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SETMA's Past Defined by Three Seven-Year Segments which Help Guide the Future
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SETMA's soon-to-be 21 years of healthcare delivery can logically be seen in three seven-year segments:

- **1995-2002** – marked by the development of a team approach to healthcare, electronic medical records, which morphed into electronic medical management, population health, and the foundation of analytics and data management with 1999-sentinel events which continue to define our care delivery.
- **2002-2009** – marked by extensive clinical decision support, chronic disease management and the integration of care utilizing the same data base for inpatient, outpatient, and long-term residential care.
- **2009-2016** – marked by the expansion of patient-centered care, with seven years of public reporting of provider performance by provider name, and the transitioning into a Patient-Centered Medical Home with accreditation and/or recognition for medical home and ambulatory care from National Committee for Quality Assurance (NCQA, 2010-2016), Accreditation Association of Ambulatory Health Care (AAAHC – 2010-2017), URAC (2014-20117) and Joint Commission (2014-2017), NCQA Diabetes (2010-2016) and Stroke/Heart (2013-2016) Recognition. The next fifteen months will see SETMA renewed all six of these accreditations.

Overarching all three segments has been SETMA's extensive participation in a capitated care model with additional payments for quality and performance outcomes and pay-for-performance, all of which began in 1996 and continue today.

This history is documented at www.jameslhollymd.com and can be reviewed in-part at these links:

- Transforming Your Practice - Introduction to SETMA's TCPI Library
- Senior Medical Student Externship - SETMA's MS4 Patient-Center Medical Home Selective Syllabus
- Medical Home
- Your Life Your Health

- Public Reporting of Provider Performance on Quality Measures
- Letters
- In the News
- Accreditations
- Electronic Patient Management Tools

How the Past Impacts the Future

Beyond a review and summary of the past, the larger question is how does this new division of SETMA's development and history influence, give direction to and determine SETMA's future? As we review this perspective, there is no part of SETMA's history which needs to be repudiated, corrected or rejected. This means that our challenge is to sustain each element of our past while strengthening them. While we expand our vision and as we increasingly work to turn our "vision" into our "reality," sustaining the progress of the past, while expanding our future not simple and it is not essentially inevitable.

What is our greatest challenge?

SETMA's greatest challenge is adjusting to the changes in reimbursement which continue to pressure our ability to support the advances of the past and to fund the challenges of the future. These challenges are not the result of capriciousness by public policy planners but is the result of the need to expand our service reach – including more people, and often more people with less ability to pay for their own care – and to respond to the economic pressure on those who are paying for their own healthcare and for the healthcare of others.

In summary, we are challenged to do more and more with less and less. Success will require SETMA to be attentive to those areas where opportunities exist to gain revenue while fulfilling the Triple Aim initiative defined by the Institute of Healthcare Improvement. Some of those are:

1. Chronic Care Management
2. Medicare Annual Wellness Examinations
3. Transitions of Care Coding
4. Preventive and Screening Care
5. Hierarchical Condition Categories (HCC and RxHCC)
6. Fulfilling Imperatives defined by State Health Departments and State Medical Boards
7. Providing administrative functions for healthcare organizations such as long-term care facilities, etc.
8. Contracting to provide indigent or uninsured care to patients who present to healthcare organizations who are required to provide those services and/or to provide those services to patients who do not have a healthcare provider.
9. The use of data analytics to extend needed and appropriate services to populations of patients who may be underserved.
10. Payments for quality outcomes and/or payments for performance.
11. Participation in Alternative Payment Models (APM) such as Accountable Care Organizations, Medicare Advantage.

Increasingly, payments for healthcare services are going to be made on the basis of quality and performance rather than on volume of services provided. The transition from volume-based reimbursement - a provider changing income by ordering more tests or doing more procedures - is very difficult without an external measure of quality which does not focus on "how much you do." Capitation provides a routine and regular payment to the provider for the acceptance of responsibility to care for the patient.

Under capitation, there is no motivation for "doing more things" to and/or for the patient. Whether "the more" are frequency of visits or volume of testing or procedures, capitation does not drive the cost of care up. However, the limitation of capitation is that a provider may be tempted to not see the patient but to pass the patient off to specialists. Additionally, capitation may tempt providers to accept for treatment only relatively well patients who do not require a great deal of care.

Three modifiers can mitigate these risks. Theses modifiers can be used both to adjust the level of capitation and to provide value-based payments:

1. The capitation payment should be adjusted by whether or not the provider and/or practice is accredited or recognized as a patient-centered medical home and/or by the level of accreditation which is held.
2. Both the capitation and the value-based payment should be adjusted by standards of care and outcomes similar to the Medicare Advantage (MA) Stars standards and/or the ACO Quality Metrics. In that both of these are taken from HEDIS measures, they should be standardized and harmonized.
3. Both the capitation and the value-based payments should be adjusted by the HCC/RxHCC coefficient scores similar to the MA, ACO and PC-MH use of these scores. (If you are not familiar with this category, it can be reviewed at the following link: HCC/RxHCC Risk Tutorial) This will reward a provider or practice for accepting responsibility for caring for sicker and needier patients.

SETMA believes that the key to the future of healthcare is an internalized ideal and a personal passion for excellence rather than reform which comes from external pressure. Transformation is self-sustaining, generative and creative. In this context, SETMA believes that efforts to transform healthcare may fail unless four strategies are employed, upon which SETMA depends in its transformative efforts:

1. The methodology of healthcare must be electronic patient management.
2. The content and standards of healthcare delivery must be evidenced-based medicine.
3. The structure and organization of healthcare delivery must be patient-centered medical home.
4. The payment methodology of healthcare delivery must be that of capitation with additional reimbursement for proved quality performance and cost savings.

When using quality metrics endorsed by the National Qualify Forum (NQF), the National Committee on Quality Assurance (NCQA, HEDIS metrics), Physician Collaborative for Performance Improvement (PC-PI), Physician Quality Reporting System (PQRS) and others, all

of which are evidenced based, peer reviewed metrics, providers are evaluating their performance by evidenced-based metrics.

At the core of the four principles identified above, is SETMA's belief and practice that one or two quality metrics will have little impact upon the processes and outcomes of healthcare delivery and, they do little to reflect quality outcomes in healthcare delivery. In the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS), healthcare providers are required to report on at least three quality metrics. This is a minimalist approach to providers quality reporting and is unlikely to change healthcare outcomes or quality. PQRS allows for the reporting of additional metrics and SETMA reports on 28 PQRS measures.

SETMA has laid the ground work for success in the future, but it does not mean that it will not be difficult and challenging.