Control – Analyzing Cost Control for Medicare Recipients in the Medical Home Setting

The following is a link to my March 21, 2012 presentation entitled, *The Future of Primary Care* to the inaugural meeting of the University of Texas Health Science Center at San Antonio School of Medicine's Chapter of the Primary Care Progress.

http://jameslhollymd.com/your-life-your-health/the-place-of-patient-centered-medical-home-in-the-future-of-healthcare-delviery

A Brief History of SETMA

Southeast Texas Medical Associates, LLP (SETMA) is a medium size multi-specialty practice in Beaumont, Texas which began using electronic health records in March, 1998. Shortly after that we determined that our –real‖ goal was –electronic patient management,‖ i.e., the leveraging of the power and capabilities of electronics to improve the quality of the care we provided to our patients. That history is well documented on our website at www.jameslhollymd.com where all of our electronic patient management tools are displayed.

In 2000, we began auditing and analyzing data including using statistical analysis to look beyond individual patients to assess the quality of our population wise. For diabetes, our mean HbA1c has improved from 7.54 in 2000 to 6.64 in 2011, and our standard deviation has improved from 1.98 in 2000 to 1.2 in 2011. Gradually, we realized that we wanted to do –real time‖ auditing and analysis of our care. In 2009, we adapted IBM's Business Intelligence software, COGNOS,

to healthcare. In that year, we began Public Reporting on over 200 quality metrics on our website.

SETMA's Model of Care evolved to:

1. Tracking metrics one patient at a time
2. Auditing metrics over panels and populations of patients
3. Analyzing the audited data to find leverage points for improvement
4. Public Reporting provider performance and transparently sharing with our patients that performance.
5. Designing quality improvement initiatives based on these four steps.

A complete description and explanation of this Model of Care can be found at:

http://jameslhollymd.com/the-setma-way/setma-model-of-care-pc-mh-healthcare-innovation-the-future-of-healthcare

In this process, SETMA, SETMA came to believe that the future of healthcare will be founded on four domains:

1. **Method** -- The methodology of healthcare must be electronic patient management.
2. **Content** -- The content and standards of healthcare delivery must be evidenced-based medicine.
3. **Structure** -- The structure and organization of healthcare delivery must be patient-centered medical home.
4. **Compensation** – The payment must be capitation with rewards for quality in both process and outcomes. .

In this time, SETMA has become an NCQA Tier-Three Patient Centered Medical Home and a AACH accredited ambulatory care clinic, an AAACH Medical Home and the first multispecialty group to become an affiliate of Josllin Diabetes Center.. We document all patient care in the same data-base whether the patient is in the hospital, home heath, physical therapy, hospice, nursing home, clinic or emergency department and are supporting the development of a regional health information exchange.

Quality Metrics Philosophy

SETMA's approach to quality metrics and public reporting is driven by these assumptions:

1. Quality metrics are not an end in themselves. Optimal health at optimal cost is the goal of quality care. Quality metrics are simply ―sign posts along the way.‖ They give directions to health. And the metrics are like a healthcare ―Global Positioning Service‖: it tells you where you want to be; where you are, and how to get from here to there.
2. The auditing of quality metrics gives providers a coordinate of where they are in the care of a patient or a population of patients.
3. Statistical analytics are like coordinates along the way to the destination of optimal health at optimal cost. Ultimately, the goal will be measured by the well-being of patients, but

the guide posts to that destination are given by the analysis of patient and patient-population data.

4. There are different classes of quality metrics. No metric alone provides a granular portrait of the quality of care a patient receives, but all together, multiple sets of metrics can give an indication of whether the patient's care is going in the right direction or not. Some of the categories of quality metrics are: access, outcome, patient experience, process, structure and costs of care.
5. The collection of quality metrics should be incidental to the care patients are receiving and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible. Notwithstanding, the very act of collecting, aggregating and reporting data will tend to create a Hawthorne effect.
6. The power of quality metrics, like the benefit of the GPS, is enhanced if the healthcare provider and the patient are able to know the coordinates while care is being received.
7. Public reporting of quality metrics by provider name must not be a novelty in healthcare but must be the standard. Even with the acknowledgment of the Hawthorne effect, the improvement in healthcare outcomes achieved with public reporting is real.
8. Quality metrics are not static. New research and improved models of care will require updating and modifying metrics.

SETMA currently tracks the following: 34 NCQA HEDIS measures; 14 NCQA Diabetes Recognition Metrics; 35 NQF-endorsed measures; 27 PQRS measures; 9 PCPI measures related to the physician role in hypertension management; 43 measures of the Bridges to Excellence program for Asthma, Chronic Stable Angina, Congestive Heart Failure, COPD, Diabetes and Hypertension; 10 PCPI related to Diabetes; 6 PCPI for Stages 4 and 5 of Chronic Kidney Disease; 5 PCPI for Chronic Stable Angina; 7 PCPI for Congestive Heart Failure; 20 PCPI Transition of Care measures. We are also participating in the Guidelines Advantage Program which is a collaborative between the American Heart Association, the American Diabetes Association and the American Cancer Society. And we are tracking the metrics associated with the MA STARS, the ACO quality metrics and the Meaning Use metrics.

In addition to endorsed-measurement sets, SETMA tracks these self-designed quality measures: 10 measures related to hyperlipidemia; 12 measures related to Chronic Kidney Disease Stages 1-III. Also, in the hospital setting, SETMA has designed an internal study to identify patterns in hospital readmissions, such as lengths of stay, morbidities and co-morbidities, socio-economic status, ethnicity, gender, age, follow-up calls, follow-up visits in clinic, etc.. The purpose is to control cost and increase safety by reducing preventable readmissions to the hospital.