Description of Applicant's Organization (SETMA, LLP)

SETMA (www.setma.com) is multispecialty, ambulatory-care clinic with four clinic locations. SETMA has a 68,000 patient base, was founded in August, 1995 and began using EHR in 1999. All care is EHR documented and managed including clinics, hospice, home health, physical therapy, hospital, emergency department, nursing home and provider homes. SETMA includes nurse practitioners, internists, family physicians, physical therapy, American Diabetes recognized Diabetes Self Management Education Program, cardiology, ophthalmology, rheumatology, neurology, infectious disease and pediatrics and delivers care over a five-county area, with a secure web portal and a health information exchange. We have a hospital-care team which cares for patients around the clock.

SETMA functions as a PC-MH (NCQA Tier III and AAAHC), is debt free and has deployed extensive Clinical Decision Support (ONC Recognized as one of 30 exemplary practices). SETMA's supports the "3-part aim" as proved by the result of the CMS, RTI-International-conducted study to analyze patterns of care, health outcomes, and costs of care for Medicare fee-for-service (FFS) beneficiaries.

SETMA employees advanced EHR and Business-Intelligence capabilities to track, audit and analyze data for public reporting by provider name and for designing quality improvement initiatives. SETMA's team approach is ideal for successful innovation. (203 words)

Interest in Innovation Advisors Program

My wife and I endowed a Distinguished Chair in PC-MH at the University of Texas Health Science Center in San Antonio. Universal American, an HMO, with which SETMA works, contributed $100,000 to that endowment. In the transmittal letter, the President of UA, said:

"Our organization works with thousands of physicians…we collaborate with dozens of physician leaders who dedicate themselves to organizing outstanding patient care by seeking new and innovative ways to improve the entire patient care process…

"…Dr. Holly is in a league by himself. His energy, passion, and unrelenting commitment to improving quality of care are without equal in my experience. He drives positive change within his practice and community, implements valued-added technology to improve clinical outcomes, reads and writes prolifically regarding clinical and public health issues and generously shares what he has learned with all interested parties across the United States. Under Dr. Holly's leadership, SETMA has been honored on countless times for their innovation, technology and services to the community…their greatest accomplishment is the care and quality that each SEMTA patient receives. They are the real beneficiaries of this extraordinary physician practice."

Similar letters have been submitted to the National Quality Forum and to The Join Commission in support of the nomination of Dr. Holly for the 2011 John M. Eisenberg Patient Safety and

Quality Awards: President of the UT Health Science Center; President of PC-PCC; Executive Director of the PC-PCC; President of NextGen Health Information; Beaumont Cardiologist; a long-time patient of Dr. Holly's. These letters are posted at www.setma.com under *In-the-News* and reflect Dr. Holly's commitment to innovation and excellence.

For the past seventeen years, I have devoted myself to the building of a platform for excellence of care. I implemented an EHR when our community mocked the expenditure and our CPA said it was a waste of money. I added education to our practice when there was no one paying for it. I led our practice to become a Joslin Diabetes Affiliate for no other reasons than to promote excellence in the care of patients with diabetes. I organized a hospital-care team to promote transitions of care when no one was talking about the subject.

My participation, in the Innovation Advisors Program is a logical and sequential step in my history and in that of SETMA. SETMA's partners and staff are prepared to support my participation; our patients, community, region and practice will benefit from it. (406)

Current Role and Responsibilities

As the CEO of SETMA, as the Director of SETMA's In-patient Care team, and as the Hospitalist, Medical Director, Chairman of the Board and President of the Golden Triangle Physicians Association – a physician owned and operated Independent Physicians Alliance (IPA) – I am in a unique position to know the healthcare improvement needs for our practice and community. SETMA's IT Department reports directly to me and works collaborative with me to support SETMA's healthcare delivery goals and to implement quality improvement programs.

SETMA is currently involved in three quality initiatives: Care Transitions founded on the Physician Consortium for Performance Improvement metric set; Medical Reconciliation founded upon the AMA's publication, *The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles*; Reducing Preventable Re-admissions to the Hospital based on SETMA's BI analytics. These three initiatives are inter-related and inter-dependent.

The CMMI Advisor program will allow me to gain new skills and for SETMA to expand its reach to involving non-SETMA providers and our patients in this process through HIE and secure web portal functionalities as well as through the strengthening of SETMA's analytics and internal processes. SETMA's PC-MH can be extended to producing a true regional Medical Neighborhood. (200)

Proposed Systems Improvement Project

SETMA changed the name of the Hospital Discharge Summary to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan," which functionally addresses the critical role it plays in Care Transitions. Since the publication by the American Medical Association (AMA) through its Physician Consortium for Performance Improvement (PCPI) of the Care Transitions Measurement Set in June, 2009, SETMA has a 99.1% efficiency of completing the 14-data point

and 4-action set. Conjoined with the Hospital Follow-up Call from SETMA's Care Coordination Department (CCD), which is a 12-30 minute health coaching call and not just a brief administrative call, the measurement set has given direction and substance to our efforts.

In addition to SEMTA's deployment of the PCPI measurement set and the involvement of SETMA's CCD, SETMA also deployed a Business Intelligence (BI) audit for Preventable Readmissions. This audit contrasts two populations: those who are and those who are not readmitted. This tool looks for leverage points for decreasing preventable readmissions. The tool examines morbidities and co-morbidities, lengths of stay, gender, age, socio-economic, care transitions and ethnicity. In addition, the tool looks at follow-up calls and follow-up visits. Thus far, the metric which relates to readmissions versus non-readmissions is the rapidity of a follow-up visit with the primary care provider.

SETMA has had some success. The result of the CMS FFS study, conducted by RIT International for CMS, for the SETMA II Clinic, where I practice, showed the following:

Table 2. Overview of Trends in Measures for Your Practice: July 2007 to June 2010.

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 %

The improvement in "potentially avoidable hospitalizations" from July, 2009 to July, 2010, corresponds to our use of the PCPI Care Transitions audit and with our deployment of the BI analytics tool.

The changes and innovations which we would add to what we are doing are to:

1. Deploy the HIE to all healthcare providers who have a key role in our project which would include: emergency department personnel (partially done), hospital administration (partially done), home health, hospice, specialists including non-SETMA cardiology, pulmonologist, gastroenterology, neurology, and general surgery.

2. Deploy risk stratification, predictive modeling, health risk assessments and tele-monitoring, none of which we currently do.
3. With number "2", all patients at high risk of readmission will be seen within 48 hours in the clinic and all other patients will be seen within five days following transition from in-patient to ambulatory care.

Our goal is to have a twenty percent improvement in readmission rates in 2012.

Support of Innovation Advisors Program Goals

This program will support each of the Advisor goals: better care, better health, lower cost.