James L. Holly, M.D.

JCAHO Call 5/27/14

Telephone Conference between The Joint Commission and Southeast Texas Medical Associates, LLP
Participants:

Lon Berkeley, BA, MS
Project Director for Community Health Center Accreditation

Mr. Berkeley has been with The Joint Commission since 1997 as Project Director for Community Health Center Accreditation. In this role, he directs operations and coordinates internal support for The Joint Commission's contract with the Bureau of Primary Health Care (part of DHHS/HRSA) to conduct unified surveys/reviews for 300 non-profit and public community primary health care centers throughout the country. This includes overseeing development and refinement of the unified survey/review process combining Joint Commission accreditation survey tools with BPHC/HRSA requirements; developing and implementing surveyor training; providing education and consultation to BPHC-supported programs; and participating in related Joint Commission survey process and standards development improvement initiatives.

Mr. Berkeley received his Bachelor of Arts degree in Psychology from Yale University, and his Masters of Science in Health Policy & Management from Harvard University School of Public Health.

Mark Albrecht, MS in Critical Care Nursing

Director Government Programs

Mr. Albrecht is Field Director for the Division of Accreditation and Certification Operations, Survey Management and Development. He provides direction and leadership to survey teams and ensures customer service to surveyed organizations. He first became involved with the Joint Commission in 1997 as a commissioned officer in the U.S. Navy, and created the joint Navy-JCAHO survey process which is still in place today. He has a master's degree in critical care and trauma nursing from the University of California, San Francisco and a bachelor's degree in nursing from San Diego State University.

James L. Holly, MD, CEO, SETMA, LLP

Margaret Ross, BS, Director of Operations, SETMA, LLP

Jon Owens, BS, Mechanical Engineering, Chief Clinical Systems Engineer, SETMA, LLP

Transcript of Conversation

Lon: Is this still a good time for you.

Dr. Holly: It is excellent. With your permission I have two people with me, they are on our accreditation team and they were part of the process. Margaret Ross is our Director of Operations and Jon Owens is the Chief Clinical Systems Engineer with our IT department. I appreciate your willingness to take the time to talk with us.

Lon: I have on the line Mark Albrecht. I'll let you introduce yourself Mark and there may be a third person Brittany Tisza, who is SETMA's senior account exec with The Joint Commission. Mark why don't you introduce yourself.

Mark: Good morning everybody. This is Mark Albrecht, I am the director of government programs for the Joint Commission. I too appreciate your time this morning. I have been looking forward to our conversation, so thank you.

Dr. Holly: Thank you.

Mark: Can you hear me okay, I apologize I am not in my office, so I apologize if I get noisy, or if there is some difficulty just let me know.

Dr. Holly: No, we can hear you well and I generally don't like to be on speaker but it enables our people to be involved. I appreciate the time you are willing to invest in this because I think the Joint. Commission has a great deal to offer and we are very pleased to be accredited by the Joint Commission As you know, I know Lon knows, that The Joint Commission was the last of the four medical home accrediting bodies that we pursued and I appreciate your willingness to discuss some of our comments and our observations and thoughts, which in no way discredit the Joint Commission, but I think could have some value.

Mark: No, absolutely. I had a chance to read the feedback that you provided and I have to say, I was very impressed that I actually agree with virtually everything that you said. So I think this is very helpful especially to carry some of these conversations forward into our organization and make some changes that I think are just on target. So I really appreciate the opportunity to hear about those, especially from your perspective and hopefully this will help us make some really important improvements, not only to our survey track processes, but even some of the comments about the surveyors approach, I think is really on target and much appreciated.

Dr. Holly: Well, you are very kind. Our surveyors were very fine men. Once we had our three-hour dialogue the second day of our survey the rest of the survey went very well. I had never sent the summary of that dialogue to Lon but I did send that to him this morning, I didn't send it before because it was an internal document, but, I thought as we have gone this far, we might as well be totally transparent.

Also, you need to know what I am telling people about the Joint Commission which is that if they are really serious about Medical Home they ought to do NCQA Tier III, which is not the ultimate goal, but is just the beginning but I do think that it's a good beginning. Then I would recommend they do one of the other three accreditations -- URAC, AAAHC or Joint Commission. Quite frankly, with your response to our observations, my recommendation would be to do Joint Commission. I think your survey is very thorough. I think, if we could get some clarification on shrinking your manual, which has redundancies and irrelevancies, that it would just be outstanding. After these two steps, I recommend Planetree, which has real interesting things to offer, not from a technical standpoint but from a cultural and an emotional or spiritual viewpoint, and from the dynamic and the ideal of patient-centeredness. To me if an organization does these three, they would have a solid foundation from which to transform their practice. I speak extremely well of the Joint Commission. I have not spoken badly about you. The things that I have said that were negative, I have said to you.

Mark: Well, I certainly appreciate that and I think you are touching on some aspects of our approach that I actually personally value a great deal. I think as we continue to develop further and that looking beyond the mechanics or structures or the standards themselves and try to get into those aspects of cultural transformation, I think that what you are describing is really, really important. We have had some similar conversations with the VA. I am not sure if you're familiar with their work in the PCMH model.

Dr. Holly: Yes, we've had several sites visits from military units that have come here and I regularly correspond with a large group in San Antonio, as you know that's a huge military environment and culture there.

Mark: So, I guess what I am getting at is that there are really similar interests in some of those key cultural issues and like you said, personal, spiritual ideals. Really there is a different approach that really understands and engages with the patients and families and coordinates their care. I think many of us are looking for that patient-centeredness and that cultural change and hopefully our approach will continue to mature enough to be able to be transparent, that is what you and others will see as we have surveyors actually look at the quality of the care not just the aspects of the resolution of the structures that are in place. Not just do you have this and this and this. It is more how well those pieces work together to address those things you say you do.

Dr Holly: Precisely. Accreditations and particularly quality metrics have been bound for so long by what is easy to measure, Bioethicist Paula O'Neil, talks about in her work that very often we

measure that which is easy to measure and the most important thing is that we need to be evaluating our difficulty to measure processes because they are multi-factorial. As a result it is very hard to get your hands around those in a quantifiable way. As you know, Einstein is famous for saying "All things cannot be quantified and all things that can be quantified are not worth quantifying." And so I think that we can easily fall into this trap of ignoring what is really important.

The other thing is that just from a philosophical standpoint, we think that quality metrics ought to be measured incidental to excellent care and not as the intention of excellence care. The difference being that you don't set about seeing a patient in order to satisfy a quality metric, it is as you see a patient and provide excellent care you incidentally fulfill quality metric sets which can let you know where you are in your transformative effort.

One of the real difficulties in health care today particularly in transformation is that it is almost like a GPS service where it tells you where you want to be. If you want to go to Dallas but in healthcare it doesn't tell where you are. If you are in Colorado and want to go to Dallas, it is a different trip than if you are in San Diego and want to go to Dallas. And if you don't know where you are and most providers are very reluctant to transparently and objectively and honestly and straightforwardly see where they are, because if you don't know where you are how can you possibly get to where you want to be?

SETMA, early in our transformation, made a decision that we were going to be open and transparent and say, "I've never been embarrassed or ashamed that somebody can prove to me I wasn't doing as well as I ought to be; but, I would only be ashamed or disappointed if I were unwilling to change." And so we see metrics and the philosophy of "incidental fulfillment of that," as stated in our Joint Commission leadership materials and also on our website, as being guideposts to let us known where we are and where we want to be. If you look at the PI-CME (Performance Improvement CME program that was defined by the AMA in, I think 2006 or 2008 when that program was first enunciated), they said there are three steps to the program. One, Is measuring where you are which is the critical first step. Second, you do self-guided studying to learn what you need in order to correct where you found you're deficient. Finally, you reassess if you have improved.

SETMA thinks there is a fourth step and I have talked to the AMA about this. SETMA is very close to the AMA in regard to quality metrics. SETMA believes that if you are going to sustain a process or quality improvement, you have to have clinical decision support tools which enable you to continually measure where you are. Because if you don't, you'll start out and you will do well, you'll know where you are, you'll study and then you'll improve, but over a period of time whether that is six months, a year, six years, you will lose that focus. I'm pleased to tell you SETMA has have continually looked at quality initiatives we started 10 years ago and that we are still performing excellently on those initiatives because we measure them, we audit them and we also have clinical decision support for them that demand that we jump through hoops, if you will, to perform that well but those are just concepts that are important to us.

Mark: Nonetheless, those are all important components to a philosophy of continuous process improvement. I only wish that all organizations adopted and applied those principles. As you well know, the state of the U.S. health care system needs some additional work

Dr. Holly: No doubt.

Mark: And you have certainly been at the forefront relative to applying that as well.

Dr. Holly: I appreciate that. You know I think two things about the Joint Commission and really respect that you'll are the elder statesman. You are 65 years old soon, that you have been in this business and you have done a great deal to advance the improvement in health care. But because you were the first and are the oldest, you've really had a monopoly for probably the first 50 years at least maybe longer. As a result there developed somewhat of adversarial relationship with your clients who had to use you, there was no other option. You go and objectionably talk to hospitals and other people that have worked with you guys for a long time. There was a real fear toward The Joint Commission because if the hospital didn't meet your standards, they couldn't get paid. I think what happened is that the culture developed where an adversarial relationship develop, as our surveyors initially said, "If you're doing something wrong, we'll find it" And, "We are not here to tell you what you're doing right, we are here to tell you what you're doing wrong."

In human behavior, if you really want to effectively change an organization, you've got to start from a positive point by saying, "You know you're doing this well but here are places you need to improve. We have always found that a little honey makes the vinegar go down.. We try to encourage people, but we also transparently by name report provider performance. As you know, on our website, we have six years of public reporting by provider name on over 300 quality metrics. We close our offices for half a day a month and we have 4 hours of training. We go over performance by provider name and when people aren't doing well, we discuss it with them publically among all our providers about what is the struggle. What is it they don't understand and we have found that improves performance tremendously. That transparency and our really critical desire to do a better job, ultimately results in the ideal which is improved health and improved processes, improved patient satisfaction and decreased costs, which is as you know the Triple Aim. But, all of this is done in the contest of affirming the value and importance of each person and the acknowledgement and celebration of what they are doing right and well.

I think the one thing that would really be helpful with the Joint Commission is that if there were a sense of a congratulatory or celebratory spirit with your accreditation. If an organization works hard and does well, The Joint Commission should acknowledge that without hesitation or reservation. I think you've got so much to offer but sometimes it's packaged in such a negative way, the good is lost in the objectionable attitude.

That came to roost for me with your certificate. You state: this "accreditation customarily lasts for up to 36 months". You know there is nothing congratulatory or celebratory about that statement. Then you say you're the "over-seer" of quality and safety. You are NOT the "over-

seer" of quality and safety WE ARE! You know, I think you are not the over-seer. I think the practice has expressed their desire or else their necessity, in our case it was the desire because there was no necessity for us to be accredited by The Joint Commission. We are the overseer of quality and safety and you are the one that helps us know how we are doing!. You come in and you review us. I think from our perspective the survey would have had more value if you were positive rather than negative. I'm not asking somebody to come in here and pat my back and scratch my ears, but if we are doing something really well, it would be nice to know.

Ultimately that did come out because I think you, Lon and the two surveyors wanted to take our leadership notebook and make that available on The Joint Commission's web site. But it would be beneficial to those of us who are doing this voluntarily to have a summary from you of saying you know, you're doing these things really well. We don't accept from that that we are perfect. We accept that we need to improve, that everybody can improve. But I think that when the attitude is, "if you're doing something wrong, we are going to find it,: that just sours my taste, if you will.

Mark: Dr. Holly, you wrote all this so elegantly. The comments I read I totally agree with especially about the certificate. That's what I mentioned earlier that this truly resonates with me personally and I think with many of the leadership at Joint Commission. As you described the evolution of The Joint Commission, I think you're right. Because of our history and the dynamics you described, there is a residue and that has actually become the main priorities for Dr. Chassin (The CEO and President of The Joint Commission). He wants to shift that around and have us look at more important issues in terms of higher performance and culture and those leadership aspects that you have described so well. He wants not to have our process be as you described it. Everything that you have written and have said too on this call, I think is really, really important and I know that we are in agreement with you.

Dr. Holly: Okay, then I won't repeat those things. But I am glad for your response; I appreciate that because I said them sincerely and genuinely and in a spirit of improvement because I think that you know what I would like to be at point of saying do NCQA Tier 3, then do Joint Commission and then do Planetree, because I think you guys have got so much to offer and I think we have benefited so much from The Joint Commission accreditation process. If you look at the numerical scores I gave you on the Joint Commission Survey questionnaire you sent, it may have seemed contradictory where I said I would absolutely recommend you. I absolutely encourage others to use Joint Commission but at some points I gave you "5's" and even "0's" because I didn't have exposure to those elements.

I think that with the kind of Joint Commission cultural change we are discussing, it could put the Joint Commission in a position of having the leadership that you deserve to have because of your years of development and the tremendous benefit it is to all of us to have access to that process.

Mark: I also agree with you in your comments that words are important. As you have said, pointing out just what it says on our certificate, it is residue from the past that we need to change

and so I totally agree with you. You would know that it may not be obvious to others, I think you chose one more symptom of that residue that needs to be changed in terms of how that is described on the certificate that perhaps the organization and how our even that little phrase (over-seers) about how our role is described, we need to update that. That is just one more symptom among the summary of comments you gave us about how the surveyors approach this.

After we talked to the surveyors, I am just guessing here, but I think when they go into a really, really good organization like yours, they are sometimes are challenged to find anything to comment on. Maybe we should say this correctly, but I think part of our challenge is we want to be helpful to the organization and sometimes it easier to be helpful to an organization that has a lot of issues, or a long ways to go. We should find opportunities to consulate with you about moving beyond where even you are. When we go out to a really, really, really good organization it is harder for them to find anything to correct.

Dr. Holly: I appreciate that you know that one of the things that can solve the problem if you went into an organization that is doing really well, you might ask them where the areas are that they struggle in. What are the things that are of concern to you? And we can name them for ourselves and say look here are some things we are really trying to understand, particularly in medical home. Early on, I didn't know what care transitions really was. When we first started with PC-MH in 2009, NCQA and AAAHC wanted a plan of care and treatment plan. Do you know how many lectures we had in medical school on plans of care and treatment plans? Zero. I had to go to the nursing literature to even find definitions of those terms and to begin to understand them. Now I do. Concepts that are common jargon such as "activation," "engagement," and "shared decision making" didn't make sense to me at first. Now I understand them.

But it might be possible for you to have a pre-document saying"Tell us of your needs," and, if we know that you are here to really help us and not play gotcha ya, and if we can trust you with our weaknesses, then we would be willing to be really transparent with you and say look here are the areas we want you to look at. You will find things we are not aware of. You know blind spots are areas you're blind in. The surveyors found one thing that was really distressing to me. We had some disinfectant that was really old. Margaret is sitting here and she remembers those conversations that we even got on ourselves about when they discovered it. That was very helpful but.

I am glad that you recognize that, if the Joint Commission could address those things it would just make you the cats-meow for going forward. I want you to see what I really want for you and it's a little bit presumptuous for me to tell you this but I want more organizations that are not associated with hospitals that have a history with Joint Commission to begin to benefit from the expertise of Joint Commission. That would include more organizations like us which have no obligation, no need, no necessity to do Joint Commission certification. Currently, Joint Commission is daunting. Lon knows this because I was very transparent with him with my anxieties about all this because we have people that had bad histories with Joint Commission from the hospital. But when I started

going through your notebook and particularly the section on leadership, which I took as my own baby and wrote extensively about it, I learned a great deal.

It really explained a lot of things to me about leadership. Next time, we will take another chapter, or in the mean time, and go through it as thoroughly as we did on leadership. We have an accreditation team and they worked so hard, we went through that entire book page by page, line by line, six times from beginning to end, because we were determined not to perform well for you but to learn for ourselves. So once we had that 3 hour conversation on the second day of our survey with the team, the spirit of the visit changed, everything changed, and our experience was excellent. The rest of the time it was encouraging to us and beneficial to us. If somehow that spirit could be captured from the beginning and communicated around the healthcare industry, I think that the Joint Commission would get a whole new generation and whole new expansiveness of market where you can fulfill your mission more effectively then ever before.

Mark: I totally agree and you know I would like to ask a personal favor too from everybody, you made a very good point I think in the feedback that I saw in terms of getting input about our standards and having part of our process be having organizations like yours help us with clarifying or getting rid of the redundancy or those sorts of aspects in which you describe so much work that you have done on. I would welcome further conservations with you, especially maybe with the leadership chapter you've done but as you take on others and you go through them so carefully, I think your perspective would very, very helpful to us. This all makes sense in those standards that really improve quality of care and there are aspects that aren't. I think we need to hear that and incorporate that into our internal improvement processes. So I would welcome conversations with you because you are right not only is there only helping the process to improve but it is critically important that we do so and I think you covered a lot of the end steps that can help us to that.

Dr. Holly: We would be delighted to do that because our mission is to practice excellent medicine. We are a medical group and all of our revenue comes from practice either from capitated payment, or fee- for- service. We also have a desire to help improve not only our care but the care of others. As I said I just got back from Maine speaking to Maine Health. As you know, Maine has only 1.2 million populations and this group takes care of probably half of those people. We were discussing care transitions and quality metrics and analytics. We had a great visit. But we really do want to help change health care and improve it and I can't think of a better way than if we could have a small influence in helping The Joint Commission make some of those transformative changes, and to improve standards book, we would be delighted to do that.

Mark: Wonderful. We really appreciate that.

Dr. Holly: If there is ever a desire to have a day or two to sit down together and have a more expansive conversation, telephone conversations are good but sometimes it is hard to really interact effectively, to have a dialogue about this we would be happy to participate in something like that on a confidential and limited distribution concept. Because ultimately we are all going to

benefit and you know I expect that over the next 10 or 15 years you guys will be in our practice a number of times, we would like to be beneficial to you and to us. You know our philosophy is that we want every patient encounter to be educational for the patient and evaluational for the patient, but more than that, we want it to be educational for the provider and evaluational for the provider. We want every provider to learn as they are treating and to evaluate themselves as they are treating. For the PCPI the Physician Consortium for Performance Improvement, the whole ideal is a point-of-care, self evaluation of professional performance and we developed that same concept in SETMA.

I know that is also your desire when I saw the 27 questions of the post-survey questionnaire you sent. That is why I sat down and wrote responds to them. You obviously want to learn too and that is going to have to take somebody saying you know, however right or wrong I am, this is how I perceive it and if we were able to transparently and straight forwardly share that with you then you as one old preacher used to say "you could swallow the meat and spit out the bones" I am fully aware that everything I say is not pontifical but it is an honest, sincere desire to grapple with the issues in a positive and constructive way.

Mark: I very much appreciate it. I honestly fully convey that to you that this has been a great conversation and I agree I would love to be able to spend more time with you and fully discuss some of the feedback and tips, because we do have shared goals and our organization is in a position hopefully to work with organizations like yours to kind of raise the bar for everyone.

Dr. Holly: That's right and I think that that would be so beneficial. At our monthly provider meetings we try to record those and we have placed a great deal of information on our website. I am adjunct professor at the University of Texas Health Science Center in San Antonio. My wife and I endowed a patient centered medical home, distinguished professorship and a distinguished lectureship, in our desire to help expand the knowledge and practice of PC-MH. We have a patient centered medical home externship for senior medical students and for residents in family medicine and internal medicine, where they come here and spend a month with us. We are discussing expanding that to have some freshmen and sophomore students as well for a month, to catch them before they get so far gone with being in love with specialty care that they don't realize that the ultimate transformation in health care is going to come from primary care and not from specialists which is not to discredit or demean what that do which is very important but the structural changes and the dynamic changes in health care is going to have to come from primary care.

Mark: Right. You know this brings another thought to mind and maybe I know you are very busy of course.

Dr. Holly: No, no, I've blocked my schedule; you will get tired before I will. I am delighted; I am so pleased that you have taken what we have sent seriously. You can imagine when I sent my first note to Lon it was with my heart in my hand because I realize that I took the chance of

alienating you guys where you would never want to work with us again. And I am so, your response is so refreshing.

Mark: I actually had another idea as you were talking about the programs you are doing. The actual development of primary care physician practices to involve some of these hot topics. We have a project that is just getting started at Joint Commission. Dr. Ronald Wyatt is one of our chief medical officers and he is developing a fellowship program for physicians to bring them to Joint Commission. I think he is looking at a six-week kind of curriculum to help develop physician mediators in the areas of patient safety and quality. I think that it might be helpful to have a conversation with you about what he is developing because I worry that maybe that might be hospital focused and some of the concepts that you are struggling with or working on should maybe incorporated in some that thought and I would love to share some of that information with about this fellowship that is being developed and then if you think its worthwhile I think that would be a nice secondary conversation that you might have with Dr. Wyatt to help us make sure that we are not missing out on something that is critically important to the future of health care.

Dr. Holly: We would be glad to, because the reality is none of us have the exact correct formula yet and we are all adding different things to the solution and ultimately we are going to come up with a real solution which I think is going to make a huge difference and I know we want to be part of it, I know you want to be part of it and anything you want us to interact with and have a conversation, we are willing to contribute the time.

Mark: Lon would you mind taking notes of stuff we could talk to Dr. Wyatt.

Lon: I am taking ferocious notes as a matter of fact.

Mark: Thank you. Well these are looking great, Dr. Holly I really appreciate it. I have a feeling that you've got a rich source of information that could be mutually beneficial on many levels. So I look forward to hopefully some more conversation.

Dr. Holly: We have a foundation and part of it is for education. We actually pay for the expenses of the students and the residents who come here, so it doesn't cost them anything and if you guys ever wanted to spend a day or two down here we would be glad to underwrite that. If you want o come and spend a couple just sitting and talking about all of these things and seeing if we can't together come up with something that would be dramatic because we know that the answers are not there yet but we are moving rapidly towards those answers.

That's why I call us the exhibitionists of health care, if we've done it; it is on our website, the good the bad and the ugly. There was a paper I wrote back in 1995 that I almost didn't put up there because it was our analytics. We understood we needed to measure things but when I look back at the things we were measuring almost 20 years ago, it was so embarrassing because we were measuring the wrong things. We knew we needed to measure something so we were trying to

measure things but I went ahead and put it up there because I want people to understand that is where we started and this is where we are.

I think that one reason I am so keen on the celebratory nature of achieving Joint Commission accreditation is in May 1999 my co-founding partner, who tragically died of pancreatic cancer five years ago, was really down in the dumps and I said, "Mark what's wrong," and he said (We had just stared with EMR three months before), "We are not even crawling yet." I said, "Mark your probably right but let me ask you a question, when your oldest son first turned over in bed did you shout and tell your wife this retarded, cerebral palsy, idiot kid cannot crawl yet, all he can do is turn over in bed." He began to smile, I said, "Or, did you celebrate that your son had turned over in bed. Now when he's 21 years old and he is only turning over in bed then, you've got a problem. You know I agree with you, we probably aren't even crawling yet but we have begun. Today I am going to celebrate that we've started; we've started the transformative process, if in a year all we are doing is what we are currently doing, I will join your lamentation but not today." For that point every progress, every advancement we make, we celebrated.

I think that as you look at your certificate, I would at it from the standpoint, "Is this congratulatory, is it celebratory:. I don't think any of us are so immature that once you give us your approval that we are going to stop doing what we are doing because in reality is we would pursue quality and safety and excellence with or without you. But with you, we think we can do it better. We think you can give us some guidance and guidelines but the transformative power comes from our philosophy, character and passion.

I don't know if you know Peter Senge at MIT but he wrote a book called *The Fifth Discipline* and it's about business but it applies perfectly to health care. I spent a week with Dr. Senge a couple of years ago and I told him the one reason I want to spend time with you and the one thing I want to know is did we co-opt his vocabulary and apply our dictionary, or did we apply his dictionary to his vocabulary. He said, Larry for what I know about you, you've perfectly understood systems thinking. Well the whole idea is that transformation comes from the recognition of where you are and where you want to be. He calls that the "creative tension" which is created by the difference between your vision and your reality. The more you are able to maintain that creative tension between where you are and where you want to be, the more likely you are to truly transform your organization comes from an internal passion, unlike reformation which is based on rules, regulations, requirements, pressure from the outside, which is, God Bless them, that's all the government really can do is apply pressure. But ultimately the elasticity of the organization is such that when that pressure is gone, the organization goes back to its previous form without any recognizable changes. Transformation is internally driven by personal passion and by the transformative, creative-tension between where you are and where you want to be.

I would love to see the Joint Commission develop the philosophy of you want to help people know where they need to be, help them understand where they are so that transformative power comes from within and to where that organization develops its own creative tension; it has its own energy.

That is where what we are doing comes from; it is that passion that comes from within. We have partners, we have collaborators like the Joint Commission that help us do it better but without that generative (creative power) within ourselves it would not be sustainable. That why what we call "continuous medical CME, continuing medical education is a misnomer. There is currently virtually no CME going on in this country. It is "episodic medication education: which is trying to increase knowledge, but the only way we have continuous anything is where it is coming from within ourselves so that every patient encounter, every time we see a patient, there is an opportunity for us to learn and improve. And that's the spirit I think that is at the heart of the Joint Commission and if you can communicate that to those people that you have contact and sometimes people think it is the warm fuzzes but it's really not, it's measurable, it's documentable, it's quantifiable and it is powerful.

Mark: Okay. Well said, and as I said earlier. I truly agree that even when I heard, when I was reading your comments, these were all a variety of symptoms that led to the picture or perception, the danger of perception that faces our organization: the language on the certificate, the language used by the surveyors, the report itself, also the language and the focus of that and the number of good things that honestly we have been trying to improve based almost as you just said. We have a working group in place to find a way to provide positive feedback along with what's necessary for improvement. We currently do and I think we are finally at framework that will help us do that and but once again even with that kind of a concept or internal projects I think that as we work on these kinds things, I would appreciate the chance to maybe include you or run things by you and say with this are we getting to the target. Are we getting to where we are able to reinforce just what your saying so that our role is not even doubted in anyone's eyes, whether it's the things that you described and help those organizations. And, as our mission statement says, "To inspire". We are supposed to evaluate and inspire and we get caught up in the historic part of the evaluation too much. So we share the goals that you are describing. And under Dr. Chassin's leadership we want to get there.

Dr. Holly: When you say would we like to be involved in this process, we would love it, it is so much part of our philosophy and our mission to constructively contribute. Often we get caught using language that while we are trying to say positive things; we use words which are so emotionally charged. We would love to be involved in any way that is beneficial to you. If you want to come down here we would love to have you and show you what we are doing. If you want us to come up there, we can do that or if you just want to have conversations. Whatever works for you because ultimately what would be beneficial to us if in five years the Joint Commission is fulfilling and superbly its mission and has really contributed to transforming health care.

Mark: Excellent. Thank you very much. I think that Lonnie and I have a bit to talk about, to move on the things that we've talked about here today and then maybe come up with some suggestions and see what the next steps could be, but I honestly would love to personally come down and spend a little time and learn more about your philosophy, it sounds like where we all want to be.

Dr. Holly: Thank you.

Mark: We do appreciate that.

Dr. Holly: You let us know and Lon thank you. I remember that when we, I remember where we were standing at the PCPCC meeting when I first met you and I have only seen you once in my life but I consider you a friend and I'm delighted now to add another friend to that and will continue to discuss. If I, Lon I've got your e-mail address, if you could add the other one then we can communicate back and forth and I will try not to inundate you with materials, although I'm capable to doing that. One guy said, you're the only guy who can write more than I can read. But, I'm as you can imagine as you do, I have a great passion for these things, as does SETMA, our practice which is really the crucible, it's kind of the laboratory in which these concepts have been tried out. And, they work and we would love to expand them.

When the Robert Wood Johnson Foundation was here, they asked how can we translate what SETMA's doing all over the country and then they said another question this one I don't talk about a lot because it sounds self-serving, they said and how can we do that without you. I said there are lots of me's around the country all we need to do is find them, train them and encourage them and we can do this. But you're right, it's going to take leadership and it's going to take innovators, it's going to take if will visionaries, people that are willing to envision a future that they can create.

Lon: Well said. I did include, if you don't mind, I forward to Mark the information that you shared just this morning.

Dr. Holly: You can see why they didn't send that to you earlier on but it was an honest. I do not think it is anything mean spirited about that but it is honest impression, because I went home and I didn't sleep a lot that first night of our survey. I was really depressed and the only thing that depresses me is when I feel like we haven't connected. No matter how difficult the problem is, if we can do something about it, we're OK. The issue is that when somebody shows us where we are doing something wrong or not doing it well, we are really eager and willing to change. So I know you guys have to go, we could spend more time talking but thank you very, very much for your willingness to interact with us.

Mark: No, thank you, we really do appreciate this. This has been great. So thank you very much.

Dr. Holly: I look forward to the changes in your certificates so that we can proudly hang it.

Mark: Okay. I was telling Lon the changes should be an easy thing but he's telling me it's not an easy thing, but we are going to change it.

Dr. Holly: Well, URAC sent us theirs and I refused it and I sent them a three page response. They changed it and we now proudly display it. Yours could be changed pretty easily

Mark: I agree

Dr. Holly: But it's, but it's going to change, it's going to change your persona of who the Joint Commission is and the key is it really needs to be celebratory and congratulatory. There has got to be some value to other than just having a certificate or an accreditation so that you can bill and charge. There has got to be value in the culture of safety and the culture of transformation and the culture of improving patient and when that happens, then you are going to see that people are going to flock to your door because they really want to do better.

Lon: Exactly. No I totally agree.

Dr. Holly: Thanks

Lon: I will foreworn you, you will be getting just the routine old version of the PCMH certificate. We are still going to do that but as Mark has indicated, we will work to try and help address this certificate improvement.

Dr. Holly: Great, thank you very much. Appreciate your calling. Okay. Bye

Lon: Talk to you later. We'll be back in touch Mark

Dr. Holly: Thank you. Bye

Lon: Bye