

Organization: Southeast Texas Medical Associates, LLP
Stage: Readiness Evaluation
License: 12968
Evaluation Option: PPC-Patient-Centered Medical Home
Unit of Assessment:
Date: 4/7/2010

Physician Practice Connections-Patient Centered Medical Home

This category includes the following standards:

PPC1 - Access and Communication

Elements: A - B

PPC2 - Patient Tracking and Registry Functions

Elements: A - B - C - D - E - F

PPC3 - Care Management

Elements: A - B - C - D - E

PPC4 - Patient Self-Management Support

Elements: A - B

PPC5 - Electronic Prescribing

Elements: A - B - C

PPC6 - Test Tracking

Elements: A - B

PPC7 - Referral Tracking

Elements: A

PPC8 - Performance Reporting and Improvement

Elements: A - B - C - D - E - F

PPC9 - Advanced Electronic Communication

Elements: A - B - C

PPC1: Access and Communication

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Intent

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

PPC1: ELEMENT A - Access and Communication Processes

Score: 100.00% of Possible Points
This is a Must Pass Element.

The practice establishes in writing standards for the following processes to support patient access:

- | | Yes | No | |
|---|-------------------------------------|--------------------------|--------------------------|
| 1. scheduling each patient with a personal clinician for continuity of care | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 2. coordinating visits with multiple clinicians and/or diagnostic tests during one trip | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 3. determining through triage how soon a patient needs to be seen | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 4. maintaining the capacity to schedule patients the same day they call | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 5. scheduling same day appointments based on practice's triage of patients' conditions | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 6. scheduling same day appointments based on patient's/family's requests | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 7. providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 8. providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 9. providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 10. providing an interactive practice Web site | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 11. making language services available for patients with limited English proficiency | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. identifying health insurance resources for patients/families without insurance. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |

Scoring

	100%	75%	50%	25%	0%
	Practice has written process for 9-12 items	Practice has written process for 7-8 items	Practice has written process for 4-6 items	Practice has written process for 2-3 items	Practice has written process for 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA is located in a predominantly English speaking area. Fewer than 1% of our patients

have a language preference other than English; those are:

- Spanish -- we have Spanish speaking employees
- Pakistani -- we have Urdu speaking providers
- French -- We have French speaking employees
- German -- We have German speaking employees
- Vietnamese -- we have Vietnamese speaking help available.

SETMA's website (www.setma.com) displays all of our electronic patient management tools, our Public Reporting of SETMA's providers' performance on the following quality measures: HEDIS, NQF (multiple comprehensive measure sets, as well as individual measures) AQA, PCPI (hypertension, diabetes, care transition, CHF, chronic stable angina and others) and several quality measure sets developed by SETMA in the absence of endorsement by national agencies, i.e., comprehensive lipids, Chronic Renal Disease Stage I-III).

We routinely have patient see multiple providers in the same day and/or schedule multiple procedures on the same days as a visit. With our multi-specialty capacity (endocrinology, cardiology, infectious disease, ophthalmology, neurology, Diabetes Center of Excellence and ADA DSME program, in house reference laboratory, physical therapy, pulmonary function laboratory, bone, density, ultrasonography, echocardiography and stress echo capacity, allergy clinic, along with specialty clinics in dyslipidemia and hypertension), this is ideal for our total care of our patients.

As is explained elsewhere, in addition to helping our patients obtain resources for needed care, through The SETMA Foundation, SETMA helps make funds available for the care of our patients when no other funding source can be found.

Supporting Documents

- PPC-1 Element A 12
- PPC-1 Element A 1
- PPC-1 Element A 2,3,5,6
- PPC-1 Element A 4
- PPC-1 Element A 7,8
- PPC-1 Element A 9,10

PPC1: ELEMENT B - Access and Communication Results	Score: 100.00% of Possible Points This is a Must Pass Element.
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The practice's data shows that it meets access and communication standards in 1A:

	Yes	No
1. visits with assigned personal clinician for each patient	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. appointments scheduled to meet the standards in items 2-6 in 1A	<input checked="" type="checkbox"/>	<input type="checkbox"/>

- 3. response times to meet standards for timely response to telephone requests
- 4. response times to meet its standards for timely response to e-mail and interactive Web requests
- 5. language services for patients with limited English proficiency.

Scoring	100%	75%	50%	25%	0%
	Practice's data meets 5 items	Practice's data meets 4 items	Practice's data meets 3 items	Practice's data meets 2 items	Practice's data meets 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-1 Element B

PPC2: Patient Tracking and Registry Functions

The practice systematically manages patient information and uses the information for population management to support patient care.

Intent

The practice has readily accessible, clinically useful information on patients that enables it to treat patients comprehensively and systematically.

PPC2: ELEMENT A - Basic System for Managing Patient Data **Score: 100.00% of Possible Points**

The practice uses an electronic data system for patients that includes the following searchable patient information:

Yes No

- 1. name
- 2. date of birth
- 3. gender
- 4. marital status
- 5. language preference
- 6. voluntarily self-identified race/ethnicity
- 7. address
- 8. telephone (primary contact number)
- 9. e-mail address (or "none" for patients)
- 10. internal ID
- 11. external ID
- 12. emergency contact information
- 13. current and past diagnoses
- 14. dates of previous clinical visits
- 15. billing codes for services
- 16. legal guardian
- 17. health insurance coverage
- 18. patient/family preferred method of communication.

Scoring

100%	75%	50%	25%	0%
12-18 items were entered for 75-100% of patients	8-11 items were entered for 75-100% of patients	6-7 items were entered for 75-100% of patients	4-5 items were entered for 75-100% of patients	0-3 items were entered for 75-100% of patients

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents • PPC-2 A Description

PPC2: ELEMENT B - Electronic System for Clinical Data	Score: 100.00% of Possible Points
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The practice's clinical data system or systems to manage care of patients include the following clinical patient information in searchable data fields:

	Yes	No
1. status of age-appropriate preventive services (immunizations, screenings, counseling)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. allergies and adverse reactions	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. height	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. body mass index (BMI) calculated	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. laboratory test results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. presence of imaging results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. presence of pathology reports	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. presence of advance directives.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. head circumference for patients 2 years or younger	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
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System has 9-11 data fields	System has 7-8 data fields	System has 5-6 data fields	System has 3-4 data fields	System has 0-2 data fields
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation Our EMR has a function for scanned documents which is where reports of procedures and tests which are done outside of our system are collected. When they are placed there a link is placed the provider's workflow where the document is able to be reviewed and where the provider can sign that it has been reviewed and any necessary action has been taken. The same is the case for pathology reports, mammograms, etc. In-house reports on echocardiograms, ultrasound, bone density, pulmonary function tests, etc are also placed into the providers' work flow for review.

Our Medical Coordination Review template has a place for documentation that code status issues, advanced directives, etc., have been discussed with the patient and family and that the document has been scanned into our system when it is made available. At every visit, a sample advanced directive is given to the appropriate patients with instructions on how to complete it.

- Supporting Documents**
- PPC-2 A
 - PPC-2 Element B

PPC2: ELEMENT C - Use of Electronic Clinical Data	Score: 100.00% of Possible Points
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The practice uses the fields listed in 2B consistently in patient records.

[In the box to the right, enter the percentage of patients]

97

Scoring	100%	75%	50%	25%	0%
	75-100% of patients seen in the past 3 months have at least 7 fields completed	50-74% of patients seen in the past 3 months have at least 7 fields completed	25-49% of patients seen in the past 3 months have at least 7 fields completed	10-24% of patients seen in the past 3 months have at least 7 fields completed	Less than 10% of patients seen in the past 3 months have at least 7 fields completed

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents • PPC-2 Element C

PPC2: ELEMENT D - Organizing Clinical Data **Score: 100.00% of Possible Points**
This is a Must Pass Element.

The practice uses the following electronic or paper-based charting tools to organize and document clinical information in the medical record:

1. problem lists
2. lists of over-the-counter medications, supplements and alternative therapies
3. lists of prescribed medications including both chronic and short-term
4. structured template for age-appropriate risk factors (at least 3)
5. structured templates for narrative progress notes
6. age appropriate standardized screening tool for developmental testing
7. growth charts plotting height, weight, head circumference and BMI, if less than 18 years.

[In the box to the right, enter the percentage of patients]

93

Scoring	100%	75%	50%	25%	0%
	75-100% of records of patients seen in the past 3 months include at least 3 tools with information documented	50-74% of records of patients seen in the past 3 months include at least 3 tools with information documented	25-49% of records of patients seen in the past 3 months include at least 3 tools with information documented	10-24% records of patients seen in the past 3 months include at least 3 tools with information documented	Less than 10% of patient records include at least 3 tools

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents • PPC-2 Element D

PPC2: ELEMENT E - Identifying Important Conditions

Score: 100.00% of Possible Points
This is a Must Pass Element.

The practice uses an electronic or paper-based system to identify the following diagnoses and conditions:

- | | Yes | No |
|---|-------------------------------------|--------------------------|
| 1. practice's most frequently seen diagnoses | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. most important risk factors in the practice's patient population | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. three conditions that are clinically important in the practice's patient population. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Scoring	100%	75%	50%	25%	0%
	Practice identifies 3 items	Practice identifies 2 items	Practice identifies 1 item	No scoring option.	Practice identifies 0 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-2 Element E 1,2,3 Medical home -- PPC 2 Element E pdf

PPC2: ELEMENT F - Use of System for Population Management

Score: 100.00% of Possible Points

The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, as follows:

- | | Yes | No |
|---|-------------------------------------|--------------------------|
| 1. patients needing pre-visit planning (obtaining tests prior to visit, etc.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. patients needing clinician review or action | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

- 3. patients on a particular medication
- 4. patients needing reminders for preventive care
- 5. patients needing reminders for specific tests
- 6. patients needing reminders for follow-up visits such as for a chronic condition
- 7. patients who might benefit from care management support.

Scoring

	100%	75%	50%	25%	0%
	Practice uses information to take action on 5-7 items	Practice uses information to take action on 3-4 items	Practice uses information to take action on 1-2 items	No scoring option.	Practice does not use information to take action

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation In regard to PPC-2 Element F Data Point 7:

SETMA has relationships for certain of our high risk patients with case management nurses from our IPA, our home health and several of our insurance carriers. We do not claim credit for this because at present, we do not have a systematic means of applying these benefits to all of our patient population. Throughout this survey tool, we have decline to take credit for this. In the future, we plan to have this systematized and in structured fields so that we can track this data and thus claim credit.

Supporting Documents

- PPC-2 Element F

PPC3: Care Management

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patients' care.

Intent

The practice maintains continuous relationships with patients by implementing evidence-based guidelines and applying them to the identified needs of individual patients over time and with the intensity needed by the patients.

PPC3: ELEMENT A - Guidelines for Important Conditions	Score: 100.00% of Possible Points This is a Must Pass Element.
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The practice adopts and implements evidence-based diagnosis and treatment guidelines for:

- | | Yes | No |
|--|-------------------------------------|--------------------------|
| 1. first clinically important condition | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. second clinically important condition | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. third clinically important condition. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

	100%	75%	50%	25%	0%
Scoring	Practice implements guidelines for 3 conditions	No scoring option.	Practice implements guidelines for 2 conditions	Practice implements guidelines for 1 condition	Practice does not implement guidelines for any conditions

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA incorporates national standards of care both as to process and outcomes into disease management tools for diabetes, hypertension and dyslipidemia. SETMA has adopted the standards of NQF, PCPI, HEDIS and AQA for the establishment of quality metrics. SETMA reports on provider performance on these measures and that performance is reporting on our website at www.setma.com under "Public Reporting."

Annually, SETMA reviews the ADA's Diabetes Treatment Update (a 100-page documented published in the winter of each year) and updates any changes into our Diabetes Treatment Plan. SETMA regularly monitors the American Heart Association and the American Cardiology Association's updates on the treatment of hypertension and update our disease management tools accordingly. The same process with ATP-III and the AHA is done with lipids.

The files attached to our document list are the disease management tools which we use daily for these diseases. While they are extensive and thorough, they are efficiently used as we train our providers and nurses in their use. We have three-hour monthly training sessions for all of our healthcare providers in the use of all PCMH and disease manage functions of our EMR.

In addition, we audit our providers use of these tools, as will be seen later.

- Supporting Documents**
- PPC-3 Element A 1
 - PPC-3 Element A 2
 - PPC-3 Element A 23

PPC3: ELEMENT B - Preventive Service Clinician Reminders	Score: 100.00% of Possible Points
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The practice uses a paper-based or electronic system with guideline-based reminders for the following services when seeing the patient:

	Yes	No	NA
1. age-appropriate screening tests	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. age-appropriate immunizations (e.g., influenza, pediatric)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. age-appropriate risk assessments (e.g., smoking, diet, depression)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. counseling (e.g., smoking cessation).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	100%	75%	50%	25%	0%
Scoring	Practice uses reminders for 4 items	Practice uses reminders for 3 items	Practice uses reminders for 2 items	Practice uses reminders for 1 item	Practice uses reminders for no items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation Thje material in this note is also linked as a document so that the data is structured correctly:

In 1999, as SETMA moved from the pursuit of electronic medical records to the pursuit of electronic patient records (for more on this see Your Life Your Health at www.setma.com the section on "Medical Records"), we began leveraging the power of electronics to improve pateint care. Over a ten-year period, we saw our performance on diabetes care improve every year.

As SETMA has analyzed our treatment of patients with diabetes, we have generated the following data from our electronic medical record. This data represents treatment of diabetes over a period of eight years and shows a consistent improvement in the treatment of diabetes.

Year Average HgbA1C (%) Change (%) No. Tests Done

2000 7.778 555
2001 7.4789 -0.299 1193
2002 7.4549 -0.024 3036
2003 7.2671 -0.188 4971
2004 7.2102 -0.057 7080
2005 6.9847 -0.226 7521
2006 6.8763 -0.108 8610
2007 6.6265 -0.250 9117
2008 6.5378 -0.089 6275

Total Decline (2000 to 2008) -1.240

From 2000 to 2008 our average Hgb A1C values have dropped from 7.778% to 6.5378% which is a collective drop of 1.240%. As you look at this data, it becomes clear that:

Between 2000 and 2001, there was a significant improvement in the Hgb A1Cs.

Another improvement is seen between 2004 and 2005.

And, another improvement is seen between 2006 and 2007.

As we examined these results, we realized that in 2000, we developed our disease management tool. In 2003-2004, we introduced our ADA approved DSME program and in 2006, we were successful in recruiting an endocrinologist.

Going forward, our strategy is to increase the use of the disease management tool, increase the use of diabetes education and to increase the use of endocrinology for difficult and recalcitrant disease.

As we developed more disease management tools, we realized that there were three life-style changes we wanted everyone of our patients to practice. We wanted them to lose weight, exercise and stop smoking, so we developed the LESS Initiative. In this program (for more see Your Life Your Health on our website), for eight years, we have assessed every patients' weight with a BMI, BMR, body fat and an explanation of who much weight they need to lose in order too improve their health. We give every patient a written personalized exercise program and we address active smoking, secondary smoking and now tertiary smoking with every patient we see.

These and other screening and prevention programs for diabetes and hypertension, enable us to provide primary and secondary disease prevention for our patients.

The following is a further example of our analysis of our diabetes treatment plan:

Mean, Standard Deviation, Median, Mode

As we looked at the data and tried to draw conclusions about it, we realized that we needed more statistical analysis than just the average (the mean). We need to know the median, the mode and the standard deviation and we needed to know them by provider.

- For a data set, such as the HgbA1C values, the mean (average) is the sum of the observations divided by the number of observations. The mean is often quoted along with the standard deviation. In that case, the mean describes the central location of the data (often called the average) and the standard deviation describes the spread. The mean may be 6.5% in the case of Hgb A1C which is excellent, but if the standard deviation is 1.6, the

range would be from 4.0 to 8.1. The 8.1% is not good.

- A median is described as the number separating the higher half of a sample from the lower half. At most half the population has values less than the median and at most half have values greater than the median.

- The mode is the value that occurs the most frequently in a data set.

The analysis by provider in SETMA's treatment of diabetes showed the following. (The provider names have been removed.) As is often the case the worst numbers were found in the case of the best physicians because they see the sickest patients. As you analyze data, you begin to be able to devise a plan for future efforts at improvement of care.

Provider Instances Average Std Dev Median Mode

2666	7.361	1.926	6.8	6.0
2143	6.875	1.492	6.5	6.2
3574	7.288	1.812	6.8	6.2
2110	7.356	1.729	6.9	6.9
20	6.785	2.003	6.0	5.6
54	6.915	2.197	6.1	6.0
2319	7.021	1.585	6.6	6.6
1281	6.117	0.897	5.9	5.6
3023	6.845	1.617	6.4	6.0
1285	6.847	1.600	6.4	6.2
2142	6.886	1.633	6.4	6.2
620	6.326	1.247	6.0	5.7
1387	6.364	1.027	6.1	5.7
1633	6.597	1.559	6.1	5.8
45	7.116	2.251	6.3	6.5
70	6.837	2.030	6.2	5.5
1568	6.764	1.410	6.5	6.2
1497	6.786	1.698	6.4	6.2
2760	6.906	1.432	6.6	6.1
197	6.203	1.146	5.9	6.0

In addition to excellence of care, there are also many population factors, not under the provider's control, which affect the results of HgbA1Cs:

- The age of the patients - younger patients tend to have better control
- The activity of the patients - older patients tend to be more sedentary
- The nutrition of the patients - nursing home patients and elderly often are under-nourished and will thusly skew the HgbA1Cs downward.
- Socio-economic status - patients with lower incomes have more difficulty eating right.
- Educational status of patients - often people with higher education are more motivated and better able to understand the complexities of DSME.
- How long the patient has been a diabetic can influence the HgbA1C.
- How long the patient has been cared for by our clinic. It would appear - and we shall examine this - that the longer a patient sees us, the better their HgbA1Cs will be.
- There are other factors in the care of a patient with diabetes which have equal and possibly superior important to the HgbA1C, i.e., blood pressure, etc. We will be looking at those factors.

Analysis and the future - plans for a 2008 breakpoint

As you analyze the data above, remember that the higher the median (the higher the value which represents the midpoint of your data set, i.e., 50% of our values are above the median

and 50% are below), the higher your mean (average) will be and in general the higher your standard deviation will be.

For analysis purposes remember that if your standard deviation is ZERO, the mean (average), the median and the mode will be the same. The problem with the mean (average) as a standard of excellence is that many patients will still be experiencing end-organ damage, even though your mean (average) may be below the ADA target of 7.0. The goal is to lower the standard deviation, the mode and the median which will be reflected in an improved mean (average).

With the treatment of diabetes, as with any other biological-system-based data-set, it will be impossible to have a zero standard deviation but the result of improving the care for each individual will be the decreasing and improvement of your standard deviation.

In planning for the creation of a new breakpoint in 2009, we believe that our improvement in the care of diabetes will come as:

- Our nurses initiate the utilization of the Diabetes Disease Management Tool - remember the first break point in the improvement of diabetes care in SETMA was the development and use of the disease management tool in NextGen. Our next breakpoint will be a combination of things including the revitalization of our use of the disease management tool for diabetes.
 - Our healthcare providers use the disease management tool and measure their performance with the Consortium for Physician Performance Improvement data set which is built into our diabetes disease management tool.
 - Also, the first thing every provider should review for ANY patient with diabetes is the date and value of their last HgbA1C. That is easily done as both of these data points are displayed on the front page of the Diabetes Disease Management tool along with all other critical indicators for quality improvement in the care of diabetes.
 - We continue auditing the above again and publishing that data to all providers so that everyone can compare their performance with their colleagues.
 - We query our system and involved all patient not to goal in diabetes education (Diabetes Self Management Education) and in specialty care.
- SETMA's goal for 2009 is going to be for all providers to improve their median HgbA1Cs by .30 at a minimum. This new breakpoint will result from the understanding that we have gained from our data analysis. The first three breakpoints happened almost by accident but they will each be a significant part of our next breakpoint.

Remember, the better your data, the better your planning can be and the better your results can be. In 2010, we will report how we did in 2009.

- Supporting Documents**
- PPC-3 Element B Description
 - PPC-3 Element B note and comment

PPC3: ELEMENT C - Practice Organization	Score: 100.00% of Possible Points
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The care team manages patient care in the following ways:

- | | Yes | No |
|---|-------------------------------------|--------------------------|
| 1. nonphysician staff remind patients of appointments and collect information prior to appointments | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. nonphysician staff execute standing orders for medication refills, order tests and deliver routine preventive services | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. nonphysician staff educate patients/families about managing conditions | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. nonphysician staff coordinate care with external disease management or case management organizations. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Scoring	100%	75%	50%	25%	0%
	Staff manage 4 items	Staff manage 3 items	Staff manage 2 items	No scoring option.	Staff manage 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA providers function as a true team. Care is coordinated between each member of the team. Our staff satisfaction, which is routinely examined in dialogue feed-back sessions with senior staff, reveals that while our staff is busy with every high expectations, they enjoy their work. We have over 60% five-year tenure with our staff which is unusual for a medical practice. We expect that to grow.

Our nurses function within their licenses and under direction of the physicians but they have independent functions as described in this section.

Supporting Documents

- PPC-3 Element C

PPC3: ELEMENT D - Care Management for Important Conditions	Score: 100.00% of Possible Points
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For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:

1. conducting pre-visit planning with clinician reminders
2. writing individualized care plans
3. writing individualized treatment goals
4. assessing patient progress toward goals
5. reviewing medication lists with patients
6. reviewing self-monitoring results and incorporating them into the medical record at each visit
7. assessing barriers when patients have not met treatment goals
8. assessing barriers when patients have not filled, refilled or taken prescribed medications
9. following up when patients have not kept important appointments
10. reviewing longitudinal representation of patient's historical or targeted clinical measurements

11. completing after-visit follow-up.

[In the box to the right, enter the percentage of patients]

77

Scoring

100%	75%	50%	25%	0%
75% or more of patients seen in the past 3 months have at least 4 items documented	50-74% of patients seen in the past 3 months have at least 4 items documented	25-49% of patients seen in the past 3 months have at least 4 items documented	11-24% of patients seen in the past 3 months have at least 4 items documented	10% or fewer patients seen in the past 3 months have at least 4 items documented

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation The PPC-3 Element D General Document link to our application is a tutorial for Coordination of Care Review tool. It is present for context and scale. It is the backbone of the documentation of our coordination of care. The following documents are also linked to these measures: A sample copy of the document generated by this function is given in the linked documents entitled PPC-3 Element D Coordination of Care Review Document.

A sample of the plan of care and treatment plan for diabetes, hypertension and dyslipidemia of a real patient (with the name removed). These documents give an idea of the extent of information we give to patients. SETMA has placed a printer in every examination room in order to facilitate the patient receiving education material, the LESS Initiative, medication lists, treatment plans, plans of care, disease management tools, coordination of care review and other documents essential to their care.

The Concept of the Baton

Athletic metaphors are commonly used in analyzing life situations. Often they are overstated and/or overused but there is one place where an athletic metaphor is apt in defining a critical point in healthcare: that is in the transitions of care from one venue of care to another. The metaphor is found in track and field relay races.

No matter how talented the members of a relay team are, the most critical point of their collective performance is in the transition from one runner to another. At this point, one runner, moving as fast as he/she can, must hand the baton to another runner, who has started running as fast as he/she can, before the first runner has even arrived in the "transfer zone." As if this were not complex enough, the rules of the race require that the transfer of the baton must take place within a certain zone.

If the baton is dropped or if the transfer is not made in the prescribed time, the team, no matter how gifted will be disqualified and will lose the race. As with life and with healthcare, it is not always the brightest, fastest, best person who wins. It is the person, in this case, the team, which not only performs well in their individual area of responsibility but who also performs well in transferring the results of his/her performance to the next participant and who does so within the constraints of the rules. 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" is not effectively transferred to the patient or caregiver, then the patient's care will suffer. In healthcare there are transition points-of-care, where the "baton", which now represents the transfer-of-care responsibility from one person to another, must be smoothly, efficiently and timely accomplished, or the value of the care provided by each care giver will be diminished to the point that the overall quality of care may be less than the sum of the contributions of each care giver. This diminishing of the value of care occurs when only a small part of the value of each participant's contribution is successfully transferred to the next point-of-care. This occurs when the "baton" is dropped.

These transfer points or interfaces of care are:

1. From the healthcare provider to the patient in the clinic setting.
2. From the emergency department to the inpatient setting.
3. From the inpatient setting to the patient or family at home.
4. From the inpatient setting to the rehabilitation unit or the nursing home.
5. From one provider to another provider.

Integrated - Coordinated - Continuous

It may be that within each patient encounter, the level of care is "fairly good." When a patient is seen by a family physician, internist, or nurse practitioner, the quality of the visit as measured by the content is good. The same is the case with procedures, labs, specialty referrals, and other points of care. The deficiencies seem to come at the transition points, or at the interface of care, i.e., when the patient is leaving the clinic, emergency department, inpatient hospital, or other point of care and moving into another sphere of care.

The most common transition of care for a patient is the moving into the sphere of personal care, family care, home care or however you wish to define, describe or denote that the patient is "going home." Often instructions, training or understanding is inadequate or absent in these transitions. Whether the interface is between the inpatient/home, clinic/home, laboratory/home, procedure/home, specialist/home or a number of others, the patient's vulnerability and the decreasing of the quality of their care most often happens at these points.

Southeast Texas Medical Associates (SETMA) has attempted to create methods for improving these transitions (interfaces) with the following tools. Each tool can be seen as a "baton" which must be successfully grasped by one provider and passed on to another in order for the content and value of one provider's work to be available to another. Remember, in the list of the providers of healthcare, the one who spends more time giving healthcare to a particular patient is the patient himself or herself. The "batons" or the "transition tools" designed and employed by SETMA and the transition points are:

The rest of this discussion can be found on our website at www.setma.com under Your Life Your Health, Medical Home.

- Supporting Documents**
- PPC-3 D 2,3,4,5
 - PPC-3 D General
 - PPC-3 Element 11
 - PPC-3 Element D 1
 - PPC-3 Element D 2

- PPC-3 Element D 2, 3 Plan of care for dyslipidemia
- PPC-3 Element D 2,3 pan of care hypertension
- PPC-3 Element D 2,3 Plan of care diabetes
- PPC-3 Element D 6,7,8,9,10
- PPC-3 Element D Coordination of caer document

PPC3: ELEMENT E - Continuity of Care

Score: 100.00% of Possible Points

The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care:

	Yes	No	
1. identifies patients who receive care in facilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2. systematically sends clinical information to the facilities with patients as soon as possible	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3. reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4. contacts patients after discharge from facilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5. provides or coordinates follow-up care to patients/families who have been discharged	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6. coordinates care with external disease management or case management organizations, as appropriate	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. communicates with patients/families receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. communicates with case managers for patients receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. for patients transitioning to other care, develops a written transition plan in collaboration with the patient and family	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10. aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	Activities include 5-10 items	Activities include 3-4 items	Activities include 2 items	No scoring option.	Activities include 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation As previously noted, created is not claimed for disease management as SETMA does not have a global disease management capacity for all of our patients but only for specifically identified groups. We hope to expand that until it is global, but at present it only applies to our HMO patients and our Medicare patients.

- Supporting Documents**
- PPC-3 Element E 1
 - PPC-3 Element E 2,3,5
 - PPC-3 Element E 5
 - PPC-3 Element E 5
 - PPC-3 Element E 9

PPC4: Patient Self-Management Support

The practice works to improve patients' ability to self-manage health by providing educational resources and ongoing assistance and encouragement.

Intent

The practice collaborates with patients and families to pursue their goals for optimal achievable health.

PPC4: ELEMENT A - Documenting Communication Needs **Score: 100.00% of Possible Points**

The practice assesses patient/family-specific barriers to communication using a systematic process to:

- | | Yes | No |
|---|-------------------------------------|-------------------------------------|
| 1. identify and display in the record the language preference of the patient and family | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. assess both hearing and vision barriers to communication. | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

	100%	75%	50%	25%	0%
Scoring	Practice assesses 2 items	No scoring option.	Practice assesses 1 item	No scoring option.	Practice does not assess any items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation The data presented shows a very low score for the barriers of hearing and vision being assessed. The reason for this is that we discovered that we do not have a field to document that we have assessed these barriers and found none. We are adding that function and in the future, this data will be dramatically improved. At present the low numbers only identifies the percentages of our patients with hearing and vision barriers to care.

Supporting Documents

- PPC-4 Element A 1,2

PPC4: ELEMENT B - Self-Management Support	Score: 100.00% of Possible Points This is a Must Pass Element.
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The practice conducts the following activities to support patient/family self-management, for the three important conditions:

1. assesses patient/family preferences, readiness to change and self-management abilities
2. provides educational resources in the language or medium that the patient/family understands
3. provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients/families to record results in the home setting where applicable
4. provides or connects patients/families to self-management support programs
5. provides or connects patients/families to classes taught by qualified instructors
6. provides or connects patients/families to other self-management resources where needed
7. provides written care plan to the patient/family.

[In the box to the right, enter the percentage of patients]

76

Scoring	100%	75%	50%	25%	0%
	75%-100% of patients seen in the past 3 months have at least 3 activities documented	50%-74% of patients seen in the past 3 months have at least 3 activities documented	25%-49% of patients seen in the past 3 months have at least 3 activities documented	11%-24% of patients seen in the past 3 months have at least 3 activities documented	10% or less patients seen in the past 3 months have at least 3 activities documented

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-4 Element B 2, 4, 5, 7

PPC5: Electronic Prescribing

The practice employs electronic systems to order prescriptions, to check for safety and to promote efficiency when prescribing.

Intent

The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions and by using drug safety checks and cost information when prescribing.

PPC5: ELEMENT A - Electronic Prescription Writing

Score: 100.00% of Possible Points

The practice uses an electronic system to write prescriptions using either:
 1. electronic prescription writer—stand-alone system (general) with either print capability at the office or ability to send fax or electronic message to pharmacy
 2. electronic prescription writer that is linked to patient-specific demographic and clinical information.

Select the choice that most closely reflects the practice's performance.

- 75-100% of new prescriptions for patients seen in the last 3 months written with item 2
- 75-100% of new prescriptions for patients seen in the last 3 months written with item 1
- Practice has system capable of doing either item 1 or item 2, but practice does not use
- System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Scoring

100%	75%	50%	25%	0%
75-100% of new prescriptions for patients seen in the last 3 months written	75-100% of new prescriptions for patients seen in the last 3 months written	No scoring option.	Practice has system capable of doing either item 1 or item 2, but practice does	System does not have capability or less than 75% of prescriptions written

with item 2	with item 1		not use	with item 1 or item 2
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA uses e-prescribing for all patients except:

1. Controlled substances which require a special prescription
2. Patients using mail order prescriptions (we hope to remedy this soon)
3. Pharmacies who do not accept electronic prescriptions

All prescriptions at SETMA are generated using an electronic prescription writer.

- Supporting Documents**
- PPC-5 Element A Audit
 - PPC-5 Element A discription

PPC5: ELEMENT B - Prescribing Decision Support—Safety	Score: 100.00% of Possible Points
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Clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, including the following types of alerts and information:

1. drug-drug interactions based on general information
2. drug-drug interactions specific to drugs the patient takes
3. drug-disease interactions based on general information
4. drug-disease interactions specific to diseases the patient has
5. drug-allergy alerts based on general information
6. drug-allergy alerts specific to the patient
7. drug-patient history alerts based on general information
8. appropriate dosing based on general information
9. appropriate dosing calculated for the patient
10. therapeutic monitoring associated with specific drug utilization based on general information (drug-lab alerts)
11. duplication of drugs in a therapeutic class based on general information
12. duplication of drugs in a therapeutic class specific to the patient
13. drugs to be avoided in the elderly based on general information
14. drugs to be avoided in the elderly based on age of the patient
15. patient-appropriate medication information.

Practice uses 8 or more kinds of alerts and information

Scoring

100%	75%	50%	25%	0%
Practice uses 8 or more kinds of alerts and information	Practice uses 4 to 7 kinds of alerts and information	Practice uses 2 to 3 kinds of alerts	System has capability of providing 6 or more kinds of alerts, but practice does not use them	No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation**Supporting Documents**

- PPC-5 Element A, B

PPC5: ELEMENT C - Prescribing Decision-Support—Efficiency	Score: 75.00% of Possible Points
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Clinicians engage in cost-efficient prescribing through one or more of the following tools:

1. electronic prescription writer with general automatic alerts for different choices including generics
2. electronic prescription writer connected to payer-specific formulary that automatically alerts clinician to alternative drugs, including generics.

Select the choice that most closely reflects the organization's performance.

- Practice uses 2 tools
- Practice uses 1 tool
- System has capability to support both options; practice does not use it
- System does not have capability or practice does not use either tool

Scoring

100%	75%	50%	25%	0%
Practice uses 2 tools	Practice uses 1 tool	No scoring option.	System has capability to support both options; practice does not use it	System does not have capability or practice does not use either tool

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-5 Element A, B
 - PPC-5 Element B Audit

PPC6: Test Tracking

The practice systematically tracks tests ordered and test results, and systematically follows up with patients.

Intent

The practice works to improve effectiveness of care, patient safety and efficiency by using timely information on all tests and results.

PPC6: ELEMENT A - Test Tracking and Follow Up

Score: 100.00% of Possible Points
This is a Must Pass Element.

The practice systematically tracks tests and follows up in the following manner:

1. tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
2. tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
3. flags abnormal test results, bringing them to a clinician's attention
4. follows up with patients/families for all abnormal test results
5. follows-up with inpatient facility on hearing screening and metabolic screening to get results
6. notifies patients/families of all normal test results.

Select the choice that most closely reflects the practice's performance.

Practice does 4-6 types of tracking and follow -up

Scoring

100%	75%	50%	25%	0%
Practice does 4-6 types of tracking and follow-up	No scoring option.	Practice does 3 types of tracking and follow-up	Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it	Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-6 Element A 1,2,3
 - PPC-6 Element A 4,5,6

PPC6: ELEMENT B - Electronic System for Managing Tests	Score: 100.00% of Possible Points
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The practice uses an electronic system to:

- | | Yes | No |
|--|-------------------------------------|-------------------------------------|
| 1. order lab tests | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. order imaging tests | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. retrieve lab results directly from source | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. retrieve imaging text reports directly from source | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. retrieve images directly from the source | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. flag duplicate tests ordered | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. generate alerts for appropriateness of tests ordered. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Scoring	100%	75%	50%	25%	0%
	Practice uses 5-8 functions	Practice uses 3-4 functions	Practice uses 1-2 functions	No scoring option.	Practice does not use system

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-6 Element B 1, 2, 3, 4, 5, 6

PPC7: Referral Tracking

The practice systematically documents and tracks referrals and referral results.

Intent

The practice seeks to improve effectiveness, timeliness and coordination of care by following through on consultations with other practitioners.

PPC7: ELEMENT A - Referral Tracking **Score: 100.00% of Possible Points**
This is a Must Pass Element.

Outside of paper medical records and patient visits, the practice uses a paper-based or electronic system to assist in tracking practitioner referrals designated as critical until the specialist or consultant report returns to the practice. The practice uses a system that includes the following information for its referrals:

- | | Yes | No |
|---------------------|-------------------------------------|--------------------------|
| 1. origination | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. clinical details | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. tracking status | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

4. administrative details.



Scoring	100%	75%	50%	25%	0%
	Practice uses system that includes all 4 items	Practice uses system that includes 2-3 items	Practice uses system that includes 1 item	No scoring option.	System does not include any of the items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents • PPC-7 Element A 1,2,23,4

PPC8: Performance Reporting and Improvement

The practice regularly measures its performance and takes actions to continuously improve.

Intent

The practice seeks to improve effectiveness, efficiency, timeliness and other aspects of quality by measuring and reporting performance, comparing itself to national benchmarks, giving physicians regular feedback and taking actions to improve.

PPC8: ELEMENT A - Measures of Performance	Score: 100.00% of Possible Points
	This is a Must Pass Element.

The practice measures or receives data on the following types of performance by physician or across the practice:

Yes No

1. clinical process (e.g., percentage of women 50+ with mammograms or

childhood vaccination rates)



2. clinical outcomes (e.g., HbA1c levels for diabetics)



3. service data (e.g., backlogs or wait times)



4. patient safety issues (e.g., medication errors).



Scoring

100%	75%	50%	25%	0%
Practice measures at least 2 types of performance	No scoring option.	Practice measures 1 type of performance	No scoring option.	No areas of performance measured

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element A 1 audit
- PPC-8 Element A 1 process and outcomes
- PPC-8 Element A 1,2,3,4
- PPC-8 Element A 2 outcomes

PPC8: ELEMENT B - Patient Experience Data Score: 100.00% of Possible Points

The practice collects data on patient experience with care in the following areas:

1. patient access to care

Yes No



2. quality of physician communication



3. patient/family confidence in self care



4. patient/family satisfaction with care.



Scoring

100%	75%	50%	25%	0%
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Practice collects data on 3-4 areas	No scoring option.	Practice collects data on 1-2 areas	No scoring option.	Practice do not collect data in any areas
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA collects patient satisfaction data and reports that data to providers and on our website to the public quarterly. The report presented here is for the entire year of 2009.

Supporting Documents

- PPC-8 Element B 1,2,3,4

PPC8: ELEMENT C - Reporting to Physicians **Score: 100.00% of Possible Points**
This is a Must Pass Element.

The practice reports on performance on the measures in 8A and 8B:

	Yes	No
1. across the practice	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. by individual physician.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

	100%	75%	50%	25%	0%
Scoring	Practice reports to physicians results both across the practice and by physician	No scoring option.	Practice reports to physicians results either across the practice or by physician	No scoring option.	No areas of performance reported to physicians

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element C 1,2 017 NQF Diabetes2
- PPC-8 Element C 1, 2
- PPC-8 Element C 1, 2, 021 NQF Female Measures2

- PPC-8 Element C 1,2 018 NQF Diabetes BP2 audit
- PPC-8 Element C 1,2 016 NQF Care for Older Adults2
- PPC-8 Element C 1,2 019 NQF Diabetes - Glyco LDL2
- PPC-8 Element C 1,2 022 NQF General Health Measures
- PPC-8 Element C 1,2 024 NQF Persistent Medications2

PPC8: ELEMENT D - Setting Goals and Taking Action	Score: 100.00% of Possible Points
--	--

The practice uses performance data to:

- | | Yes | No |
|--|-------------------------------------|-------------------------------------|
| 1. set goals based on measurement results referenced in Elements 8A and 8B | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. take action where identified to improve performance of individual physicians or of the practice as a whole. | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

Scoring	100%	75%	50%	25%	0%
	Practice does 2 items	No scoring option.	Practice does 1 item	No scoring option.	Practice does no items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-8 Element D 1 2

PPC8: ELEMENT E - Reporting Standardized Measures	Score: 100.00% of Possible Points
--	--

The practice produces reports on its performance using nationally approved clinical performance measures.

[In the box to the right, enter the number of measures]

30

Scoring

100%	75%	50%	25%	0%
Practice produces reports using 10 or more nationally approved performance measures	Practice produces reports using 5-9 nationally approved performance measures	Practice produces reports using 3-4 nationally approved performance measures	No scoring option.	Practice produces reports using 0-2 nationally approved performance measures

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents • PPC-8 Element E

PPC8: ELEMENT F - Electronic Reporting— External Entities	Score: 100.00% of Possible Points
--	--

The practice electronically reports results on nationally approved measures to the public sector, health plans, or others.

[In the box to the right, enter the number of measures]

30

Scoring

100%	75%	50%	25%	0%
Practice transmits 10 or more nationally approved performance measures to an external entity	Practice transmits at least 5-9 nationally approved performance measures to an external entity	Practice transmits 3-4 nationally approved performance measures to an external entity	Practice transmits 1-2 nationally approved measures to an external entity	Practice does not transmit any measures

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element F

PPC9: Advanced Electronic Communication

The practice uses electronic systems to communicate with patients/families and other care providers.

Intent

The practice maximizes use of electronic communication to improve timeliness, effectiveness, efficiency and coordination of care.

PPC9: ELEMENT A - Availability of Interactive Website

Score: 75.00% of Possible Points

The practice provides patients/families with access to an interactive Website that allows them to:

	Yes	No
1. request appointments by reviewing clinicians schedules	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. request referrals	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. request test results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. request prescription refills	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. see elements of their medical record	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. import elements of their medical record into a personal health record.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice provides 5-6	Practice provides 3-4	Practice provides 1-2	No scoring option.	Practice does not

items	items	items		provide any items
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA has chosen not to submit materials on this measure as our satisfaction of all of the elements of PPC-9 are in their infancy. We have an interactive website www.setma.com. We have a web portal www.NextGen.com both of which satisfy many of the elements of this Standard. We also are in the midst of launching NextGen's Community Health Services which will enable us to communicate seamlessly with other organizations delivery and receiving electronic patient data in a secure, HIPPS compliant environment.

Rather than await all of this being in place, we chose to make our application now and to continue with our launching of these new and exciting functions and capacities.

PPC 9: Advanced Electronic Communications

The practice maximizes use of electronic communication to improve timeliness, effectiveness, efficiency and coordination of care.

Element A: Availability of interactive web site

The practice provides patients/families with access to an interactive web site that allows them to:

1. Request appointments by reviewing clinicians schedules
2. Request referrals
3. Request test results
4. Request Prescription refills
5. See elements of their medical records
6. Import elements of their medical record into a personal health record

Element B: Electronic patient Identification

The practice combines use of electronic information and clinical decision-support to contact the following types of patients, once identified by e-mail

1. Patients needing clinical review or action
2. Patients on a particular medication
3. Patients needing preventive care
4. Patients needing specific tests
5. Patients needing follow-up visits
6. Patients who might benefit from disease or case management support.

Element C: Electronic Care Management Support

For patients with the three clinically important conditions the practice care management team uses electronic communication for the following:

1. To communicate with disease or case managers about patient needs
2. Web-based education modules for patient self management.

Supporting Documents No Supporting Documents were provided.

PPC9: ELEMENT B - Electronic Patient Identification	Score: 100.00% of Possible Points
--	--

The practice combines use of electronic information and clinical decision-support to contact the following types of patients, once identified, by e-mail:

	Yes	No
1. patients needing clinical review or action	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. patients on a particular medication	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. patients needing preventive care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. patients needing specific tests	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. patients needing follow up visits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. patients who might benefit from disease or case management support.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses electronic information and communication for 5-6 items	Practice uses electronic information and communication for 3-4 items	Practice uses electronic information and communication for 1-2 items	No scoring option.	Practice does not use electronic information for any items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-9 Element A, B, C

PPC9: ELEMENT C - Electronic Care Management Support

Score: 0.00% of Possible Points

For patients with the three clinically important conditions, the practice care management team uses electronic communication for the following:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. to communicate with disease or case managers about patient needs | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Web-based educational modules for patient self-management. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring	100%	75%	50%	25%	0%
	Practice uses electronic communication for 2 items	Practice uses electronic communication for 1 item	No scoring option	No scoring option	Practice does not use electronic communication for any items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-9 Element A, B, C

Organization: Southeast Texas Medical Associates, LLP
Stage: Readiness Evaluation
License: 12968
Evaluation Option: PPC-Patient-Centered Medical Home
Unit of Assessment:
Date: 4/7/2010

Physician Practice Connections-Patient Centered Medical Home

This category includes the following standards:

PPC1 - Access and Communication

Elements: A - B

PPC2 - Patient Tracking and Registry Functions

Elements: A - B - C - D - E - F

PPC3 - Care Management

Elements: A - B - C - D - E

PPC4 - Patient Self-Management Support

Elements: A - B

PPC5 - Electronic Prescribing

Elements: A - B - C

PPC6 - Test Tracking

Elements: A - B

PPC7 - Referral Tracking

Elements: A

PPC8 - Performance Reporting and Improvement

Elements: A - B - C - D - E - F

PPC9 - Advanced Electronic Communication

Elements: A - B - C

PPC1: Access and Communication

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Intent

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

PPC1: ELEMENT A - Access and Communication Processes	Score: 100.00% of Possible Points
	This is a Must Pass Element.

The practice establishes in writing standards for the following processes to support patient access:

- | | Yes | No |
|---|-------------------------------------|--------------------------|
| 1. scheduling each patient with a personal clinician for continuity of care | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. coordinating visits with multiple clinicians and/or diagnostic tests during one trip | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

3. determining through triage how soon a patient needs to be seen
4. maintaining the capacity to schedule patients the same day they call
5. scheduling same day appointments based on practice's triage of patients' conditions
6. scheduling same day appointments based on patient's/family's requests
7. providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time
8. providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week
9. providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time
10. providing an interactive practice Web site
11. making language services available for patients with limited English proficiency
12. identifying health insurance resources for patients/families without insurance.

Scoring

100%	75%	50%	25%	0%
Practice has written process for 9-12 items	Practice has written process for 7-8 items	Practice has written process for 4-6 items	Practice has written process for 2-3 items	Practice has written process for 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

SETMA is located in a predominantly English speaking area. Fewer than 1% of our patients have a language preference other than English; those are:

- Spanish -- we have Spanish speaking employees
- Pakistani -- we have Urdu speaking providers
- French -- We have French speaking employees
- German -- We have German speaking employees
- Vietnamese -- we have Vietnamese speaking help available.

SETMA's website (www.setma.com) displays all of our electronic patient management tools, our Public Reporting of SETMA's providers' performance on the following quality measures: HEDIS, NQF (multiple comprehensive measure sets, as well as individual measures) AQA, PCPI (hypertension, diabetes, care transition, CHF, chronic stable angina and others) and several quality measure sets developed by SETMA in the absence of endorsement by national agencies, i.e., comprehensive lipids, Chronic Renal Disease Stage I-III).

We routinely have patient see multiple providers in the same day and/or schedule

multiple procedures on the same days as a visit. With our multi-specialty capacity (endocrinology, cardiology, infectious disease, ophthalmology, neurology, Diabetes Center of Excellence and ADA DSME program, in house reference laboratory, physical therapy, pulmonary function laboratory, bone, density, ultrasonography, echocardiography and stress echo capacity, allergy clinic, along with specialty clinics in dyslipidemia and hypertension), this is ideal for our total care of our patients.

As is explained elsewhere, in addition to helping our patients obtain resources for needed care, through The SETMA Foundation, SETMA helps make funds available for the care of our patients when no other funding source can be found.

Supporting Documents No Supporting Documents were provided.

PPC1: ELEMENT B - Access and Communication Results	Score: 100.00% of Possible Points This is a Must Pass Element.
---	---

The practice's data shows that it meets access and communication standards in 1A:

	Yes	No
1. visits with assigned personal clinician for each patient	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. appointments scheduled to meet the standards in items 2-6 in 1A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. response times to meet standards for timely response to telephone requests	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. response times to meet its standards for timely response to e-mail and interactive Web requests	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. language services for patients with limited English proficiency.	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice's data meets 5 items	Practice's data meets 4 items	Practice's data meets 3 items	Practice's data meets 2 items	Practice's data meets 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

No Supporting Documents were provided.

PPC2: Patient Tracking and Registry Functions

The practice systematically manages patient information and uses the information for population management to support patient care.

Intent

The practice has readily accessible, clinically useful information on patients that enables it to treat patients comprehensively and systematically.

PPC2: ELEMENT A - Basic System for Managing Patient Data

Score: 100.00% of Possible Points

The practice uses an electronic data system for patients that includes the following searchable patient information:

	Yes	No	
1. name	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2. date of birth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3. gender	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4. marital status	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. language preference	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6. voluntarily self-identified race/ethnicity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
7. address	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
8. telephone (primary contact number)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

- 9. e-mail address (or "none" for patients) ☐ ☐
- 10. internal ID ☐ ☐
- 11. external ID ☐ ☐
- 12. emergency contact information ☐ ☐
- 13. current and past diagnoses ☐ ☐
- 14. dates of previous clinical visits ☐ ☐
- 15. billing codes for services ☐ ☐
- 16. legal guardian ☐ ☐ ☐
- 17. health insurance coverage ☐ ☐
- 18. patient/family preferred method of communication. ☐ ☐

Scoring	100%	75%	50%	25%	0%
	12-18 items were entered for 75-100% of patients	8-11 items were entered for 75-100% of patients	6-7 items were entered for 75-100% of patients	4-5 items were entered for 75-100% of patients	0-3 items were entered for 75-100% of patients

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-2 A Description

PPC2: ELEMENT B - Electronic System for Clinical Data	Score: 100.00% of Possible Points
--	--

The practice's clinical data system or systems to manage care of patients include the following clinical patient information in searchable data fields:

- | | Yes | No | |
|--|--------------------------|--------------------------|--------------------------|
| 1. status of age-appropriate preventive services (immunizations, screenings, counseling) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. allergies and adverse reactions | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. height | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. weight | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. body mass index (BMI) calculated | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. laboratory test results | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. presence of imaging results | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. presence of pathology reports | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. presence of advance directives. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. head circumference for patients 2 years or younger | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

100%	75%	50%	25%	0%
System has 9-11 data fields	System has 7-8 data fields	System has 5-6 data fields	System has 3-4 data fields	System has 0-2 data fields

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Our EMR has a function for scanned documents which is where reports of procedures and tests which are done outside of our system are collected. When they are placed there a link is placed the provider's workflow where the document is able to be reviewed and where the provider can sign that it has been reviewed and any necessary action has been taken. The same is the case for pathology reports, mammograms, etc. In-house reports on echocardiograms, ultrasound, bone density, pulmonary function tests, etc are also placed into the providers' work flow for review.

Our Medical Coordination Review template has a place for documentation that code status issues, advanced directives, etc., have been discussed with the patient and family and that the document has been scanned into our system when it is made available. At every visit, a sample advanced directive is given to the appropriate patients with instructions on how to complete it.

Supporting Documents

- PPC-2 A
- PPC-2 Element B

PPC2: ELEMENT C - Use of Electronic Clinical Data	Score: 100.00% of Possible Points
--	--

The practice uses the fields listed in 2B consistently in patient records.

[In the box to the right, enter the percentage of patients]

97

Scoring

100%	75%	50%	25%	0%
75-100% of patients seen in the past 3 months have at least 7 fields completed	50-74% of patients seen in the past 3 months have at least 7 fields completed	25-49% of patients seen in the past 3 months have at least 7 fields completed	10-24% of patients seen in the past 3 months have at least 7 fields completed	Less than 10% of patients seen in the past 3 months have at least 7 fields completed

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-2 Element C

PPC2: ELEMENT D - Organizing Clinical Data	Score: 100.00% of Possible Points This is a Must Pass Element.
---	---

The practice uses the following electronic or paper-based charting tools to organize and document clinical information in the medical record:

1. problem lists
2. lists of over-the-counter medications, supplements and alternative therapies
3. lists of prescribed medications including both chronic and short-term
4. structured template for age-appropriate risk factors (at least 3)
5. structured templates for narrative progress notes

- 6. age appropriate standardized screening tool for developmental testing
- 7. growth charts plotting height, weight, head circumference and BMI, if less than 18 years.

[In the box to the right, enter the percentage of patients]

93

Scoring

100%	75%	50%	25%	0%
75-100% of records of patients seen in the past 3 months include at least 3 tools with information documented	50-74% of records of patients seen in the past 3 months include at least 3 tools with information documented	25-49% of records of patients seen in the past 3 months include at least 3 tools with information documented	10-24% records of patients seen in the past 3 months include at least 3 tools with information documented	Less than 10% of patient records include at least 3 tools

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-2 Element D

PPC2: ELEMENT E - Identifying Important Conditions	Score: 100.00% of Possible Points
	This is a Must Pass Element.

The practice uses an electronic or paper-based system to identify the following diagnoses and conditions:

	Yes	No
1. practice's most frequently seen diagnoses	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. most important risk factors in the practice's patient population	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. three conditions that are clinically important in the practice's patient population.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice identifies 3 items	Practice identifies 2 items	Practice identifies 1 item	No scoring option.	Practice identifies 0 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-2 Element E 1,2,3 Medical home -- PPC 2 Element E pdf

PPC2: ELEMENT F - Use of System for Population Management	Score: 100.00% of Possible Points
--	--

The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, as follows:

	Yes	No
1. patients needing pre-visit planning (obtaining tests prior to visit, etc.)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. patients needing clinician review or action	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. patients on a particular medication	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. patients needing reminders for preventive care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. patients needing reminders for specific tests	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. patients needing reminders for follow-up visits such as for a chronic condition	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. patients who might benefit from care management support.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice uses information to take action on 5-7 items	Practice uses information to take action on 3-4 items	Practice uses information to take action on 1-2 items	No scoring option.	Practice does not use information to take action

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation In regard to PPC-2 Element F Data Point 7:

SETMA has relationships for certain of our high risk patients with case management nurses from our IPA, our home health and several of our insurance carriers. We do not claim credit for this because at present, we do not have a systematic means of applying these benefits to all of our patient population. Throughout this survey tool, we have decline to take credit for this. In the future, we plan to have this systematized and in structured fields so that we can track this data and thus claim credit.

Supporting Documents

- PPC-2 Element F

PPC3: Care Management

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patients' care.

Intent

The practice maintains continuous relationships with patients by implementing evidence-based guidelines and applying them to the identified needs of individual patients over time and with the intensity needed by the patients.

PPC3: ELEMENT A - Guidelines for Important Conditions

Score: 100.00% of Possible Points
This is a Must Pass Element.

The practice adopts and implements evidence-based diagnosis and treatment guidelines for:

- | | Yes | No |
|--|-------------------------------------|--------------------------|
| 1. first clinically important condition | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. second clinically important condition | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

3. third clinically important condition.



Scoring

100%	75%	50%	25%	0%
Practice implements guidelines for 3 conditions	No scoring option.	Practice implements guidelines for 2 conditions	Practice implements guidelines for 1 condition	Practice does not implement guidelines for any conditions

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

SETMA incorporates national standards of care both as to process and outcomes into disease management tools for diabetes, hypertension and dyslipidemia. SETMA has adopted the standards of NQF, PCPI, HEDIS and AQA for the establishment of quality metrics. SETMA reports on provider performance on these measures and that performance is reporting on our website at www.setma.com under "Public Reporting."

Annually, SETMA reviews the ADA's Diabetes Treatment Update (a 100-page documented published in the winter of each year) and updates any changes into our Diabetes Treatment Plan. SETMA regularly monitors the American Heart Association and the American Cardiology Association's updates on the treatment of hypertension and update our disease management tools accordingly. The same process with ATP-III and the AHA is done with lipids.

The files attached to our document list are the disease management tools which we use daily for these diseases. While they are extensive and thorough, they are efficiently used as we train our providers and nurses in their use. We have three-hour monthly training sessions for all of our healthcare providers in the use of all PCMH and disease manage functions of our EMR.

In addition, we audit our providers use of these tools, as will be seen later.

Supporting Documents

- PPC-3 Element A 1
- PPC-3 Element A 2
- PPC-3 Element A 23

PPC3: ELEMENT B - Preventive Service Clinician Reminders	Score: 100.00% of Possible Points
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The practice uses a paper-based or electronic system with guideline-based reminders for the following services when seeing the patient:

- | | Yes | No | NA |
|---|-----------------------|-----------------------|-----------------------|
| 1. age-appropriate screening tests | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. age-appropriate immunizations (e.g., influenza, pediatric) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. age-appropriate risk assessments (e.g., smoking, diet, depression) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. counseling (e.g., smoking cessation). | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Scoring

100%	75%	50%	25%	0%
Practice uses reminders for 4 items	Practice uses reminders for 3 items	Practice uses reminders for 2 items	Practice uses reminders for 1 item	Practice uses reminders for no items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

The material in this note is also linked as a document so that the data is structured correctly:

In 1999, as SETMA moved from the pursuit of electronic medical records to the pursuit of electronic patient records (for more on this see Your Life Your Health at www.setma.com the section on "Medical Records"), we began leveraging the power of electronics to improve patient care. Over a ten-year period, we saw our performance on diabetes care improve every year.

As SETMA has analyzed our treatment of patients with diabetes, we have generated the following data from our electronic medical record. This data represents treatment of diabetes over a period of eight years and shows a consistent improvement in the treatment of diabetes.

Year Average HgbA1C (%) Change (%) No. Tests Done

2000 7.778 555
 2001 7.4789 -0.299 1193
 2002 7.4549 -0.024 3036
 2003 7.2671 -0.188 4971
 2004 7.2102 -0.057 7080
 2005 6.9847 -0.226 7521
 2006 6.8763 -0.108 8610
 2007 6.6265 -0.250 9117
 2008 6.5378 -0.089 6275

Total Decline (2000 to 2008) -1.240

From 2000 to 2008 our average Hgb A1C values have dropped from 7.778% to 6.5378% which is a collective drop of 1.240%. As you look at this data, it becomes clear that:

Between 2000 and 2001, there was a significant improvement in the Hgb A1Cs.

Another improvement is seen between 2004 and 2005.

And, another improvement is seen between 2006 and 2007.

As we examined these results, we realized that in 2000, we developed our disease management tool. In 2003-2004, we introduced our ADA approved DSME program and in 2006, we were successful in recruiting an endocrinologist.

Going forward, our strategy is to increase the use of the disease management tool, increase the use of diabetes education and to increase the use of endocrinology for difficult and recalcitrant disease.

As we developed more disease management tools, we realized that there were three life-style changes we wanted everyone of our patients to practice. We wanted them to lose weight, exercise and stop smoking, so we developed the LESS Initiative. In this program (for more see Your Life Your Health on our website), for eight years, we have assessed every patients' weight with a BMI, BMR, body fat and an explanation of who much weight they need to lose in order too improve their health. We give every patient a written personalized exercise program and we address active smoking, secondary smoking and now tertiary smoking with every patient we see.

These and other screening and prevention programs for diabetes and hypertension, enable us to provide primary and secondary disease prevention for our patients.

The following is a further example of our analysis of our diabetes treatment plan:

Mean, Standard Deviation, Median, Mode

As we looked at the data and tried to draw conclusions about it, we realized that we needed more statistical analysis than just the average (the mean). We need to know the median, the mode and the standard deviation and we needed to know them by provider.

- For a data set, such as the HgbA1C values, the mean (average) is the sum of the observations divided by the number of observations. The mean is often quoted along with the standard deviation. In that case, the mean describes the central location of the data (often called the average) and the standard deviation describes the spread. The mean may be 6.5% in the case of Hgb A1C which is excellent, but if the standard deviation is 1.6, the range would be from 4.0 to 8.1. The 8.1% is not good.
- A median is described as the number separating the higher half of a sample from the lower half. At most half the population has values less than the median and at most half have values greater than the median.
- The mode is the value that occurs the most frequently in a data set.

The analysis by provider in SETMA's treatment of diabetes showed the following. (The provider names have been removed.) As is often the case the worst numbers were found in the case of the best physicians because they see the sickest patients. As you analyze data, you begin to be able to devise a plan for future efforts at improvement of care.

Provider Instances Average Std Dev Median Mode

2666	7.361	1.926	6.8	6.0
2143	6.875	1.492	6.5	6.2

3574 7.288 1.812 6.8 6.2
 2110 7.356 1.729 6.9 6.9
 20 6.785 2.003 6.0 5.6
 54 6.915 2.197 6.1 6.0
 2319 7.021 1.585 6.6 6.6
 1281 6.117 0.897 5.9 5.6
 3023 6.845 1.617 6.4 6.0
 1285 6.847 1.600 6.4 6.2
 2142 6.886 1.633 6.4 6.2
 620 6.326 1.247 6.0 5.7
 1387 6.364 1.027 6.1 5.7
 1633 6.597 1.559 6.1 5.8
 45 7.116 2.251 6.3 6.5
 70 6.837 2.030 6.2 5.5
 1568 6.764 1.410 6.5 6.2
 1497 6.786 1.698 6.4 6.2
 2760 6.906 1.432 6.6 6.1
 197 6.203 1.146 5.9 6.0

In addition to excellence of care, there are also many population factors, not under the provider's control, which affect the results of HgbA1Cs:

- The age of the patients - younger patients tend to have better control
- The activity of the patients - older patients tend to be more sedentary
- The nutrition of the patients - nursing home patients and elderly often are under-nourished and will thusly skew the HgbA1Cs downward.
- Socio-economic status - patients with lower incomes have more difficulty eating right.
- Educational status of patients - often people with higher education are more motivated and better able to understand the complexities of DSME.
- How long the patient has been a diabetic can influence the HgbA1C.
- How long the patient has been cared for by our clinic. It would appear - and we shall examine this - that the longer a patient sees us, the better their HgbA1Cs will be.
- There are other factors in the care of a patient with diabetes which have equal and possibly superior important to the HgbA1C, i.e, blood pressure, etc. We will be looking at those factors.

Analysis and the future - plans for a 2008 breakpoint

As you analyze the data above, remember that the higher the median (the higher the value which represents the midpoint of your data set, i.e., 50% of our values are above the median and 50% are below), the higher your mean (average) will be and in general the higher your standard deviation will be.

For analysis purposes remember that if your standard deviation is ZERO, the mean (average), the median and the mode will be the same. The problem with the mean (average) as a standard of excellence is that many patients will still be experiencing end-organ damage, even though your mean (average) may be below the ADA target of 7.0. The goal is to lower the standard deviation, the mode and the median which will be reflected in an improved mean (average).

With the treatment of diabetes, as with any other biological-system-based data-set, it will be impossible to have a zero standard deviation but the result of improving the care for each individual will be the decreasing and improvement of your standard

deviation.

In planning for the creation of a new breakpoint in 2009, we believe that our improvement in the care of diabetes will come as:

- Our nurses initiate the utilization of the Diabetes Disease Management Tool - remember the first break point in the improvement of diabetes care in SETMA was the development and use of the disease management tool in NextGen. Our next breakpoint will be a combination of things including the revitalization of our use of the disease management tool for diabetes.
 - Our healthcare providers use the disease management tool and measure their performance with the Consortium for Physician Performance Improvement data set which is built into our diabetes disease management tool.
 - Also, the first thing every provider should review for ANY patient with diabetes is the date and value of their last HgbA1C. That is easily done as both of these data points are displayed on the front page of the Diabetes Disease Management tool along with all other critical indicators for quality improvement in the care of diabetes.
 - We continue auditing the above again and publishing that data to all providers so that everyone can compare their performance with their colleagues.
 - We query our system and involved all patient not to goal in diabetes education (Diabetes Self Management Education) and in specialty care.
- SETMA's goal for 2009 is going to be for all providers to improve their median HgbA1Cs by .30 at a minimum. This new breakpoint will result from the understanding that we have gained from our data analysis. The first three breakpoints happened almost by accident but they will each be a significant part of our next breakpoint.

Remember, the better your data, the better your planning can be and the better your results can be. In 2010, we will report how we did in 2009.

Supporting Documents

- PPC-3 Element B Description
- PPC-3 Element B note and comment

PPC3: ELEMENT C - Practice Organization	Score: 100.00% of Possible Points
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The care team manages patient care in the following ways:

	Yes	No
1. nonphysician staff remind patients of appointments and collect information prior to appointments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. nonphysician staff execute standing orders for medication refills, order tests and deliver routine preventive services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. nonphysician staff educate patients/families about managing conditions	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4. nonphysician staff coordinate care with external disease management or case management organizations.



Scoring

100%	75%	50%	25%	0%
Staff manage 4 items	Staff manage 3 items	Staff manage 2 items	No scoring option.	Staff manage 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

SETMA providers function as a true team. Care is coordinated between each member of the team. Our staff satisfaction, which is routinely examined in dialogue feed-back sessions with senior staff, reveals that while our staff is busy with every high expectations, they enjoy their work. We have over 60% five-year tenure with our staff which is unusual for a medical practice. We expect that to grow.

Our nurses function within their licenses and under direction of the physicians but they have independent functions as described in this section.

Supporting Documents

- PPC-3 Element C

PPC3: ELEMENT D - Care Management for Important Conditions	Score: 100.00% of Possible Points
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For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:

1. conducting pre-visit planning with clinician reminders
2. writing individualized care plans
3. writing individualized treatment goals
4. assessing patient progress toward goals
5. reviewing medication lists with patients
6. reviewing self-monitoring results and incorporating them into the medical record at each visit
7. assessing barriers when patients have not met treatment goals
8. assessing barriers when patients have not filled, refilled or taken prescribed medications
9. following up when patients have not kept important appointments
10. reviewing longitudinal representation of patient's historical or targeted clinical measurements
11. completing after-visit follow-up.

[In the box to the right, enter the percentage of patients]

77

Scoring

100%	75%	50%	25%	0%
75% or more of patients seen in the past 3 months have at least 4 items documented	50-74% of patients seen in the past 3 months have at least 4 items documented	25-49% of patients seen in the past 3 months have at least 4 items documented	11-24% of patients seen in the past 3 months have at least 4 items documented	10% or fewer patients seen in the past 3 months have at least 4 items documented

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

The PPC-3 Element D General Document link to our application is a tutorial for Coordination of Care Review tool. It is present for context and scale. It is the backbone of the documentation of our coordination of care. The following documents are also linked to these measures: A sample copy of the document generated by this function is given in the linked documents entitled PPC-3 Element D Coordination of Care Review Document.

A sample of the plan of care and treatment plan for diabetes, hypertension and dyslipidemia of a real patient (with the name removed). These documents give an idea of the extent of information we give to patients. SETMA has placed a printer in every examination room in order to facilitate the patient receiving education material, the LESS Initiative, medication lists, treatment plans, plans of care, disease management tools, coordination of care review and other documents essential to their care.

The Concept of the Baton

Athletic metaphors are commonly used in analyzing life situations. Often they are overstated and/or overused but there is one place where an athletic metaphor is apt in defining a critical point in healthcare: that is in the transitions of care from one venue of care to another. The metaphor is found in track and field relay races.

No matter how talented the members of a relay team are, the most critical point of their collective performance is in the transition from one runner to another. At this point, one runner, moving as fast as he/she can, must hand the baton to another runner, who has started running as fast as he/she can, before the first runner has even arrived in the "transfer zone." As if this were not complex enough, the rules of the race require that the transfer of the baton must take place within a certain zone.

If the baton is dropped or if the transfer is not made in the prescribed time, the team, no matter how gifted will be disqualified and will lose the race. As with life and with healthcare, it is not always the brightest, fastest, best person who wins. It is the person, in this case, the team, which not only performs well in their individual area of responsibility but who also performs well in transferring the results of his/her performance to the next participant and who does so within the constraints of the rules. 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" is not effectively transferred to the patient or caregiver, then the patient's care will suffer.

In healthcare there are transition points-of-care, where the "baton", which now represents the transfer-of-care responsibility from one person to another, must be smoothly, efficiently and timely accomplished, or the value of the care provided by each care giver will be diminished to the point that the overall quality of care may be less than the sum of the contributions of each care giver. This diminishing of the

value of care occurs when only a small part of the value of each participant's contribution is successfully transferred to the next point-of-care. This occurs when the "baton" is dropped.

These transfer points or interfaces of care are:

1. From the healthcare provider to the patient in the clinic setting.
2. From the emergency department to the inpatient setting.
3. From the inpatient setting to the patient or family at home.
4. From the inpatient setting to the rehabilitation unit or the nursing home.
5. From one provider to another provider.

Integrated - Coordinated - Continuous

It may be that within each patient encounter, the level of care is "fairly good." When a patient is seen by a family physician, internist, or nurse practitioner, the quality of the visit as measured by the content is good. The same is the case with procedures, labs, specialty referrals, and other points of care. The deficiencies seem to come at the transition points, or at the interface of care, i.e., when the patient is leaving the clinic, emergency department, inpatient hospital, or other point of care and moving into another sphere of care.

The most common transition of care for a patient is the moving into the sphere of personal care, family care, home care or however you wish to define, describe or denote that the patient is "going home." Often instructions, training or understanding is inadequate or absent in these transitions. Whether the interface is between the inpatient/home, clinic/home, laboratory/home, procedure/home, specialist/home or a number of others, the patient's vulnerability and the decreasing of the quality of their care most often happens at these points.

Southeast Texas Medical Associates (SETMA) has attempted to create methods for improving these transitions (interfaces) with the following tools. Each tool can be seen as a "baton" which must be successfully grasped by one provider and passed on to another in order for the content and value of one provider's work to be available to another. Remember, in the list of the providers of healthcare, the one who spends more time giving healthcare to a particular patient is the patient himself or herself. The "batons" or the "transition tools" designed and employed by SETMA and the transition points are:

The rest of this discussion can be found on our website at www.setma.com under Your Life Your Health, Medical Home.

Supporting Documents

- PPC-3 D 2,3,4,5
- PPC-3 D General
- PPC-3 Element 11
- PPC-3 Element D 1
- PPC-3 Element D 2
- PPC-3 Element D 2, 3 Plan of care for dyslipidemia
- PPC-3 Element D 2,3 pan of care hypertension
- PPC-3 Element D 2,3 Plan of care diabetes
- PPC-3 Element D 6,7,8,9,10

- PPC-3 Element D Coordination of caer document

PPC3: ELEMENT E - Continuity of Care	Score: 100.00% of Possible Points
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The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care:

	Yes	No	
1. identifies patients who receive care in facilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2. systematically sends clinical information to the facilities with patients as soon as possible	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3. reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4. contacts patients after discharge from facilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5. provides or coordinates follow-up care to patients/families who have been discharged	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6. coordinates care with external disease management or case management organizations, as appropriate	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. communicates with patients/families receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. communicates with case managers for patients receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. for patients transitioning to other care, develops a written transition plan in collaboration with the patient and family	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10. aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Scoring

100%	75%	50%	25%	0%
Activities include 5-10 items	Activities include 3-4 items	Activities include 2 items	No scoring option.	Activities include 0-1 items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation As previously noted, created is not claimed for disease management as SETMA does not have a global disease management capacity for all of our patients but only for specifically identified groups. We hope to expand that until it is global, but at present it only applies to our HMO patients and our Medicare patients.

Supporting Documents

- PPC-3 Element E 1
- PPC-3 Element E 2,3,5
- PPC-3 Element E 4
- PPC-3 Element E 5
- PPC-3 Element E 9

PPC4: Patient Self-Management Support

The practice works to improve patients' ability to self-manage health by providing educational resources and ongoing assistance and encouragement.

Intent

The practice collaborates with patients and families to pursue their goals for optimal achievable health.

PPC4: ELEMENT A - Documenting Communication Needs **Score: 100.00% of Possible Points**

The practice assesses patient/family-specific barriers to communication using a systematic process to:

- | | Yes | No |
|---|-------------------------------------|--------------------------|
| 1. identify and display in the record the language preference of the patient and family | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. assess both hearing and vision barriers to communication. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Scoring

100%	75%	50%	25%	0%
Practice assesses 2 items	No scoring option.	Practice assesses 1 item	No scoring option.	Practice does not assess any items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation The data presented shows a very low score for the barriers of hearing and vision

being assessed. The reason for this is that we discovered that we do not have a field to document that we have assessed these barriers and found none. We are adding that function and in the future, this data will be dramatically improved. At present the low numbers only identifies the percentages of our patients with hearing and vision barriers to care.

Supporting Documents

- PPC-4 Element A 1,2

PPC4: ELEMENT B - Self-Management Support	Score: 100.00% of Possible Points This is a Must Pass Element.
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The practice conducts the following activities to support patient/family self-management, for the three important conditions:

1. assesses patient/family preferences, readiness to change and self-management abilities
2. provides educational resources in the language or medium that the patient/family understands
3. provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients/families to record results in the home setting where applicable
4. provides or connects patients/families to self-management support programs
5. provides or connects patients/families to classes taught by qualified instructors
6. provides or connects patients/families to other self-management resources where needed
7. provides written care plan to the patient/family.

[In the box to the right, enter the percentage of patients]

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Scoring

100%	75%	50%	25%	0%
75%-100% of patients seen in the past 3 months have at least 3 activities documented	50%-74% of patients seen in the past 3 months have at least 3 activities documented	25%-49% of patients seen in the past 3 months have at least 3 activities documented	11%-24% of patients seen in the past 3 months have at least 3 activities documented	10% or less patients seen in the past 3 months have at least 3 activities documented

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- PPC-4 Element B 2, 4, 5, 7

PPC5: Electronic Prescribing

The practice employs electronic systems to order prescriptions, to check for safety and to promote efficiency when prescribing.

Intent

The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions and by using drug safety checks and cost information when prescribing.

PPC5: ELEMENT A - Electronic Prescription Writing

Score: 100.00% of Possible Points

The practice uses an electronic system to write prescriptions using either:

1. electronic prescription writer—stand-alone system (general) with either print capability at the office or ability to send fax or electronic message to pharmacy
2. electronic prescription writer that is linked to patient-specific demographic and clinical information.

Select the choice that most closely reflects the practice's performance.

- 75-100% of new prescriptions for patients seen in the last 3 months written with item 2
- 75-100% of new prescriptions for patients seen in the last 3 months written with item 1
- Practice has system capable of doing either item 1 or item 2, but practice does not use
- System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Scoring

100%	75%	50%	25%	0%
75-100% of new prescriptions for patients seen in the last 3 months written with item 2	75-100% of new prescriptions for patients seen in the last 3 months written with item 1	No scoring option.	Practice has system capable of doing either item 1 or item 2, but practice does not use	System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA uses e-prescribing for all patients except:

1. Controlled substances which require a special prescription
2. Patients using mail order prescriptions (we hope to remedy this soon)
3. Pharmacies who do not accept electronic prescriptions

All prescriptions at SETMA are generated using an electronic prescription writer.

- Supporting Documents**
- PPC-5 Element A Audit
 - PPC-5 Element A discription

PPC5: ELEMENT B - Prescribing Decision Support—Safety	Score: 100.00% of Possible Points
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Clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, including the following types of alerts and information:

1. drug-drug interactions based on general information
2. drug-drug interactions specific to drugs the patient takes
3. drug-disease interactions based on general information
4. drug-disease interactions specific to diseases the patient has
5. drug-allergy alerts based on general information
6. drug-allergy alerts specific to the patient
7. drug-patient history alerts based on general information
8. appropriate dosing based on general information
9. appropriate dosing calculated for the patient
10. therapeutic monitoring associated with specific drug utilization based on general information (drug-lab alerts)
11. duplication of drugs in a therapeutic class based on general information
12. duplication of drugs in a therapeutic class specific to the patient
13. drugs to be avoided in the elderly based on general information
14. drugs to be avoided in the elderly based on age of the patient
15. patient-appropriate medication information.

Practice uses 8 or more kinds of alerts and information

Scoring

100%	75%	50%	25%	0%
Practice uses 8 or more kinds of alerts	Practice uses 4 to 7 kinds of alerts and	Practice uses 2 to 3 kinds of alerts	System has capability of	No system capability, system

and information	information		providing 6 or more kinds of alerts, but practice does not use them	has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-5 Element A, B

PPC5: ELEMENT C - Prescribing Decision-Support—Efficiency	Score: 75.00% of Possible Points
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Clinicians engage in cost-efficient prescribing through one or more of the following tools:

1. electronic prescription writer with general automatic alerts for different choices including generics
2. electronic prescription writer connected to payer-specific formulary that automatically alerts clinician to alternative drugs, including generics.

Select the choice that most closely reflects the organization's performance.

- Practice uses 2 tools
- Practice uses 1 tool
- System has capability to support both options; practice does not use it
- System does not have capability or practice does not use either tool

Scoring

100%	75%	50%	25%	0%
Practice uses 2 tools	Practice uses 1 tool	No scoring option.	System has capability to support both options; practice does not use it	System does not have capability or practice does not use either tool

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-5 Element A, B
- PPC-5 Element B Audit

PPC6: Test Tracking

The practice systematically tracks tests ordered and test results, and systematically follows up with patients.

Intent

The practice works to improve effectiveness of care, patient safety and efficiency by using timely information on all tests and results.
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PPC6: ELEMENT A - Test Tracking and Follow Up
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Score: 100.00% of Possible Points
--

This is a Must Pass Element.

The practice systematically tracks tests and follows up in the following manner:

1. tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
2. tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
3. flags abnormal test results, bringing them to a clinician's attention
4. follows up with patients/families for all abnormal test results
5. follows-up with inpatient facility on hearing screening and metabolic screening to get results
6. notifies patients/families of all normal test results.

Select the choice that most closely reflects the practice's performance.

Practice does 4-6 types of tracking and follow -up
--

Scoring

100%	75%	50%	25%	0%
Practice does 4-6 types of tracking and follow-up	No scoring option.	Practice does 3 types of tracking and follow-up	Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it	Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-6 Element A 1,2,3
 - PPC-6 Element A 4,5,6

PPC6: ELEMENT B - Electronic System for Managing Tests	Score: 100.00% of Possible Points
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The practice uses an electronic system to:

- | | Yes | No |
|--|-------------------------------------|-------------------------------------|
| 1. order lab tests | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. order imaging tests | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. retrieve lab results directly from source | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. retrieve imaging text reports directly from source | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. retrieve images directly from the source | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. flag duplicate tests ordered | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. generate alerts for appropriateness of tests ordered. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Scoring

100%	75%	50%	25%	0%
Practice uses 5-8 functions	Practice uses 3-4 functions	Practice uses 1-2 functions	No scoring option.	Practice does not use system

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-6 Element B 1, 2, 3, 4, 5, 6

PPC7: Referral Tracking

The practice systematically documents and tracks referrals and referral results.

Intent

The practice seeks to improve effectiveness, timeliness and coordination of care by following through on consultations with other practitioners.

PPC7: ELEMENT A - Referral Tracking

Score: 100.00% of Possible Points
This is a Must Pass Element.

Outside of paper medical records and patient visits, the practice uses a paper-based or electronic system to assist in tracking practitioner referrals designated as critical until the specialist or consultant report returns to the practice. The practice uses a system that includes the following information for its referrals:

	Yes	No
1. origination	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. clinical details	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. tracking status	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4. administrative details.



Scoring

100%	75%	50%	25%	0%
Practice uses system that includes all 4 items	Practice uses system that includes 2-3 items	Practice uses system that includes 1 item	No scoring option.	System does not include any of the items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-7 Element A 1,2,23,4

PPC8: Performance Reporting and Improvement

The practice regularly measures its performance and takes actions to continuously improve.

Intent

The practice seeks to improve effectiveness, efficiency, timeliness and other aspects of quality by measuring and reporting performance, comparing itself to national benchmarks, giving physicians regular feedback and taking actions to improve.

PPC8: ELEMENT A - Measures of Performance

Score: 100.00% of Possible Points
This is a Must Pass Element.

The practice measures or receives data on the following types of performance by physician or across the practice:

Yes No

1. clinical process (e.g., percentage of women 50+ with mammograms or

childhood vaccination rates)



2. clinical outcomes (e.g., HbA1c levels for diabetics)



3. service data (e.g., backlogs or wait times)



4. patient safety issues (e.g., medication errors).



Scoring

100%	75%	50%	25%	0%
Practice measures at least 2 types of performance	No scoring option.	Practice measures 1 type of performance	No scoring option.	No areas of performance measured

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element A 1 audit
- PPC-8 Element A 1 process and outcomes
- PPC-8 Element A 1,2,3,4
- PPC-8 Element A 2 outcomes

PPC8: ELEMENT B - Patient Experience Data Score: 100.00% of Possible Points

The practice collects data on patient experience with care in the following areas:

1. patient access to care



2. quality of physician communication



3. patient/family confidence in self care



4. patient/family satisfaction with care.



Scoring

100%	75%	50%	25%	0%
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Practice collects data on 3-4 areas	No scoring option.	Practice collects data on 1-2 areas	No scoring option.	Practice do not collect data in any areas
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA collects patient satisfaction data and reports that data to providers and on our website to the public quarterly. The report presented here is for the entire year of 2009.

Supporting Documents

- PPC-8 Element B 1,2,3,4

PPC8: ELEMENT C - Reporting to Physicians **Score: 100.00% of Possible Points**
This is a Must Pass Element.

The practice reports on performance on the measures in 8A and 8B:

- | | Yes | No |
|-----------------------------|-------------------------------------|--------------------------|
| 1. across the practice | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. by individual physician. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

	100%	75%	50%	25%	0%
Scoring	Practice reports to physicians results both across the practice and by physician	No scoring option.	Practice reports to physicians results either across the practice or by physician	No scoring option.	No areas of performance reported to physicians

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element C 1,2 017 NQF Diabetes2
- PPC-8 Element C 1, 2

- PPC-8 Element C 1, 2, 021 NQF Female Measures2
- PPC-8 Element C 1,2 018 NQF Diabetes BP2 audit
- PPC-8 Element C 1,2 016 NQF Care for Older Adults2
- PPC-8 Element C 1,2 019 NQF Diabetes - Glyco LDL2
- PPC-8 Element C 1,2 022 NQF General Health Measures
- PPC-8 Element C 1,2 024 NQF Persistent Medications2

PPC8: ELEMENT D - Setting Goals and Taking Action	Score: 100.00% of Possible Points
--	--

The practice uses performance data to:

- | | Yes | No |
|--|-------------------------------------|-------------------------------------|
| 1. set goals based on measurement results referenced in Elements 8A and 8B | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. take action where identified to improve performance of individual physicians or of the practice as a whole. | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

Scoring

	100%	75%	50%	25%	0%
Practice does 2 items		No scoring option.	Practice does 1 item	No scoring option.	Practice does no items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element D 1 2

PPC8: ELEMENT E - Reporting Standardized Measures	Score: 100.00% of Possible Points
--	--

The practice produces reports on its performance using nationally approved clinical performance measures.

[In the box to the right, enter the number of measures]

Scoring

100%	75%	50%	25%	0%
Practice produces reports using 10 or more nationally approved performance measures	Practice produces reports using 5-9 nationally approved performance measures	Practice produces reports using 3-4 nationally approved performance measures	No scoring option.	Practice produces reports using 0-2 nationally approved performance measures

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation**Supporting Documents**

- PPC-8 Element E

PPC8: ELEMENT F - Electronic Reporting— External Entities
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Score: 100.00% of Possible Points
--

The practice electronically reports results on nationally approved measures to the public sector, health plans, or others.

[In the box to the right, enter the number of measures]

Scoring

100%	75%	50%	25%	0%
Practice transmits 10 or more nationally approved performance measures to an external entity	Practice transmits at least 5-9 nationally approved performance measures to an external entity	Practice transmits 3-4 nationally approved performance measures to an external entity	Practice transmits 1-2 nationally approved measures to an external entity	Practice does not transmit any measures

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-8 Element F

PPC9: Advanced Electronic Communication

The practice uses electronic systems to communicate with patients/families and other care providers.

Intent

The practice maximizes use of electronic communication to improve timeliness, effectiveness, efficiency and coordination of care.

PPC9: ELEMENT A - Availability of Interactive Website

Score: 75.00% of Possible Points

The practice provides patients/families with access to an interactive Website that allows them to:

	Yes	No
1. request appointments by reviewing clinicians schedules	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. request referrals	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. request test results	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. request prescription refills	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. see elements of their medical record	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. import elements of their medical record into a personal health record.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice provides	Practice provides	Practice provides	No scoring option.	Practice does not

5-6 items	3-4 items	1-2 items		provide any items
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Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation SETMA has chosen not to submit materials on this measure as our satisfaction of all of the elements of PPC-9 are in their infancy. We have an interactive website www.setma.com. We have a web portal www.NextGen.com both of which satisfy many of the elements of this Standard. We also are in the midst of launching NextGen's Community Health Services which will enable us to communicate seamlessly with other organizations delivery and receiving electronic patient data in a secure, HIPPS compliant environment.

Rather than await all of this being in place, we chose to make our application now and to continue with our launching of these new and exciting functions and capacities.

PPC 9: Advanced Electronic Communications

The practice maximizes use of electronic communication to improve timeliness, effectiveness, efficiency and coordination of care.

Element A: Availability of interactive web site

The practice provides patients/families with access to an interactive web site that allows them to:

1. Request appointments by reviewing clinicians schedules
2. Request referrals
3. Request test results
4. Request Prescription refills
5. See elements of their medical records
6. Import elements of their medical record into a personal health record

Element B: Electronic patient Identification

The practice combines use of electronic information and clinical decision-support to contact the following types of patients, once identified by e-mail

1. Patients needing clinical review or action
2. Patients on a particular medication
3. Patients needing preventive care
4. Patients needing specific tests
5. Patients needing follow-up visits
6. Patients who might benefit from disease or case management support.

Element C: Electronic Care Management Support

For patients with the three clinically important conditions the practice care management team uses electronic communication for the following:

1. To communicate with disease or case managers about patient needs
2. Web-based education modules for patient self management.

Supporting Documents

- PPC-9 Element A, B, C

PPC9: ELEMENT B - Electronic Patient Identification	Score: 100.00% of Possible Points
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The practice combines use of electronic information and clinical decision-support to contact the following types of patients, once identified, by e-mail:

	Yes	No
1. patients needing clinical review or action	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. patients on a particular medication	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. patients needing preventive care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. patients needing specific tests	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. patients needing follow up visits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. patients who might benefit from disease or case management support.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice uses electronic information and communication for 5-6 items	Practice uses electronic information and communication for 3-4 items	Practice uses electronic information and communication for 1-2 items	No scoring option.	Practice does not use electronic information for any items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

Supporting Documents

- PPC-9 Element A, B, C

- PPC-9 Element A, B, C

PPC9: ELEMENT C - Electronic Care Management Support	Score: 0.00% of Possible Points
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For patients with the three clinically important conditions, the practice care management team uses electronic communication for the following:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. to communicate with disease or case managers about patient needs | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Web-based educational modules for patient self-management. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring	100%	75%	50%	25%	0%
	Practice uses electronic communication for 2 items	Practice uses electronic communication for 1 item	No scoring option	No scoring option	Practice does not use electronic communication for any items

Scope of Review ONCE--NCQA scores this element once for the organization.

Evaluation

- Supporting Documents**
- PPC-9 Element A, B, C
 - PPC-9 Element A, B, C