HIMSS11

ANNUAL CONFERENCE & EXHIBITION

Conflict of Interest Disclosure

James L. Holly, MD

Has no real or apparent conflicts of interest to report.

Conflict of Interest Disclosure

James L. Holly, MD

- Salary: No
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- Receipt of Intellectual Property Rights/Patent Holder: No
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- Other: None

Designing a Quality Initiative: Principles, Quality Metrics, Public Reporting

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Technology Alone Is Not The Answer

While an Electronic Health Record (EMR) has tremendous capacity to capture data, it is only part of the solution. The ultimate goal must be to improve patient care, not to just capture and store data. We must begin to think of ***Electronic Patient Management*** which leads to improved care rather than just an Electronic Health Record that simply stores data.

Quality Initiatives Are The Solution

Electronic Patient Management is the foundation for designing and implementing quality initiatives to improve outcomes in care.

The design and implementation of quality initiatives allows leveraging of resources to improve care and outcomes.

Steps to Selecting a Quality Initiative

1. Begin a new project while completing another
2. Build upon your past work
3. Leverage your resources in improving care
4. Think about what you want to accomplish
5. Examine your past work and ask if it has made a difference
6. Develop an algorithm to electronically audit to transform data to information
7. Use the information to implement change that will make a difference

Selection of a Quality Initiative
Steps 1 & 2

1. Begin the design of a new project while you are completing a project.

2. Build upon your past work and design a new function which is a logical extension of what you have already done.

These principles will contribute to the success of new initiatives.

Getting Started

April, 2010, SETMA completed a 14-month project to achieve NCQA and AAAHC Medical Home Recognition.

Simultaneously, we were completing an 18-month, two-phase Business Intelligence (BI) project which was necessary for our medical home recognition.

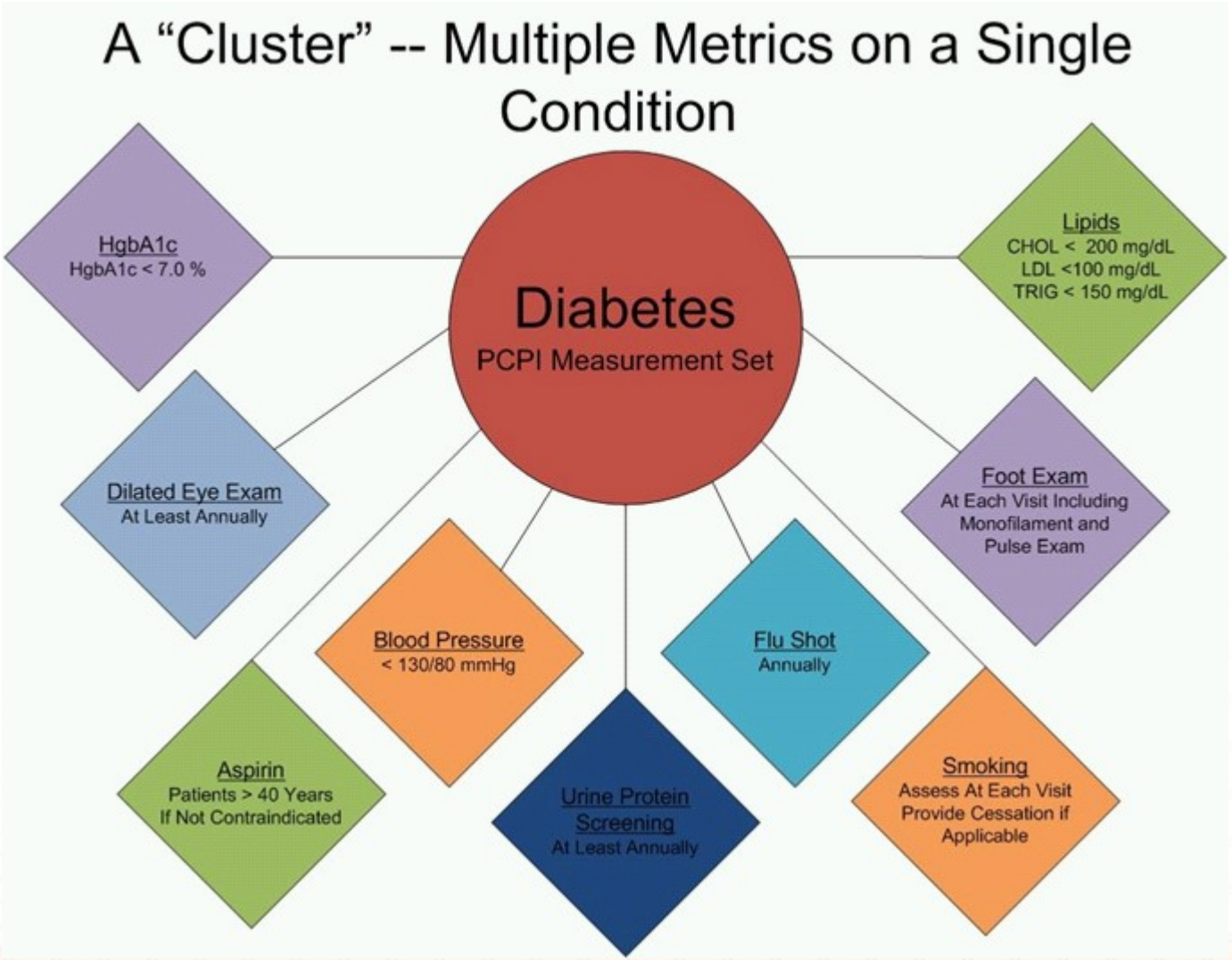
And, at the same time we were developing a third phase to extend our BI capabilities.

Critical Issues About Quality Metrics

Fulfilling a single or a few quality metrics does not change outcomes, but fulfilling "clusters" and "galaxies" of metrics at the point-of-care can and ***will change outcomes***.

- A "cluster" is seven or more quality metrics for a single condition, i.e., diabetes, hypertension, etc.
- A "galaxy" is multiple clusters for the same patient, i.e., diabetes, hypertension, lipids, CHF, etc.

A "Cluster" -- Multiple Metrics on a Single Condition



A "Galaxy" -- Multiple "Clusters" Tracked on a Single Patient at a Single Visit

Clusters and Galaxies

Unlike a single metric, such as “was the blood pressure taken,” which will not improve care, fulfilling and then auditing a “cluster” or a “galaxy of clusters” in the care of a patient **will improve treatment outcomes and will result in quality care.**

SETMA's Business Intelligence Project

The first two phases of our BI project allowed us to analyze quality metrics by provider, practice or clinic, over any period of time.

Also, at the time of a visit, with the click of a button, the provider can display the patient's status on the fulfillment of quality metrics published by HEDIS, NQF, AQA, PQRI, NCQA, PCPI. BTE plus three quality measurement sets developed by SETMA.

Healthcare Effective Data Information Set (HEDIS)

2010 HEDIS Technical Specifications for Physician Measurement

Legend Measures in red are measures which apply to this patient that are not in compliance
Measures in black are measures which apply to this patient that are in compliance.
Measures in gray are measures which do not apply to this patient.

Effectiveness of Preventive Care

View Adult BMI Assessment
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Childhood Immunization Status
Immunizations for Adolescents
Lead Screening in Children
Colorectal Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Glaucoma Screening in Older Adults
Use of High-Risk Medications in the Elderly
Care for Older Adults

Effectiveness of Acute Care

View Appropriate Treatment for Children with Upper Respiratory Infection
View Appropriate Testing for Children with Pharyngitis
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Effectiveness of Chronic Care

View Persistence of Beta-Blocker Therapy After a Heart Attack
View Controlling High Blood Pressure
View Cholesterol Managment for Patients with Cardiovascular Disease
View Comprehensive Adult Diabetes Care
View Use of Appropriate Medications for People with Asthma
View Use of Spirometry Testing in the Assessment and Diagnosis of COPD
View Pharmacotherapy Management of COPD Exacerbation
View Follow-Up After Hospitalization for Mental Illness
View Antidepressant Medciation Management
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication
Osteoporsis Management in Women
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
View Annual Monitoring for Patients on Persistent Medications
Medication Reconciliation Post-Discharge

National Quality Forum

National Quality Forum (NQF)
National Voluntary Consensus Standards

Legend
Measures in red are measures which apply to this patient that are not in compliance.
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Measures in gray are measures which do not apply to this patient.

General Health Measures
- View Body Mass Index Measurement
- View Smoking Cessation
- Proper Assessment for Chronic COPD
- Adult Immunization Status

Blood Pressure Measures
- View Blood Pressure Measurement
- View Blood Pressure Classfication/Control

Medication Measures
- View Current Medciation List
- View Documentation of Allergies/Reactions
- View Therapeutic Monitoring of Long Term Medications
- Drugs to Avoid in the Elderly
- View Appropriate Medications for Asthma
- View Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis
- View LDL Drug Therapy for Patients with CAD

Chronic Conditions Measures
- Comprehensive CHF Care
- Osteoarthritis Care

Care for Older Adults
- Counseling on Physical Activity
- View Urinary Incontinence in Older Adults
- Colorectal Cancer Screening
- Fall Risk Management

Diabetes Measures
- Dilated Eye Exam
- Foot Exam
- Hemoglobin A1c Testing/Control
- Blood Pressure
- Urine Protein Screening
- Lipid Screening

Female Specific Measures
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Osteoporosis Management

Pediatric Measures
- Appropriate Screening for Children with Pharyngitis
- Childhood Immunization Status

Ambulatory Quality Care Alliance (AQA)

AQA Clinic Performance Meaures Set

Legend
Measures in red are measures which apply to this patient that are not in compliance
Measures in black are measures which apply to this patient that are in compliance.
Measures in gray are measures which do not apply to this patient.

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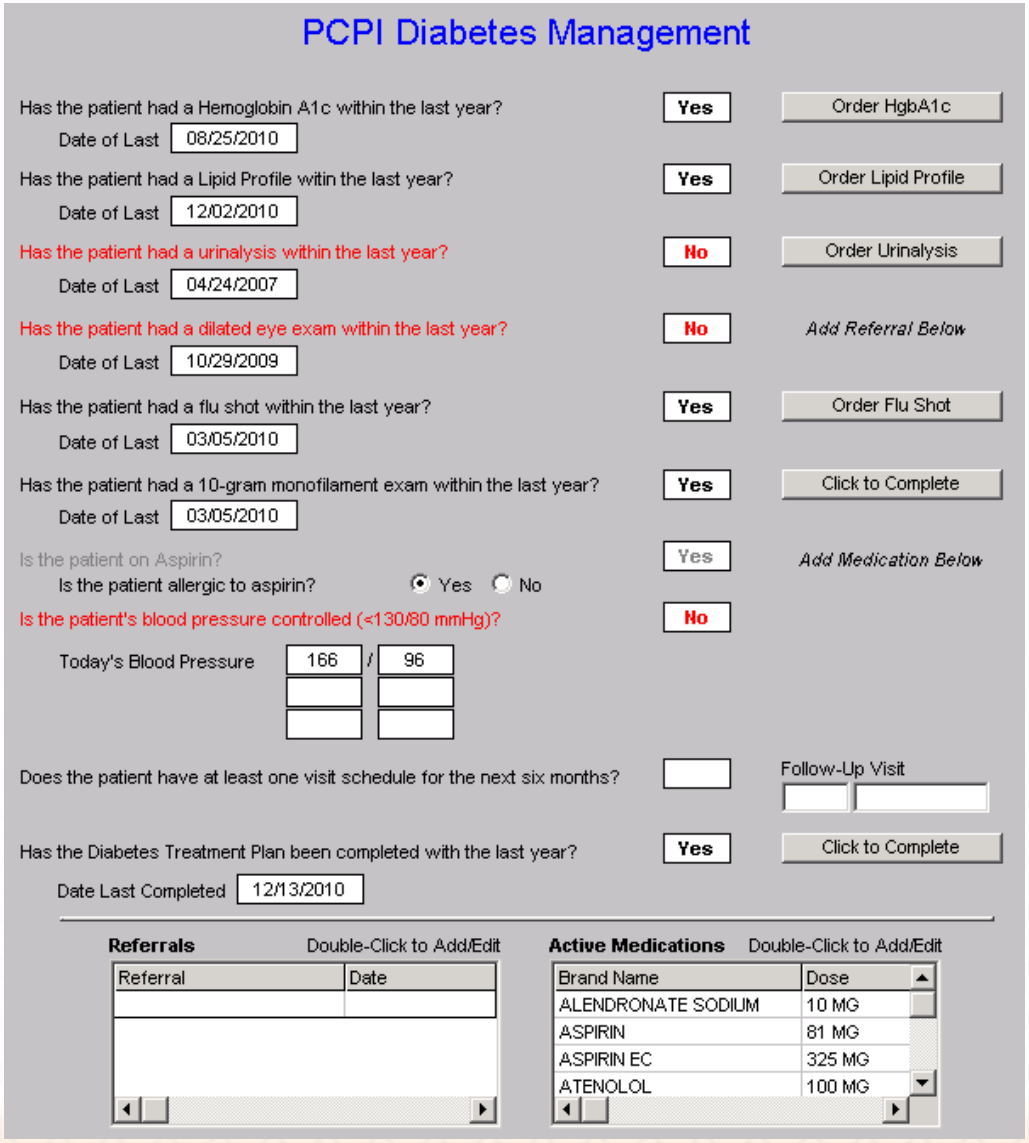
Medication Reconciliation Post-Discharge

Physician Consortium for Performance Improvement (PCPI)



Physician Quality Reporting Initiative (PQRI)

Fall Risk Measures Group

This patient **IS NOT** eligible for submittal of the measures in the fall risk group.

Patients ages 65 and older are eligible for this measure.

History of Falls

Patient has a history of falls.

Fall Risk Assessment

Fall risk assessment not completed.

Plan of Care for Falls

Fall risk plan of care not completed.

Back Pain Measures Group

This patient **IS NOT** eligible for submittal of the measures in the back pain group.

Patients 18 to 79 with a diagnosis of back pain, either newly diagnosed or not addressed within the previous 4 months, are eligible for this measure.

Comprehensive Initial Assessment

Patient not eligible for submittal of back pain measures.

Physical Exam

Patient not eligible for submittal of back pain measures.

Advice for Normal Activities

Patient not eligible for submittal of back pain measures.

Advice Against Bed Rest

Patient not eligible for submittal of back pain measures.

Chronic Kidney Disease Measures Group

This patient **IS NOT** eligible for submittal of the measures in the CKD measures group.

Patients with stage 4 or 5 kidney disease who are not receiving renal replacement therapy are eligible for this measure.

Laboratory Testing Ca, Phos, PTH, Lipids

Patient not eligible for submittal of CKD measures.

Blood Pressure Target < 130/80

Patient not eligible for submittal of CKD measures.

Blood Pressure Plan

Patient not eligible for submittal of CKD measures.

Influenza Immunization

Patient not eligible for submittal of CKD measures.

Referral for AV Fistula

Patient not eligible for submittal of CKD measures.

Elevated Hemoglobin for Patients Receiving ESA Therapy

Patient not eligible for submittal of CKD measures.

Not applicable. Patient not on ESA therapy.

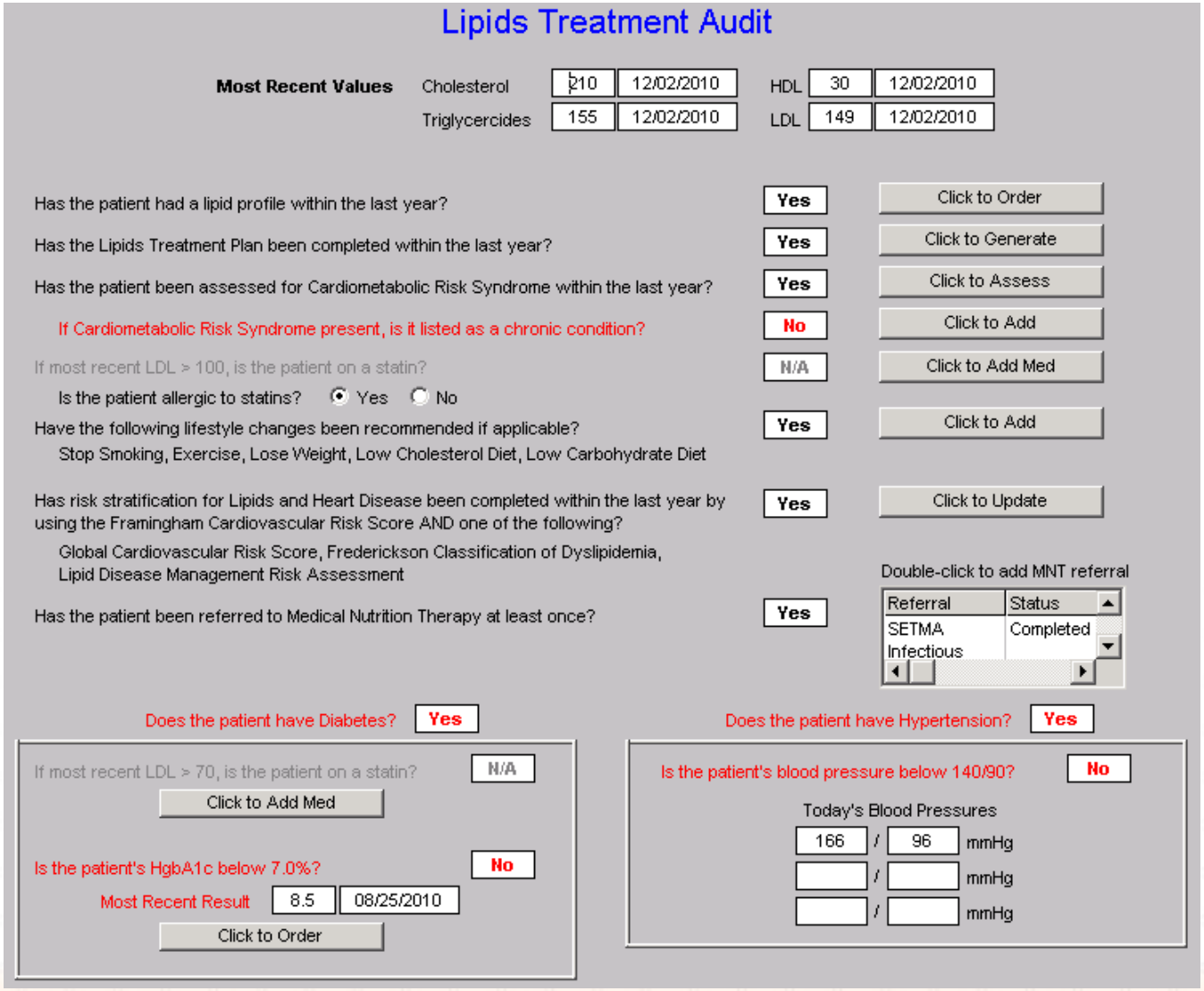
Not applicable. Patient not on ESA therapy.

SETMA's Business Intelligence Project

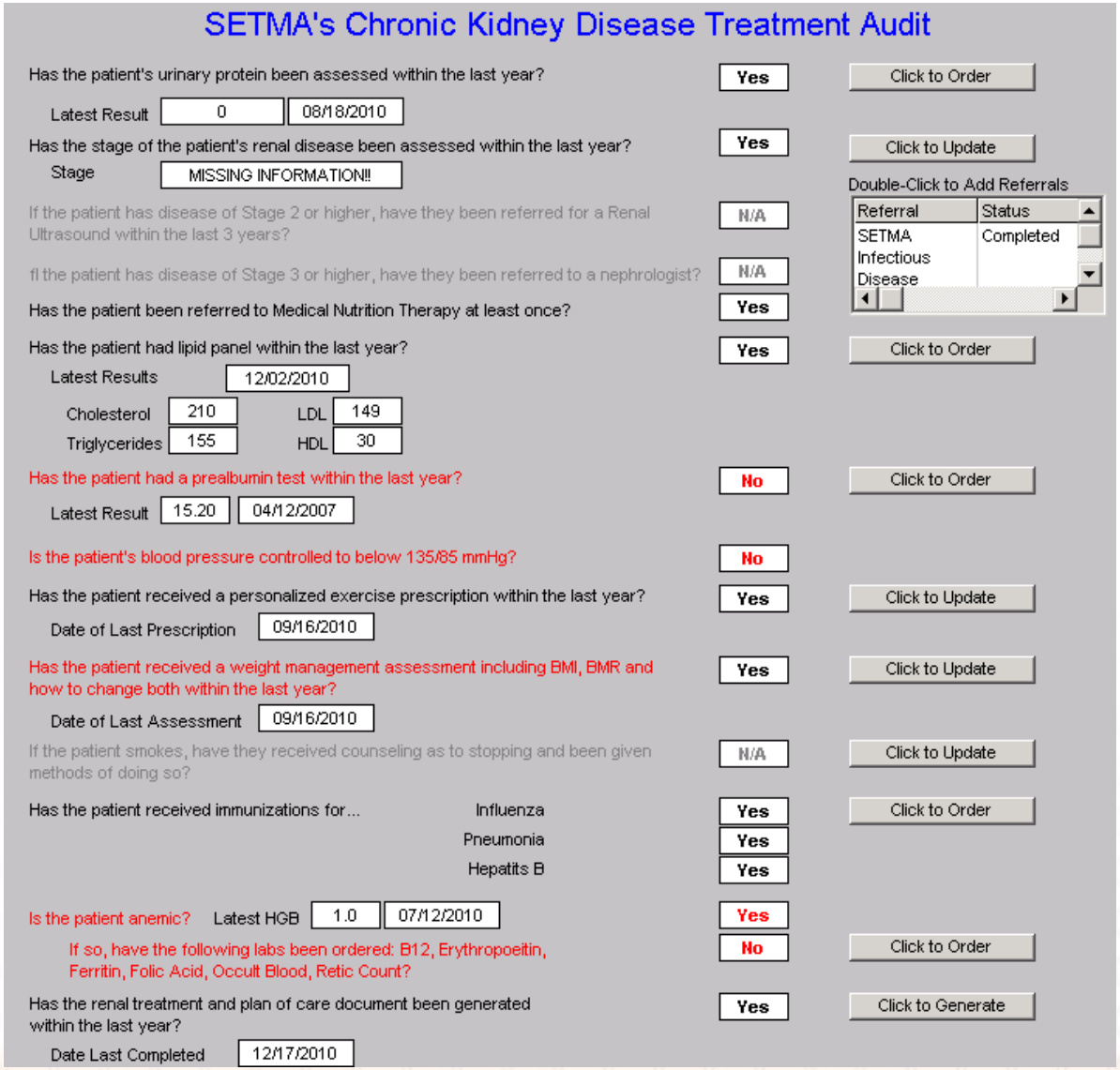
During our BI project, we identified areas where no quality measures existed and we created our own. Those include quality metrics for Lipids, elements of Hypertension not included in other metric sets and Stages I, II and III for Chronic Renal Disease.

This creative thinking allowed us to leverage our work in other areas of quality metrics to help improve care for other disease processes.

SETMA's Lipid Audit



SETMA's Chronic Renal Disease Audit

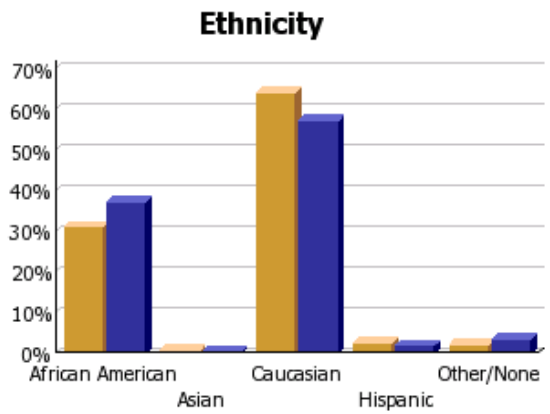


SETMA's Business Intelligence Project

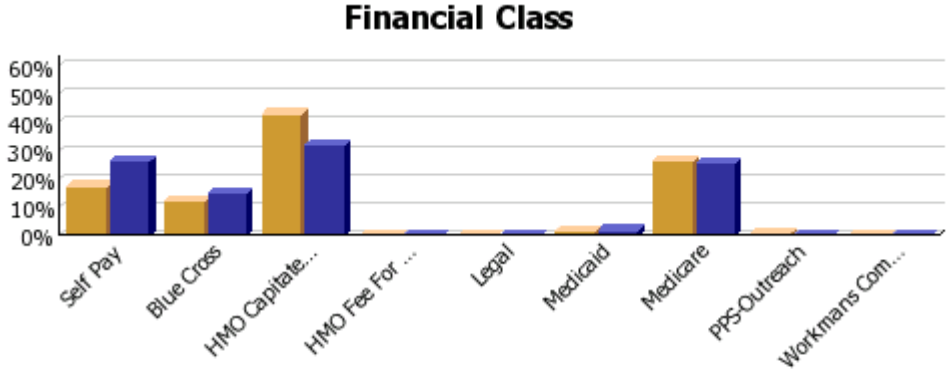
Our BI project also allows us to examine population management performance by

- Ethnicities
- Socio-economic groups
- Payer class
- Age
- Gender

SETMA's Business Intelligence Project
Diabetes Dashboard



	African American	Asian	Caucasian	Hispanic	Other/None
Controlled	31.0%	0.6%	64.0%	2.4%	2.0%
Selected	37.1%	0.4%	57.3%	1.8%	3.4%



	Self Pay	Blue Cross	HMO Capitated	HMO Fee For Service	Legal	Medicaid	Medicare	PPS-Outreach	Workmans Comp
Controlled	17.3%	11.8%	43.0%	0.0%	0.0%	1.2%	26.2%	0.5%	0.0%
Selected	26.0%	14.7%	32.0%	0.0%	0.0%	1.6%	25.4%	0.1%	0.0%

SETMA's Business Intelligence Project

The purpose of this population analysis was to examine whether we have, as we think, eliminated the disparities of care commonly reported for the economically disadvantaged and for certain ethnic groups.

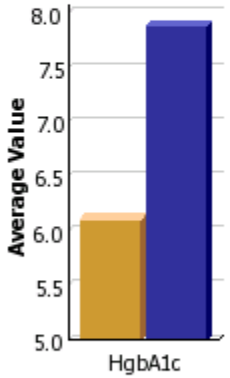
We can also do these comparisons within a subpopulation. For example, we can compare the statistics of all patients with diabetes who are treated to goal versus the statistics for the patients who are not treated to goal.

SETMA's Business Intelligence Project

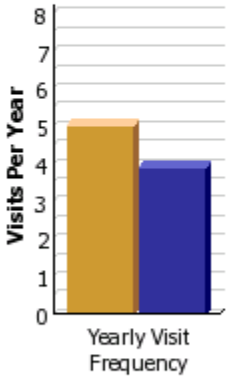
Chronic Diabetes - Measures Comparison (Most Recent 12 Months)

Controlled Group Time Basis: **Prior 12 Months**
Controlled Group Constrained to: **All SETMA**
Practice: **SETMA 1, SETMA 2, SETMA West**
Provider: **None**

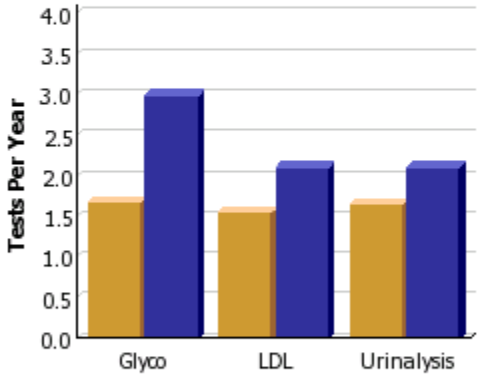
Controlled Group
Selected Group



	HgbA1c Avg	Standard Deviation
Controlled	6.1	0.6
Selected	7.9	1.5



	Visit Frequency
Controlled	5.0
Selected	3.9



	Yearly Glyco Tests	Yearly LDL Tests	Yearly UA Tests
Controlled	1.7	1.6	1.7
Selected	3.0	2.1	2.1

Why can we do this?

This robust reporting is possible because over the past 12 years SETMA has designed disease management tools which automatically capture provider performance at the point of care.

Remember, the first two principles of a quality initiative: **it is both built upon past work and the new process is a logical extension of the previous work.**

Why can we do this?

An illustration of this is PCPI's Care Transition quality metrics. When these metrics were released in June, 2009, it became apparent that we were only lacking two of the fourteen data points.

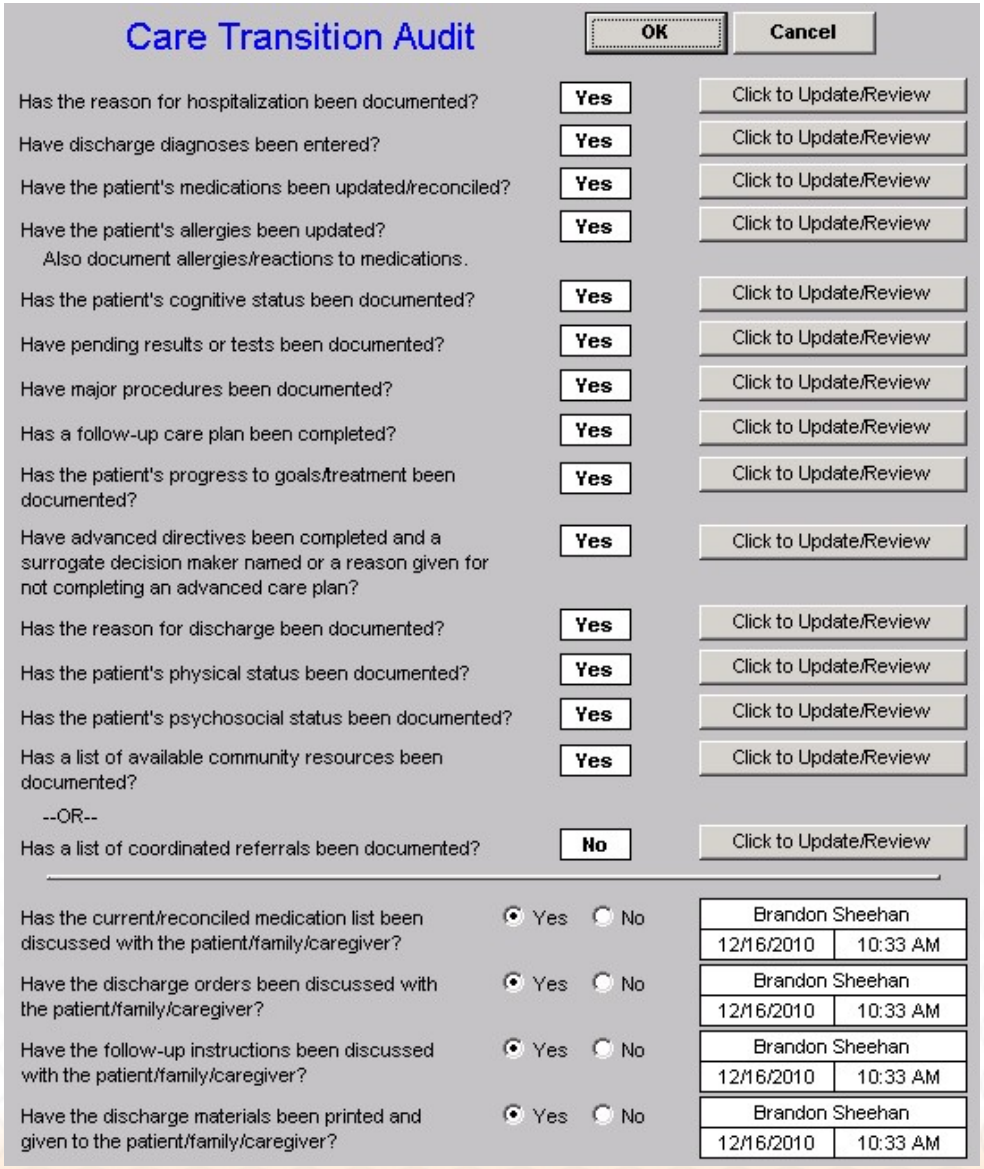
As a result of our previous work, we were able to implement all of the Care Transition elements into our workflow in just two days.

Selection of a Quality Initiative
Step Number 3

The third element of designing a quality initiate is to select a topic which will **leverage your resources in improving care and/or in improving outcomes**.

As a result, due to our hospital care transitions, hospital care summary and post-hospital plan of care and treatment plan, we selected to audit preventable readmissions to the hospital which will leverage the work we are already doing in electronic patient management and BI auditing.

Care Transition Audit



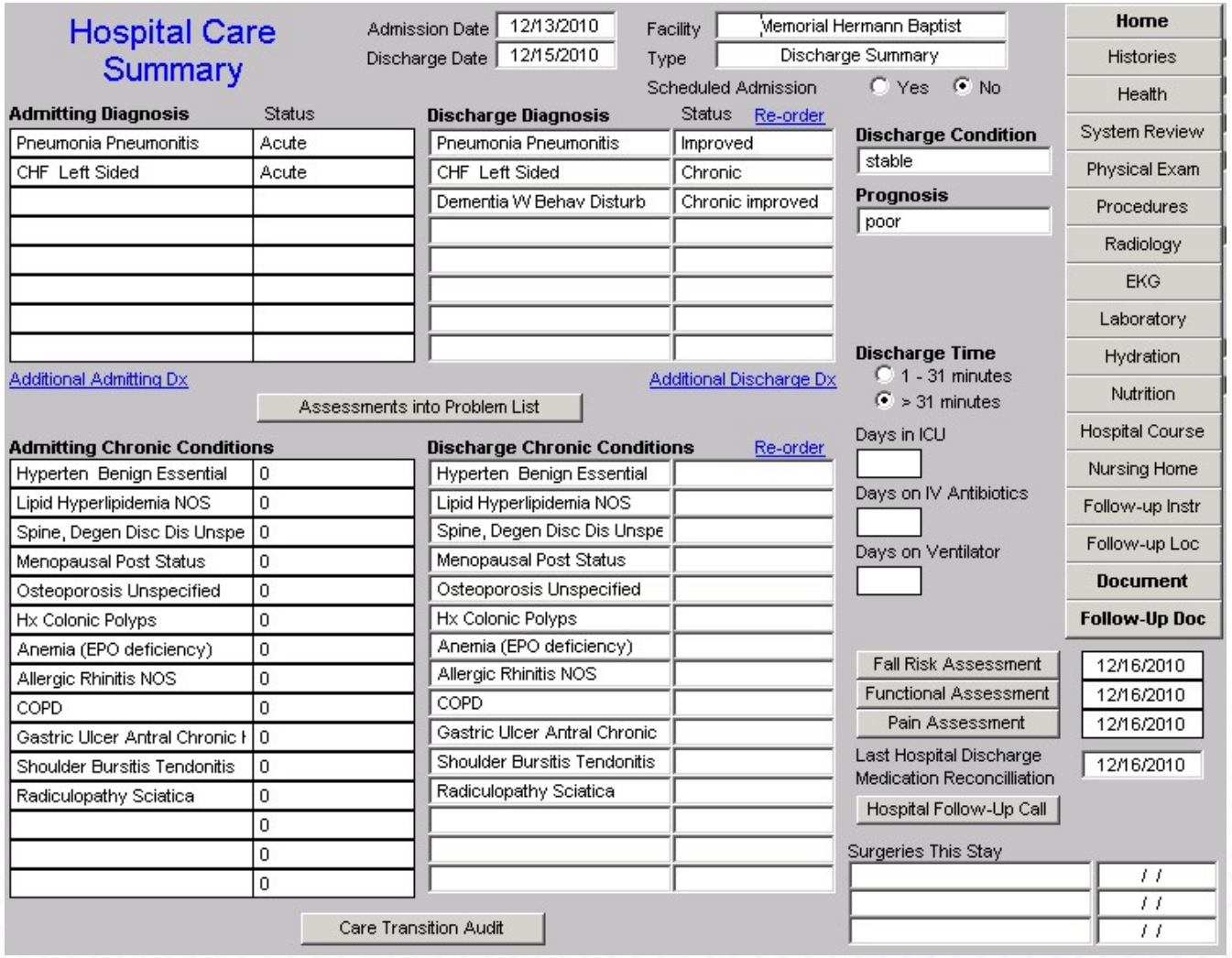
Care Transition Audit

OK | Cancel

Has the reason for hospitalization been documented?	Yes	Click to Update/Review
Have discharge diagnoses been entered?	Yes	Click to Update/Review
Have the patient's medications been updated/reconciled?	Yes	Click to Update/Review
Have the patient's allergies been updated? Also document allergies/reactions to medications.	Yes	Click to Update/Review
Has the patient's cognitive status been documented?	Yes	Click to Update/Review
Have pending results or tests been documented?	Yes	Click to Update/Review
Have major procedures been documented?	Yes	Click to Update/Review
Has a follow-up care plan been completed?	Yes	Click to Update/Review
Has the patient's progress to goals/treatment been documented?	Yes	Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	Yes	Click to Update/Review
Has the reason for discharge been documented?	Yes	Click to Update/Review
Has the patient's physical status been documented?	Yes	Click to Update/Review
Has the patient's psychosocial status been documented?	Yes	Click to Update/Review
Has a list of available community resources been documented?	Yes	Click to Update/Review
--OR--		
Has a list of coordinated referrals been documented?	No	Click to Update/Review

Has the current/reconciled medication list been discussed with the patient/family/caregiver?	(•) Yes ( ) No	Brandon Sheehan	12/16/2010 10:33 AM
Have the discharge orders been discussed with the patient/family/caregiver?	(•) Yes ( ) No	Brandon Sheehan	12/16/2010 10:33 AM
Have the follow-up instructions been discussed with the patient/family/caregiver?	(•) Yes ( ) No	Brandon Sheehan	12/16/2010 10:33 AM
Have the discharge materials been printed and given to the patient/family/caregiver?	(•) Yes ( ) No	Brandon Sheehan	12/16/2010 10:33 AM

Hospital Care Summary



Hospital Care Summary

Admission Date: 12/13/2010
Discharge Date: 12/15/2010
Facility: Memorial Hermann Baptist
Type: Discharge Summary
Scheduled Admission: Yes / No

Admitting Diagnosis	Status
Pneumonia Pneumonitis	Acute
CHF Left Sided	Acute

Discharge Diagnosis	Status
Pneumonia Pneumonitis	Improved
CHF Left Sided	Chronic
Dementia W Behav Disturb	Chronic improved

Re-order

Additional Admitting Dx

Additional Discharge Dx

Assessments into Problem List

Admitting Chronic Conditions	
Hyperten Benign Essential	0
Lipid Hyperlipidemia NOS	0
Spine, Degen Disc Dis Unspe	0
Menopausal Post Status	0
Osteoporosis Unspecified	0
Hx Colonic Polyps	0
Anemia (EPO deficiency)	0
Allergic Rhinitis NOS	0
COPD	0
Gastric Ulcer Antral Chronic H	0
Shoulder Bursitis Tendonitis	0
Radiculopathy Sciatica	0

Discharge Chronic Conditions
Hyperten Benign Essential
Lipid Hyperlipidemia NOS
Spine, Degen Disc Dis Unspe
Menopausal Post Status
Osteoporosis Unspecified
Hx Colonic Polyps
Anemia (EPO deficiency)
Allergic Rhinitis NOS
COPD
Gastric Ulcer Antral Chronic
Shoulder Bursitis Tendonitis
Radiculopathy Sciatica

Re-order

Care Transition Audit

Discharge Condition: stable

Prognosis: poor

Discharge Time
- 1 - 31 minutes
- > 31 minutes

Days in ICU

Days on IV Antibiotics

Days on Ventilator

Fall Risk Assessment	12/16/2010
Functional Assessment	12/16/2010
Pain Assessment	12/16/2010
Last Hospital Discharge Medication Reconcilliation	12/16/2010
Hospital Follow-Up Call	

Surgeries This Stay

	/ /
	/ /
	/ /

Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Post Hospital Plan of Care and Treatment Plan

SETMA I - 2929 Calder, Suite 100
SETMA II - 3570 College, Suite 200
SETMA West - 2010 Dowlen
(409) 833-9797
www.setma.com

Post Hospital Plan of Care and Treatment Plan

Patient	**Annie Winkel**
Date of Birth	**10/14/1919**
Age	**91 years**
Ethnicity	**Caucasian**
Sex	**F**
Encounter Date	**December 16, 2010**

Reason for Hospitalization

You have been hospitalized for CHF Unspecified.

Reason for Discharge

You have been discharged from the hospital because you have recovered from your acute condition.
You have been discharged from the hospital because you have reached the maximum benefit in the hospital setting.
You have been discharged from the hospital because your condition is now stable.

Discharge Diagnoses

Your diagnoses at the time of your discharge are as follows:

Auditing Re-admission Rates

1. We have the capacity to do this audit because of previous work.
2. It is a matter of national interest and concern due to the cost of preventable readmissions.
3. It will increase patient satisfaction, safety and quality of care.
4. Because SETMA has a population of patients for which we are “at risk” financially, this initiative has potential positive implications, also.

Selection of a Quality Initiative
Step Number 4

The fourth principle of design is to "**think" through the process and determine what you want to ask of your data.** In the re-admission audit, we want to:

1. Know what our readmission rate is by condition.
2. Know if there are discernable differences between patients who were or were not readmitted.
3. If differences exist, can we leverage that information to decrease readmission rates?

Selection of a Quality Initiative
Step Number 5

The fifth principle of design is to **examine whether or not we have done things in the past which have may have already, unknowingly reduced readmission rates**.

1. We can audit the use of the Transition of Care standards to see if they have improved our readmission rates.
2. We can audit to see if our hospital follow-up calls have had an effect on readmission rates.

Our BI project has allowed us to do this already.

Selection of a Quality Initiative
Step Number 6

The sixth principle of design is to **develop an algorithm based on the information gathered from the previous five steps to create an electronic audit out of which data can be come useful information.**

Once data has been transformed into information, you can make treatment decisions which **will make a difference**.

Selection of a Quality Initiative
Step Number 7

The final step is to **be prepared to make changes based on the data and information that you develop**.

However, you must be aware that if you make a change, **it must make a difference**.

Quality initiatives which change a process have no value until they make a difference in the outcome.

The Necessity of Public Reporting

The connection between quality initiatives and improved outcomes is public reporting because data without the determination to change will only lead to frustration.

The Necessity of Public Reporting

One of the most insidious problems in healthcare delivery is reported in the medical literature as “clinical inertia.” This is caused by the natural inclination of human beings to resist change.

“Clinical inertia” is defined as the lack of treatment intensification in a patient not at evidenced-based goals for care. It affects both provider and patient. The solution must address both.

The Necessity of Public Reporting

Public reporting of data helps to overcome this “clinical inertia” by creating a level of discomfort in the provider to encourage an improvement in their performance.

The Necessity of Public Reporting

All of the quality metrics that SETMA tracks, along with patient satisfaction survey results, are publicly reported ***by provider name*** on our website at www.jameslhollymd.com.

The Necessity of Public Reporting

Published Patient Satisfaction Survey Results

Third Quarter 2010 Aggregate
All SETMA

	Total	Poor	Fair	Average	Good	Very Good	Excellent	Comments
1	2879	33	35	81	421	902	1407	
2	2833	37	39	95	418	979	1265	
3	2658	6	14	50	349	927	1312	
4	2832	6	17	46	284	998	1481	
5	2783	3	3	24	302	918	1533	
6	2731	31	33	110	409	877	1271	
7	2834	4	7	46	303	910	1564	
8	2818	5	4	36	249	890	1634	
9	2815	8	6	23	269	882	1627	
10	2836	5	5	26	236	866	1698	
11	2824	43	36	137	416	918	1274	
12	2800	3	8	29	259	957	1544	

	Total	Poor	Fair	Average	Good	Very Good	Excellent	Comments
1 Ease obtaining appt	100%	1%	1%	3%	15%	31%	49%	57.56% Pt. Response
2 Speed of answering phone calls to office	100%	1%	1%	3%	15%	35%	45%	
3 Comfort level in administering self care	100%	0%	1%	2%	13%	35%	49%	
4 Office staff helpful w/ques. & probs.	100%	0%	1%	2%	10%	35%	52%	
5 Quality of nursing care received	100%	0%	0%	1%	11%	33%	55%	
6 Speed nursing staff return calls	100%	1%	1%	4%	15%	32%	47%	
7 Time physician spent with you	100%	0%	0%	2%	11%	32%	55%	
8 Communication from provider	100%	0%	0%	1%	9%	32%	58%	
9 Physician dx problem & rx treatment & f/u instructions	100%	0%	0%	1%	10%	31%	58%	
10 Confidence in physician	100%	0%	0%	1%	8%	31%	60%	

The Necessity of Public Reporting

NQF Diabetes Measures

NQF - Diabetes Measures

E & M Codes: Clinic Only
Encounter Date(s): Jan 1, 2010 through Dec 31, 2010

Location	Provider	Dilated Eye within 12 Months	Micral Strip within 12 Months	Foot Exam within 12 Months
SETMA 1	Aziz	54.2%	68.3%	63.2%
	Duncan	56.3%	55.3%	79.8%
	Groff	56.2%	53.5%	81.9%
	Henderson	59.9%	69.2%	91.3%
	Murphy	40.3%	73.4%	86.3%
	Sims	46.9%	56.8%	72.9%
	Thomas	65.4%	61.1%	75.6%
SETMA 1 Totals:		52.9%	65.5%	79.1%
SETMA 2	Ahmed	67.6%	43.9%	98.8%
	Anthony	64.4%	87.8%	97.1%
	Anwar	71.3%	87.2%	89.1%
	Cricchio	67.2%	84.5%	81.5%
	Holly	77.9%	92.3%	85.6%
	Leifeste	72.7%	85.5%	81.3%
	Vardiman	100.0%	100.0%	100.0%
	Wheeler	55.4%	79.3%	86.1%
SETMA 2 Totals:		67.9%	68.5%	92.0%
SETMA West	Curry	57.7%	69.2%	88.7%
	Delparine	56.1%	55.7%	92.2%
	Halbert	47.0%	37.1%	66.5%
	Horn	45.8%	70.6%	96.9%
	Qureshi	62.7%	57.6%	91.5%
	Satterwhite	65.5%	84.0%	78.0%
	Vardiman	51.2%	53.7%	80.2%
	Young	48.7%	44.0%	84.1%
SETMA West Totals:		52.1%	57.4%	83.0%
SETMA Totals:		60.0%	65.0%	86.4%

The Necessity of Public Reporting

NCQA Diabetes Recognition

NCQA Diabetes Measures
Encounter Date(s): January 1, 2010 to December 31, 2010

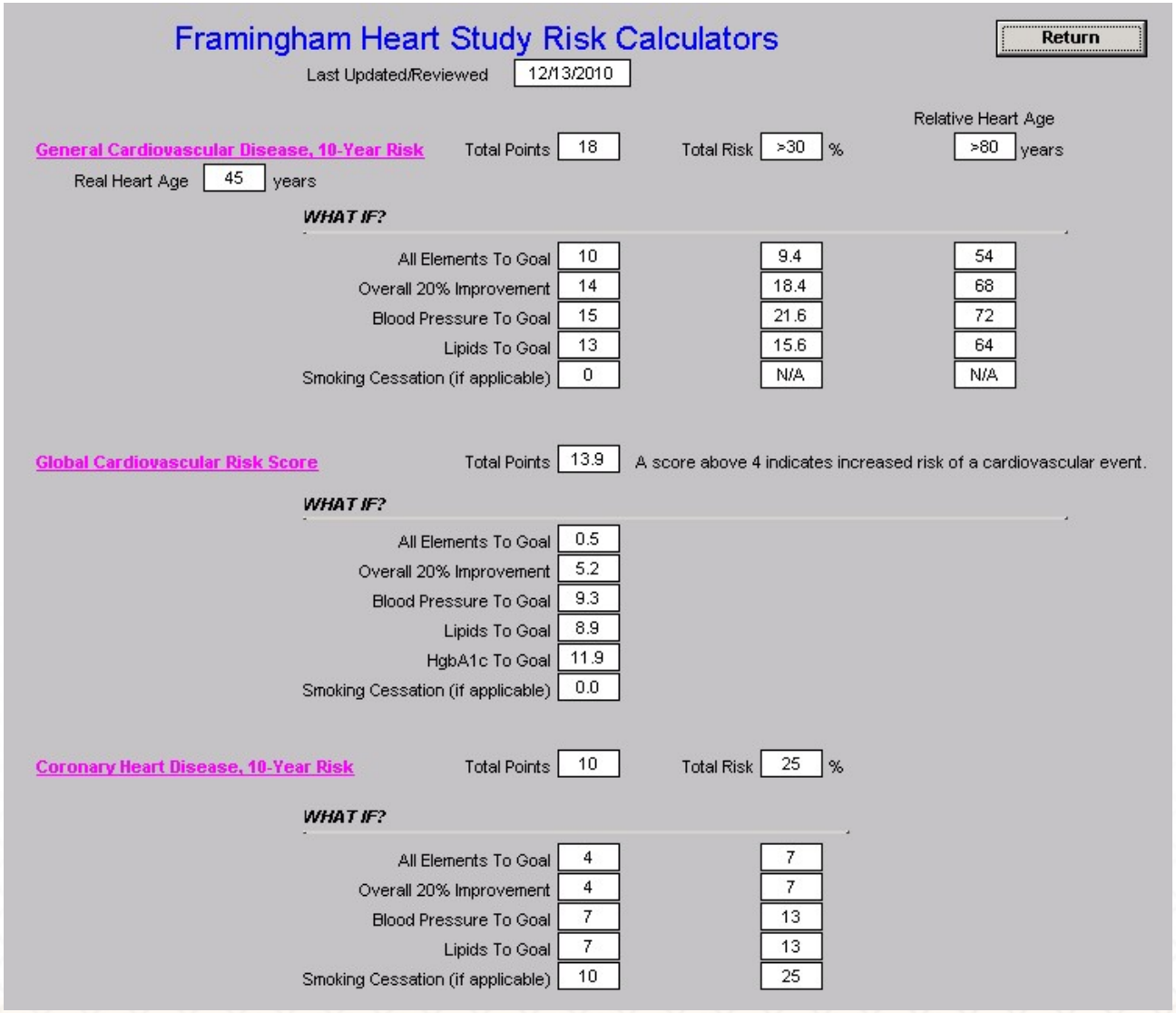
Location	Provider	Encounters	HgbA1c > 9.0	HgbA1c < 8.0	HgbA1c < 7.0	BP > 140/90	BP < 130/80	Eye Exam	Smoking Cessation	LDL >= 130	LDL < 100	Nephropathy	Foot Exam
SETMA 1	Aziz	949	12.2%	81.0%	61.4%	30.0%	43.7%	53.0%	71.7%	11.9%	67.5%	69.0%	63.3%
	Duncan	669	8.8%	81.3%	63.1%	11.5%	72.0%	58.7%	77.9%	14.5%	67.9%	60.4%	81.5%
	Henderson	747	11.2%	78.2%	58.9%	9.6%	68.1%	60.4%	86.8%	17.1%	65.3%	72.0%	92.8%
	Murphy	1,408	7.2%	83.2%	63.6%	20.2%	55.8%	42.3%	55.7%	10.2%	71.8%	75.3%	85.4%
	Sims	420	11.7%	79.0%	59.3%	22.6%	51.4%	47.1%	81.9%	17.6%	60.7%	62.4%	73.1%
	Thomas	697	11.8%	70.6%	49.6%	14.8%	59.1%	66.6%	73.2%	14.3%	57.7%	62.6%	75.8%
SETMA 2	Ahmed	3,450	18.8%	63.0%	38.1%	9.1%	62.6%	66.7%	51.1%	10.9%	67.4%	46.3%	98.7%
	Anthony	995	12.1%	78.1%	59.9%	13.6%	70.3%	62.9%	68.8%	14.0%	64.9%	89.1%	97.0%
	Anwar	1,488	7.1%	81.5%	57.7%	5.9%	77.8%	71.8%	70.5%	12.2%	63.7%	85.8%	88.1%
	Cricchio	838	10.5%	79.2%	62.8%	8.5%	72.4%	66.0%	60.3%	14.7%	63.8%	85.3%	81.4%
	Holly	458	10.5%	79.9%	63.3%	6.1%	74.5%	77.9%	61.3%	10.0%	65.1%	92.8%	86.7%
	Leifeste	960	8.7%	79.0%	63.5%	13.4%	63.6%	72.4%	58.9%	9.7%	66.0%	86.0%	81.7%
	Wheeler	623	9.0%	81.9%	59.2%	17.5%	56.0%	56.5%	77.2%	16.4%	59.6%	79.1%	86.8%
SETMA West	Curry	477	11.7%	70.9%	50.5%	15.1%	61.2%	61.2%	57.7%	10.5%	64.2%	72.1%	89.9%
	Deiparine	687	8.2%	64.3%	47.7%	18.2%	57.9%	58.7%	87.3%	9.3%	52.4%	57.4%	91.1%
	Halbert	1,217	10.4%	75.9%	58.0%	26.8%	48.8%	47.6%	53.1%	14.5%	58.6%	40.3%	68.8%
	Horn	857	6.7%	79.0%	61.3%	4.2%	71.9%	47.7%	75.9%	12.7%	56.5%	70.9%	96.1%
	Satterwhite	426	11.3%	70.0%	50.0%	28.9%	47.2%	66.4%	82.7%	15.3%	51.6%	80.8%	76.1%

Engaging The Patient In Their Care

While we use public reporting to induce change in the care given by our providers, we also take steps to engage the patient and avoid “patient inertia.”

We challenge the patient by giving them information needed to change and the knowledge that making a change will make a difference.

Patient Inertia



Framingham Heart Study Risk Calculators

Return

Last Updated/Reviewed 12/13/2010

General Cardiovascular Disease, 10-Year Risk

Total Points 18 Total Risk >30 % Relative Heart Age >80 years

Real Heart Age 45 years

WHAT IF?

All Elements To Goal	10	9.4	54
Overall 20% Improvement	14	18.4	68
Blood Pressure To Goal	15	21.6	72
Lipids To Goal	13	15.6	64
Smoking Cessation (if applicable)	0	N/A	N/A

Global Cardiovascular Risk Score

Total Points 13.9 A score above 4 indicates increased risk of a cardiovascular event.

WHAT IF?

All Elements To Goal	0.5
Overall 20% Improvement	5.2
Blood Pressure To Goal	9.3
Lipids To Goal	8.9
HgbA1c To Goal	11.9
Smoking Cessation (if applicable)	0.0

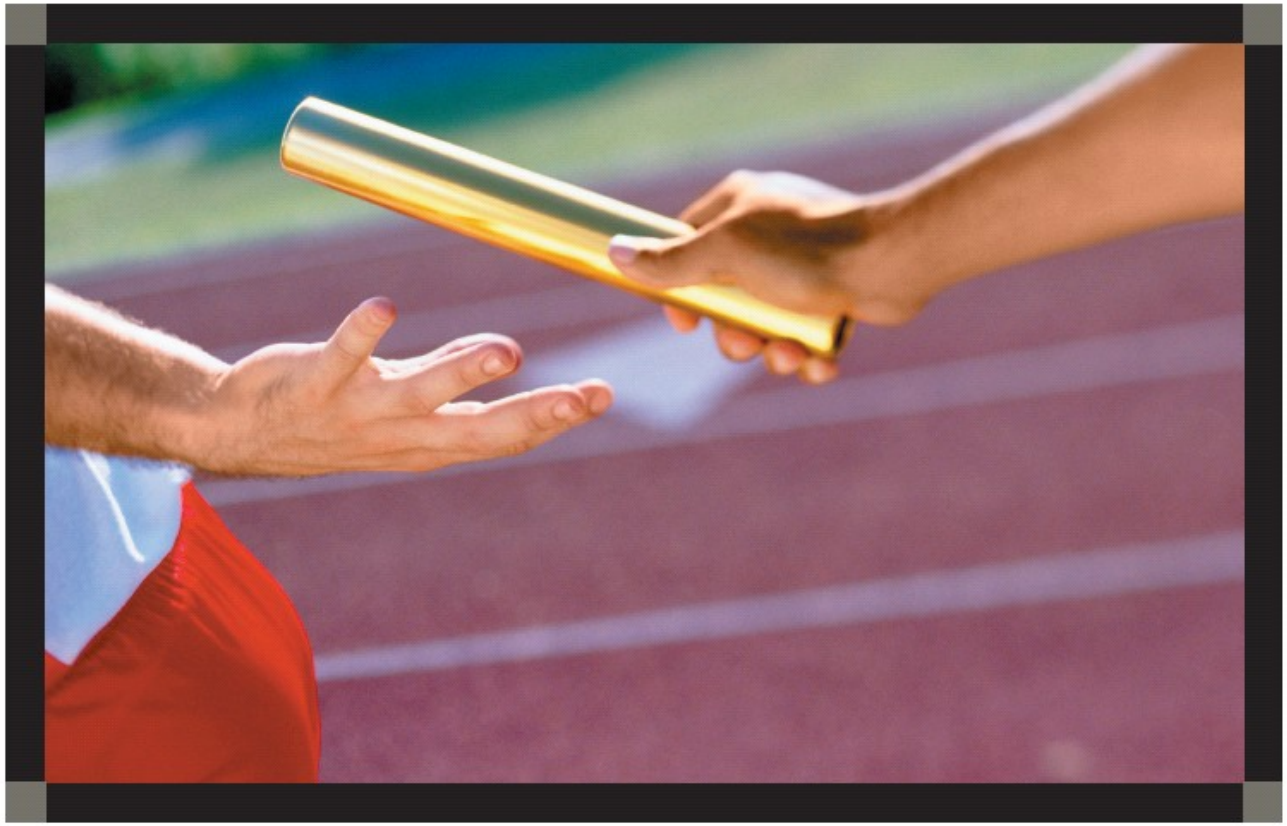
Coronary Heart Disease, 10-Year Risk

Total Points 10 Total Risk 25 %

WHAT IF?

All Elements To Goal	4	7
Overall 20% Improvement	4	7
Blood Pressure To Goal	7	13
Lipids To Goal	7	13
Smoking Cessation (if applicable)	10	25

Patient Inertia



Firmly in the provider's hand,
the baton – *the care and treatment plan* –
must be confidently and securely grasped by the patient,
if change is to make a difference,
8,760 hours a year.

Patient Inertia

Your Cardiovascular Risk

As we have discussed, the Framingham Study is the longest longitudinal study ever done. It was started in 1949 and is now multi-generational. While the scores have been criticized for overestimating the cardiovascular and cerebrovascular risk, the values give you a good estimate of the state of your heart health. These are your Framingham Risk Scores calculated on the basis of your current condition. For some scores, you will see a section entitled, "What IF?," which will give you your scores if you made a variety of changes in your life, health or habits. This will let you know how making changes in your life can improve your future health and how those changes will affect your risk scores. These changes are achievable and they will improve your scores and your health. These "What IF?" scores lets you know "if you make a change, it will make a difference."

The good news is that you are not bound by your current scores. If your scores are good, congratulations, but if they are not, you can make a change and that change WILL MAKE A DIFFERENCE. There are a number of elements used in calculating the various risk scores. Some of them are not changeable, such as age, gender, past medical history, etc. However, many of them are changeable, such as: smoking, blood pressure, diabetes control as measured by hemoglobin A1C, cholesterol control as measured by cholesterol or HDL (the good cholesterol), weight, etc.

Global Cardiovascular Risk

Your current Global Cardiovascular Risk Score is 13.9 points. (a score below 4 is desirable)

WHAT IF?

If you improved only your blood pressure to a controlled value, you would reduce your risk to 9.3 points.
If you improved only your cholesterol and HDL to controlled values, you would reduce your risk to 8.9 points.
If you improved only your HgbA1c to a controlled value, you would reduce your risk to 11.9 points.
If you improved your blood pressure, cholesterol and HDL and HgbA1c by only 20%, you would reduce your risk to 5.2 points.
If you brought your blood pressure, cholesterol and HDL and HgbA1c each to controlled values, you would reduce your risk to .5 points.

The SETMA Model of Care

1. Performance Tracking – one patient at a time
2. Performance Auditing – by panel or population
3. Performance Analysis – statistical analysis
4. Public Reporting by Provider Name
5. Quality Assessment/Performance Improvement

Steps to Selecting a Quality Initiative

1. Begin a new project while completing another
2. Build upon your past work
3. Leverage your resources in improving care
4. Think about what you want to accomplish
5. Examine your past work and ask if it has made a difference
6. Develop an algorithm to electronically audit to transform data to information
7. Use the information to implement change that will make a difference

The SETMA Model of Care & Selection of Quality Initiatives in Practice

Employing the SETMA Model of Care together with the seven steps of Selecting and Quality Initiative will transform healthcare outcomes.

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