

2011 John M. Eisenberg patient Safety and Quality Awards
Individual Achievement
By James L. Holly, MD

As the Founder and Chief Executive Officer of Southeast Texas medical Associates, LLP (SETMA, LLP, www.setma.com), James L. Holly, MD led SETMA to adopt electronic health records (EHR) in March, 1998. Quickly realizing that EHR and the electronic documenting of a patient encounter was too limited a goal, SETMA morphed the EHR-project into the pursuit of electronic patient management (EPM). This led to the development of award-winning disease management tools, an active wellness program through SETMA's LESS Initiative, diabetes and hypertension prevention programs and ultimately to the definition of The SETMA Model of Care.

SETMA's work has resulted in among others, the receiving of:

- **HIMSS Davies Award, 2005**
- **HIMSS Peer-Reviewed Stories of Success, 2011**
- **Joslin Diabetes Clinic Affiliation** as The Joslin Diabetes Affiliate at Southeast Texas Medical Associates, 2010
- **NCQA Tier Three Medical Home** Recognition, 2010-2013
- **NCQA Diabetes Recognition Program, 2010-2013**
- **Accreditation Association for Ambulatory Health Care (AAAH)** accreditation for Ambulatory Care, 2010, 2011-2014
- **AAAH** accreditation for Medical Home 2010, 2011-2014
- **Office of National Coordinator** of Health Information Technology of Health and Human Services' naming SETMA as one of thirty exemplary practices in the nation for Clinical Decision Support, 2011
- **Gartner Business Intelligence** Semi-Finalist Award for Business Analytics, 2011
- **Agency for Health Care Research and Quality (AHRQ)** accepting and publishing SETMA's LESS Initiative as AHRQ Health Care Innovations Exchange: Innovations and Tools to Improve Quality and Reduce Disparities, 2011
- **American Medical Association Physician Consortium for Performance Improvement (PCPI), Joslin Diabetes Clinic and Center for Medicare and Medicaid** using SETMA's data base as a research tool for Care Transitions research (2011); Performance Improvement CME research in Glucose control and cardiometabolic risk syndrome identification and treatment (2011); cost-analysis research for Medicare recipients in a Medical Home setting (2011).

SETMA's work has also resulting in Dr. Holly contributing a chapter entitled, "*Innovation for the Future of Health Care The SETMA Model of Care*" to a new book entitled, "*Changing the Game: The Power of Combining Innovative Thinking with Information Technologies in Healthcare.*" (General Editors Dr. Lyle Berkowitz, MD, Medical Director of Clinical Information Systems, Northwestern Memorial Physicians Group, Director, Szollosi healthcare Innovation Program and Christ McCarthy, MBA, MPH, Director, ILN, Specialist, KP, Innovation Consultancy)

SETMA's Model of Care has five steps:

- The **tracking** of quality metrics by each provider on each patient seen in the clinic, on preventive care, screening care and quality standards for acute and chronic care. SETMA's design is such that tracking occurs simultaneously with the performing of these services by the entire healthcare team, including the patient's personal provider, nurse, clerk, management, etc.
- The **auditing** of performance on the same standards for the entire practice, each individual clinic, each provider on a population, or for each provider's panel of patients. SETMA believes that this is the piece missing from most healthcare quality and safety programs.
- The **statistical analyzing** of the above audit-performance in order to measure the need for improvement by practice, by clinic or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, payer class, socio-economic groupings, education, frequency of visit, frequency of

testing, etc. This allows SETMA to look for leverage points through which can be improved. The analysis of means and standard deviations also allows for population-based quality improvement.

- The **public reporting** by provider of performance on hundreds of quality measures. This places pressure on all providers to improve, and it allows patients to know what to expect of their healthcare. The disease-management “plans of care” and the medical-home-coordination document summarizes a patient’s state of care and encourages them to ask their provider for any preventive or screening care which has not been provided. Any such services which are not completed are clearly identified for the patient. We believe this is the best way to overcome provider and patient “treatment or clinical inertia.”

Once you “open your books on performance” to public scrutiny, the only safe place you have in which to hide is excellence (James L. Holly, MD)

- The design of **Quality Assessment and Permanence Improvement (QAPI) Initiatives** – For 2011, SETMA’s initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital. SETMA has now completed a COGNOS BI Report which allows us to analyze our hospital care in detail.

The SETMA Model is the foundation of our medical home which includes:

- **Transitions of Care** using PCPI’s 18-point quality measurement set on care transitions.
- **Coordination of Care** through our Department of Care Coordination which also recommends to The **SETMA Foundation** those who need our help in paying for their healthcare. In the past three years, the partners of SETMA have given \$1.5 million dollars to The Foundation for the support of the care of our patients. Through the Foundation, we have paid for tests, medications, treatments, surgeries, dental care and other care of our patients. None of the Foundation’s money can be paid to or profit SETMA.
- **Medication Reconciliation** at multiple locations including hospital, emergency department, clinic, nursing home, home health, hospice, etc. In that the same data base is used in all locations, SETMA’s patients receive dozens of instances of medication coordination each year which adds to patient safety.
- **The Baton** – out of 8,760 hours in a year, the patient is in charge of his/her care for over 8,700 hours. The patients “plan of care” and “treatment plan,” with goal setting, education, information and current status of care is “the baton,” which is passed from the provider to the patient to empower the patient to care for himself or herself.

“Often, it is forgotten that the member of the healthcare delivery team who carries the ‘baton’ for the majority of the time is the patient and/or the family member who is the principal caregiver. If the ‘baton’—the plan of care and treatment plan -- is not effectively transferred to the patient or caregiver, then the patient’s care will suffer.” (James L. Holly, MD)

- **Care Coaching** – done by 12-30 minute telephone calls, American Diabetes Association (ADA) accredited Diabetes Self Management Education (DSME) and Medical Nutrition Therapy (MNT) Education programs, as well as home visits by nurses, patients are further engaged with their own care.
- **A Team** – multi-specialty, multi-discipline team which coordinates care, accepts responsibility for patient safety and quality care, and which documents to the same data base, works together to provide outstanding care with documented excellent outcomes.

SETMA’s LESS Initiative is the foundation of our wellness program. “LESS” stands for “lose weight, “exercise” and “stop smoking.” Completed on all patients seen in the clinic, The LESS gives each patient a weight assessment of BMI, BMR, Body Fat, disease risk of current weight and instructions on how to change the BMR in order to facilitate weight control. The patient also receives a personalized exercise program based on their health, age, heart rate and over all conditions. Exercise programs are modified for diabetes, congestive heart failure and other physical limitations. Finally, every patient, even pediatric are assessed for smoking or exposure to tobacco smoke. Smoking cessation and nicotine addiction educational materials, and, if the patient smokes, an “electronic tickler file,” are generated to trigger a personal telephone call 30-days later to assess progress in stopping smoking.

SETMA’s use of **Clinic Decision Support (CDS)** has improved provider performance and outcomes significantly. One element of our EHR deployment is described as “we want to make it easier to do it right than not do it at all.”

This is illustrated by our population management of infectious diseases. In Texas, 78 diseases are reportable to the State Health Department. There are five categories of the timing requirement of that reporting. SETMA designed a program which is triggered by the placement of one of the reportable diagnoses in the assessment template. When that occurs, the following happens without any further action by the provider:

1. The Reportable Disease template has the infectious disease documented.
2. An e-mail is sent to the Department of Care Coordination
3. The Department notifies the State either by telephone, e-mail or letter.
4. The Department notifies the provider that the report has been made.
5. If there is a confirmatory test, when the result returns it is matched with the assessment and a follow-up report is sent to the State.
6. Quarterly and annually an audit is completed for all infectious diseases and the incidence of their being reported.

All of this happens without the provider doing anything but making the diagnosis. The same processes take place with our HIV Surveillance Program. All patients 13-64 are screened for HIV. Our EHR has a Screening and Prevention screen which displays the standards of care for preventive and screening care. If the element applies to the patient and has been done, it appears in black. If it applies and has not been done, it appears in red. If it does not apply to this patient, it is in grey. If the HIV testing is red, the provider simply clicks a button and the following happens:

1. The test is ordered and the order is sent to the lab.
2. A document is printed for the patient to sign for permission
3. The charge is sent to business office
4. The screening template is updated to show that the test has been done.

For years SETMA has calculated several Framingham Risk Scores for our patients but in 2010, we expanded that to include all twelve Framingham Risk Calculators. We then added a feature which allows us to tell our patients, "If you make a change, it will make a difference." In order to do this, we not only calculate the risk scores, but we add a "what if" scenario. The principle risk score shows the patient's 10-years Cardiovascular Risk and shows the patient's "relative" heart age. In addition to showing the patient's actual and relative heart age on the plan of care and treatment plan, SETMA produces five "what if" scenarios. "What if" each element is treated to goal? The "baton" shows the patient how his/her risk and relative heart age will change. The same is done for a 20% improve in each element of the Risk Calculator. As public reporting changes provider behavior, the "what if" scenario can change patient behavior.

SETMA's EHR and EPM make it possible to complete tasks in seconds which previously took minutes. It also allows us to do in less than a minute audits which once took hours. Because the same data base is used in the hospital, emergency department, nursing home, clinic, hospice, home health, physical therapy and all other points of care, SETMA is able to replace the typical medical record silhouette of a patient with a granular portrait which allows the patients continuity of care to be maintained no matter who is seeing the patient. And, all of this contributes to patient safety.

This has allowed SETMA to eliminate ethnic disparities of care in diabetes and hypertension and to address complex issues of transitions of care and preventable readmissions to the hospital. SETMA's public reporting of provider performance by provider name has added a transparency to our care delivery, which has encouraged our patients to hold us and themselves accountable for improved outcomes. Our attention to statistical analysis has allowed us to move our standard deviations on hemoglobin A1C from 1.98 in 2000 to 1.2 in 2011. It has challenged us to change and improve processes which affect an improvement in outcomes. And, as members of the National Quality Forum, SETMA continues to work to improve health in our practice, in our community, in our region and in our nation.

End Note: The electronic version of Dr. Holly's Curriculum Vitae which is enclosed has hyperlinks to hundreds of SETMA's electronic tools, articles and innovations.