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NextGen Large Group Users Meeting
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Dallas, Texas

NextGen As A Tool For Redesigning Primary Care To Fulfill IHI's Triple Aim

Overview

- The History and Imperative of the Triple Aim
- SETMA's Redesign in Pursuit of the Triple Aim: The SETMA Model of Care
- Patient-Centered Medical Home as an "integrator" of The Triple Aim
- Accountable Care Organizations as an "integrator" of the Triple Aim
- SETMA's Hospital Readmission Initiative: redesign in pursuit of the Triple Aim through Medicare Advantage, Medical Home & ACO.

Institute for Healthcare Improvement

In October, 2007, the **IHI** launched the **Triple Aim Initiative** which includes the "simultaneous pursuit of three aims":

1. Improving the experience of care
2. Improving the health of populations
3. Reducing per capita costs of health care"

Redesign of Primary Care Services and Structures

"(IHI's)…concept design (included)…an initial set of components of a system that would fulfill the **Triple Aim**. Five of the components are:

1. Focus on individuals and families
2. ***Redesign of primary care services and structures***
3. Population health management
4. Cost control platform
5. System integration and execution"

For details see:
(http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/Approach.aspx)

Institute for Healthcare Improvement

"IHI's Triple Aim is a framework for partnering with local government agencies, social service organizations, health plans, faith groups, and other community stakeholders to achieve three powerful goals simultaneously…

"(IHI's)…program is ideal for **change agents** in health related organizations who are responsible for developing strategy, delivering front-line care, or crafting policy for a specific population."

The Triple Aim

The ***IHI Triple Aim*** restated by CMS Administrator as:

1. Improved Care
2. Improved Health
3. Decreased Cost

Donald M. Berwick, Thomas W. Nolan and John Whittington

Health Affairs May 2008 vol. 27 no. 3 759-769

The Triple Aim

"Improving U.S. health care system requires simultaneous pursuit of three aims: **improving the experience of care**, **improving the health of populations**, and **reducing per capita costs of health care**.

"Preconditions for this include: enrollment of identified population, a commitment to universality for its members, and the existence of an organization (an "**integrator**") that accepts responsibility for all three aims for that population."

Donald M. Berwick, Thomas W. Nolan and John Whittington

Health Affairs May 2008 vol. 27 no. 3 759-769

The Triple Aim

"Integrator's role includes…five components:

1. Partnership with individuals and families
2. **Primary Care Redesign and Structure**
3. Population health management
4. Financial management
5. Macro system integration"

Donald M. Berwick, Thomas W. Nolan and John Whittington

Health Affairs May 2008 vol. 27 no. 3 759-769

The Triple Aim

The scope of the Triple Aim was defined by Senator Hubert Humphrey in 1977; he said:

"The moral test of government is how it treats those who are In the dawn of life, the children; those who are in the twilight of life, the aged; and those in the shadows of life, the sick, the needy and the handicapped." (November 4, 1977, Senator Humphrey, Inscribed on the entrance of the Hubert Humphrey building, HHS Headquarters)

Donald Berwick, "The Moral Test"
Keynote Presentation, December 7, 2011
IHI 23rd Annual National Forum on
Quality Improvement in Health Care

Are You Ready To Be An ***Integrator***?

From the healthcare provider's perspective, t**he Triple Aim *Integrators* are**:

- Medicare Advantage
- Medical Home
- Accountable Care Organizations

Each of these "structures" requires primary care redesign in order to be successful.

CMS' Triple Aim Focus

Strategic Area 3

- Help Accountable Care Organizations Thrive
- Help Dual Eligible Beneficiaries Get Better Care
- Strengthen Medicare Advantage
- Increase Utilization of Medical and Health Homes

Don Berwick, Administrator, CMS, January 19, 2011

SETMA as an ***Integrator***

- Medicare Advantage – October, 1997 to Present
- Patient-Centered Medical Home – June, 2010 to Present (NCQA & AAAHC)
- Accountable Care Organization Participation – 2012

Questions

How does NextGen advance the “integrator’s” role?

How SETMA transformed to become an “integrator?”

How is SETMA redesigning to meet the Triple Aim?

As “Integrator”
Does the SETMA Model of Care Work?

Diabetes Care Improvements

From 2000 to 2011

- HgbA1C standard deviation improvement from
  1.98 to 1.33
- HgbA1C mean (average) improvement from
  7.48% to 6.65%
- Elimination of Ethnic Disparities of Care in Diabetes

Diabetes: SETMA's Redesign Steps

- 2000 - Design and Deployment of EHR-based Diabetes Disease Management Tool
  - **HgbA1C improvement 0.3%**
- 2004 - Design and Deployment of American Diabetes Association certified Diabetes Self Management Education (DSME) Program
  - **HgbA1C improvement 0.3%**
- 2006 - Recruitment of Endocrinologist
  - **HgbA1C improvement 0.25%**

Diabetes: SETMA's Redesign Steps

Other Steps:

1. SETMA Foundation, eliminating financial barriers to care – PC-MH Poster Child
2. Diabetes: Seven Stations for Success
3. Telemeter: Glucometers which report blood glucose electronically and automatically.

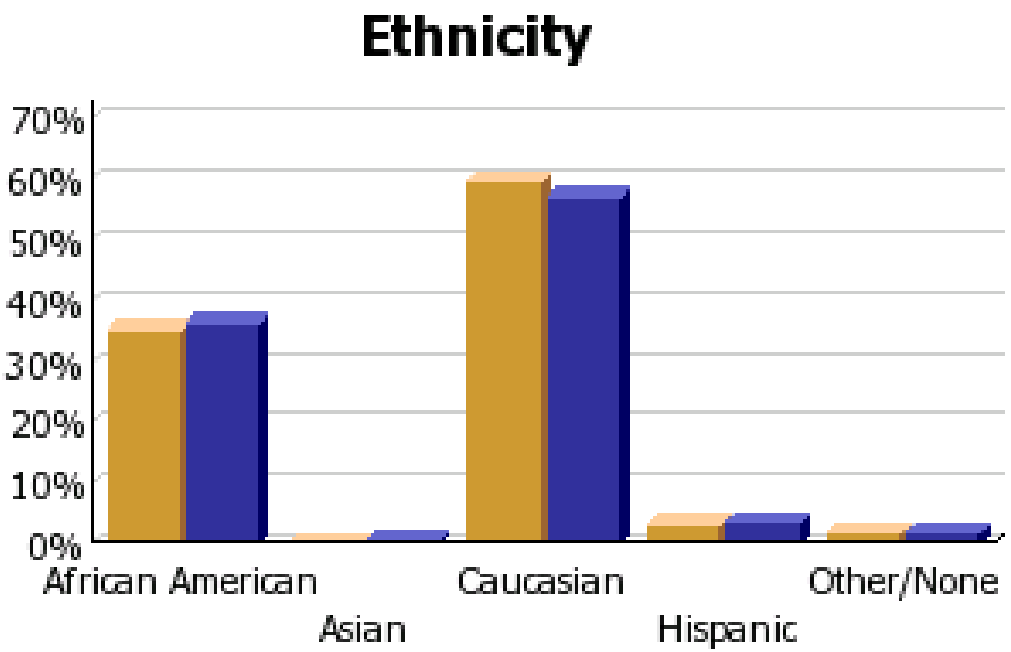
Results: NCQA Diabetes Metrics

NCQA Diabetes Measures

Encounter Date(s): January 1, 2012 to March 31, 2012

Provider	Encounters	A1c >9.0 <= 15%	A1c < 8.0 >= 60%	A1c < 7.0 >= 40%	BP > 140/90 <= 35%	BP < 130/80 >= 25%	Eye Exam >= 60%	Smoking Cessation >= 80%	LDL >= 130 <= 37 %	LDL < 100 >= 36%	Nephropathy >= 80%	Foot Exam >= 80%	Total Points
Ahmed	855	15.1%	58.1%	37.3%	6.2%	58.0%	63.2%	76.2%	11.5%	66.3%	77.0%	98.1%	60
Anthony	315	9.5%	79.0%	65.1%	17.1%	57.1%	75.9%	79.7%	9.5%	71.4%	96.2%	92.4%	90
Anwar	319	6.9%	77.1%	59.6%	5.0%	72.4%	68.3%	98.3%	11.6%	61.4%	90.9%	69.6%	95
Aziz	242	10.3%	74.0%	60.3%	24.8%	53.3%	54.1%	92.9%	13.2%	66.1%	92.1%	63.6%	85
Curry	141	8.5%	66.0%	54.6%	20.6%	56.7%	62.4%	100.0%	14.9%	60.3%	76.6%	70.2%	90
Deiparine	259	12.0%	66.0%	51.4%	13.5%	54.8%	37.5%	95.3%	15.1%	54.8%	70.3%	71.8%	80
Duncan	223	6.7%	81.2%	62.8%	8.5%	70.9%	54.3%	94.7%	11.7%	67.7%	83.0%	73.1%	85
Halbert	368	7.3%	74.2%	57.3%	21.7%	54.3%	28.5%	84.0%	17.4%	60.3%	63.9%	61.4%	80
Henderson	218	8.7%	80.3%	63.8%	9.6%	67.0%	51.4%	100.0%	18.8%	62.8%	86.7%	82.1%	90
Holly	82	6.1%	82.9%	70.7%	7.3%	84.1%	79.3%	83.3%	11.0%	65.9%	95.1%	96.3%	100
Horn	233	7.7%	75.5%	62.2%	6.0%	60.1%	41.6%	97.8%	21.5%	53.6%	85.0%	86.3%	90
Leifeste	261	5.0%	82.8%	68.2%	16.9%	60.9%	77.0%	56.1%	8.0%	73.6%	90.4%	85.8%	90
Murphy	361	5.8%	83.9%	65.1%	20.2%	48.2%	45.4%	90.2%	9.7%	73.4%	87.0%	78.4%	85
Palang	291	8.6%	59.8%	49.1%	15.1%	63.2%	22.7%	94.9%	12.4%	54.0%	42.6%	25.4%	72
Qureshi	179	14.5%	67.6%	53.1%	11.2%	67.6%	38.5%	92.3%	11.7%	58.7%	72.1%	81.0%	85
Thomas	11	18.2%	72.7%	72.7%	9.1%	63.6%	81.8%	100.0%	0.0%	45.5%	90.9%	72.7%	83
Vardiman	82	7.3%	74.4%	56.1%	31.7%	42.7%	50.0%	90.0%	20.7%	52.4%	62.2%	80.5%	85
Wheeler	193	6.2%	84.5%	72.0%	17.1%	59.1%	64.8%	77.4%	16.6%	60.1%	93.3%	82.9%	90

Results: Elimination of Ethnic Disparities



	African American	Ethnicity Asian	Caucasian	Hispanic	Other/None
Controlled	35.3%	0.3%	59.6%	3.2%	1.6%
Selected	36.4%	0.9%	57.2%	3.6%	2.0%

Trust and Hope

Nevertheless, in the midst of health information technology innovation, we must never forget that the **foundations of healthcare change are "trust" and "hope**."

Without these, science is helpless!

SETMA's Model of Care

Key to SETMA as an **"integrator" of the Triple Aim** is the Patient Centered – Medical Home (PC-MH) and key to SETMA's PC-MH is **SETMA's Model of Care.**

The second of IHI's five components of The Triple Aim is the **Redesign of "Primary Care" Services and Structures** is that "Basic health care services are provided by a variety of professions: doctors, nurses, mental health clinicians,' nutritionists, pharmacists, and others." The steps to this redesign are:

A. **"Have a team** for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
B. **"Deliberately build an access** platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
C. "**Cooperate and coordinate** with other specialties, hospitals, and community services related to health." (IHI)

SETMA's Model of Care

SETMA's Redesign of Primary Healthcare involved five steps:

1. Performance Tracking – one patient at a time
2. Performance Auditing – by panel or by population
3. Performance Analytics – statistical analysis
4. Performance Reporting – publicly by Provider Name – www.jameslhollymd.com under ***Public Reporting***
5. Quality Assessment & Performance Improvement

Step I - Performance Tracking at Point-of-Care

SETMA currently tracks the following published quality performance measure sets:

- HEDIS
- NQF
- AQA
- PQRI
- BTE

Each is available to the provider interactively within the EHR at the time of the encounter.

National Quality Forum (NQF)
National Voluntary Consensus Standards

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.

General Health Measures
View Body Mass Index Measurement
View Smoking Cessation
View Proper Assessment for Chronic COPD
View 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
View 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
View Warfarin Therapy for Atrial Fibrilation

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

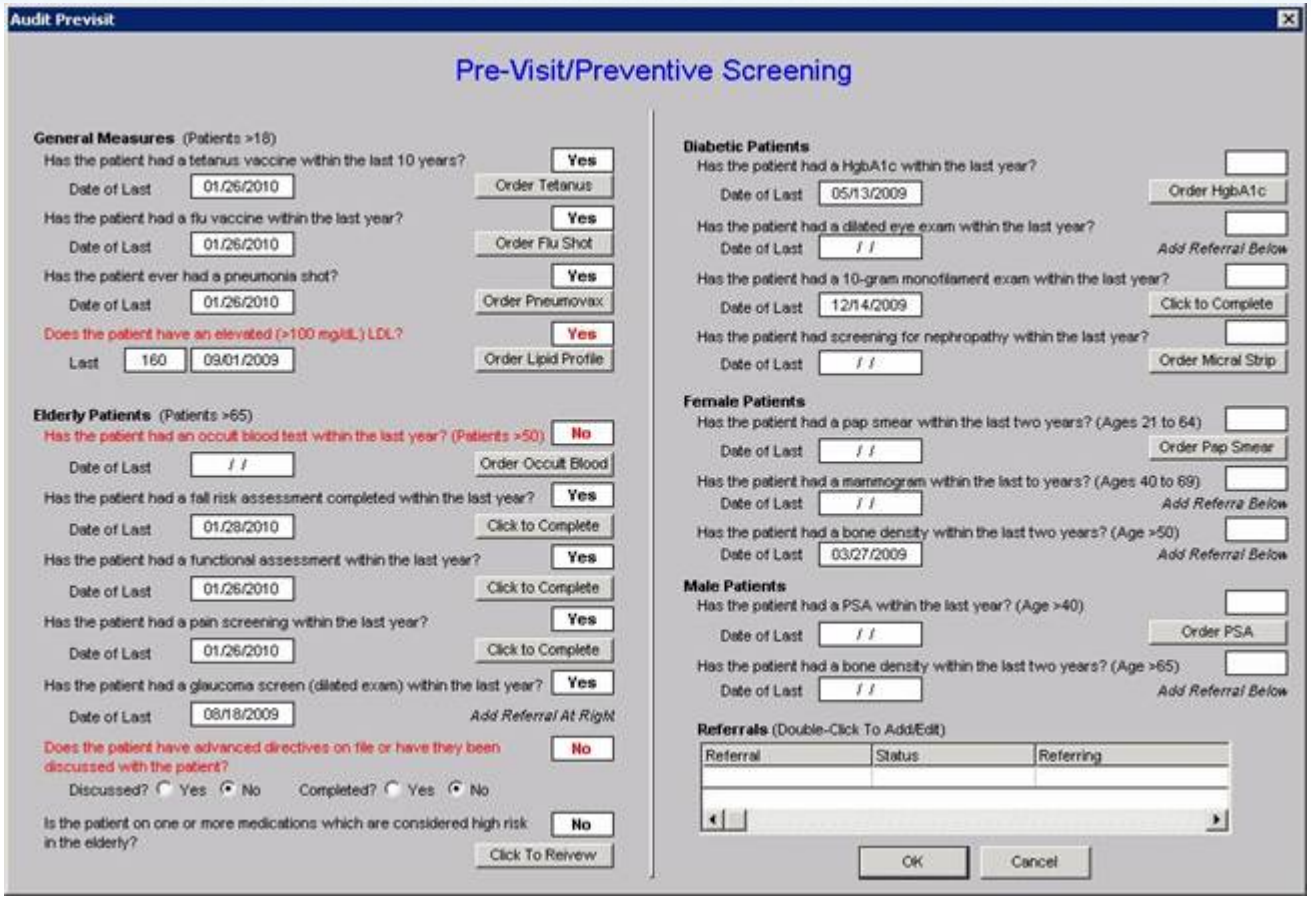
Diabetes Measures
View Dilated Eye Exam
View Foot Exam
View Hemoglobin A1c Testing/Control
View Blood Pressure
View Urine Protein Screening
View Lipid Screening

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

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

Step I - Performance Tracking at Point-of-Care

A pre-visit screening tool allows each provider to assess quality measures for each patient at each encounter.



Tracking Performance At The Point of Care

HEDIS

2011 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

- 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
- View Glaucoma Screening in Older Adults
- View Use of High-Risk Medications in the Elderly
- View Care for Older Adults

Effectiveness of Acute Care

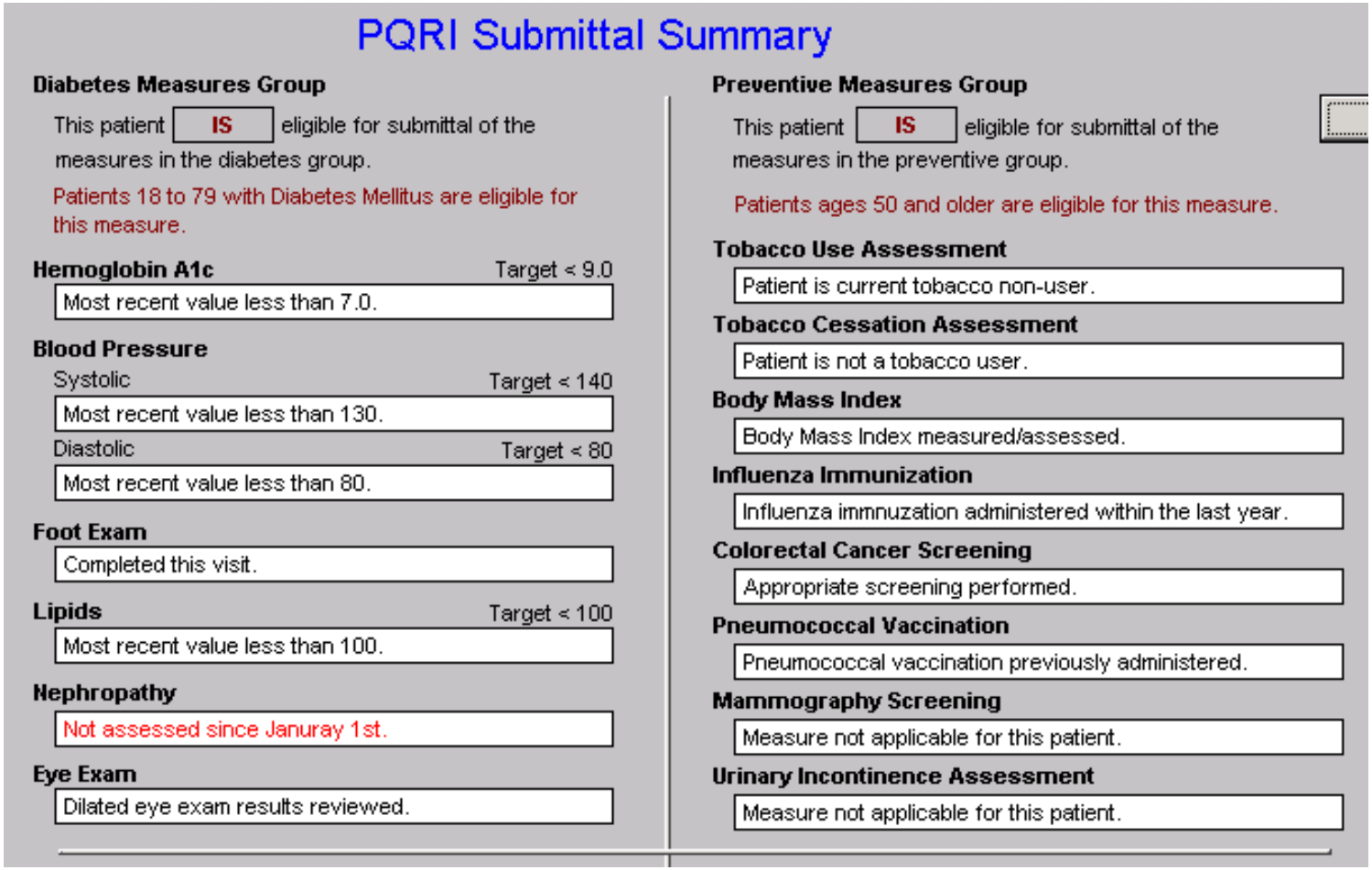
- View Appropriate Treatment for Children with Upper Respiratory Infection
- View Appropriate Testing for Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Effectiveness of Chronic Care

- View Persistence of Beta-Blocker Therapy After a Heart Attack
- Controlling High Blood Pressure
- Cholesterol Managment for Patients with Cardiovascular Disease
- Comprehensive Adult Diabetes Care
- 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
- View Medication Reconciliation Post-Discharge

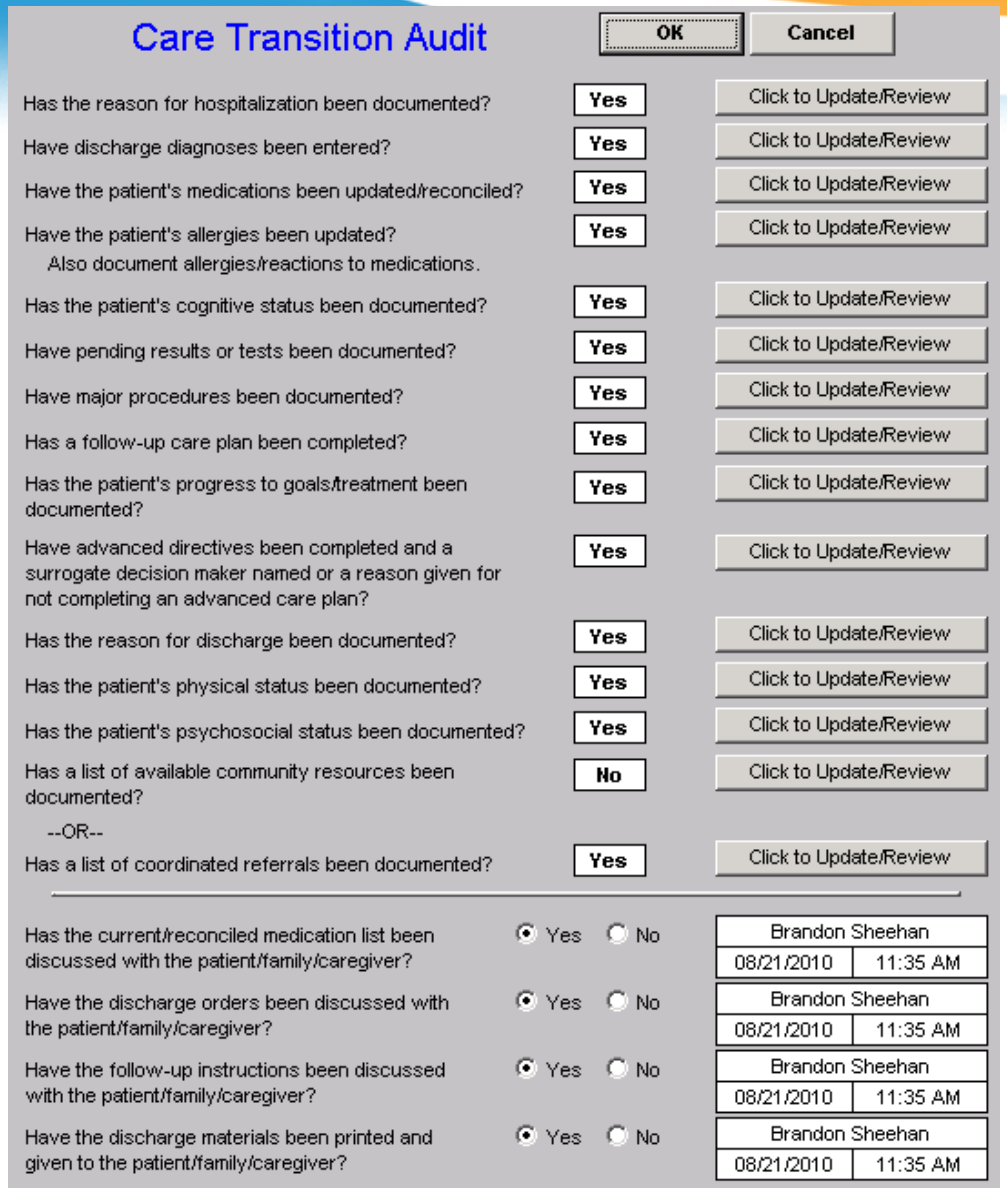
Step I - Performance Tracking at Point-of-Care

PQRI



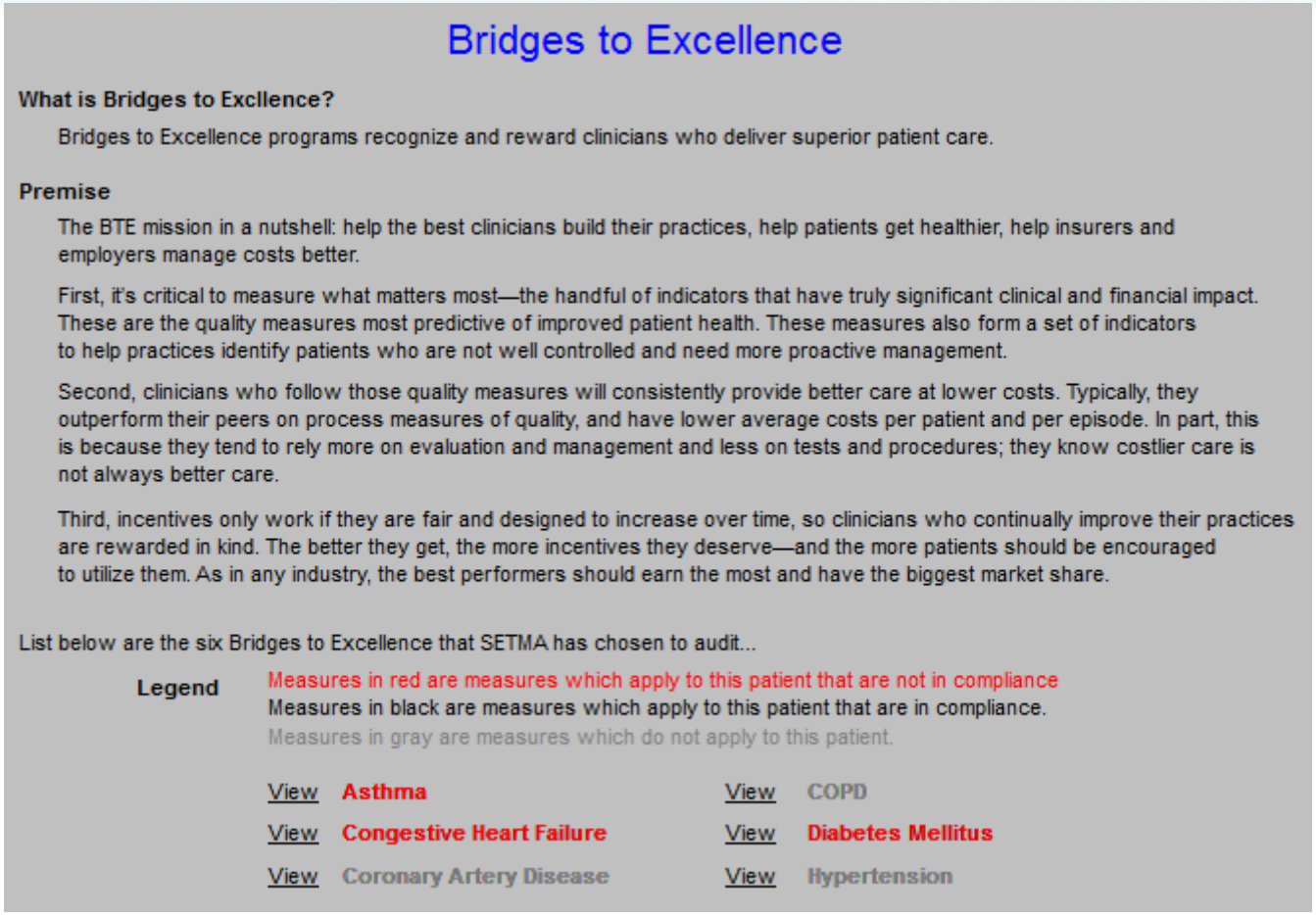
Step I - Performance Tracking at Point-of-Care

Care Transition Audit



Step I - Performance Tracking at Point-of-Care

Bridges to Excellence



Bridges to Excellence

What is Bridges to Excllence?

Bridges to Excellence programs recognize and reward clinicians who deliver superior patient care.

Premise

The BTE mission in a nutshell: help the best clinicians build their practices, help patients get healthier, help insurers and employers manage costs better.

First, it's critical to measure what matters most—the handful of indicators that have truly significant clinical and financial impact. These are the quality measures most predictive of improved patient health. These measures also form a set of indicators to help practices identify patients who are not well controlled and need more proactive management.

Second, clinicians who follow those quality measures will consistently provide better care at lower costs. Typically, they outperform their peers on process measures of quality, and have lower average costs per patient and per episode. In part, this is because they tend to rely more on evaluation and management and less on tests and procedures; they know costlier care is not always better care.

Third, incentives only work if they are fair and designed to increase over time, so clinicians who continually improve their practices are rewarded in kind. The better they get, the more incentives they deserve—and the more patients should be encouraged to utilize them. As in any industry, the best performers should earn the most and have the biggest market share.

List below are the six Bridges to Excellence that SETMA has chosen to audit...

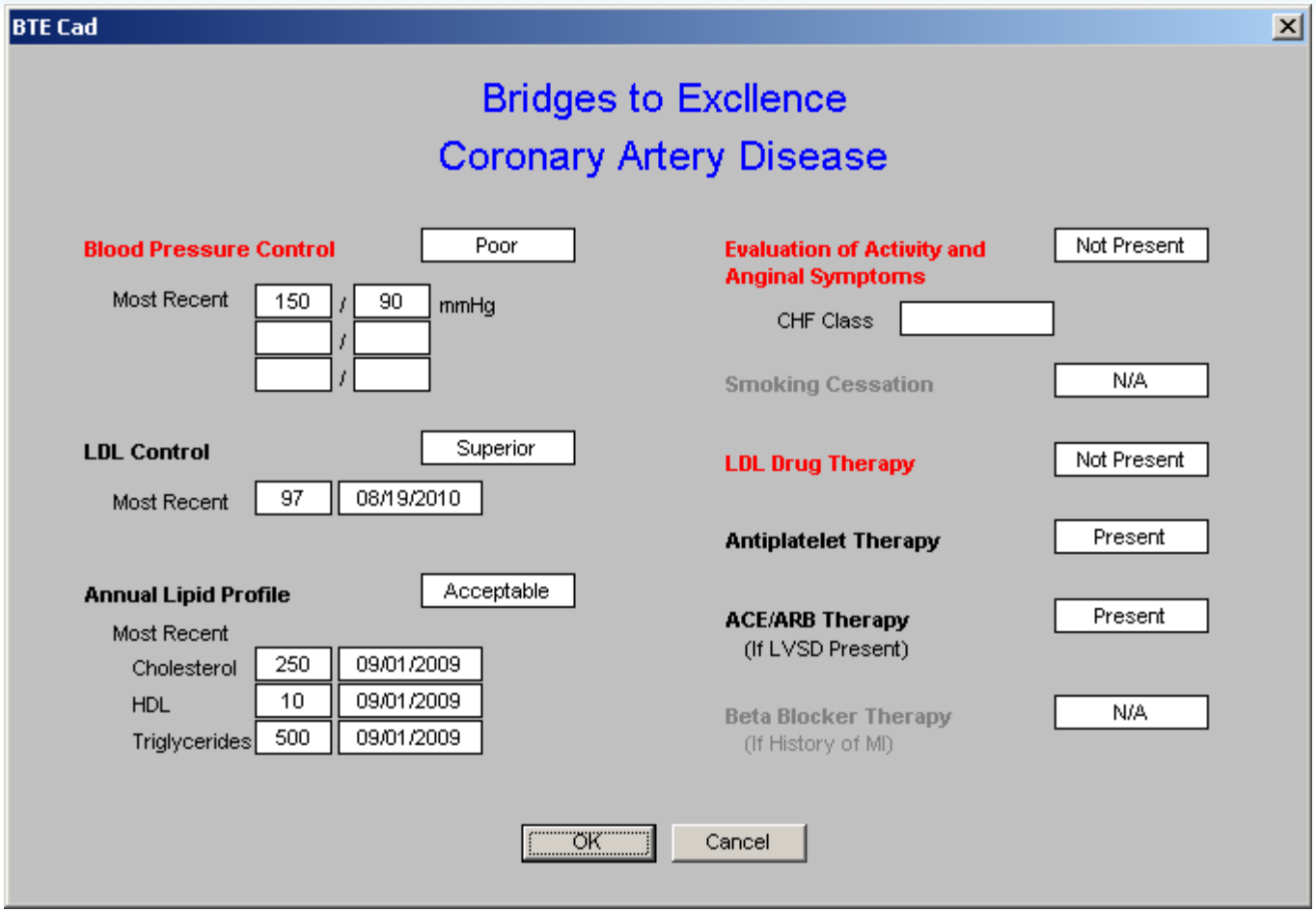
Legend

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.

View **Asthma**
View **COPD**
View **Congestive Heart Failure**
View **Diabetes Mellitus**
View **Coronary Artery Disease**
View **Hypertension**

Step I - Performance Tracking at Point-of-Care

Bridges to Excellence



Step I - Provider Performance Tracking

Integrators and Quality Measurement

Medicare Advantage

STARS Program has 50 metrics – this determines the level of reimbursement Five Star is the highest level

Accountable Care Organization

33 quality metrics – if these metrics are not met, there is no shared savings no matter how good the performance

Patient Centered Medical Home

Must report on 10 National Quality Forum endorsed quality metrics; SETMA reports on 50.

Step I - Provider Performance Tracking

Medicare Advantage STARS Programs

Medicare Advantage 2012 STARS Program

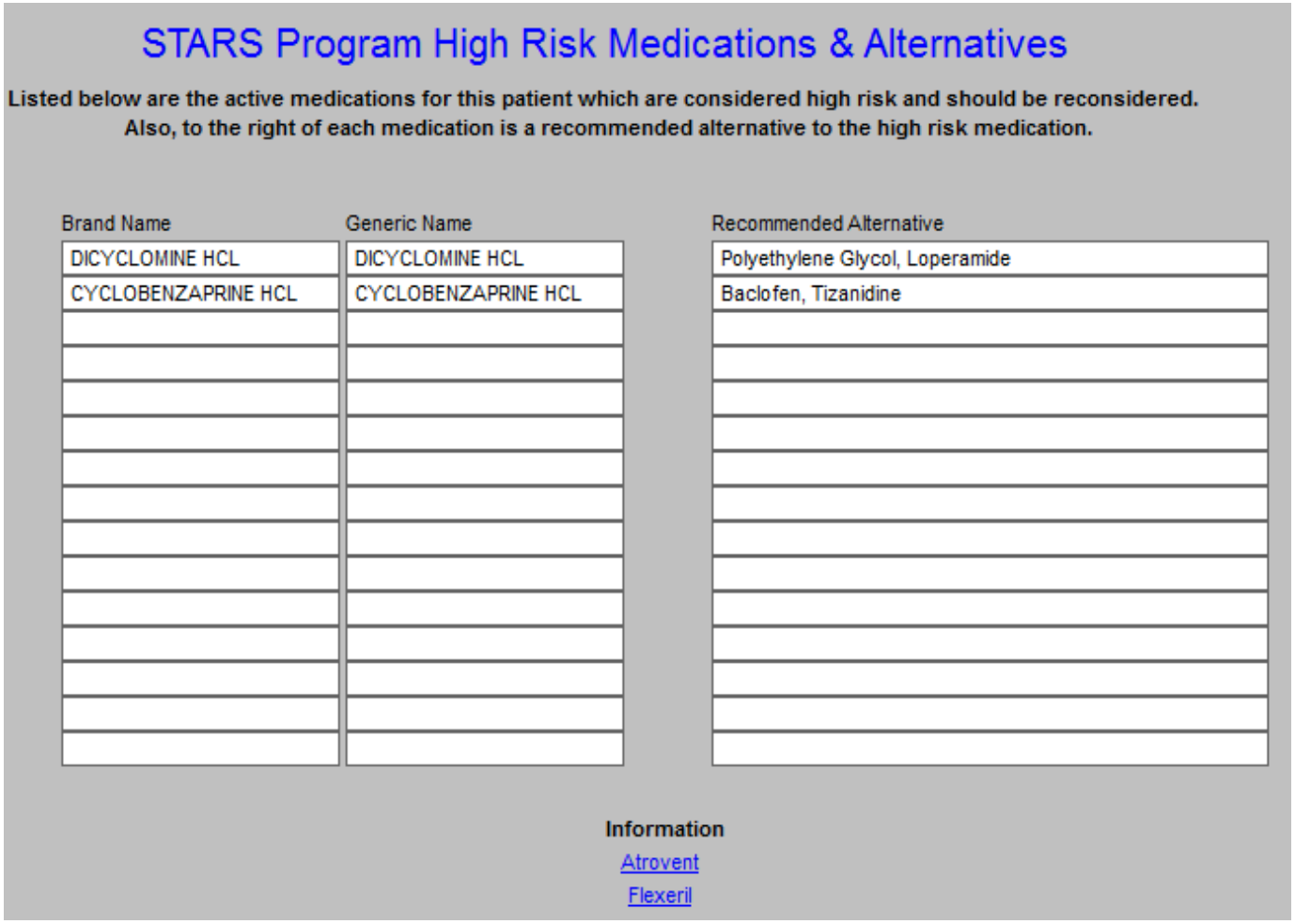
Legend

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.

View	Adult BMI Assessment
View	Colorectal Cancer Screening
	Breast Cancer Screening
View	Glaucoma Screening in Older Adults
View	Use of High-Risk Medications in the Elderly
View	Care for Older Adults
View	Controlling High Blood Pressure
View	Cholesterol Managment for Patients with Cardiovascular Disease
View	Comprehensive Adult Diabetes Care
	Osteoporsis Management in Women
	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
View	Flu Vaccine
View	Pneumonia Vaccine
View	Improving Bladder Control
View	Fall Risk
View	High Risk Medications
View	Diabetes Medications
View	Hypertension Medications
View	Cholesterol Medications

Step I - Provider Performance Tracking

Medicare Advantage STARS Programs



STARS Program High Risk Medications & Alternatives

Listed below are the active medications for this patient which are considered high risk and should be reconsidered. Also, to the right of each medication is a recommended alternative to the high risk medication.

Brand Name	Generic Name	Recommended Alternative
DICYCLOMINE HCL	DICYCLOMINE HCL	Polyethylene Glycol, Loperamide
CYCLOBENZAPRINE HCL	CYCLOBENZAPRINE HCL	Baclofen, Tizanidine

Information

Atrovent

Flexeril

Step I - Provider Performance Tracking

Medicare Advantage STARS

- As part of SETMA's CME program, our Chief Medical Officer, Dr. Syed Anwar, is writing short descriptions of each high risk medication.
- **Atrovent**

The study behind the news analyzed data collected between 1991 and 1993 as part of a large study into the decline of mental functioning in people aged over 65. The new research re-analyzed the participants' records to look at how their mental decline was linked to their use of drugs with "anticholinergic" side effects (such as dry mouth, reduced mucous secretion and constipation). Anticholinergic drugs block the chemical acetylcholine, which is involved in the transmission of electrical impulses between nerve cells. The drugs in question have a range of applications, from blocking hayfever to improving breathing in some chronic lung conditions. Researchers found that the 4% of people who used drugs with definite anticholinergic effects had a small but significantly greater decline in mental ability compared to people not using these drugs. ***People using drugs with definite or possible anticholinergic effects had an increased risk of death within the two-year period.***

Step I - Provider Performance Tracking

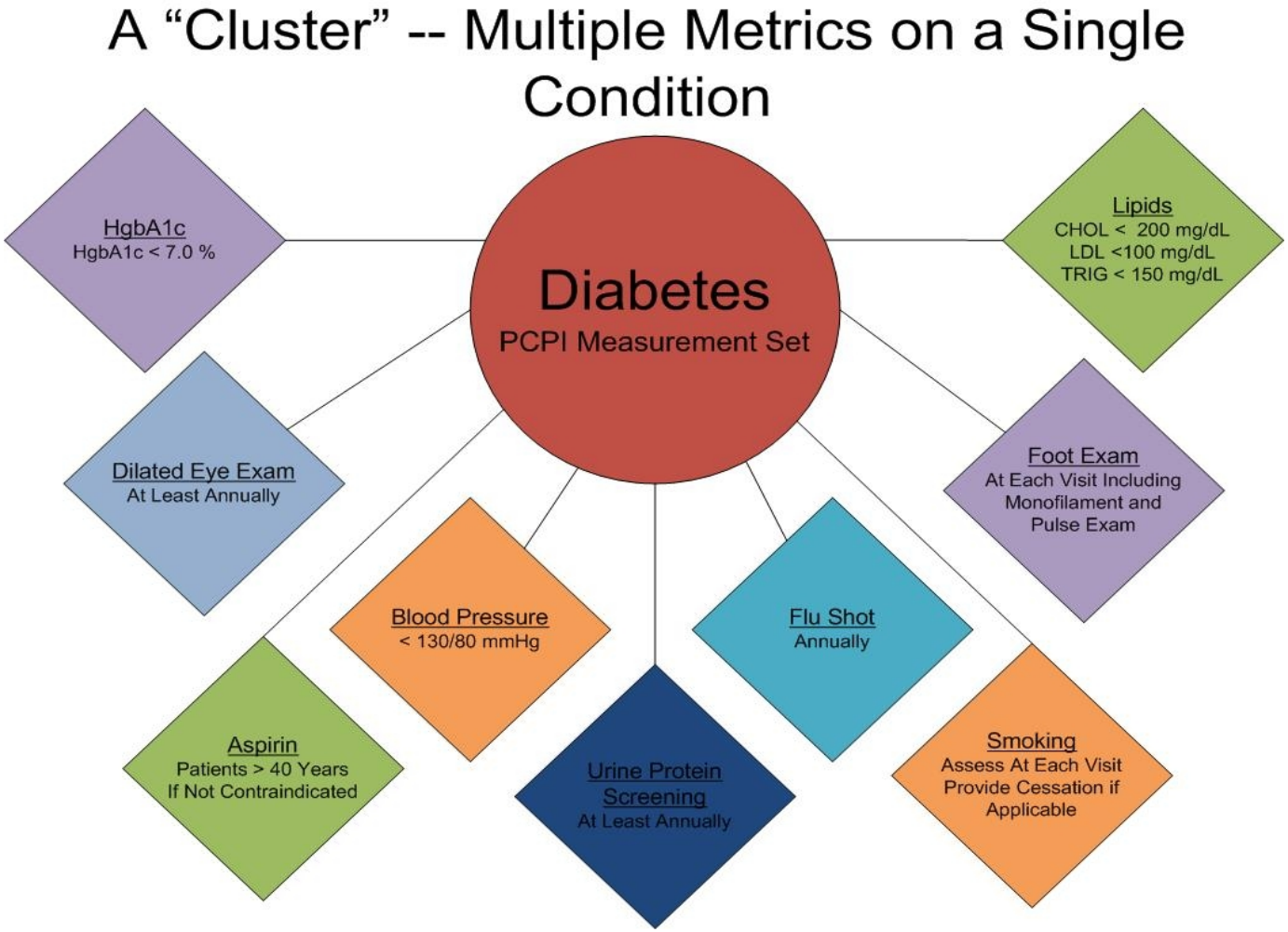
Accountable Care Organization – 33 Quality Metrics and Standards			
Preventive Health	Influenza Immunization	NQF #41 AMA-PCPI	GPRO Web Interface
Preventive Health	Pneumococcal Vaccination	NQF #43 NCQA	GPRO Web Interface
Preventive Health	Adult Weight Screening and Follow-up	NQF #421 CMS	GPRO Web Interface
Preventive Health	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #28 AMA-PCPI	GPRO Web Interface
Preventive Health	Depression Screening	NQF #418 CMS	GPRO Web Interface
Preventive Health	Colorectal Cancer Screening	NQF #34 NCQA	GPRO Web Interface
Preventive Health	Mammography Screening	NQF #31 NCQA	GPRO Web Interface
Preventive Health	Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years	CMS	GPRO Web Interface
At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)	NQF #0729 MN Community Measurement	GPRO Web Interface
At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100)	NQF #0729 MN Community Measurement	GPRO Web Interface
At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90	NQF #0729 MN Community Measurement	GPRO Web Interface

Step II -- Auditing Provider Performance

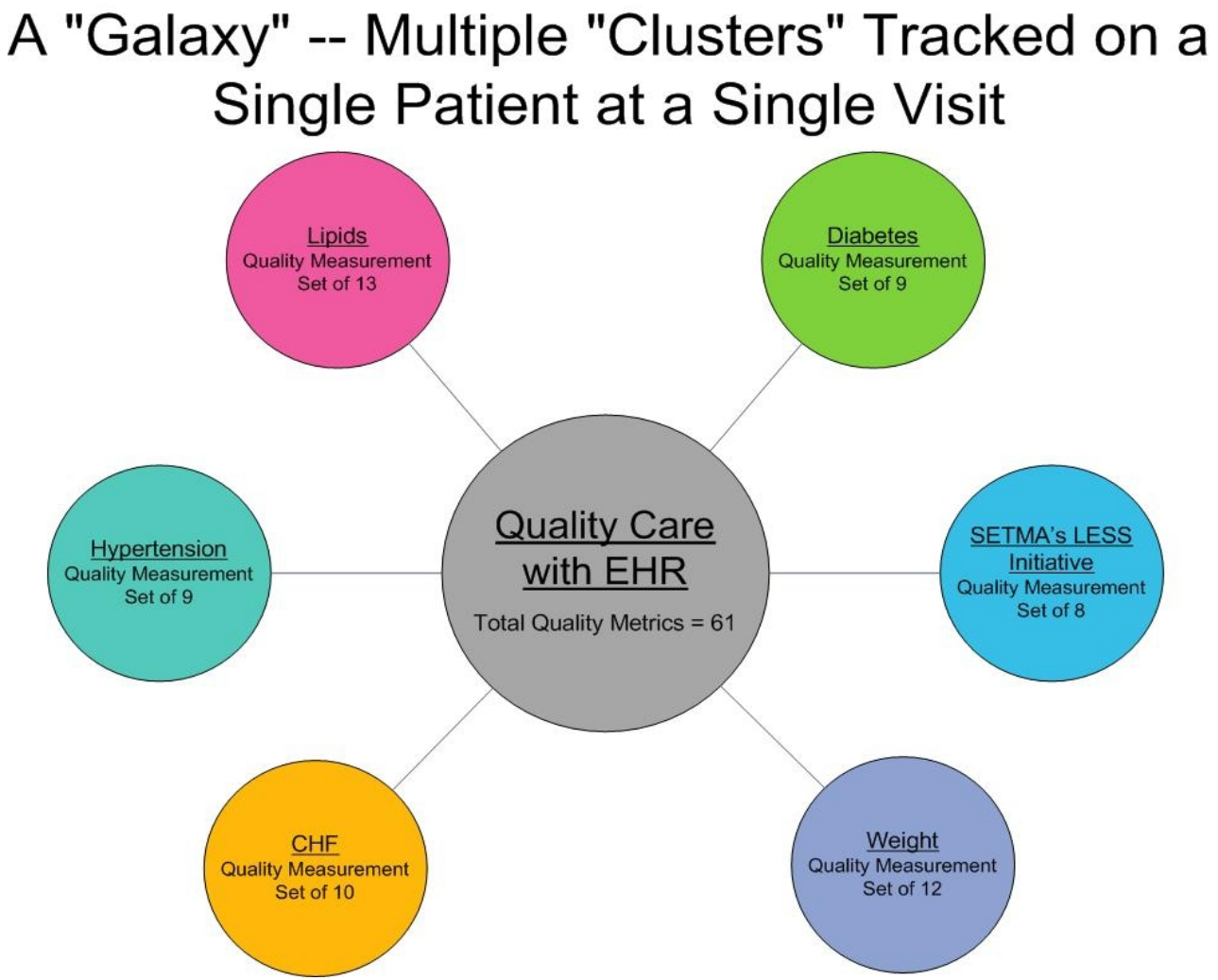
Clusters and Galaxies

- A single or a few quality metrics do not change outcomes
- **A cluster** – seven or more quality metrics for a single condition, i.e., diabetes, etc.
- **A galaxy** – multiple clusters for the same patient, i.e., diabetes, hypertension, lipids, CHF, etc.

Clusters & Galaxies



Clusters & Galaxies



Clusters & Galaxies

Unlike a single metric, such as “was the blood pressure taken,” which will not improve care, fulfilling a cluster or a galaxy of clusters in the care of a patient **WILL** improve the outcomes and result in quality care. The only way to “prove” that quality is with auditing.

Quality Metrics

Quality metrics 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.

Metrics are like a healthcare "Global Positioning System": it tells you where you are, where you want to be, and how to get from here to there.

Quality Metrics

Business Intelligence (BI) statistical analytics are like coordinates to the destination of optimal health at manageable 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 population data.

Quality Metrics

There are different classes of quality metrics. No metric alone provides a granular portrait of the quality of care a patient receives, but together, multiple sets of metrics can give an indication of whether the patient's care is going in the right direction. Some of the categories of quality metrics are:

i. access,
ii. outcome,
iii. patient experience,
iv. process,
v. structure and
vi. costs of care.

Quality Metrics

The tracking 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 an Hawthorne effect. Emphasis on the patient's health will overcome any distortion in care of the Hawthorne effect.

Quality Metrics

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 – their performance on the metrics -- while care is being received.

SETMA's information system is designed so that the provider can know how she/he is performing at the point-of-service.

Step II -- Auditing Provider Performance

- SETMA employs IBM's Business Intelligence software, *Cognos* to audit provider performance and compliance ***after*** patient encounters.
- *Cognos* allows all providers to:

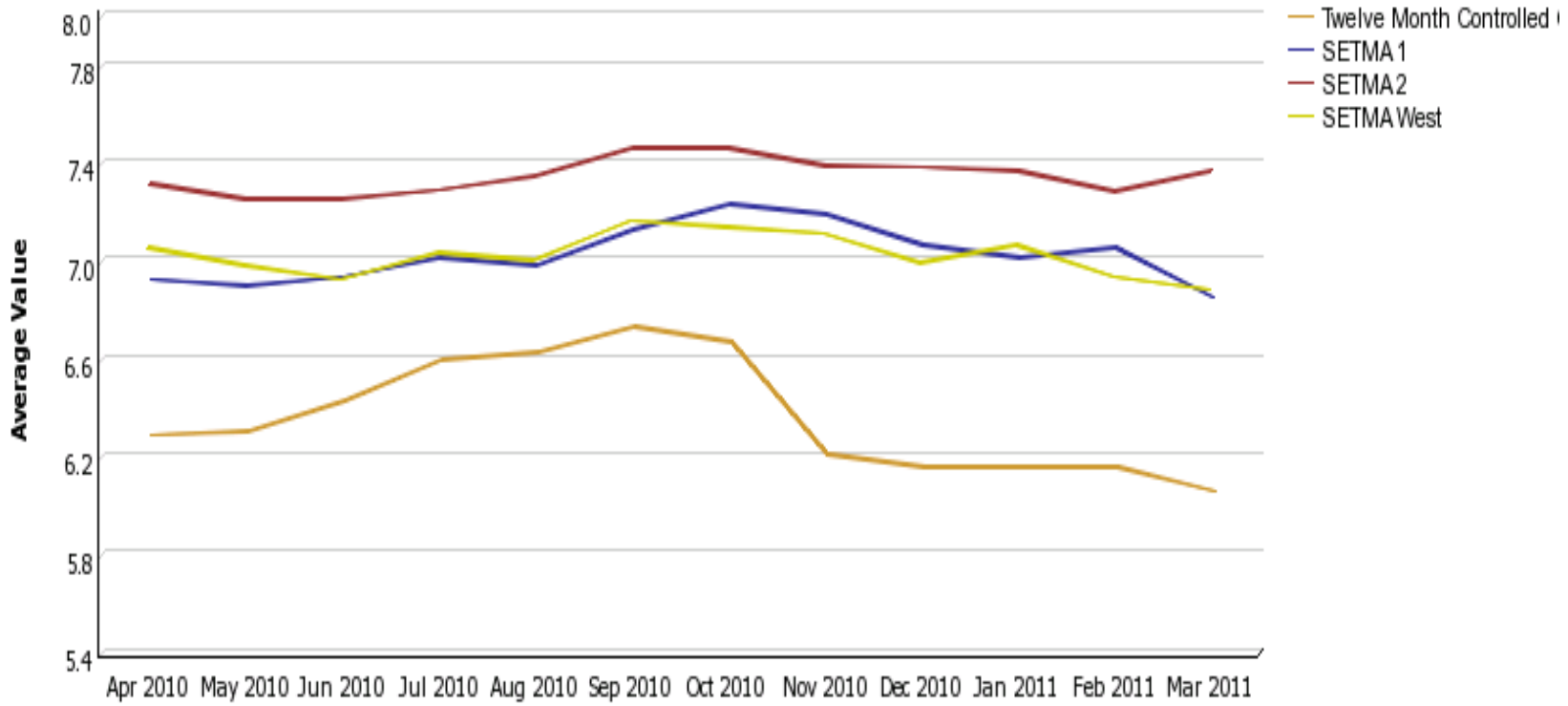
1. Display their performance for their entire patient base
2. Compare their performance to all practice providers
3. See outcome trends to identify areas for improvement
4. See this contemporaneous with care given

SETMA's COGNOS Project

COGNOS allows SETMA to:

1. Be confident of the data
2. See areas which need improvement
3. Audit and analyze the data to find leverage points with which to design quality improvement initiatives.

Step II -- Auditing Provider Performance



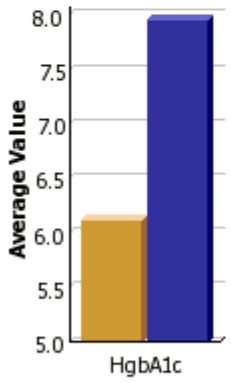
Step III -- Analyzing Performance

- Beyond how one provider performs (auditing) SETMA looks look at data as a whole (analyzing) to develop new strategies for improving patient care.
- We analyze patterns which may explain why one population is not to goal while another is. Some of the parameters, we analyze are:
  - Frequency of visits
  - Frequency of key testing
  - Number of medications prescribed
  - Changes in treatments if any, if patient not to goal
  - Referrals to educational programs

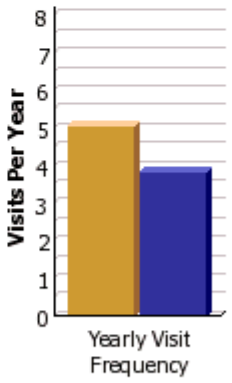
Step III -- Analyzing Performance

Chronic Diabetes - Measures Comparison (Most Recent 12 Months)

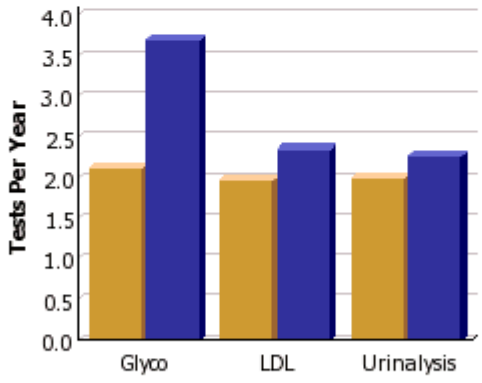
Controlled Group	Selected Group
Population: **All SETMA**	Practice: **SETMA 1, SETMA 2, SETMA West**
Time Basis: **Prior 12 Months**	Provider: **None**
	Controlled or Not Controlled: **Not Controlled**



	HgbA1c Avg	Standard Deviation
Controlled	6.1	0.7
Selected	8.0	1.7



	Visit Frequency
Controlled	5.1
Selected	3.8



	Yearly Glyco Tests	Yearly LDL Tests	Yearly UA Tests
Controlled	2.1	2.0	2.0
Selected	3.7	2.4	2.3

Step III -- Analyzing Performance

Raw data can be misleading. For example, with diabetes care, a provider may have many patients with very high HgbA1cs and the same number with equally low HgbA1cs which would produce a misleadingly good average. As a result, SETMA also measures the:

- Mean
- Median
- Mode
- Standard Deviation

Analytics Transform Knowledge

- Analytics transform knowledge into an agent for change. In reality, without analytics, we will neither know where we are, where we are going or how to sustain the effort to get there.

- For transformation to take place through knowledge, we must be prepared to ask the right questions, courageously accept the answers and to require ourselves to change.

Analytics and Transformation

- The greatest frustration to transformation is the unwillingness or the inability to face current reality. Often, the first time healthcare provides see audits of their performance, they say, “That can’t be right!”
- Through analytics – tracking data, auditing performance, statistical analysis of results – we learn the truth. For that truth to impact our performance, we must believe it.

Analytics and Transformation

Through acknowledging truth, privately and publicly, we empower sustainable change, making analytics a critical aspect of healthcare transformation.

Step III -- Analyzing Performance

- SETMA's average HgbA1c as been steadily improving for the last 10 years. Yet, our standard deviation calculations revealed that a small subset of our patients were not being treated successfully and were being left behind.

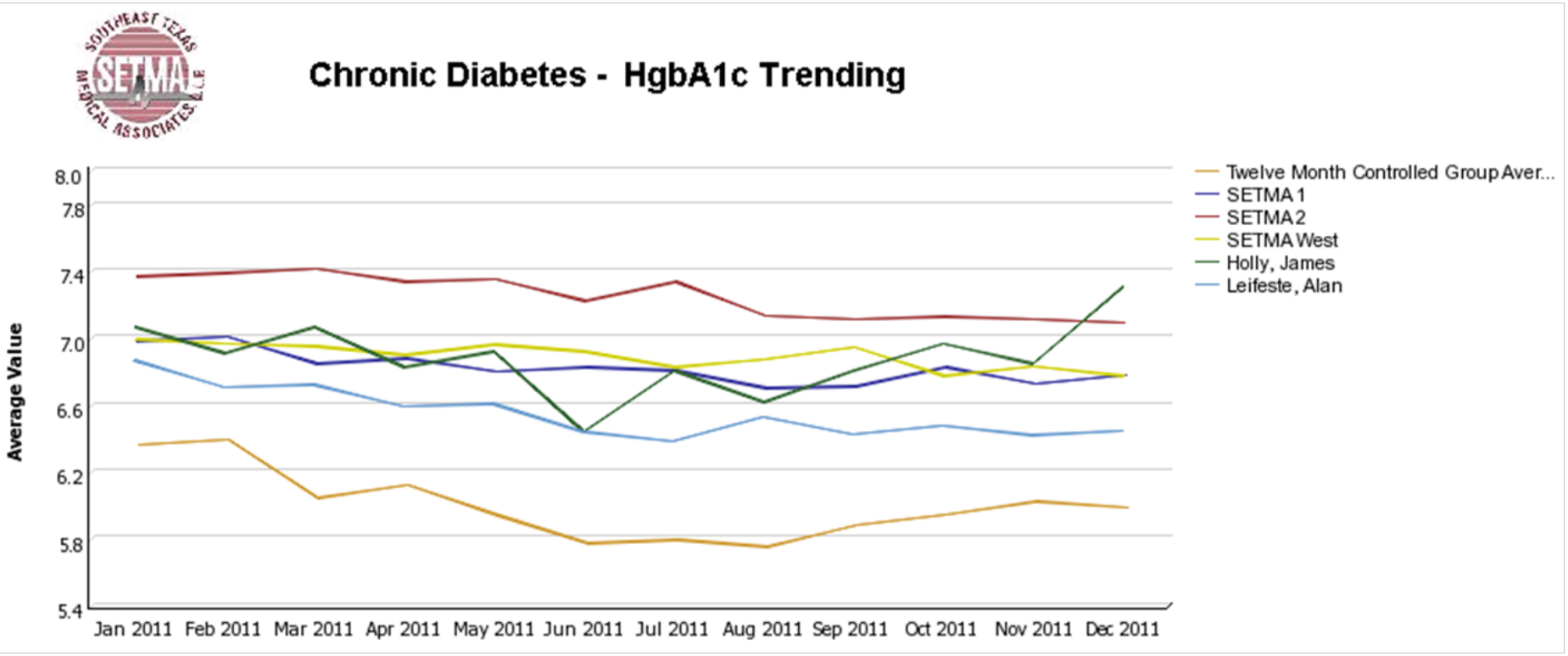
- As we have improved our treatment and brought more patients to goal, we have skewed our average.

- By analyzing the standard deviation of our HgbA1c we have been able to address the patients whose values fall far from the average of the rest of the clinic.

Mean Versus Standard Deviation

Year	Mean	Standard Devation
2001	7.48	1.98
2002	7.44	1.85
2003	7.40	1.78
2004	7.33	1.68
2005	7.01	1.53
2006	6.87	1.48
2007	6.63	1.53
2008	6.56	1.58
2009	6.65	1.48
2010	6.83	1.33
2011	6.50	1.59

Diabetes Audit - Trending



The Value of Trending

In 2009, SETMA launched a Business Intelligence software solution for real-time analytics. Trending revealed that from October-December,2009, many patients were losing HbA1C control. Further analysis showed that these patients were being seen and tested less often in this period than those who maintained control.

The Value of Trending

- A 2010 Quality Improvement Initiative included writing all patients with diabetes encouraging them to make appointments and get tested in the last quarter of the year.
- A contract was made, which encouraged celebration of holidays while maintaining dietary discretion, exercise and testing.
- ***In 2011, trending analysis showed that the holiday-induced loss of control had been eliminated.***

Step IV - Public Reporting of Performance

- One of the most insidious problems in healthcare delivery is reported in the medical literature as “treatment inertia.” This is caused by the natural inclination of human beings to resist change. As a result, when a patient’s care is not to goal, often no change in treatment is made.

- To help overcome this “treatment inertia,” SETMA publishes all of our provider auditing (both the good and the bad) as a means to increase the level of discomfort in the healthcare provider and encourage performance improvement (**Boiled Frog Analogy**).

Step IV - Public Reporting of Performance

NQF Diabetes Measures

NQF - Diabetes Measures

E & M Codes: Clinic Only
Encounter Date(s): Jan 1, 2012 through Mar 31, 2012

Location	Provider	Dilated Eye within 12 Months	Micral Strip within 12 Months	Foot Exam within 12 Months
SETMA 1	Aziz	56.6%	90.6%	64.2%
	Duncan	49.4%	79.0%	69.8%
	Henderson	45.6%	84.4%	83.8%
	Holly	82.9%	95.1%	100.0%
	Murphy	44.0%	86.3%	77.6%
	Palang	22.6%	44.6%	24.2%
	Thomas	80.0%	90.0%	80.0%
	SETMA 1 Totals:	45.2%	77.8%	65.7%
SETMA 2	Ahmed	63.6%	75.6%	97.8%
	Anthony	73.6%	94.7%	91.8%
	Anwar	68.6%	88.8%	70.7%
	Cricchio, M	68.2%	100.0%	95.5%
	Holly	63.6%	100.0%	100.0%
	Leifeste	78.3%	89.7%	87.0%
	Read	60.0%	95.0%	85.0%
	Wheeler	62.2%	93.7%	82.5%
	SETMA 2 Totals:	67.4%	84.3%	90.5%
SETMA West	Curry	61.2%	75.9%	69.0%
	Darden	50.0%	80.0%	70.0%
	Deiparine	37.2%	69.3%	71.6%
	Halbert	29.1%	64.2%	59.6%
	Horn	43.0%	82.4%	85.5%
	Qureshi	41.1%	74.0%	81.5%
	Vardiman	51.9%	59.3%	79.6%
	SETMA West Totals:	40.4%	71.5%	72.7%
	SETMA Totals:	53.3%	78.7%	78.3%

Step IV - Public Reporting of Performance

NQF Diabetes Measures

NQF - Diabetes Measures - Blood Pressure Control

E & M Codes: Clinic Only
Encounter Date(s): Jan 1, 2012 through Mar 31, 2012

		Blood Pressure on Last Visit			
Location	Provider	< 120 / 70	< 130 / 80	< 140 / 90	> 140 / 90
SETMA 1	Aziz	15.7%	52.2%	78.6%	21.4%
	Duncan	24.1%	69.1%	91.4%	8.6%
	Henderson	30.6%	62.5%	90.6%	9.4%
	Holly	22.0%	82.9%	92.7%	7.3%
	Murphy	19.9%	48.5%	78.8%	21.2%
	Palang	17.2%	61.3%	86.0%	14.0%
	Thomas	20.0%	70.0%	100.0%	0.0%
SETMA 1 Totals:		21.3%	59.1%	85.1%	14.9%
SETMA 2	Ahmed	21.2%	56.4%	93.1%	6.9%
	Anthony	32.2%	57.7%	84.6%	15.4%
	Anwar	9.6%	71.3%	95.2%	4.8%
	Cricchio, M	31.8%	63.6%	77.3%	22.7%
	Holly	27.3%	90.9%	90.9%	9.1%
	Leifeste	20.7%	59.2%	81.0%	19.0%
	Read	30.0%	65.0%	70.0%	30.0%
	Wheeler	19.6%	55.9%	80.4%	19.6%
SETMA 2 Totals:		21.4%	59.3%	88.8%	11.2%
SETMA West	Curry	27.6%	55.2%	80.2%	19.8%
	Darden	20.0%	70.0%	80.0%	20.0%
	Deiparine	21.6%	51.4%	84.9%	15.1%
	Halbert	17.7%	52.5%	78.1%	21.9%
	Horn	22.8%	58.0%	94.3%	5.7%
	Qureshi	25.3%	67.1%	88.4%	11.6%
	Vardiman	14.8%	40.7%	66.7%	33.3%
SETMA West Totals:		21.7%	55.3%	83.8%	16.2%
SETMA Totals:		21.4%	58.1%	86.3%	13.7%

Step IV - Public Reporting of Performance

At www.jameslhollymd.com under Public Reporting, SETMA's quality performance on

over 250 quality metrics can be reviewed. The following are for the Physician Consortium for Performance Improvement Diabetes Measurement Set.

- 2012 - Diabetes Consortium - Blood Pressure Management
- 2011 - Diabetes Consortium - Blood Pressure Management
- 2010 - Diabetes Consortium - Blood Pressure Management
- 2009 - Diabetes Consortium - Blood Pressure Management
- 2012 - Diabetes Consortium - HgbA1c Measures
- 2011 - Diabetes Consortium - HgbA1c Measures
- 2010 - Diabetes Consortium - HgbA1c Measures
- 2009 - Diabetes Consortium - HgbA1c Measures
- 2012 - Diabetes Consortium - Lipid Measures
- 2011 - Diabetes Consortium - Lipid Measures
- 2010 - Diabetes Consortium - Lipid Measures
- 2009 - Diabetes Consortium - Lipid Measures
- 2012 - Diabetes Consortium - Smoking Cessation
- 2011 - Diabetes Consortium - Smoking Cessation
- 2010 - Diabetes Consortium - Smoking Cessation
- 2009 - Diabetes Consortium - Smoking Cessation
- 2012 - Diabetes Consortium - Urinalysis, Microalbumin, Dilated Eye, Flu Shot, Foot Exam and Aspirin
- 2011 - Diabetes Consortium - Urinalysis, Microalbumin, Dilated Eye, Flu Shot, Foot Exam and Aspirin

Step IV - Public Reporting of Performance

- **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. Nothing overcomes clinical inertia as does performance transparency through public reporting of quality performance by provider name.

Step V -- Quality Assessment & Performance Improvement

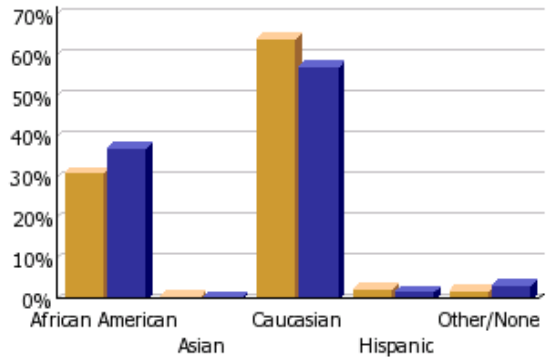
- **Quality Assessment and Performance Improvement** (QAPI) is SETMA's roadmap for the future. With data in hand, we can begin to use the outcomes to design quality initiatives for our future.
- We can analyze our data to identify disparities in care between
  - Ethnicities
  - Socio-Economic Groups
  - Age Groups
  - Gender

Step V -- Quality Assessment & Performance Improvement

Chronic Hypertension - Measures Comparison (Most Recent 12 Months)

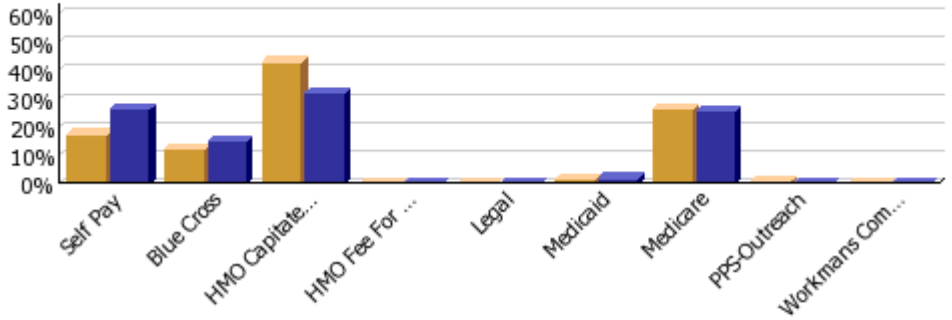
Controlled Group	Selected Group
Population: **All SETMA**	Practice: **SETMA 1, SETMA 2, SETMA West**
Time Basis: **Prior 12 Months**	Provider: **None**
	Controlled or Not Controlled: **Not Controlled**

Ethnicity



	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%

Financial Class



	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%

Summary - SETMA Model of Care

With the evidenced-based, science foundation of SETMA's Model of Care, Coordination and integration of Care, with the deployment of NextGen's *NextMD* @ and *Health Information Exchange*@, continue to place the patient at the center of all healthcare delivery in SETMA's PC-MH.

Domains of Healthcare Transformation

1. **The Substance** -- Evidenced-based medicine and comprehensive health promotion
2. **The Method** -- Electronic Patient Management
3. **The Organization** -- Patient-centered Medical Home
4. **The Funding** -- Capitation with payment for quality outcomes

Integrator: Medical Home

Medical Home prepares you for the future by helping you recapture the best of the past

- The foundations of health care are trust and hope.
- Today, patients have more trust in technology than in their healthcare provider.
- PC-MH helps you engage the patient as a part of their healthcare team and helps them take charge of their own care with the trust and hope that “making a change will make a difference.”

Integrator: Medical Home

- You are the healthcare generation which is bridging the health science revolution with health delivery transformation. **Medical Home is the substance, structure and support of that bridge**.
- Future generations of healthcare providers will not experience the quality chasm which has motivated the Medical Home movement and they will not see a “bridge,” only a continuum of care.

Integrator: Medical Home

- In the Medical Home the care is “coordinated.” While this process traditionally has referred to scheduling, i.e., that visits to multiple providers with different areas of responsibility are “scheduled” on the same day for patient convenience, it has come to mean much more to SETMA.

- Because many of our patients are elderly and some have limited resources, the quality of care they receive very often depends upon this “coordination.” It is hard for the frail elderly to make multiple trips to the clinic. It is impossible for those who live at a distance on limited resources to afford the fuel for multiple visits to the clinic.

Integrator: Medical Home

Convenience is the new word for quality:

1. **Convenience** for the patient which
2. Results in increased patient **satisfaction** which contributes to
3. The patient having **confidence** that the healthcare provider cares personally which
4. Increases the **trust** the patient has in the provider, all of which,
5. Increases **compliance** in obtaining healthcare services recommended which,
6. Promotes **cost** savings in travel, time and expense of care which
7. Results in increased patient **safety and quality** of care.

Integrator: Medical Home

- Scheduling procedures or other tests spontaneously on that same day when a patient is seen and a need is discovered.
- Recognizing when patients will benefit from case management, or disease management, or other ancillary services and working to resources those needs.
- Connecting patients who need help with medications or other health expenses to be connected with the resources to provide those needs such as The SETMA Foundation, or sources.

Time, energy, and expense are conserved with these efforts in addition to increasing adherence, thus improving outcomes!

Integrator: Medical Home

- **Continuity of care** in the modern electronic age means not only personal contact but it means the availability of the patient's record at every point-of-care

- SETMA's NextGen Health Information Exchange will provide patient records to providers and facilities throughout the community

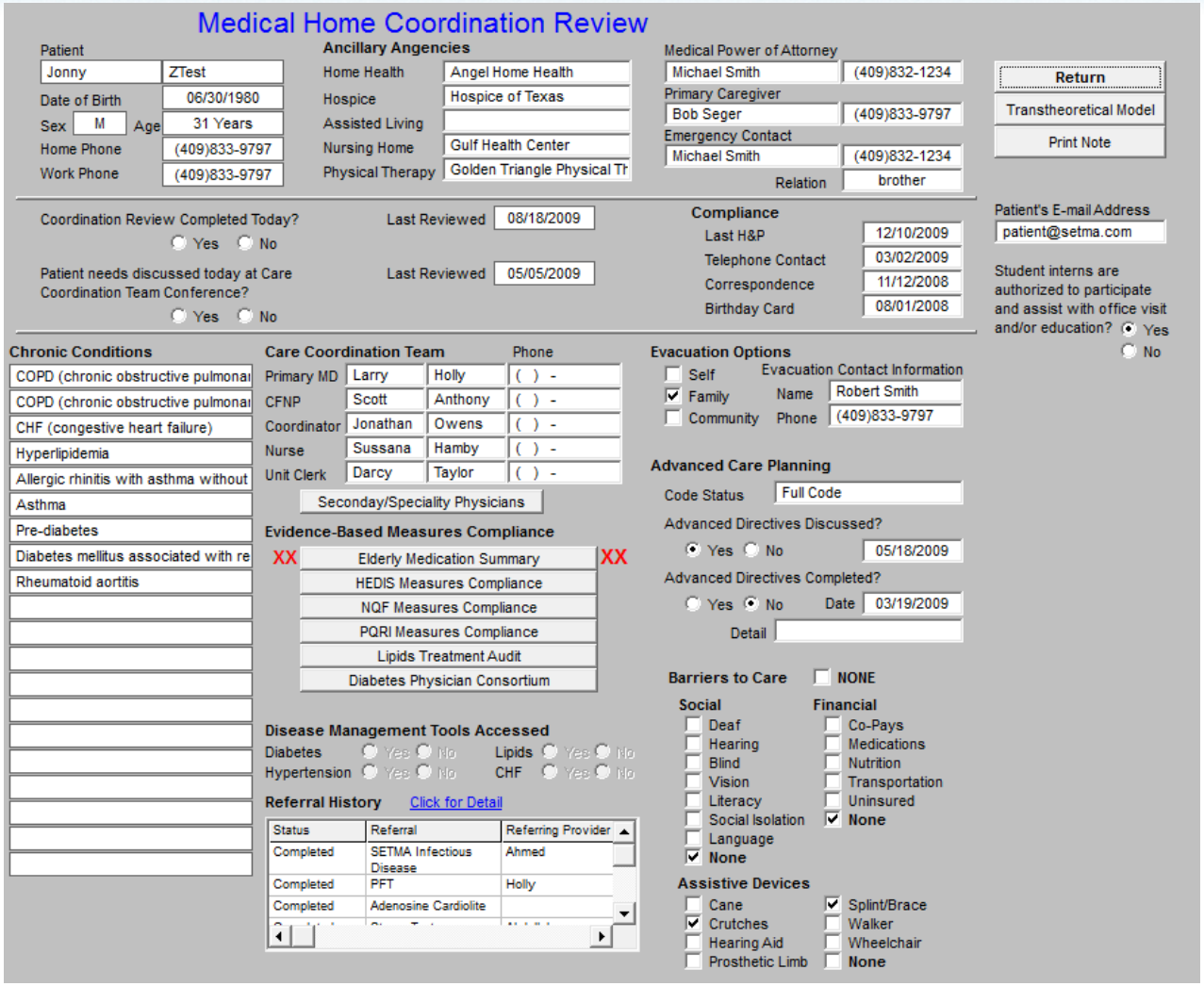
- SETMA's NextMD provides patients access to maintain and review their own records

Integrator: Medical Home

- As SETMA has continued to develop its Patient-Centered Medical Home, we have worked with the guidance of the standards published by CMS, NCQA and AAAHC, as well as the medical literature. We have also worked independent of the published materials to develop our concept of ***Care Coordination*** in our efforts to achieve ***Coordinated Care***.

- At www.jameslhollymd.com, under ***Your Life Your Health***, there are over 100 articles on PC-MH, Care Coordination, and Care Transitions. Produced by SETMA, this material represents our efforts to redesign the structures and processes of primary care in order to meet The Triple Aim.

Medical Home Template



Medical Home Coordination Review

Patient
Jonny ZTest
Date of Birth 06/30/1980
Sex M Age 31 Years
Home Phone (409)833-9797
Work Phone (409)833-9797

Ancillary Angencies
Home Health: Angel Home Health
Hospice: Hospice of Texas
Assisted Living:
Nursing Home: Gulf Health Center
Physical Therapy: Golden Triangle Physical Th

Medical Power of Attorney
Michael Smith (409)832-1234
Primary Caregiver
Bob Seger (409)833-9797
Emergency Contact
Michael Smith (409)832-1234
Relation: brother

Return
Transtheoretical Model
Print Note

Coordination Review Completed Today? ( ) Yes ( ) No
Last Reviewed 08/18/2009

Patient needs discussed today at Care Coordination Team Conference? ( ) Yes ( ) No
Last Reviewed 05/05/2009

Compliance
Last H&P 12/10/2009
Telephone Contact 03/02/2009
Correspondence 11/12/2008
Birthday Card 08/01/2008

Patient's E-mail Address: patient@setma.com

Student interns are authorized to participate and assist with office visit and/or education? (•) Yes ( ) No

Chronic Conditions
- COPD (chronic obstructive pulmonar
- COPD (chronic obstructive pulmonar
- CHF (congestive heart failure)
- Hyperlipidemia
- Allergic rhinitis with asthma without
- Asthma
- Pre-diabetes
- Diabetes mellitus associated with re
- Rheumatoid aortitis

Care Coordination Team

			Phone
Primary MD	Larry	Holly	( ) -
CFNP	Scott	Anthony	( ) -
Coordinator	Jonathan	Owens	( ) -
Nurse	Sussana	Hamby	( ) -
Unit Clerk	Darcy	Taylor	( ) -

Seconday/Speciality Physicians

Evidence-Based Measures Compliance
XX Elderly Medication Summary XX
HEDIS Measures Compliance
NQF Measures Compliance
PQRI Measures Compliance
Lipids Treatment Audit
Diabetes Physician Consortium

Disease Management Tools Accessed
Diabetes ( ) Yes ( ) No Lipids ( ) Yes ( ) No
Hypertension ( ) Yes ( ) No CHF ( ) Yes ( ) No

Referral History Click for Detail

Status	Referral	Referring Provider
Completed	SETMA Infectious Disease	Ahmed
Completed	PFT	Holly
Completed	Adenosine Cardiolite	

Evacuation Options
[ ] Self
[x] Family
[ ] Community
Evacuation Contact Information
Name: Robert Smith
Phone: (409)833-9797

Advanced Care Planning
Code Status: Full Code
Advanced Directives Discussed? (•) Yes ( ) No 05/18/2009
Advanced Directives Completed? ( ) Yes (•) No Date 03/19/2009
Detail:

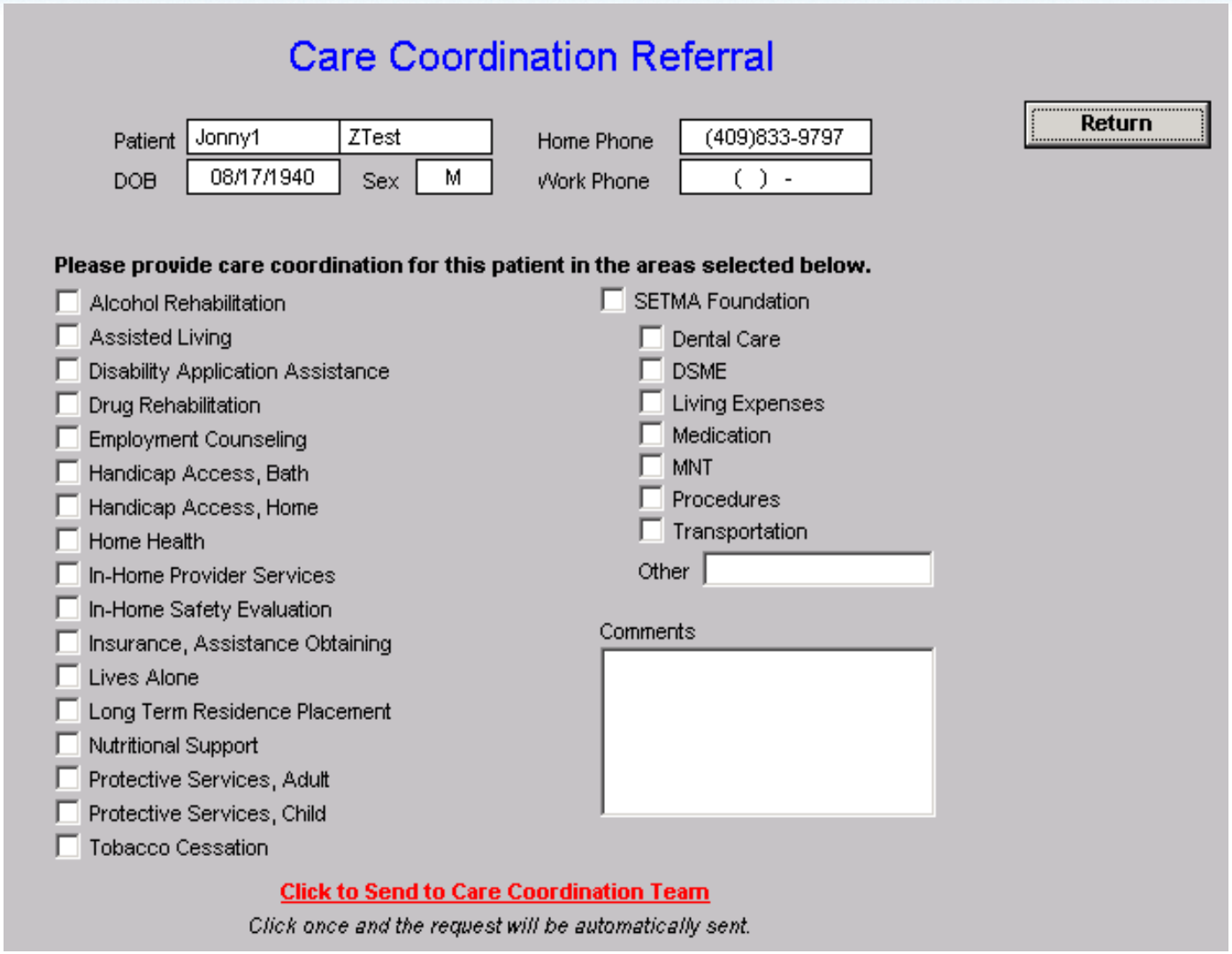
Barriers to Care [ ] NONE

Social	Financial
[ ] Deaf	[ ] Co-Pays
[ ] Hearing	[ ] Medications
[ ] Blind	[ ] Nutrition
[ ] Vision	[ ] Transportation
[ ] Literacy	[ ] Uninsured
[ ] Social Isolation	[x] None
[ ] Language	
[x] None	

Assistive Devices

[ ] Cane	[x] Splint/Brace
[x] Crutches	[ ] Walker
[ ] Hearing Aid	[ ] Wheelchair
[ ] Prosthetic Limb	[ ] None

Care Coordination Referral



Becoming an Integrator

- **Get started!**

  In my life, I have started many things which I never finished, but I have never finished anything I didn't start. No matter how daunting the task, the key to success is to start.

- **Compete with yourself, not others!**

  "I do not try to dance better than anyone else. I only try to dance better than myself "– Mikhail Baryshnikov.

  It doesn't matter what someone else is or is not doing; set your goal and pursue it with a passion. Measure your success by your own advancement and not by whether someone else is ahead or behind you.

Becoming an Integrator

- **Don’t give up!**

  The key to success is the willingness to fail successfully. Every story of success is filled with times of failure but is also characterized by the relentlessness of starting over again and again and again until you master the task.. When we started our IT project, we told people about what we are doing. We call that our “Cortez Project”. Like Cortez, we scuttled our ships so there was no going back. We had to succeed.

Becoming an Integrator

- **Have fun! Celebrate! Enjoy what you are doing and celebrate where you are.**

  In May of 1999, my co-founding partner of SETMA lamented about our EMR work; he said, “We are not even crawling yet.” I said, “You are right but let me ask you a question. ‘When your son turned over in bed, did you shout and say to your wife, “this retard, dimwitted brat can’t even crawl, all he can do is turn over in bed?” Or, did you shout to your wife, “He turned over in bed?” Did you celebrate his turning over in bed?” He smiled and I added, “I am going to celebrate that we have begun. If in a year, we aren’t doing more, I will join your lamentation, but today I celebrate!”

Integrator: Accountable Care Organization

Description of an ACO

"…(An ACO) is a local health care organization that is accountable for 100 percent of the expenditures and care of a defined population of patients. Depending on the sponsoring organization, an ACO may include primary care physicians, specialists and, typically, hospitals, that work together to provide evidence-based care in a coordinated model."

Integrator: Accountable Care Organization

"Collaborations of primary care and other health service providers…Organized around the capacity to improve health outcomes &…quality of care while slowing the growth in costs for…patients cared for by a well-defined group of primary care professionals…Capable of measuring improvement in performance and receiving payments that increase when such improvements occur."

(Engelberg Center for Health Care Reform, The Dartmouth Institute, page 8, January, 2011)

Integrator: Accountable Care Organization

Key Design Features of an ACO:

1. Local Accountability
2. Legal Structure
3. Primary Care Focus
4. Sufficient Size in Patient Population
5. Investment in Delivery System Improvements
6. Shared Savings
7. Performance Measures

(Engelberg Center for Health Care Reform, The Dartmouth Institute, page 9, January, 2011)

Integrator: Accountable Care Organization

With greater experience and…technical progress, ACO care…(is) expected to become more sophisticated (i.e. with) more comprehensive care improvement activities, better performance measures -- such as more meaningful outcome measures, including patient experience measures – and payment systems and other incentives that rely more on performance than volume, intensity, or other factors unrelated – or often inversely related – to value. *IBID, Engleberg*

Integrator: Accountable Care Organization

To be successful an ACO must be built:

- upon multiple Medical Homes
- an existing infrastructure
- without a hospital as a partner
- as a bridge to Medicare Advantage
- with patient engagement and agreement

With the realization that without the above five elements, ACOs may not succeed.

Integrator: Accountable Care Organization

- Some ACO functions are like those of traditional insurance. The differences are that Medicare still pays the bills rather than the ACO and Medicare is liable for paying all costs whether they exceed a budget or not. The ACO may increase its portion of the shared savings by increasing its liability for cost overruns.
- In Medicare Advantage programs, Medicare transfers its risk to the HMO which allows Medicare to budget its cost for each member. No matter what the actual cost of care is, Medicare will never pay the HMO more than the contracted per member payment.

Integrator: Accountable Care Organization

Traditional insurance defines its risk by contract. Medicare Advantage defines its risk by its “bid,” which is a contractual relationship with CMS which defines benefits in addition to the regular Medicare benefits. In both cases, insurance companies and Medicare Advantage plans have no Protection from “down-side” risk, i.e., the potential for the care of a patient or client costing more than what the insurance company is paid.

Integrator: Accountable Care Organization

The highest probability of success may occur in integrated delivery networks that already have an electronic infrastructure which can be adapted to the functions needed for ACO accountability and accounting and have strong relationships with IPAs. The principle reason for the higher potential of success is that the HMO/IPA partnership already has a model for the sharing of revenue. This will be one of the biggest hurdles for other ACOs.

Integrator: Accountable Care Organization

As noted above, most patients have more confidence in technology than a personal relationship with physicians, which means that the principle way to decrease the cost of care is to ration care. But, the most effective way to change the cost curve is to restore patient's trust in their doctor so that their counsel is sought before a test is ordered.

This is the reason why, any ACO which has the least potential for success must be built upon healthcare providers who not only have the designation but who are also actually functioning in a patient-centered medical home.

Integrator: Accountable Care Organization

In a compassionate, comprehensive, coordinated and collaborative relationship, it possible to recreate the trust bond which supersedes technology in the healthcare-decision-making equation. In that relationship, wise decisions can be made about watchful waiting, appropriate end-of-life care and a balance between life expectance with and without expensive but unhelpful care. Increasingly, we have to wonder if technological advances are actually resulting in a decreased rather than an increased quality of life.

Integrator: Accountable Care Organization

IBNR stands for “incurred but not received” and refers to services which have been provided but for which the bill has not yet been presented. Financial planning for a successful ACO must take into account fluctuations in results.

Careful cash management with adequate capitalization initially can help the ACO weather revenue shortfalls and benefit from positive results in the good times. The first step is to anticipate multi-year reconciliation and to build a business model on that expectation.

Integrator: Accountable Care Organization

Inherent in this entire discussion is the fact that the ACO is a public-policy initiative which has no inherent value to the patient but only to the ACO and to CMS.

In reality, in the ACO, there is no structural benefit for the patient. This can be resolved by the policies of the ACO which concentrates on comprehensive, preventative health with wellness metrics and with coordination of care. In this way, the patient returns to the central of all care delivery whether or not the ACO "makes money."

Strengths & Weaknesses of Payment Models

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Providers are accountable for total per-capita costs. Does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care.	Supports new efforts of primary care physicians to coordinate care, but does not provide accountability for total per-capita costs.	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs.	By combining FFS and prospective fixed payment, it provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/ providers. May be viewed as risky by many providers.	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs. Requires patient "lock-in." May be viewed as risky by many providers.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

Do Payment Models Strengthen Primary Care Directly or Indirectly?

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Yes – Provides incentive to focus on disease management. Can be strengthened by adding medical home or partial capitation payments to primary care physicians.	Yes – Changes care delivery model for primary care physicians, allowing for better care coordination and disease management.	Yes/No – Only for bundled payments that result in greater support for primary care physicians.	Yes – When primary care services are included in a partial capitation model, it can allow for infrastructure and process improvement, and a new model for care delivery.	Yes – It gives providers "upfront" payments and changes the care delivery model for primary care physicians.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

Do Payment Models Foster Coordination Among All Participating Providers?

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Yes – Significant incentive to coordinate among participating providers.	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination.	Yes (for those included in the bundled payment) – Depending on how the payment is structured, it can improve care coordination.	Yes – Strong incentive to coordinate and take other steps to reduce overall costs.	Yes – Strong incentive to coordinate and take other steps to reduce overall costs.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

Do Payment Models Remove Payment Incentives To Increase Volume?

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Yes - Incentives are based on value, not volume.	No - There is no incentive in the medical home to decrease volume.	No - For payments outside the bundle. There are strong incentives to increase the number of bundles and to shift costs outside the bundle.	Yes - Strong efficiency incentive to the degree that prospective fixed payment is weighted in overall payment.	Yes - Very strong efficiency incentive.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

Do Payment Models Foster Accountability For Total Per-Capita Costs?

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Yes – In the form of shared savings based on total per-capita costs.	No – Incentives are not aligned across providers. No global accountability.	No – For payments outside the bundle. No accountability for total per-capita cost.	Yes – Strong efficiency incentive to the degree that prospective fixed payment is weighted in overall payment.	Yes – Very strong accountability for per-capita cost.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

Do Payment Models Require Providers To Bear Risks For Excess Cost?

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Limited risk – While there might be risk-sharing in some models, the model does not require providers to take risks.	No - No risks for providers who continue to increase volume and intensity.	Yes, within the episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment.	Yes – To the degree that prospective fixed payment is weighted in overall payment.	Yes – Providers are responsible for costs that are greater than the payment.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

Do Payment Models Require "Lock-In" Of Patients To Specific Providers?

Accountable Care Organization	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
No - Patients are assigned based on previous care patterns. There are incentives to provide services within participating providers.	Yes - In order to give providers a PMPM payment, patients must be assigned.	No - Bundled payments are for a specific duration or procedure and do not require patient "lock-in."	Likely - Depending on the model, patients might need to be assigned to a primary-care physician.	Yes - To calculate appropriate payments, patients must be assigned.

*Accountable Care Organization Learning Network Toolkit (www.acolearningnetwork.org)

ACO Integrator: Exercise in Accountability

The following discussion addresses how SETMA which participates in Medicare Advantage capitation, Patient-Centered Medical Home and in a federally qualified ACO, addresses one of the biggest challenges to success which is decreasing preventable readmissions to the hospital.

Preventable Hospital Readmissions Public Policy

- Care planning that begins with an assessment at admission — nurse care managers representing the insurer, the hospital, and the primary providers must collaborate.
- Clear discharge instructions with particular attention to medication management — incorporating the input of the inpatient and outpatient pharmacist has proven effective.
- Discharge to a proper setting of care — Hospital case management screenings should determine rehab/skilled nursing requirements before discharge to outpatient care.

Preventable Hospital Readmissions Public Policy

- Timely physician follow-up visits — with primary care provider and appropriate specialists; preferably the appointment should be scheduled prior to discharge.

- Appropriate use of palliative care and end-of-life planning should be built into the hospital discharge process. Palliative specialists and hospice expertise need to be integrated components of post-hospital planning.

SETMA's Hospital Discharges

	Total Discharges	Readmission Rate (Days)	
		30	60
• 2009	– 2995	--	--
• 2010	– 3001	16.5%	21.9%
• 2011	– 4194	17.4%	24.6%
• 2012 *	– 946	--	--
• Total	– 11055	--	--

*Jan, Feb 2012

CMS Fee For Service Medicare Study –Medical Homes vs. Benchmarks

	30 Day Readmission (%)	Benchmark (%)		Two Week (%) Follow-Up	Benchmark (%)		Potentially Avoidable Inpatient Stays ($)	Benchmark ($)
SETMA 1	25.7	47.7		57.8	47.7		1766.00	3290.00
SETMA 2	17.5	30.9		56.5	40.4		962.00	2259.00
SETMA West	20.0	14.4		56.9	62.0		731.00	300.00

Care Transition Audit

- Quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "**Public Reporting**," along with over 200 other quality metrics which we track routinely.

- The following is the care transition audit results by provider name for 2011.

Care Transition Audit

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2012 through 03/31/2012

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Anwar	97.4%	99.1%	94.9%	98.3%	98.3%	97.4%	98.3%	96.6%	97.4%
Aziz	98.9%	100.0%	96.6%	100.0%	99.4%	98.9%	99.4%	98.9%	98.9%
Curry	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine	97.9%	98.7%	95.7%	98.3%	99.1%	98.3%	98.7%	97.0%	97.9%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	98.6%	100.0%	98.6%
Holly	97.6%	99.5%	96.7%	98.6%	99.0%	97.6%	97.1%	97.1%	98.1%
Leifeste	99.5%	100.0%	99.5%	99.5%	99.5%	100.0%	98.9%	99.5%	99.5%
Murphy	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Palang	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	98.6%	100.0%	98.6%
Qureshi	98.3%	100.0%	93.9%	98.3%	98.3%	97.4%	97.4%	97.4%	97.4%
Shepherd	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.7%	100.0%	93.7%	99.5%	99.5%	97.7%	98.2%	97.7%	97.7%
Vardiman	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
SETMA Totals :	98.5%	99.6%	96.5%	99.0%	99.2%	98.5%	98.5%	98.1%	98.3%

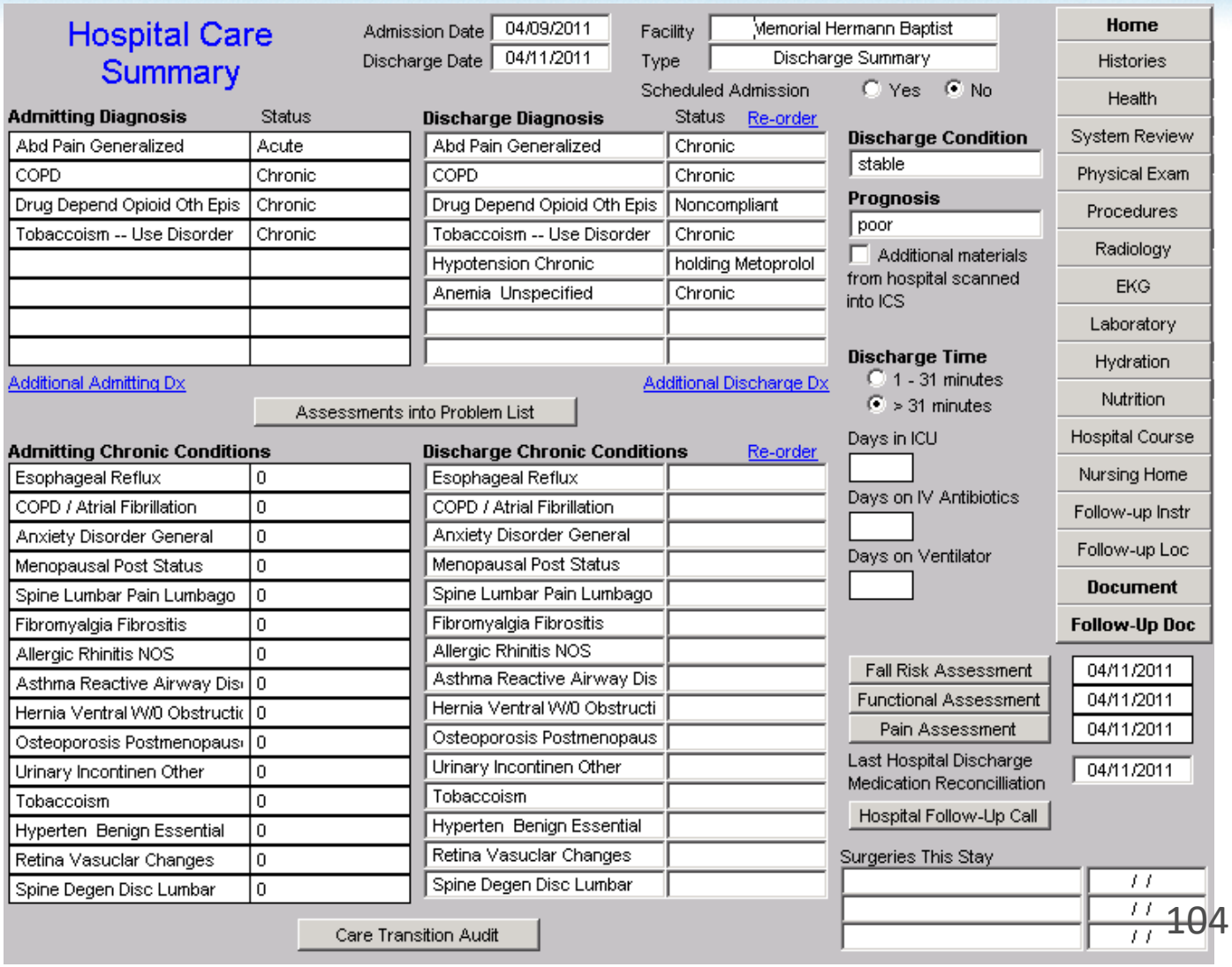
Care Transition Audit

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2012 through 03/31/2012

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	94.9%	97.4%	98.3%	97.4%	95.7%	94.0%	94.0%	94.0%	94.0%
Aziz	96.6%	98.9%	99.4%	98.9%	94.9%	96.1%	96.1%	96.1%	94.9%
Curry	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine	95.7%	97.9%	99.1%	98.7%	94.8%	94.8%	94.8%	94.8%	94.4%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.6%	98.6%	100.0%	100.0%	95.8%	98.6%	97.2%	95.8%	93.0%
Holly	96.7%	98.1%	99.0%	98.6%	96.2%	94.8%	94.8%	94.8%	94.8%
Leifeste	98.9%	100.0%	99.5%	99.5%	97.3%	98.9%	98.9%	98.9%	98.4%
Murphy	98.6%	100.0%	100.0%	100.0%	97.1%	98.6%	98.6%	97.1%	97.1%
Palang	100.0%	100.0%	98.6%	100.0%	97.3%	100.0%	100.0%	98.6%	98.6%
Qureshi	93.9%	98.3%	98.3%	98.3%	94.8%	92.2%	92.2%	92.2%	92.2%
Shepherd	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	93.7%	97.3%	99.5%	98.2%	97.3%	93.2%	93.2%	92.8%	93.2%
Vardiman	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%
SETMA Totals :	96.4%	98.5%	99.2%	98.8%	96.1%	95.7%	95.6%	95.4%	95.0%

Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan



Hospital Care Summary

Admission Date 04/09/2011
Discharge Date 04/11/2011
Facility Memorial Hermann Baptist
Type Discharge Summary
Scheduled Admission ○ Yes ◉ No

Admitting Diagnosis	Status
Abd Pain Generalized	Acute
COPD	Chronic
Drug Depend Opioid Oth Epis	Chronic
Tobaccoism -- Use Disorder	Chronic

Discharge Diagnosis	Status
Abd Pain Generalized	Chronic
COPD	Chronic
Drug Depend Opioid Oth Epis	Noncompliant
Tobaccoism -- Use Disorder	Chronic
Hypotension Chronic	holding Metoprolol
Anemia Unspecified	Chronic

Re-order

Additional Admitting Dx | Additional Discharge Dx

Assessments into Problem List

Admitting Chronic Conditions	
Esophageal Reflux	0
COPD / Atrial Fibrillation	0
Anxiety Disorder General	0
Menopausal Post Status	0
Spine Lumbar Pain Lumbago	0
Fibromyalgia Fibrositis	0
Allergic Rhinitis NOS	0
Asthma Reactive Airway Dis	0
Hernia Ventral W/0 Obstructi	0
Osteoporosis Postmenopaus	0
Urinary Incontinen Other	0
Tobaccoism	0
Hyperten Benign Essential	0
Retina Vasuclar Changes	0
Spine Degen Disc Lumbar	0

Discharge Chronic Conditions
Esophageal Reflux
COPD / Atrial Fibrillation
Anxiety Disorder General
Menopausal Post Status
Spine Lumbar Pain Lumbago
Fibromyalgia Fibrositis
Allergic Rhinitis NOS
Asthma Reactive Airway Dis
Hernia Ventral W/0 Obstructi
Osteoporosis Postmenopaus
Urinary Incontinen Other
Tobaccoism
Hyperten Benign Essential
Retina Vasuclar Changes
Spine Degen Disc Lumbar

Re-order

Care Transition Audit

Discharge Condition
stable

Prognosis
poor

☐ Additional materials from hospital scanned into ICS

Discharge Time
○ 1 - 31 minutes
◉ > 31 minutes

Days in ICU

Days on IV Antibiotics

Days on Ventilator

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**

Fall Risk Assessment	04/11/2011
Functional Assessment	04/11/2011
Pain Assessment	04/11/2011
Last Hospital Discharge Medication Reconcilliation	04/11/2011
Hospital Follow-Up Call	

Surgeries This Stay

	/ /
	/ /
	/ /

Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan

Hospital Care Summary completed at the time the patient is discharged from the hospital:

Year	Completion (%)
2010	98.8
2011	97.7
2012*	92.1
Cumulative	97.7

* January 1, 2010 to date

Hospital Readmission Reporting

Hospital Discharge Analysis

Section I - Admissions and Follow-ups

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	Selection Group 1	Selection Group 2
Readmission		
Average Days:	11.81	
Mode:	1.00	
Previous Hospitilization		
Average Days:	9.39	10.24
Mode:	2.00	2.00
Follow-up (Clinic Visit)		
Average Days:	6.65	18.14
Follow-up Visit (%):	37.85%	68.04%
Follow-up (Call)		
Call Completed (%):	74.67%	77.53%
Unable to Complete (%):	6.48%	6.91%

Hospital Readmission Reporting

Hospital Discharge Analysis

Section II - Patient Measures

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	Selection Group 1	Selection Group 2
Ancillary Services		
Hospice:	1.62%	1.36%
Home Health:	4.27%	2.82%
Physical Therapy:	0.15%	0.25%
Case Management:	0.00%	0.00%
Assisted Living:	0.44%	0.37%
Nursing Home:	21.35%	16.24%
Living Alone		
Patient Lives Alone:	1.62%	2.39%
Barriers to Care		
Financial Barriers:	5.60%	4.90%
Social Barriers:	5.30%	6.54%
Assistive Device:	12.96%	9.02%
Habits		
Tobacco Use:	21.35%	23.47%
Alcohol Use:	10.16%	12.24%
Illicit Drug Use:	2.50%	1.64%
Disease - Not in Compliance		
Diabetic:	40.95%	39.20%
Hyperlipidemia:	23.60%	28.43%
Hypertension:	23.77%	22.72%
CHF:	89.45%	88.51%
Care Transition Audit		
Transition Audit Completed:	94.85%	94.17%

Hospital Readmission Reporting

Hospital Discharge Analysis

Section III - Patient BMI and Changes Made

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	Selection Group 1	Selection Group 2
Body Mass Index		
Less than 18.5:	6.04%	6.82%
Between 18.5 and 25:	24.59%	23.93%
Between 25 and 30:	28.13%	25.26%
Between 30 and 35:	15.46%	18.07%
Between 35 and 40:	9.43%	8.18%
Greater than 40:	7.81%	9.65%

Hospital Readmission Reporting

Hospital Discharge Analysis

Section IV - Readmission Diagnoses

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

Selection Group 1

Top 5 Principle Diagnoses of Readmission

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	486	Pneumonia organism NOS
4	78097	Altered Mental Status
5	5789	Hem gi tract

Top 5 Supporting Diagnoses of Readmission

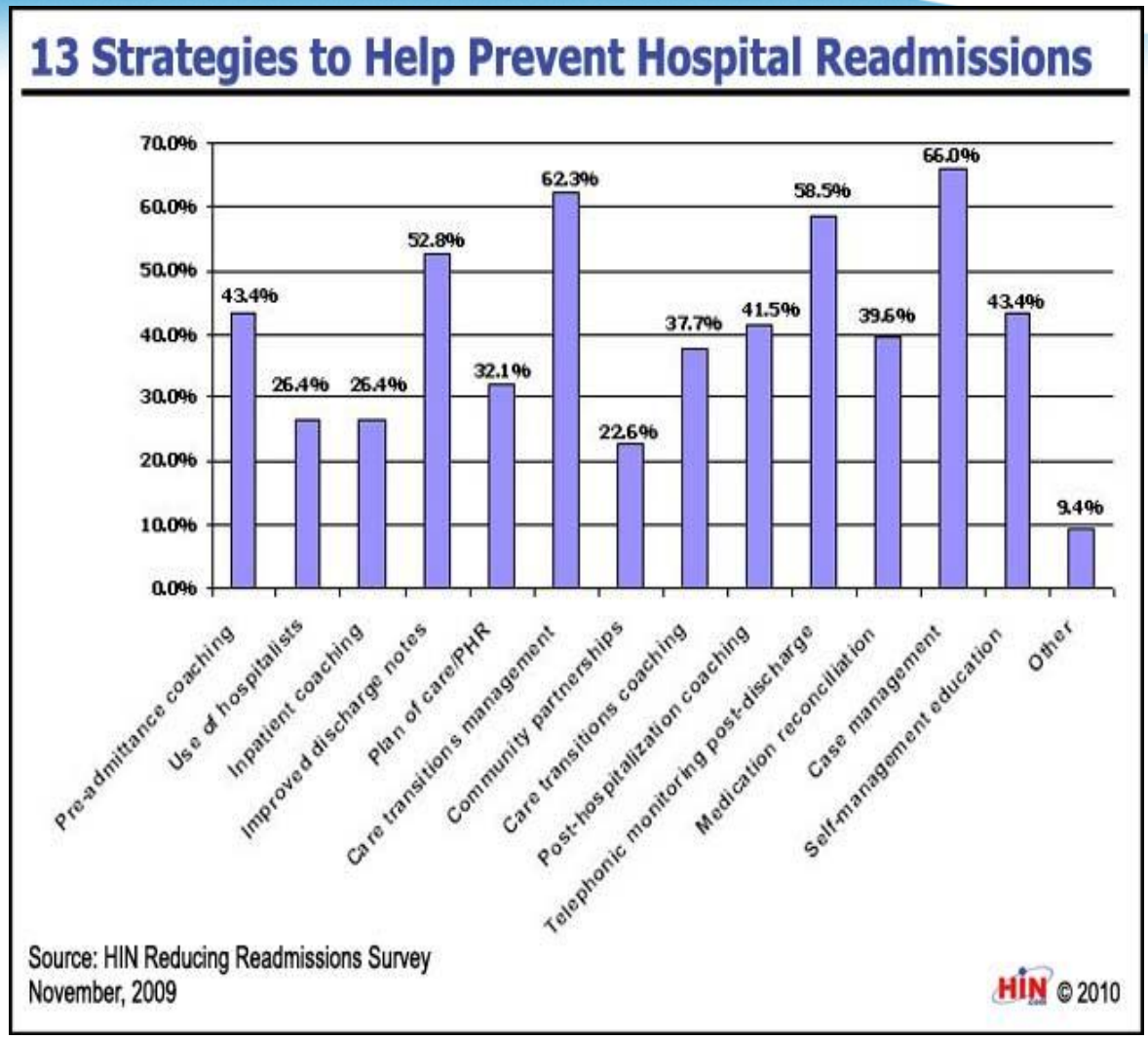
Rank	Readmission Diagnoses	Description
1	4011	Essential hypertension benig
2	4019	Essential hypertension unsp
3	496	Chronic airway obstruction NEC
4	2859	Anemia unsp
5	25040	Diab mellitus ren manif typ II

Selection Group 2

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	7802	Gen symp syncope/collapse
4	2859	Anemia unsp
5	486	Pneumonia organism NOS

Rank	Readmission Diagnoses	Description
1	4019	Essential hypertension unsp
2	4011	Essential hypertension benig
3	25040	Diab mellitus ren manif typ II
4	2859	Anemia unsp
5	41400	Coron athero unsp typ ves nati

Hospital Readmission Strategies



All Readmissions Are Not Preventable

"Critical to the analysis of readmissions is appropriateness. Some readmissions may be unavoidable. Other readmissions may be avoidable, but nevertheless occur, due to a *lack* of follow-up care coordination or some other problem. Obtaining a readmissions rate of zero is not feasible and may even indicate poor quality care, as many readmissions are medically appropriate due to an unavoidable change in condition or a new condition. For example, physicians may provide patient centered care by discussing early discharge with patients, with the mutual understanding that readmission may be necessary."

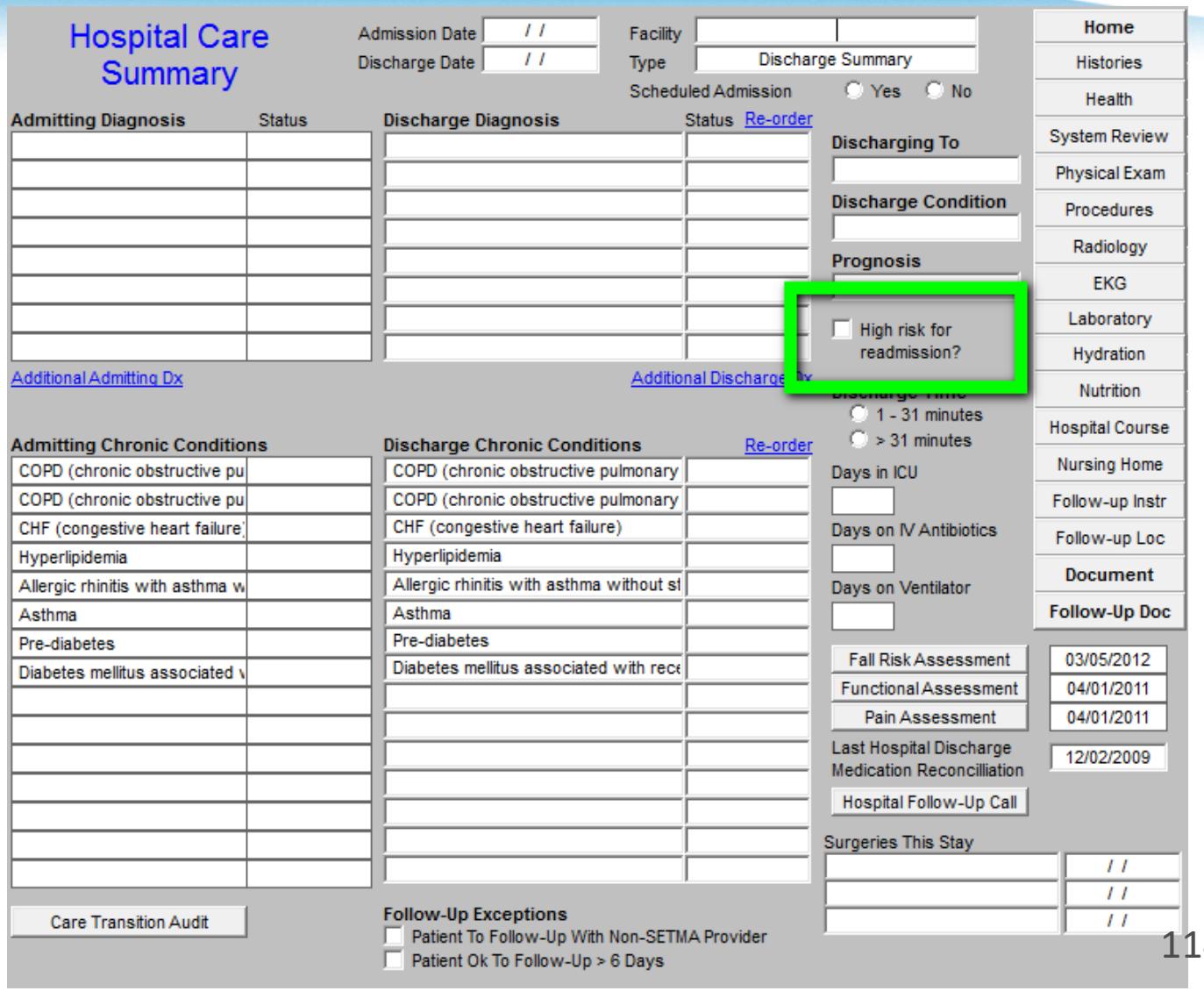
Risk of Readmissions

Recent studies continue to suggest the risk of readmission can be quantified based on a patient's risk factors and therefore are an important tool in establishing evidence-based best practices.

Risk of Readmissions

- The *Journal of Hospital Medicine* recently published a pair of studies in which researchers analyzed data from California and Austria to determine the risk factors of hospital readmission.
    - Medicare
    - Medicaid
    - Black Race
    - Inpatient use of narcotics
    - Inpatient use of corticosteroids
    - Cancer with and without metastasis
    - Renal Failure
    - Congestive Heart Failure
    - Weight loss

Risk of Readmissions



Managing High Risk Patients

When a person is identified as a high risk for readmissions, SETMA's Department of Care Coordination is alerted. The following ten steps are then instituted:

1. ***Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan*** is given to patient, care giver or family member.
2. The post hospital, care coaching call, which is done the day after discharge, goes to the top of the queue for the call – made the day after discharge by SETMA's Care Coordination Department. It is a 12-30 minute call.

Managing High Risk Patients

3. Medication reconciliation is done at the time of discharge, is repeated in the care coordination call the day after discharge and is repeated at the follow-up visit in the clinic.

4. MSW makes a home visit for need evaluation, including barriers and social needs for those who are socially isolated.

5. A clinic follow-up visit within three days for those at high risk for readmission.

Managing High Risk Patients

6. A second care coordination call in four days.

7. Plan of care and treatment plan discussed with patient, family and/or care giver at EVERY visit and a written copy with the patient's reconciled medication list, follow-up instructions, state of health, and how to access further care needs.

8. MSW documents barriers to care and care coordination department designs a solution for each.

Managing High Risk Patients

9. The patient's end of life choices and code status are discussed and when appropriate hospice is recommended.

10. Referral to disease management is done when appropriate, along with telehealth monitoring measures.

Managing High Risk Patients

- Currently, SETMA's determination of whether patients are high risk for readmissions is intuitively determined, i.e., at discharged based on experience and judgment, a patient is designated as potentially high risk for readmission. SETMA is designing a "predictive model" for identifying patients at high risk for readmissions and instituting the above plan for interdicting a readmission. This is an attempt to quantify the most effective opportunities for decreasing preventable readmissions.

Managing High Risk Patients

- There is a significant body of science associated with "**predictive modeling**." It is clear that tradition models of care delivery will not "work" in a sustainable program for decreasing readmissions. Traditional disease management will not result in changing the patterns of care. In a January/February, 2012 *Professional Care Management* Journal article, the following abstract addressed changes needed to affect a decrease in preventable readmissions:

Managing High Risk Patients

- "**Purpose/Objectives**: The move to the Accountable Care Organization model of care calls for broad-sweeping structural, operational, and cultural changes in our health care systems. The use of predictive modeling as part of the discharge process is used as a way to highlight just one of the common processes that will need to be transformed to maximize reimbursement under the Accountable Care Organization model. The purpose of this article is to summarize what has been learned about predictive modeling from the population health management industry perspective, to discuss how that knowledge might be applied to discharge planning in the Accountable Care Organization model of patient care, and then to outline how the Accountable Care Organization environment presents various challenges, opportunities, and implications for the case management role."

Managing High Risk Patients

- "**Findings/Conclusions**: The development of predictive models to identify patients at risk for readmission and can positively impact the discharge planning process by lowering readmission rates. Examples of the structural, operational, cultural, and case management role changes necessary to maximize the benefits of an Accountable Care Organization are critical."

- "**Implications for Case Management Practice**: There is a growing need for advanced practice nurses to fill the leadership, resource management, analytical, informatics-based, and organizational development roles that are sorely needed to advance the Accountable Care Organization model of care. Case managers are well-positioned to lend their expertise to the development efforts, but they will need to be educationally prepared for the many advanced practice roles that will emerge as our nation evolves this new system of health care delivery."

National Priorities Partnership

Focus in care coordination by NPP are the links between:

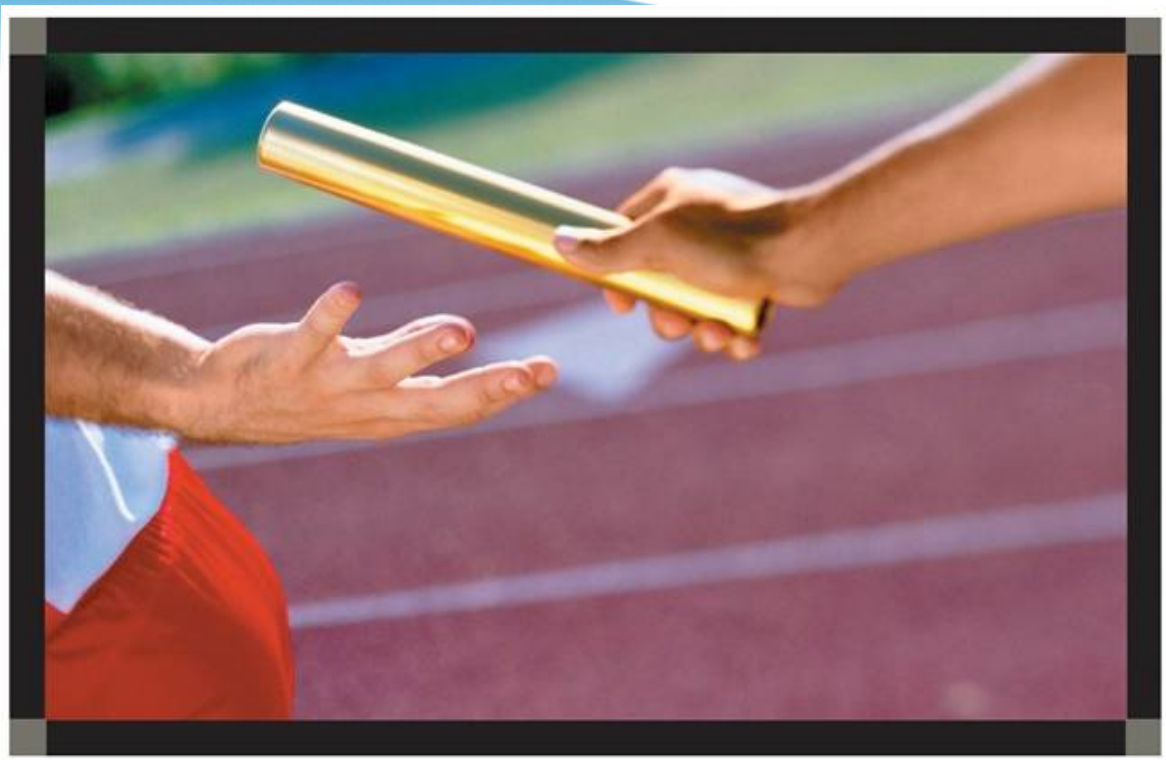
- **Care Transitions -** …continually strive to improve care by … considering feedback from all patients and their families… regarding coordination of their care during transitions between healthcare systems and services, and…communities.
- **Preventable Readmissions -** …work collaboratively with patients to reduce preventable 30-day readmission rates.

Hospital Care Summary

- Once the **Care Transition** issues are completed, The **Hospital Care-Summary-and-Post- Hospital-Plan-of Care-and Treatment-Plan** document is generated and printed. It is given to the patient and/or to the patient's family and to the hospital.

An Integrator's Tool: The Baton

The following picture is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race.



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.

An Integrator's Tool: The Baton

"The Baton" is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

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.

•

An Integrator's Tool: The Baton

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton," which has been developed by the healthcare team, is a coordinated effort between the provider and the patient.

An Integrator's Tool: The Baton

4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.

5. That the imperative for the plan – the "baton" – is that it must be transferred from the provider to the patient, **if change in the life of the patient is going to make a difference in the patient's health.**

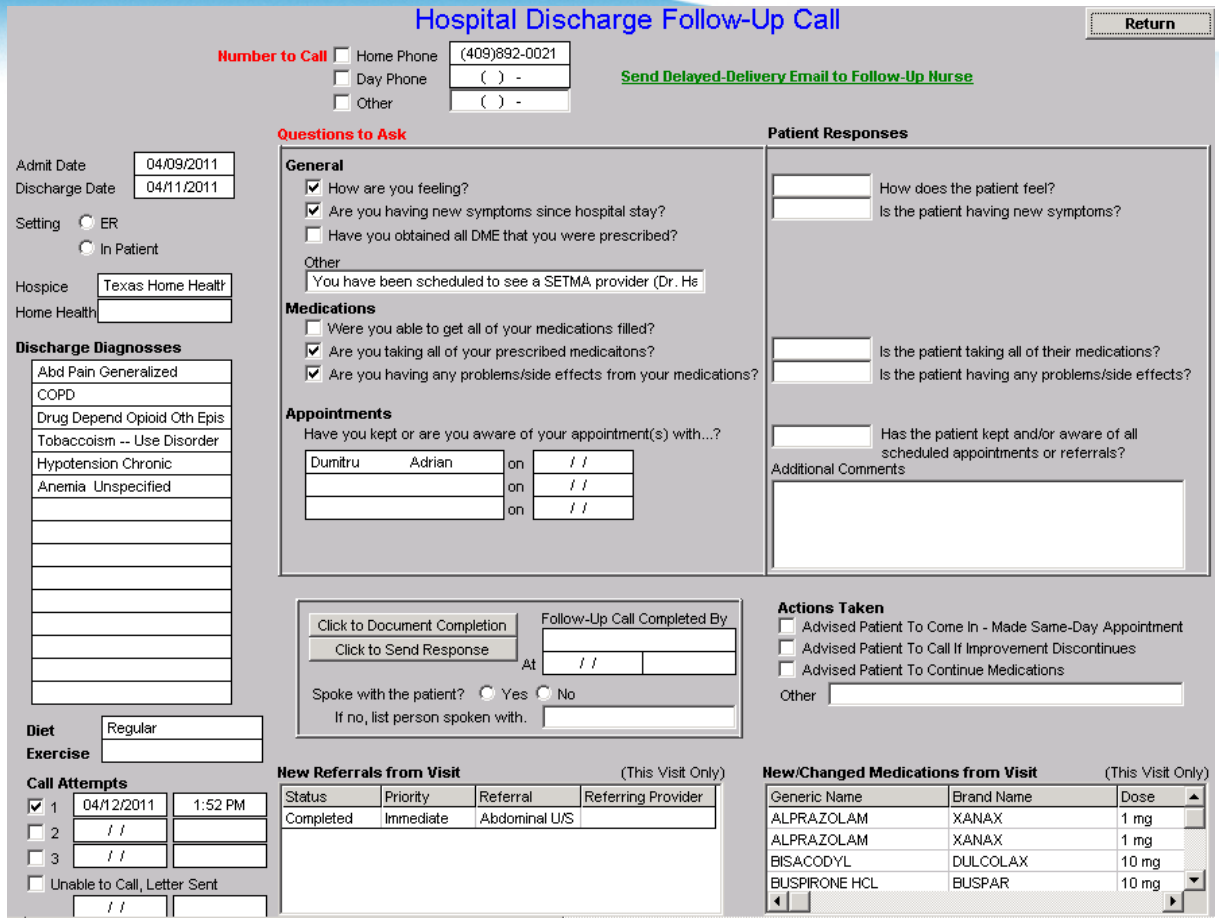
An Integrator's Tool: The Baton

6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient **accepts**, **receives**, **understands** and **comprehends** the plan, and that the patient is equipped and empowered to carry out the plan successfully.

7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

An Integrator's Tool: The Baton

After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:



Hospital Discharge Follow-Up Call

Return

Number to Call
- [ ] Home Phone (409)892-0021
- [ ] Day Phone ( ) -
- [ ] Other ( ) -

Send Delayed-Delivery Email to Follow-Up Nurse

Admit Date 04/09/2011
Discharge Date 04/11/2011

Setting
- ( ) ER
- ( ) In Patient

Hospice Texas Home Healt
Home Health

Discharge Diagnoses

Abd Pain Generalized
COPD
Drug Depend Opioid Oth Epis
Tobaccoism -- Use Disorder
Hypotension Chronic
Anemia Unspecified

Diet Regular
Exercise

Call Attempts

[x] 1	04/12/2011	1:52 PM
[ ] 2	/ /	
[ ] 3	/ /	

[ ] Unable to Call, Letter Sent / /

Questions to Ask

General
- [x] How are you feeling?
- [x] Are you having new symptoms since hospital stay?
- [ ] Have you obtained all DME that you were prescribed?

Other: You have been scheduled to see a SETMA provider (Dr. He

Medications
- [ ] Were you able to get all of your medications filled?
- [x] Are you taking all of your prescribed medicaitons?
- [x] Are you having any problems/side effects from your medications?

Appointments

Have you kept or are you aware of your appointment(s) with...?

Dumitru	Adrian	on	/ /
		on	/ /
		on	/ /

Patient Responses

How does the patient feel?
Is the patient having new symptoms?
Is the patient taking all of their medications?
Is the patient having any problems/side effects?
Has the patient kept and/or aware of all scheduled appointments or referrals?

Additional Comments

Click to Document Completion
Click to Send Response

Follow-Up Call Completed By
At / /

Spoke with the patient? ( ) Yes ( ) No
If no, list person spoken with.

Actions Taken
- [ ] Advised Patient To Come In - Made Same-Day Appointment
- [ ] Advised Patient To Call If Improvement Discontinues
- [ ] Advised Patient To Continue Medications

Other

New Referrals from Visit (This Visit Only)

Status	Priority	Referral	Referring Provider
Completed	Immediate	Abdominal U/S	

New/Changed Medications from Visit (This Visit Only)

Generic Name	Brand Name	Dose
ALPRAZOLAM	XANAX	1 mg
ALPRAZOLAM	XANAX	1 mg
BISACODYL	DULCOLAX	10 mg
BUSPIRONE HCL	BUSPAR	10 mg

An Integrator's Tool: The Baton

- During that preparation of the "baton," the provider checks off the questions which are to be asked the patient in the follow-up call.

- The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called.

- The call is the beginning of the "**coaching**" of the patient to help make them successful in the transition from the inpatient setting.

Preventing Hospital Readmission

1. The problem of readmissions will not be solved by more care: more medicines, more tests, more visits, etc.

2. The problem will be solved by redirecting the patient's attention for a safety net away from the emergency department.

3. The problem will be solved by our having more proactive contact with the patient.

Preventing Hospital Readmission

4. The problem will be solved by more contact with the patient and/or care giver in the home: home health, social worker, provider house calls.

5. The problem will be solved by the patient and/or care giver having more contact electronically (telephone, e-mail, web portal, cell phone) with the patient giving immediate if not instantaneous access.