James L. Holly, M.D.

HealthLeaders' The Doctor's Office for Carrie Vaugh December 10, 2010: SETMA's Pilgrimage to Patient Centered Medical Home by James L Holly, MD

1. **What we're driving forces behind your decision to adopt a patient-centered medical home model?**

   It was a logical decision based on SETMA's (Southeast Texas Medical Associates) growth and development. As the pressures for change in healthcare grew, SETMA began aggressively working with managed care in 1997. After first objecting to some of its elements and after additional examination, we realized that this was an effective way to address many of the needs of our patients especially the cost, the quality and the access to care by our medically most vulnerable friends and neighbors. Shortly after that we became involved in Medicare Advantage through Select Care of Texas and Universal American Insurance Company. Through this relationship we were and are able to extend care to many who previously could not afford or obtain care.

   In 1998, SETMA adopted electronic health records (EHR - we chose NextGen^{R}). Shortly after that, we realized that this method was too expensive and too hard if all were to gain was an electronic method of documenting a patient encounter. In May, 1999, we redirected our efforts to "electronic patient management" and began developing disease management tools and data managing tools based largely based the principles of a business management book written by Peter Senge, PhD (*The Fifth Discipline*, MIT). That decision resulted in SETMA receiving The Davies Award in 2006.

   In 2000, we realized that it was not enough to want to do provide excellent care, we needed to track the quality of care give to each care, audit the care given to panels or populations to patient and to analyze statically our outcomes in order to know where we needed improvement. As a result, we began tracking and auditing various quality metrics including diabetes, hypertension, care transitions, congestive heart failure, chronic stable angina, most of which were published by Physician Consortium for Performance Improvement (PCPI). In time, we expanded that to include HEDIS, National Quality Forum, NCQA, PQRI, Bridges to Excellence and others.

The last step in our pilgrimage to PC-MH began when we first heard about Patient-Centered Medical Home® (PC-MH, a registered trademark of NCQA) was when we attended an evening seminar on PC-MH on February 16, 2009. Dissatisfied with the explanations we received, we began to read, study, write and think about medical home and came to believe that it was the third and final "piece" in our transforming of the healthcare we deliver.

The principle features of medical home which intrigued, attracted and challenged us were:

a. The process of coordination of care and the outcome of coordinated care.
b. The maturing of and the further development of our concept of a team approach to healthcare which we have been developing for the past fifteen years which includes a truly collegial relationship between nurses, medical assistants, administration, information technology, nurse practitioners and physicians.
c. The realization that the "patient centered" element of medical home was the ultimate reality of the principle we have stated to our patients for the past fifteen years, "We will no longer be your health constable attempting to impose health upon you, but we will be your colleague, your counselor, your collaborator to help you achieve the level of health which you have determined to have."
d. We have long given our patients "report cards" which told them what they should expect from their healthcare provider. Now, we have added outcomes transparency to those expectations with our decision to publicly report out process and outcomes metrics so that patients would know what they could and should expect of us and so that they would do the quality of care they should and were receiving from SETMA by provider name.
e. Our COGNOS Project (using IBM BI Software to build a data mart and auditing tools) allows us to do real-time auditing and reporting on all of our care processes and outcomes.
f. Believing that the key to 21st Century health care is that we are "thinking about our patient when they are not in our presence" and that we must use technology to fulfill the requirements of excellent care led us logically to PC-MH.

This sequential and logical process led us to seek Medical Home "recognition from the National Committee for quality Assurance (NCQA) and "accreditation" from the Accreditation Association for Ambulatory Healthcare (AAAHC), the two bodies currently offering evaluation of medical groups as medical homes.

2. Please describe your model of care - how it works?

The Future of Healthcare

Efforts to reform healthcare may fail unless they employ three elements upon which SETMA depends in its transformative efforts:

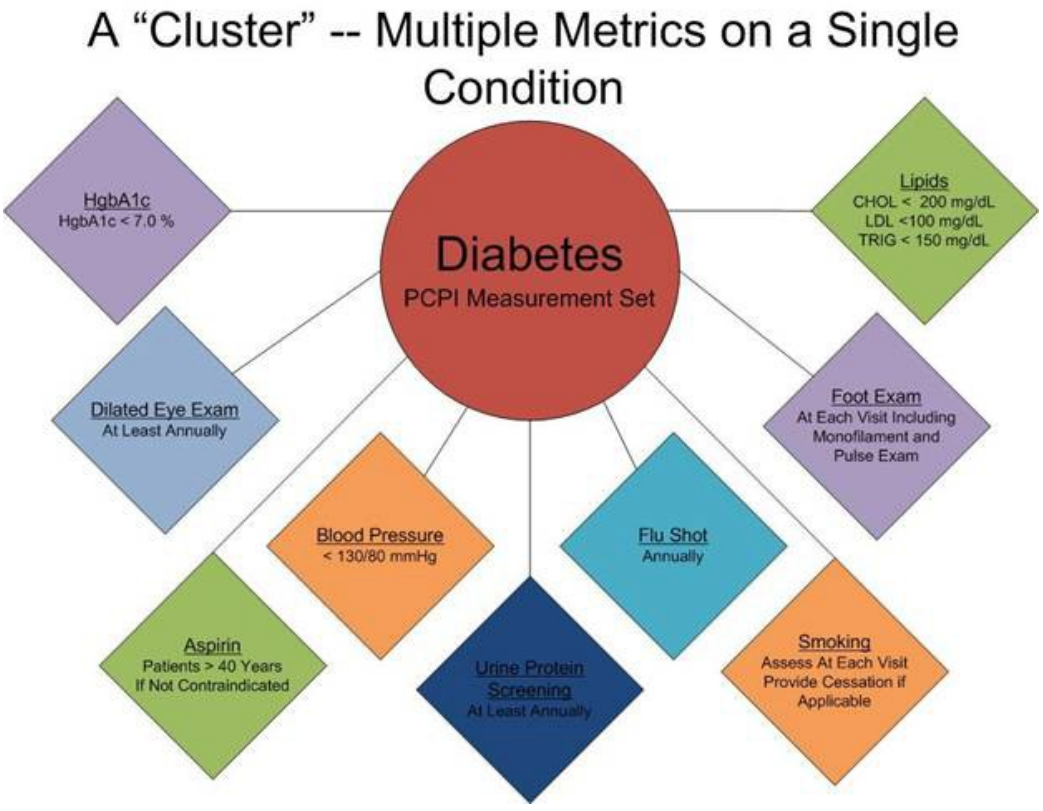
1. The content and standards of healthcare delivery must be evidenced-based medicine.
2. The structure and organization of healthcare delivery must be patient-centered medical home.
3. The payment methodology of healthcare delivery must be that of "Medicare Advantage".

At the core of these principles is SETMA's belief and practice that one or two quality metrics will have little impact upon the processes and outcomes of healthcare delivery. SETMA employs two definitions in this analysis:

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

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

The following illustrates the principle of a "cluster" of quality metrics. A single patient, at a single visit, for a single condition, will have eight or more quality metrics fulfilled for a condition, which WILL change the outcome of that patient's treatment.



The following illustrates a "galaxy" of quality metrics. A single patient, at a single visit, may have as many as 60 or more quality metrics fulfilled in his/her care which WILL change the quality of outcomes.

SETMA's model of care is based on these three principles and these concepts of "clusters" and "galaxies" of quality metrics. We are achieving significant results with them.

Contrasting SETMA's "model of care" with the other organizations participating in the Center's study will allow SETMA and the Center to understand the processes of healthcare transformation more fully.

The SETMA Model of Care

- The **tracking** by each provider on each patient of their performance on preventive care, screening care and quality standards for acute and chronic care. SETMA's

design is such that tracking occurs simultaneously with the performing of these services by the entire healthcare team, including the personal provider, nurse, clerk, management, etc.

- The **auditing** of performance on the same standards either of the entire practice, of each individual clinic, and of each provider on a population, or of a panel of patients. SETMA believes that this is the piece missing from most healthcare programs.
- The **statistical analyzing** of the above audit-performance in order to measure improvement by practice, by clinic or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, payer class, socio-economic groupings, education, frequency of visit, frequency of testing, etc. This allows SETMA to look for leverage points through which SETMA can improve the care we provide.
- The **public reporting** by provider of performance on hundreds of quality measures. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease management tool plans of care and the medical home coordination document summaries a patient's state of care and encourages them to ask their provider for any preventive or screening care which has not been provided. Any such services which are not completed are clearly identified for the patient. We believe this is the best way to overcome provider and patient "treatment inertia."
- The design of **Quality Assessment and Permanence Improvement** (QAPI) **Initiatives** - this year SETMA's initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital. We have completed a COGNOS Report which allows us to analyze our hospital care carefully.

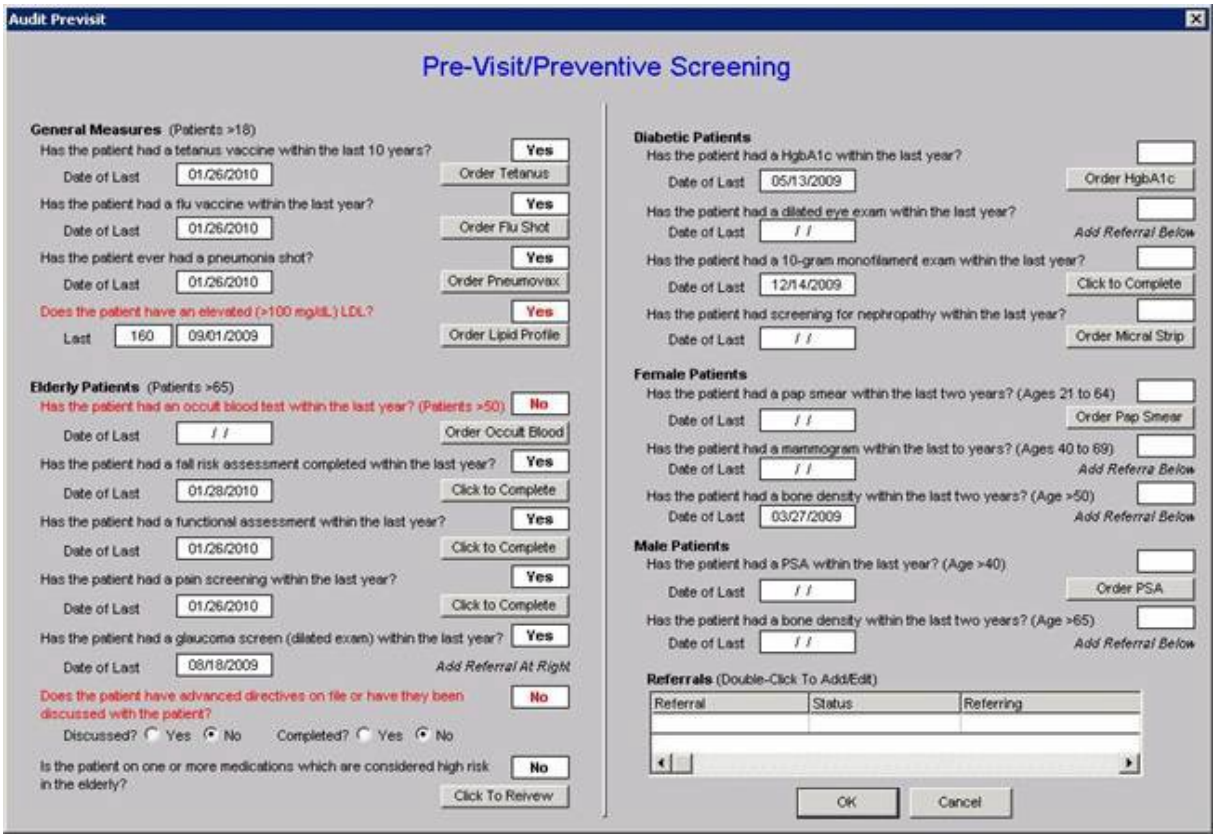
The SETMA Model Detailed

The SETMA Model Step I -- Provider Performance Tracking

The Physician Consortium for Performance Improvement (PCPI) is an organization created by the AMA, CMS, Institute of Medicine and others to develop measurement sets for quality assessment. The intent is to allow healthcare providers to evaluate their own performance at the time they are seeing a patient. SETMA is tracking a number of these measurement sets including: Chronic Stable Angina, Congestive Heart Failure, Diabetes, Hypertension, and Chronic Renal Disease Stages IV through ESRD, Adult Weight Management, and Care Transitions. Others will be added overtime. The details of these measurement sets and SETMA's provider performance on each can be found at ***Public Reporting PCPI***.

In addition to Provider Performance Tracking tools such as those produced by PCPI, the National Quality Foundation (see Public Reporting NQF), and National Committee for Quality Assurance (see Public Reporting HEDIS and/or NCQA), SETMA has designed

a pre-visit quality measures screening and preventive care tool. This allows a SETMA provider and a patient to quickly and easily assess whether or not the patient has received all of the appropriate preventive health care and the appropriate screening health care which national standards establish as being needed by this patient. The following is the Pre-visit Preventive Screening tool. All measures in black apply to the current patient and are fulfilled. All measures in red apply to the current patient and have not been fulfilled and all measures in grey do not apply to the current patient. If a point of care is missing, it can be fulfilled with the single click of a single button.



There are similar tracking tools for all of the quality metrics which SETMA providers track each day. The following is the tool for NQA measures:

The providers' compliance with these measures is color coded for quick reference. The "view" button allows the provider to quickly review the content of the metric and to review the patient's results.

Passing the Baton

While healthcare provider performance is important for excellent care of a patient's health, there are 8,760 hours in a year. A patient who receives an enormous amount of care in a year is in a provider's office or under the provider's direct care less than 60 hours a year. This makes it clear that the patient is responsible for the overwhelming amount of their own care which includes compliance with formal healthcare initiatives and with lifestyle choices which support their health.

If responsibility for a patient's healthcare is symbolized by a baton, the healthcare provider carries the baton for .68% of the time. That is less than 1% of the time. The patient carries the baton 99.22% of the time. The coordination of the patient's care between healthcare providers is important but the coordination of the patient's care between the healthcare providers and the patient is imperative. (For more on this concept see: *Passing the Baton: Effective Transitions in Healthcare Delivery* By James L. Holly, MD Your Life Your Health *The Examiner* March 12, 2010 under Related Articles below). The following is a direct quote from this article. The emphasis and italics appear in the original:

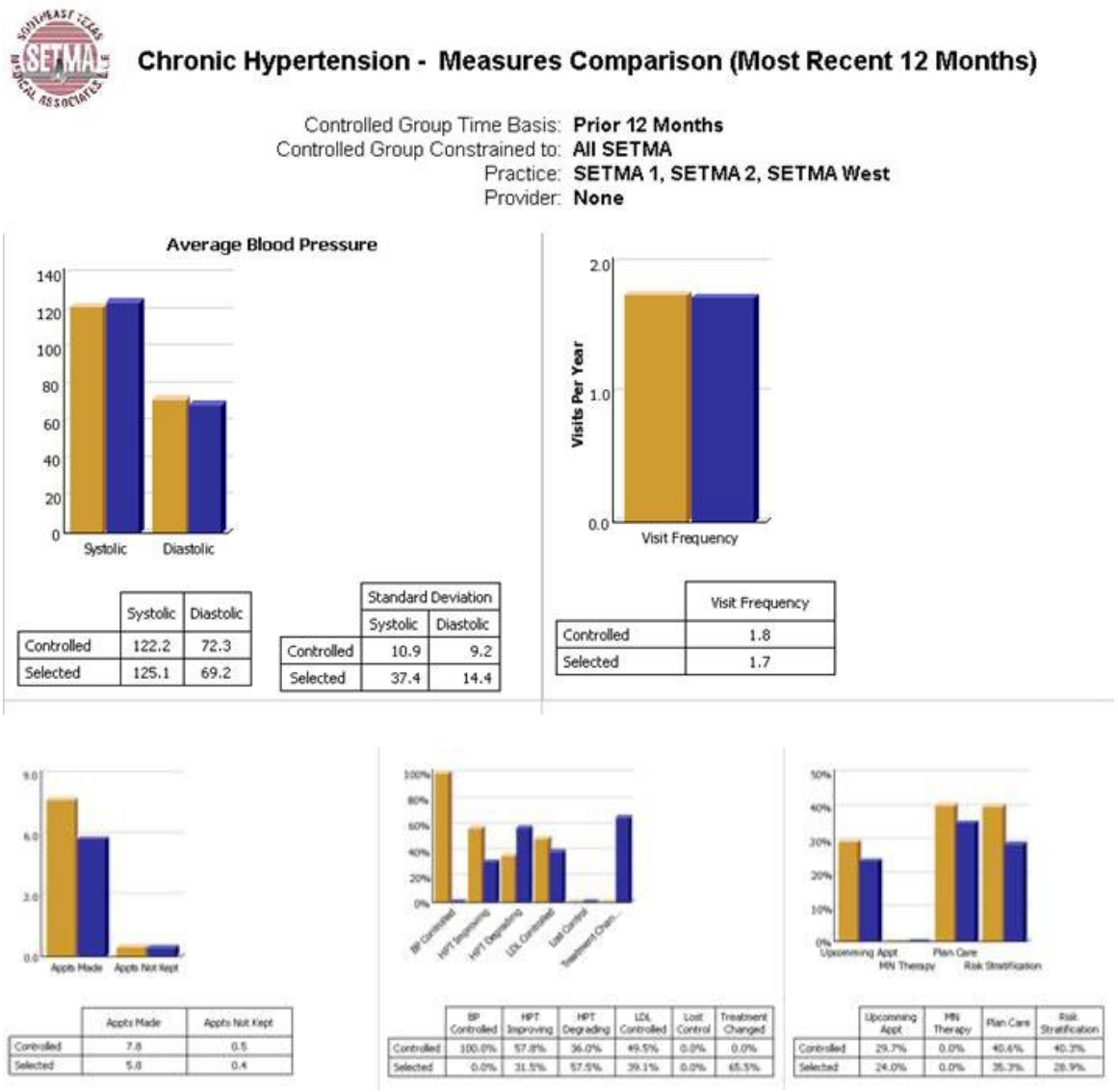
"Often, it is forgotten that the member of the healthcare delivery team who carries the 'baton' for the majority of the time is the patient and/or the family member who is the principal caregiver. If the 'baton' is not effectively transferred to the patient or caregiver, then the patient's care will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

The SETMA Model - Step 2 -- Auditing of Provider Performance - SETMA's COGNOS Project

The creating of quality measures is a complex process. That is why it is important for agencies such as the Ambulatory Care Quality Alliance (AQA), the NCQA, the NQF, the Physician Quality Reporting Initiative (PQRI) and PCPI, among others, to identify, endorse and publish quality metrics. The provider's ability to monitor their own performance and the making of those monitoring results available to the patient is important, but it only allows the provider to know how they have performed on one patient. However, the aggregation of provider performance over his/her entire panel of patients through an auditing tool carries the process of designing the future of healthcare delivery a further and a critical step. The problem with most auditing results, such as HEDIS, is that it is presented to the provider 12 to 18 months after the fact. SETMA believes that "real time" immediate auditing and giving of the audit results to providers can change provider behavior and can overcome "treatment inertia."

Auditing of provider performance allows physicians and nurse practitioners to know how they are doing in the care of all of their patients. It allows them to know how they are doing in relationship to their colleagues in their clinic or organization, and also how they are performing in relationship to similar practices and providers around the country.

As a result, SETMA has designed auditing tools through the adaptation to healthcare of IBM's business intelligence software, COGNOS. Multiple articles on SETMA's COGNOS Project can be found at www.jameslhollymd.com under ***Your Life Your Health*** and the icon ***COGNOS***. Those discussions will not be repeated here but auditing is an indispensable tool for the improvement of the quality of healthcare performance and for improvement in the design of healthcare delivery.
The following are a few examples of the auditing SETMA does of provider performance.



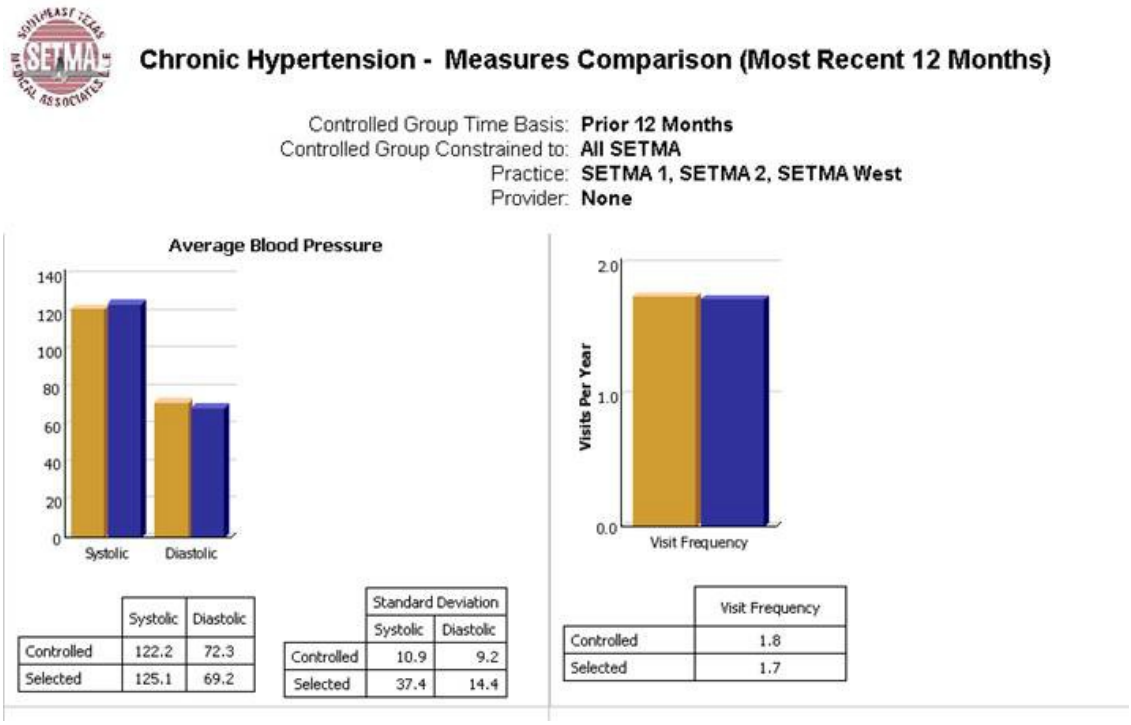
Through COGNOS, SETMA is able to display outcomes trending which can show seasonal patterns of care and trending comparing one provider with another. It is also possible to look at differences between the care of patients who are treated to goal and those who are not. Patients can be compared as to socio-economic characteristics, ethnicity, frequency of evaluation by visits and by laboratory analysis, numbers of medication, payer class, cultural, financial and other barriers to care, gender and other differences. This analysis can suggest ways in which to modify care in order to get all patients to goal.

Using digital dashboard technology, SETMA analysis provider and practice performance in order to find patterns which can result in improved outcomes practice wide for an entire population of patients. We analyze patient populations by:

- Provider Panel
- Practice Panel
- Financial Class - payer
- Ethic Group
- Socio-economic groups

We are able to analyze if there are patterns to explain why one population or one patient is not to goal and others are. WE can look at:

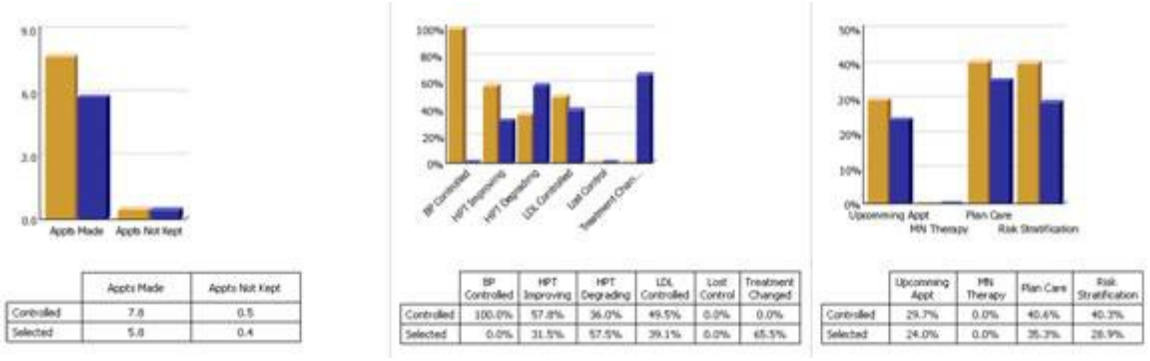
- Frequency of visits
- Frequency of testing
- Number of medications
- Change in treatment
- Education or not
- Many other metrics



	Systolic	Diastolic
Controlled	122.2	72.3
Selected	125.1	69.2

	Standard Deviation	
	Systolic	Diastolic
Controlled	10.9	9.2
Selected	37.4	14.4

	Visit Frequency
Controlled	1.8
Selected	1.7



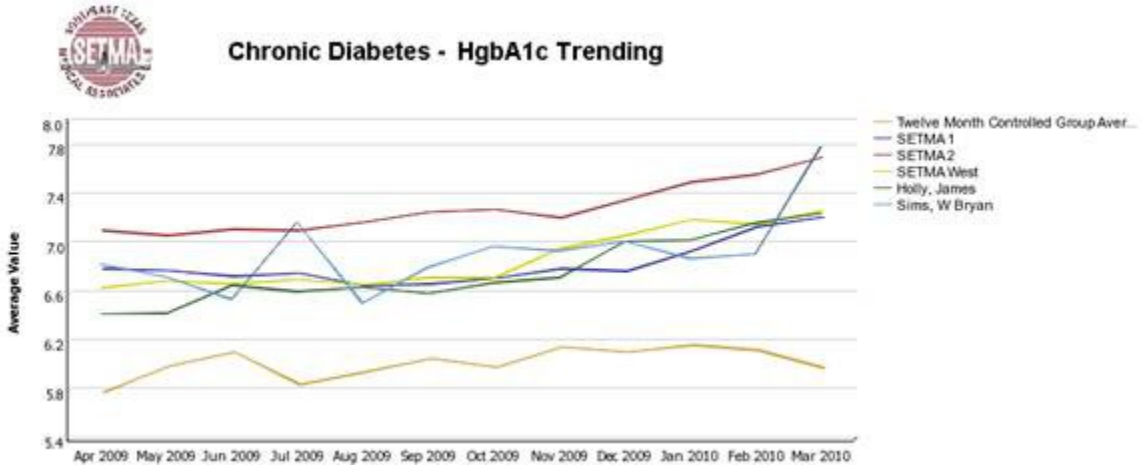
	Appts Made	Appts Not Kept
Controlled	7.8	0.5
Selected	5.8	0.4

	BP Controlled	HPT Improving	HPT Degrading	LDL Controlled	Lost Control	Treatment Changed
Controlled	100.0%	57.8%	36.0%	49.5%	0.0%	0.0%
Selected	0.0%	31.5%	57.5%	39.1%	0.0%	65.5%

	Upcomming Appt	MN Therapy	Plan Care	Risk Stratification
Controlled	29.7%	0.0%	40.6%	40.3%
Selected	24.0%	0.0%	35.3%	28.9%

We are able to present over-time patient results comparing:

- Provider to practice
- Provider to provider
- Provider current to provider over time
- Trending of results to see seasonal changes, etc.



The SETMA Model - Step 3 -- Analysis of Provider Performance through Statistics

Raw data can be misleading. It can cause you to think you are doing a good job when in fact many of your patients are not receiving optimal care. For instance the tracking of your average performance in the treatment of diabetes may obscure the fact that a large percentage of your patients are not getting the care they need. Provider Performance at the point of service is important for the individual patient. Provider Performance over an entire population of patients is important also. However, until you analyze your performance data statistically, a provider will not know how well he or she is doing or how to change to improve the care they are providing.

Each of the statistical measurements which SETMA tracks, the mean, the median, the mode and the standard deviation, tells us something about our performance. And, each measurement helps us design quality improvement initiatives for the future. Of particular, and often, of little known importance is the standard deviation.

From 2000 to 2010, SETMA has shown annual improvement in the mean (the average) and the median results for the treatment of diabetes. There has never been a year when we did not improve. Yet, our standard deviations revealed that there were still significant numbers of our patients who are not being treated successfully. Even here, however, we have improved. From 2008 to 2009, SETMA experience a 9.3% improvement in standard deviation. Some individual SETMA providers had an improvement of over 16% in their standard deviations. Our goal for 2010 is to have another annualized improvement in mean and in median, and also to improve our standard deviation. When our standard deviations are below 1 and as they approach .5, we can be increasingly confident that all of our patients with diabetes are being treated well.

An example of a statistical analysis of SETMA's diabetes care in regard to the elimination of ethnic disparities of care is given in the article *Eliminating Ethnic Disparities in Diabetes Care* Your Life Your Life Your Health *The Examiner* May 13, 2010, which is posted under Related Articles below.

The SETMA Model - Step 4 -- Public Reporting of Provider Performance

One of the most insidious problems in healthcare delivery is reported in the medical literature as "treatment inertia." This is caused by the natural inclination of human beings to resist change. Often, when patients' care is not to goal, no change in treatment is made. As a result, one of the auditing elements in SETMA's COGNOS Project is the assessment of whether a treatment change was made when a patient was not treated to goal. Overcoming "treatment inertia" requires the creating of an increased level of discomfort in the healthcare provider and in the patient so that both are more inclined to change their performance. SETMA believes that one of the ways to do this is the public reporting of provider performance. That is why we are publishing provider performance by provider name under ***Public Reporting***.

A more complete explanation of SETMA's philosophy and intent in "public reporting" of provider performance can be found in the following articles under Related Articles below:

- *Transforming Healthcare Public Reporting of Provider Performance on Quality Measures* Your Life Your Health December 3, 2009;
- *Patient-centered Medical Home SETMA's COGNOS Project Changing Patient and Provider Behavior* Your Life Your Health October 29, 2009.
- *County Health Rankings - Part II Quality of Care - What Will Be Gained by Public Reporting* Your Life Your Health March 4, 2010

The SETMA Model - Step 5 -- QAPI - Quality Assessment and Performance Improvement

Quality Improvement Initiatives based on tracking, auditing, statistical analysis and public reporting of provider performance are critical to the transformation of healthcare both as to quality of care and as to cost of care.

With the above described data in hand and with the analysis of that data, it is possible to design quality initiatives for future improvement in care. Currently SETMA is designing two major quality initiatives. One is for diabetes. It is an attempt to eliminate the last vestiges of ethnic disparity in the care of diabetes. This will require the use of additional internal resources and attention but it is our intent to do so and to permanently and totally eliminate ethnic disparities. The other is in regard to decreasing avoidable readmissions to the hospital.

The details of these two initiatives can be reviewed under Related Articles below :

- *Designing a Quality Initiative: How? Hospital Re-admissions* Your Life Your Health April 29, 2010.
- *Eliminating Ethnic Disparities in Diabetes Care* Your Life Your Life Your Health May 13, 2010

Without a systems approach to healthcare, each of these steps are impossible; certainly, the analysis and transformation of healthcare is impossible. With a systems approach, this logical and sequential process is possible and rewarding for provider and patient. This process has set SETMA on a course for successful and excellent healthcare delivery. Our tracking, auditing, analysis, reporting and design will keep us on that course.

SETMA's Model of Care has and is transforming our delivery of healthcare, allowing us to provide cost-effective, excellent care with high patient satisfaction. This Model is evolving and will certainly change over the years as will the quality metrics which are at its core.

3. How easy was it to transition to this model of care? How long did the journey take?

It is one of the most difficult things we have done. I use the word "is" because I believe that all of us who already have medical home "recognition" or "accreditation" or both, are still in the process of transforming the practice of medicine by the principles, ideals and goals of medical home. The formal process took SETMA from February 16, 2009 to the date we first submitted our NCQA application on April 12, 2010. As I have already said, the process did not end there.

The transition was and is a true "transformation" rather than a "reformation." In function, the distinction between these two concepts as applied to healthcare is that "reformation" comes from pressure from the outside, while "transformation" comes from an essential change of motivation and dynamic from the inside." Anything can be reformed - reshaped, made to conform to an external dimension - if enough pressure is brought to bear. Unfortunately, reshaping under pressure can fracture the object being confined to a new space. And, it can do so in such a way as to permanently alter the structural integrity of that which is being reformed. Also, once the external pressure is eliminated, redirected or lessened, the object often returns to its previous shape as nothing has fundamentally changed in its nature.

Being from within, transformation results in change which is not simply reflected in shape, structure, dimension or appearance, but transformation results in a change which is part of the nature of the organization being transformed. The process itself creates a dynamic which is generative, i.e., it not only changes that which is being transformed but it creates within the object of transformation the energy, the will and the necessity of continued and constant change and improvement. Transformation is not dependent upon external pressure but is sustained by an internal drive which is energized by the evolving nature of the organization.

While this may initially appear to be excessively abstract and unwieldy, it really begins to address the methods or tools needed for reformation or for transformation. They are significantly different. The tools of reformation, particularly in healthcare administration are rules, regulations, and restrictions. Reformation is focused upon establishing limits and boundaries rather than realizing possibilities. There is nothing generative - creative - about reformation. In fact, reformation has a "lethal gene" within its structure. That gene is the natural order of an organization, industry or system's ability and will to resist, circumvent and overcome the tools of reformation, requiring new tools, new rules, new regulations and new restrictions. This becomes a vicious cycle. While the nature of the system actually does change, where the goal was reformation, it is most often a dysfunctional change which does not produce the desired results and often makes things worse.

The tools of transformation may actually begin with the same ideals and goals as reformation, but now rather than attempting to impose the changes necessary to achieve those ideals and goals, a transformative process initiates behavioral changes which become self-sustaining, not because of rules, regulations and restrictions but because the images of the desired changes are internalized by the organization which then finds creative and novel ways of achieving those changes.

It is possible for an organization to meet rules, regulations and restrictions perfunctorily without ever experiencing the transformative power which was hoped for by those who fashioned the external pressure for change. In terms of healthcare administration, policy makers can begin reforms by restricting reimbursement for units of work, i.e., they can

pay less for office visits or for procedures. While this would hopefully decrease the total cost of care, it would only do so per unit. As more people are added to the public guaranteed healthcare system, the increase in units of care will quickly outstrip any savings from the reduction of the cost of each unit. Historically, this has proved to be the case. When Medicare was instituted in 1965, projections were made about the increase in cost. In 1995, it was determined that the actual utilization was 1000% more than the projections. No one had anticipated the appetite for care and the consequent costs which would be created by a system which made access to care universal for those over 65 and which eliminated most financial barriers to the accessing of that care.

Reformation of healthcare promises to decrease the cost of care by improving preventive care, lifestyles and quality of care. This ignores the initial cost of preventive care which has a payoff almost a generation later. It ignores the fact that people still have the right, which they often exercise, to adopt unhealthy lifestyles. Even the President of the United States continues to smoke.

The currently proposed reformation of the healthcare system does nothing to address the fact that the structure of our healthcare system is built upon a "patient" coming to a healthcare provider who is expected to do something "for" the patient. The expectation by the system and by the recipient of care is that something is going to be done "to" or "for" the patient in which process the patient is passive. There is little personal responsibility on the part of the patient for their own healthcare, whether as to content, cost or appropriateness. The healthcare provider is responsible for the health of the patient.

Transformation of healthcare would result in a radical change in relationship between patient and provider. The patient would no longer be a passive recipient of care given by the healthcare system. The patient and provider would become an active team where the provider would cease to be a constable attempting to impose health upon an unwilling or unwitting patient. The collaboration between the patient and the provider would be based on the rational accessing of care. There would no longer be a CAT scan done every time the patient has a headache. There would be a history and physical examination and an appropriate accessing of imaging studies based on need and not desire.

This transformation will require a great deal more communication between patient and provider which would not only take place face-to-face, but by electronic or written means. There was a time when healthcare providers looked askance at patients who wrote down their symptoms. The medical literature called this "*la maladie du petit papier*" or "the malady of the small piece of paper." Patients who came to the office with their symptoms written on a small piece of paper where thought to be neurotic. No longer is that the case. Providers can read faster than a patient can talk and a well thought out description of symptoms and history is an extremely valuable starting point for accurately recording a patient's history. Many practices with electronic patient

records are making it possible for a patient to record their chief complaint, history of present illness and review of systems, before they arrive for an office visit. This increases both the efficiency and the excellence of the medical record and it part of a transformation process in healthcare delivery.

This transformation will require patients becoming much more knowledgeable about their condition than ever before. It will be the fulfillment of Dr. Joslin's dictum, "The person with diabetes who knows the most will live the longest." It will require educational tools being made available to the patient in order for them to do self-study. Patients are already undertaking this responsibility as the most common use of the internet is the looking up of health information. It will require a transformative change by providers who will welcome input by the patient to their care rather seeing such input as obstructive.

This transformation will require the patient and the provider to rethink their common prejudice that technology - tests, procedures, and studies - are superior methods of maintaining health and avoiding illness than communication, vigilance and "watchful waiting." Both provider and patient must be committed to evidence-based medicine which has a proven scientific basis for medical-decision making. This transformation will require a community of patients and providers who are committed to science. This will eliminate "provider shopping" by patients who did not get what they want from one provider so they go to another.

This transformation will require the reestablishment of the trust which once existed between provider and patient to be regained. That cannot be done by fiat. It can only be done by the transformation of healthcare into systems which we had fifty to seventy-five years ago. The patient must be absolutely confident that they are the center of care but also they must know that they are principally responsible for their own health. The provider must be an extension of the family. This is the ultimate genius behind the concept of Medical Home and it cannot be achieved by regulations, restrictions and rules.

The transformation will require patient and provider losing their fear of death and surrendering their unspoken idea that death is the ultimate failure of healthcare. Death is a part of life and, in that, it cannot forever be postponed, it must not be seen as the ultimate negative outcome of healthcare delivery. While the foundation of healthcare is that we will do no harm, recognizing the limitations of our abilities and the inevitability of death can lead us to more rational end-of-life healthcare choices.

As SETMA works with transformation and medical home, we have also finalized our affiliate relationship with Joslin Diabetes Center which is affiliated with Harvard Medical School. In this process, I have been taken with a paragraph from the essay, *Elliott P. Joslin, MD: A Centennial Portrait* (Joslin Diabetes Center, 1998, p. 45), which states:

"Joslin and later his associates developed an elaborate dictation system that extended greatly beyond the polite written communication tradition expected from the Boston or urban gentleman physician of the Edwardian era. For example, each patient received a "report" dictated the same day as their office appointment. These letters not only provided the patient with the laboratory figures and the essential facts of the physical exam, but more often than not included a whole range of advice that might even involve bargaining with the patients about health matters."

The core elements of Patient-Centered Medical Home are contained in this simple paragraph:

1. Providing the patient with a written plan of care and a treatment plan.
2. Reporting test results to the patient in a timely fashion.
3. Collaborating with the patient about their care, not only **empowering** and **enabling** patients to carry out the treatment plan and plan of care but also having the patient **embrace** the plan.
4. And, it illustrates the essence of Patient-Centered Medical Home which is, "**Thinking about the patient when he/she is not in your presence**."

It has long been my assertion that Patient-Centered Medical Home has as its goal a return to the healthcare structure of the 1940s and 50s with the benefits and capabilities of the technological advances of the 21st Century. This paragraph lets me know we must go back further than the 40s and 50s.

Dr. Joslin's work and treatment of patients with diabetes illustrates the best of care of his day and it also illustrates the structure and methods of the future of care. Remember, from Dr. Joslin's writing of his first paper on diabetes while a medical student in 1893, it was 100 years (1993) before the Diabetes Control and Complications Trial (DCCT) was published, which confirmed Dr. Joslin ideas about glucose control and patient education in the treatment of diabetes... As seen here, it was not only Dr. Joslin's treatment of diabetes which was prescient but his organization and methods of his practice were also.

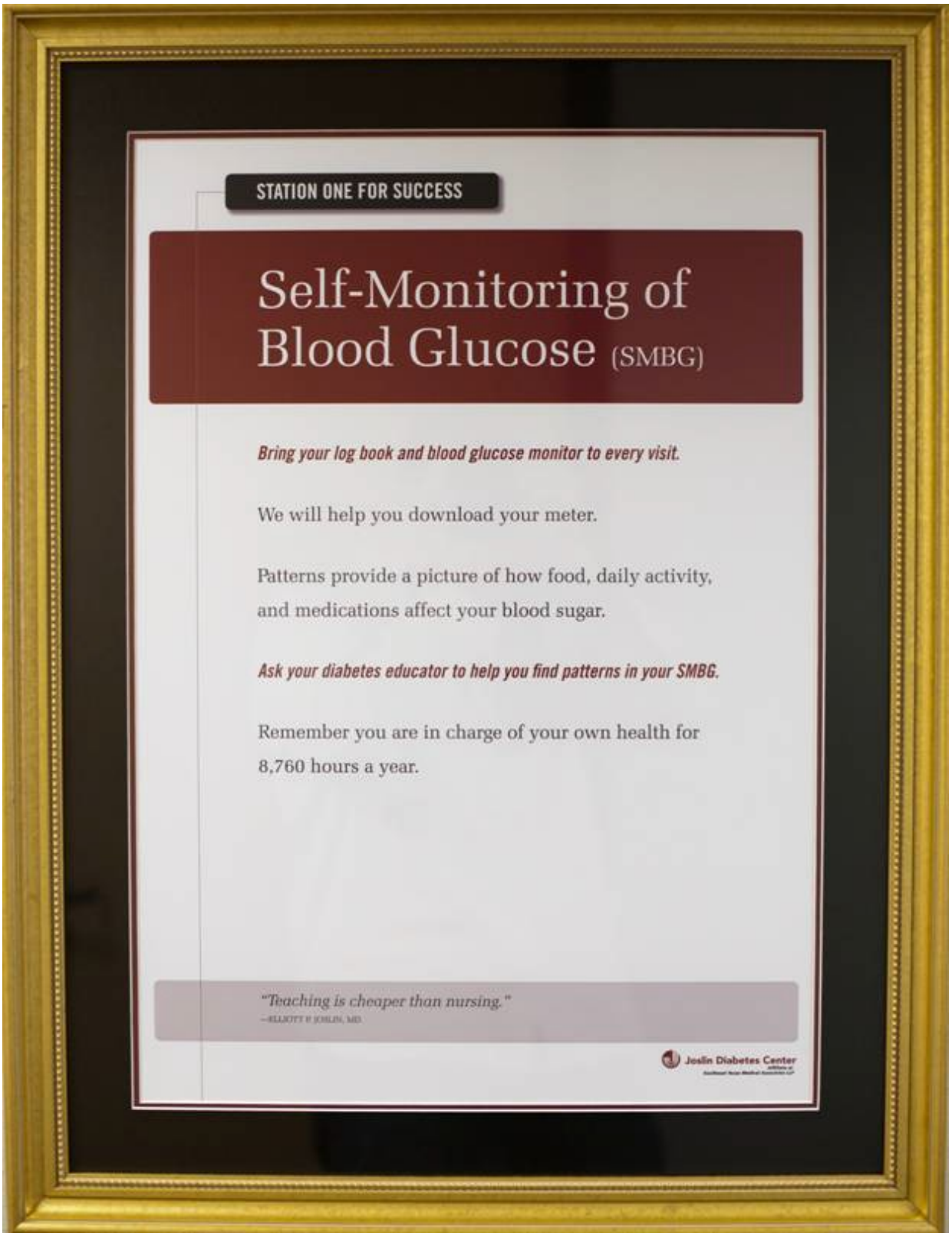
4. How is the patient experience different today under this model than 15 years ago (benefits)?

One of the pressing issues in relationship to any changing process is the answer to the question, "If I make a change, will it make a difference." This is really the distinction between "coordination of care" - this is the process by which we design and execute changes and it is the responsibility of the healthcare team - and "coordinated care" - this is the result and it is measured by the patient's "perception" of their experience

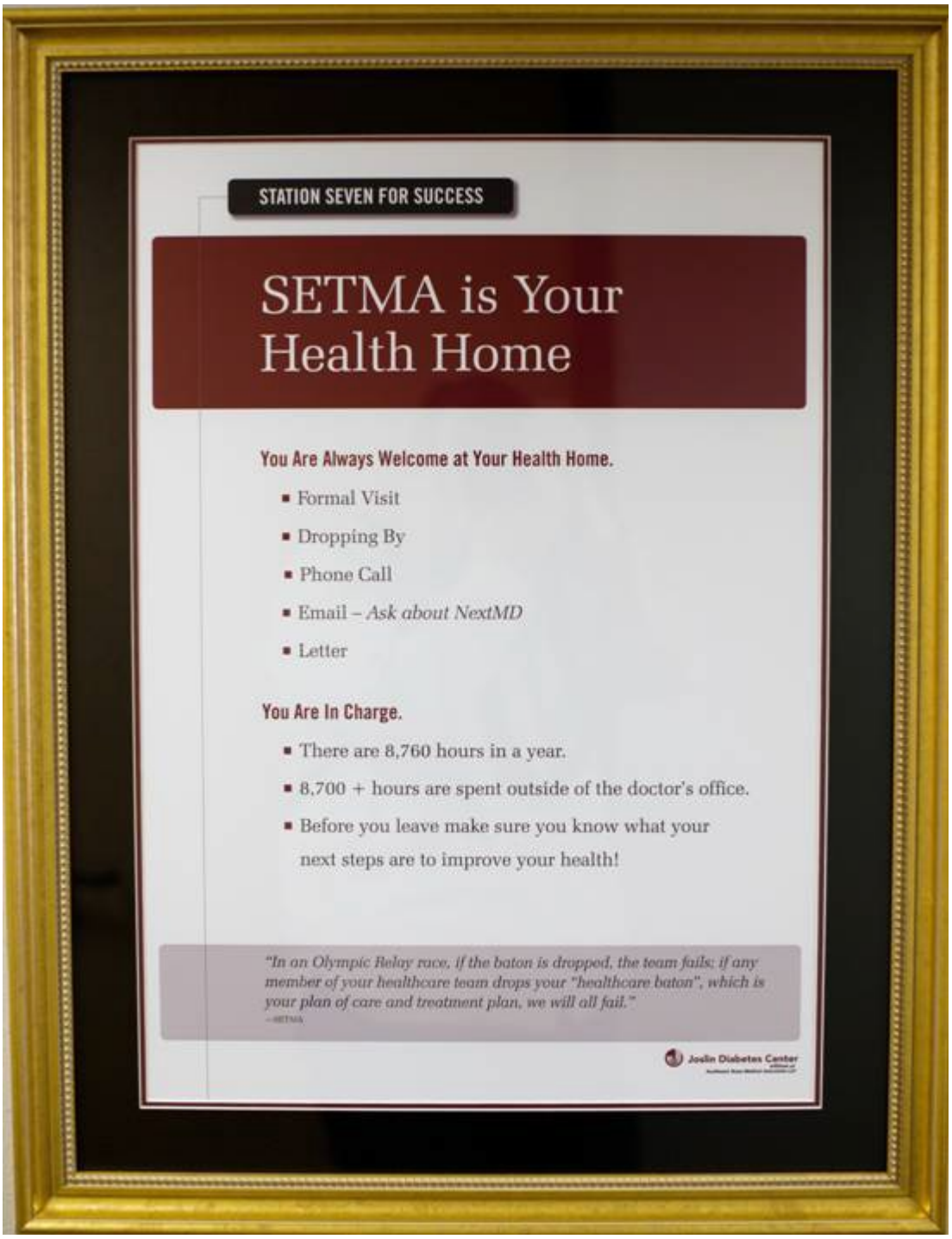
The former is the easy part; the latter is the difficult part. In process the patient experience has dramatically changed:

1. The patient's care is evaluated on the basis of over 200 quality metrics which represent multiple "clusters" of quality metrics and in any given patient visit will represent the evaluation of multiple clusters, or a galaxy of clusters, for any single patient.
2. The patient receives a summary of these "clusters" and galaxies" with a recommendation to contact his/her healthcare provider to request that any metrics not completed be done.
3. "Care transition" points are attended to and a "plan of care" and "treatment plan" baton is handed off to the patient so that they can participate effectively as a member and as the head of their healthcare team.
4. Because of SETMA's Department of Care Coordination, ever patient who leaves the hospital receives a follow-up call the day after discharge. This is not a fifteen second "administrative call" to fulfill a metric, but it is a twelve to thirty minute call which has substance and is an active part of the care of the patient. Selected patients seen in the clinic receive follow-up calls at any interval determined by the healthcare provider related to vulnerabilities, uncertainties or complexities of their care.
5. The Joslin Diabetes Clinic Affiliate at Southeast Texas Medical Associates is built on a medical home platform. Seven Stations of Success in the care of patients with diabetes guides the patient through their clinic experience and prepares them to lead their team. Station one and station seven address the dynamic of medical home in the experience of our patients:

   Station one - there are 8,760 hours in the year. The patient is the leader of his/her healthcare team for all 8,760 hours.


STATION ONE FOR SUCCESS
Self-Monitoring of Blood Glucose (SMBG)
Bring your log book and blood glucose monitor to every visit.
We will help you download your meter.
Patterns provide a picture of how food, daily activity, and medications affect your blood sugar.
Ask your diabetes educator to help you find patterns in your SMBG.
Remember you are in charge of your own health for 8,760 hours a year.
"Teaching is cheaper than nursing."
Joslin Diabetes Center

The last thing the patient sees as he/she leaves the clinic is Station Seven for Success which is placed on the back of the entrance/exit door to the clinic. It details the "health home principles and states:



6. The patient's cerebrovascular and cardiovascular risk is assessed at every visit rather than every five years as recommended by the AAFP. In

addition, both during the visit and in the "plan of care' and "treatment plan" a section is included which is entitled "**WHAT IF?**". Consistent with the question, "If I make a change, will it make a difference?" this section shows the patient how his/her risk will change if a number of individual elements or a combination of multiple elements used to calculate the risk is changed.

7. Four years ago, the SETMA partners founded The SETMA Foundation. In the fifteen months, the SETMA partners have given $1,000,000 to the foundation and we just received our first non-SETMA contribution of $150,000. This money is used to pay for the care of our patients who cannot afford it. None of the money can profit SETMA.

Previously, I have discussed how the patient's experience has changed:

"... At the foundation of quality healthcare, there is an emotional bond - a trust bond - between the healthcare provider and the patient. It is possible to fulfill all quality metrics without this bond; it is not possible to provide quality healthcare without it. That is why the patient-centered medical home (PC-MH), coupled with the fulfilling of quality metrics is the solution to the need for quality healthcare.

"The genius of PC-MH is to discover the true implications of SETMA's motto which was adopted in August, 1995, which is, 'Healthcare Where Your Health is the Only Care'" It is to put the patient and their needs first. And, it is to include the patient as a member of the healthcare team. There are 8,760 hours in a year. If responsibility for a patient's healthcare is seen as a 'baton,' the patient carries that 'baton' for over 8,700 hours a year. PC-MH promotes methods for effectively 'passing the baton' to the patient so that the patient's healthcare does not suffer under the patient's own supervision. SETMA has placed the patient's healthcare at the center of our healthcare delivery in many ways. One way is that we developed The SETMA Foundation, through which we help provide funding for the care of our patients who cannot afford it. Our resources are meager in comparison with the need, but it is a start.

"The following is one example of how PC-MH and the SETMA Foundation have worked together to produce quality healthcare. A patient came to the clinic angry, hostile and bitter and was found not to be a bad person but to be depressed because he could not work, could not afford his medication and was losing his eye sight. He left the clinic with The Foundation paying for his medications, giving him a gas card to get to our ADA certified DSME program, waiving the fees for the classes, helping him apply for disability, and getting him an appointment to an experimental program for preserving his eyesight. He returned in six weeks with something we could not prescribe. He had hope and joy. By the way, his diabetes was treated to goal for the first time in years. This is PC-MH; it is caring and it is humanitarianism. .

"... As the Patient-Centered Medical Home is restoring the personal aspect of healthcare, the Medicare Advantage (MA) program and/or the Accountability of Care Organizations (ACO) are modifying the 'piece' payment system of healthcare. While the President has been convinced that Medicare Advantage is the problem; it is the solution. The supposed increase in the cost of Medicare Advantage is because it is being compared to traditional Medicare costs where the administrative cost of Medicare is not calculated in the formulae. There are bright examples of success with Medicare Advantage, success marked by quality outcomes and high patient satisfaction. That success also is marked by a dramatic change in the trajectory of health care cost while maintaining its quality.

"The third piece to true healthcare transformation is including quality process and quality outcomes in the payment formula. There are fledgling programs such as the Physician Quality Reporting Initiative (PQRI) where healthcare providers are being paid for the demonstration of quality outcomes rather than just for piece work. The accountability of the public reporting of provider performance on quality measures completes this picture. This is why SETMA has begun quarterly reporting on our website of our providers' performance on multiple quality metrics. Included in that reporting is the examination of whether disparities of care in ethnic and socio-economic groups have been eliminated.

"...Quality healthcare is a complex problem. Measurable processes and outcomes are only one part of that complexity. Communication, collaboration and collegiality between healthcare provider and patient, between healthcare provider and healthcare provider, between healthcare providers and other healthcare organizations are important aspects of that complexity also. Data and information sharing within the constraints of confidentiality add another layer of complexity. All of these aspects of healthcare quality can be addressed by technology but only when that technology is balanced by humanitarianism. .

5. What steps did you take to ensure your providers and support staff were on board?

Communication! The first step we took in transforming our practice was an in-depth evaluation of our practice by the medical home standards published as a preliminary document by Centers for Medicare and Medicaid Services (CMS) and by NCQA. All of our Executive Management staff and providers were involved in this evaluation. The evaluation by the CMS standards resulted in a 400-page review of our practice. This allowed all of our providers to see where we were and where we needed to go and it allowed them to be part of the transformative process.

Creative tools! We looked at the requirements for medical home and we designed tools which made it "easier to fulfill the requirements than not to fulfill them." Building on our previous work - which is the key to transformation -- we were able to "transform" our disease-management-tool "follow-up documents" into "plans of care" and "treatment plans." We made it possible for all members of the healthcare team to

participate in a synergistic way to fulfill the elements of medical home rather than having all of the burden fall on one or the other.

Continuous Education! We close the clinic one-half day a month and have a seminar in which we discuss elements of medical home, the ideal of medical home and how we are performing or not performing in medical home. As we have illustrations of where we are doing it well, we share that by e-mail daily and when we do not do it well, we share that as well.

Collaboration! We welcome and seek ideas from all members of our team to improve our processes and outcome.

Circulate! We post on our website by provider name performance on over 200 quality metrics. This not only addresses "clinical inertia" but it assures everyone giving attention to the processes and outcomes which we "track," "audit" and "analyze."

6. **What advice do you have for practices seeking to undergo a similar transition?**
    - Get started!
    - Celebrate where you are as you work to go where you wish to be!
    - Compete with yourself, not with others!
    - Have as your goal to be better next month than you are this month.
    - Make sure you are making progress.
    - Don't be afraid to innovate or to fail, only be afraid of not trying.
    - Follow Winston Churchill's dictum, "Never, Never Surrender!"

Look into your own organization for the creativity and energy to change. There are many consultants and agencies who would like to charge you hundreds of thousands of dollars to "transform you." At best that will be reformation. Transformation can only come from within and it can only be sustained by your own passion, resolve and relentless pursuit of excellence.

Get counsel from those who have succeeded; evaluate their ideas and modify them to your situation. Often the best help is free. **Don't ever forget: excellence and expensive are not synonyms.**

7. **For practices seeking to be recognized as a medical home by NCQA, what should they know about the application process?**

It is tedious and complex, particularly NCQA. But remember, that may just reflect my prejudice about forms, others may find them simple and straightforward. Currently, less than 1% of medical practices have any form of medical home recognition so the process is in its infancy. Let others know your response to the process. It will and it should change. In actuality, it is SETMA's judgment that an ideal process would be a combination of AAAHC and NCQA.

8. **What lessons have you learned along this journey that your peers may find helpful?**

   It is worth the process, the price and the pain! It is our judgment that this is the future of healthcare and it is possible to be part of that future now. It is not easy but it is not impossible. The following steps to success will help:

   - Determine where you are.
   - Decide where you want to be.
   - Select the template or model you will follow.
   - Outline the steps you will take.
   - Develop a time line for completing each task.
   - Be innovative - emulate the best of others but expand upon their work and make it yours.
   - Be patient but eager - it will take time but work toward the finish.

9. **Additional thoughts?**
   - I repeat: Get started! In my life, I have started many things which I never finished, but I have never finished anything I didn't start. No matter how daunting the task, the key to success is to start.
   - Compete with yourself, not others! In his book, *If Aristotle Ran General Motors*, Tom Morris states, "I do not try to dance better than anyone else. I only try to dance better than myself - Mikhail Baryshnikov." It doesn't matter what someone else is or is not doing; set your goal and pursue it with a passion. Measure your success by your own advancement and not by whether someone else is ahead or behind you. In the same way, share your success with others. In helping others succeed, you will find true fulfillment.
   - Don't give up! The key to success is the willingness to fail successfully. Every story of success is filled with times of failure but is also characterized by the relentlessness of starting over again and again and again until you master the task.. When we started our IT project, we told people about what we are doing. We call that our "Cortez Project". Like Cortez, we scuttled our ships so there was no going back. We had to succeed.
   - Have fun! Celebrate! Enjoy what you are doing and celebrate where you are. In May of 1999, my co-founding partner of SETMA lamented about our EMR work; he said, "We are not even crawling yet." I said, "You are right but let me ask you a question. 'When your son turned over in bed, d id you shout and say to your wife, "this retard, dimwitted brat can't even crawl, all he can do is turn over in bed?" Or, did you shout to your wife, "He turned over in bed?" Did you celebrate his turning over in bed?" He smiled and I added, "I am going to celebrate that we have begun. If in a year, we aren't doing more, I will join your lamentation, but today I celebrate!" We have had a celebratory spirit since that day and we have gone from success to success.