James L. Holly, M.D.

NQF - Summary of Dr. Holly's Comments - September 1st, 2010

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Comments by James L. Holly, MD
September 1, 2010

Today, has been enlightening and challenging. Major Sims and I are pleased to have attended and I am grateful to have been given the opportunity to participate. I look forward to tomorrow. At SETMA, we track multiple quality metrics at the point of care. We then audit those metrics by population or panel of patients. We analyze our audit statistically and then report the results publicly. We believe these steps have the potential for contributing to the transforming of healthcare.

As I discussed with Dr. Naylor, the first attachment above is an address which I delivered at HIMSS several years ago. It addresses the design of an EHR on the basis of Peter Senge's *The Fifth Discipline* (he is at MIT). Eight principles of EHR design are listed. Dr. Senge's said, "The more complex a problem, the more systemic the solution must be." He is not talking about IT systems, but all of his work applies precisely to medicine. My outline of his book is also attached. Perhaps the diagram on page eight of my address is worth the paper.

Finally, two articles are attached entitled "Entrepreneurism and Professionalism" in which I try to deal with the causes of our healthcare issues. I would be very interested in any response you have, particularly Dr. Goldmann with whom I discussed these concepts.

The following two links cover some of my work at HIMSS. They were both posted today.

- Quality 101
- **Trust Is the Foundation of Quality Medicine** *James L. Holly, MD*

The following is an edited and slightly expanded version of my comments today and **finally below that is my response to the idea that a Personal health Record should be he core of a patient's healthcare rather than an EHR.**

Mr. jerkins was discharged from hospital with instructions to schedule a follow-up in seven days. Dr. Coleman said that patients receive seven calls following their hospitalization with little benefit and a significant amount of confusion and contradictory instruction.

For 14 months, SETMA has been doing Care Transition using Physician Consortium for Performance Improvement's (PCPI) quality metric set.. We are publicly reporting these metrics on our website. In care transitions, the following should NEVER be heard:

- Make an appointment
- Stay on your medications
- stay on your diet.

Care Transitions in regard to post hospital appoints includes at least:

- **Follow-up** -- this is visits with those who were involved in the hospital

- Must have in writing and legible with a copy in the discharge summary, the name, address and telephone number of the providers with a date and time, and a reason for follow-up.
- Follow-up call to the patient and/or care giver the day after discharge.

    - This call is for the patient and not for the organization.
    - The content of the call is clearly defined (see SETMA's "follow-up telephone tutorial at www.Jameslhollymd.com under Electronic Patient Management Tools.
    - The duration of the call will vary from five minutes to tenth minutes
    - The call is made by nurses and the results are reported to the healthcare provider
    - An extremely successful call will result in the scheduling of another follow call via SETMA 's Electronic Tickler File (for more information see www.Jameslhollymd.com Electronic Patient Management Tools)
    - Calls made to fulfill a metric are generally worthless

- **Referrals** -- these are visits to providers who were not involved in the patient 's hospital care.

The same issues apply concerning the appointments actually being made before the patient leaves the hospital.

- **Procedures not performed in the hospital and unreported results** from the hospital stay to be completed out of hospital or reported to the patient.

Reducing Preventable Re-Admissions

Causes:

- Safety Net - Using the ER and the hospital as safely nets because they are accessible
- 2. Trust -- patients often trust technology more than their healthcare provider. (see articles on "Entrepreneurism and Professionalism Parts I and II" at www.Jameslhollymd.com under Your Life Your Health)
- Relationship -- the patient often has a stronger relationship with their insurance company than with their health care provider.
- Loss of confidence in access to healthcare provider.

(Comment -- **ERs, Hospitals, Insurance companies are not good a care coordination**)

Health Home or Medical Home can move trust and safety net back to healthcare providers:

- Same day appointments
- Walk-in capacity
- Communication

- Telephone with two-hour call back rule.
- Secure e-mail with 8 hour answer rule
- Provider home phone listed and/or
- provider cell phone number given to patient

Quality improvement decreasing readmissions

SETMA has two quality initiatives his year:

- Eliminating racial and/or ethnic disparities' in the care of patients with diabetes, dyslipidemia and/or hypertension.
- Reducing preventable readmission to the hospital in 30 and 60 days.

Evaluating the following between those who are readmitted and those who aren't:

- Length of stay
- Primary admitting diagnosis (es)
- Co-morbidities
- Follow-up call or not
- Follow-up length of time between discharge and primary care visit
- Socio-economic differences
- Gender
- Age
- Ethnicity
- Literacy

- Empowerment -- Knowledge -- understanding and Information -- data
- Social setting -lives alone, etc.

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EHR versus PHR

I don't agree that the Personal Heath Record (PHR) would be a superior hub for healthcare management than a physician-driven and controlled Electronic Health Record (EHR). The EHR and the PHR have distinctive roles and must interact and communicate but they are not synonymous and one cannot and should not replace the other.

What the provider needs in "knowledge" (understanding) and "information" (data) to provide evidence-based, high-quality care includes but goes beyond what a patient needs in a "personal health record".

James L. Holly MD