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Texas A&M Health IT Academy
Response to *Healthcare Informatics*
June 20, 2014 article
By James L. Holly, MD

I have read **Healthcare Informatics'** article on Texas A&M's Health IT Academy written by Senior Editor Gabriel after an interview with A&M's School of Medicine, interim dean, Paul Ogden, MD. Two things are pivotal in this article. The Dean's affirmative statement, "I would like to change the way we practice medicine in the US," echoes my personal statement from 14 years ago when a friend asked me, "What do you want to accomplish?" I answered, "I want to change how healthcare is delivered in America." Not being delusional, I mean, "I want to help transform healthcare." I applaud the Dean's vision and passion. As a Clinical Associate Professor of Internal Medicine at Texas A&M, I and Southeast Texas Medical Associates, LLP look forward to doing anything we can do to support and promote this Academy.

However, I have a different judgment as to the nature of the problem. It is in my judgment that the issue is not so much one of knowledge about electronic medical records (EMR) or how to use them as it is an issue of why we must use them. It is the philosophical foundation of the transformation of our healthcare system which demands EMR use and really which demands electronic patient management (EPM) which is critical to the success of using the EMR. I will discuss this more below.

The Impact of Joint Commission Accreditation as a Patient-Centered Medical Home (PC-MH)

In March of 2014, SETMA completed accreditation by all four organizations which accredit Patient-Centered Medical Home. With accreditation by NCQA, AAAHC and URAC, SETMA's success in receiving accreditation by The Joint Commission completed the process. Perhaps the most significant benefit to SETMA from The joint commission was that the surveyors at how proud our employees are of SETMA. They commented that it is not commonly seen where all the employees share in the pride of ownership and that they not only understand **what** they are to do but **why** they are to do it. After this, I sent the following set of questions to SETMA's Accreditation Team members. I made these conditions: I would like each of you to answer the following questions for me (this will not be publicized; if I wish to share any of this with anyone, I will get your permission prior to doing so):

1. Have you grown personally during your tenure with SETMA

2. Have you grown professionally during your tenure with SETMA
3. Have your activities and your responsibilities been satisfying to you personally and professionally.
4. Do you feel that you are engaged in a job that is important which gives you personal pride in what SETMA is doing
5. What would you change if you could
6. Do you feel respected and appreciated
7. Are you treated with dignity and respect

When we shared these seven things with Planetree (http://www.jameslhollymd.com/medical-home/pdfs/Planetree.pdf), they commented, "These questions are spot on."

When The Joint Commission surveyors made this comment about SETMA's team, I told them I thought I knew why. There are many reasons, compensation, no harassment, safe and supportive environment, but I think the biggest reason is the same for providers, executive management, administration, and staff. That is, everyone is aware that they are part of something more than a medical practice. Everyone feels that they are part of something which is very special. Interestingly the very reason that makes others dislike us is the reason which makes us like ourselves. With 217 articles published about SETMA in national publications posted on our website, we can know that we are considered special by others. With honors, awards, acknowledgements, achievements posted on our website, we can know that we are doing extraordinary things. With many of our staff able to attend national meetings where they hear and see how others respond to SETMA, they feel proud and special. The dividends that our website and these awards pay cannot be found in dollars and cents, but it can be found in satisfaction, fulfillment and personal pride. Most of all perhaps, is that we continually acknowledge that our achievements while founded on hard work and perseverance is also the result of God's blessings. This is why SETMA's staff is special, feels special and acts special.

1. People at SETMA are experiencing what it means to be part of a great team; that is describe by Peter Senge in *The Fifth Discipline*:

   "Most of us at one time or another have been part of a great 'team,' a group of people who functioned together in an extraordinary way - who trusted one another, who complemented each other others' strengths and compensated for each others' limitations, who had common goals that were larger than individual goals, and who produced extraordinary results. I have met many people who have experienced this sort of profound teamwork - in sports, or in the performing arts or in business. Many say that they have spent much of their life looking for that experience again. What they experienced was a learning organization. The team that became great didn't start off great - it learned how to produce extraordinary results." (p. 4)

   Being part of such a team:

   a. Requires each of us to be better than we have ever been before
   b. Enables us to be better than we have ever been before
   c. Motivates us to be better than we have ever been before
   d. Allows us to take the risk of becoming better than we have ever been before

2. Everything SETMA does is based upon philosophical principles and foundations

   Both the surveyors and one of the executives at The Joint Commission commented about the philosophical foundation of SETMA's work. Wednesday afternoon (March 5, 2014) I called my executive contact at The Joint Commission. He said "I was just talking to one of my colleagues and showing him SETMA's notebook which was prepared in response to The Joint Commission's Standards and Requirements Chapter Seven o leadership." The executive said, "Look at this; everything they do is founded upon a philosophical foundation. They know 'what they are doing,' but more importantly, they know why they are doing it.'" SETMA is not the result of random efforts but of innovations and advances which are consistent with a structured set of ideals, principles and goals.

   It is helpful that The Joint Commission recognized this and commented upon it. It is one of the strengths of SETMA and it is one of the principle guides to SETMA's development history, i.e., what caused SETMA to become what it is.

3. Part of SETMA's culture is our willingness and ability to accept who we are, while expecting ourselves to improve. That can be expressed in the statement: ***Rarely can it be said that some one is THE best of ALL because we have strengths that place us at the head of the pack and we have weaknesses which make us one of the pack. Our progress and success is dependent upon our willingness to celebrate our strengths without arrogance and hubris and to acknowledge our weaknesses with humility and resolve to improve.***

   Peter Senge expressed this in terms of ***Personal Mastery*** which is described by ten principles shared by people with personal mastery:

   - The have a special sense of purpose that lies behind their vision and goals. For such a person, a vision is a calling rather than simply a good idea.
   - They see current reality as an ally, not an enemy. They have learned how to perceive and work with forces of change rather than resist those forces.
   - They are deeply inquisitive, committed to continually seeing reality more and more accurately.
   - They feel connected to others and to life itself.
   - Yet, they sacrifice none of their uniqueness.
   - They feel as if they are part of a larger creative process, which they can influence but cannot unilaterally control. (p. 142)
   - Live in a continual learning mode.
   - They never ARRIVE!
   - (They) are acutely aware of their ignorance, their incompetence, their growth areas.
   - And they are deeply self-confident! (p. 142)

4. SETMA is willing to take the risk and to subject ourselves to the scrutiny of the highest standards. We are also prepared to be transparent and to publish by provider name our performance on hundreds of quality metrics. This transparency drives our improvement. It allows SETMA to be the best we can be. It allows us to declare: **Once you "open your**

books on performance" to public scrutiny; the only place you have in which to hide is excellence!

This is the critical requirement for success in EHR utilization. Without a philosophical commitment to healthcare transformation, all the information about EMR, in my judgment, will not help. SETMA purchased our EMR March 29, 1998. We used it for the first time, January 26, 1999.

Four Seminal Events

In October, 1997, SETMA attended the Medical Group Management Association meeting to preview electronic-health-record (EHR) solutions. In March, 1998, SETMA signed a contract with an EHR vendor. We deployed the enterprise practice management (EMP) side of the system in August, 1998 and the EHR on January 26, 1999. By Friday, January 29th, we documented every patient encounter in the EHR. In May, 1999, four seminal events transformed SETMA's healthcare vision and delivery.

First, we concluded that EHR was too hard and too expensive if all we gained was the ability to document an encounter electronically. EHR was only "worth it," if we leveraged electronics to improve care for each patient; to eliminate errors which were dangerous to the health of our patients; and, if we could develop electronic functionalities for improving the health and the care of our patients. We also recognized that healthcare costs were out of control and that EHR could help decrease that cost while improving care. Therefore, we began designing disease-management and population-health tools, which included "follow-up documents," allowing SETMA providers to summarize patients' healthcare goals with personalized steps of action through which to meet those goals. We transformed our vision from how many x-rays and lab tests were done and how many patients were seen, to measurable standards of excellence of care and to actions for the reducing of the cost of care. We learned that excellence and expensive are not synonyms.

Second, from Peter Senge's *The Fifth Discipline*, we defined the principles which guided our development of an EHR and the steps of our practice transformation from an EMR to electronic patient management; they were to:

1. Pursue Electronic Patient Management rather than Electronic Patient Records
2. Bring to every patient encounter what is known, not what a particular provider knows
3. Make it easier to do "it" right than not to do it at all
4. Continually challenge providers to improve their performance
5. Infuse new knowledge and decision-making tools throughout an organization instantly
6. Promote continuity of care with patient education, information and plans of care
7. Enlist patients as partners and collaborators in their own health improvement
8. Evaluate the care of patients and populations of patients longitudinally
9. Audit provider performance based on endorsed quality measurement sets
10. Integrate electronic tools in an intuitive fashion giving patients the benefit of expert knowledge about specific conditions

In 2009, we would discover that these principles are essentially the principles of patient-centered medical home and that the past ten years had prepared SETMA to formally become a patient-centered Medical home. Between 2009 and 2014, SETMA would become accredited as a medical home by NCQA, AAAHC, URAC and The Joint Commission.

The **third** seminal event was the preparation of a philosophical base for our future; developed in May, 1999, this blueprint was published in October, 1999. It was entitled, More Than a Transcription Service: Revolutionizing the Practice of Medicine With Electronic Health Records which Evolves into Electronic Patient Management". The first eight pages of this current paper were developed from an update of this paper.

As we began defining and developing critical supports required for success in Performance Improvement, we found them to be:

1. Care where the same data base is being used at ALL points of care.
2. A robust EHR to accomplish the above.
3. A robust business-intelligence analytics system, which allows for real-time data analysis at the point of care.
4. A laser printer in every examination room so that personalized evaluational, educational and engagement materials can be provided to every patient at every encounter, with the patient's personal health data displayed and analyzed for individual goal setting and decision making.
5. Quality metric tracking, auditing and statistical analysis.
6. Public Reporting of quality metric performance by provider name.
7. Quality Improvement initiatives based on tracking, auditing and analysis of metrics.
8. Shared vision among all providers, support staff and administrators - a personal passion for excellence -- which creates its own internalized, sustainable energy for the work of healthcare transformation.
9. Celebratory culture which does not compete with others but continually improves the organization's own performance, using others as motivation but not as a standard.
10. Monthly peer-review sessions with all providers, to review provider performance and to provide education in the use of electronic tools.
11. Adequate financial support for the infrastructure of transformation.
12. Respect of the personal value of others and the caring for people as individuals.
13. An active Department of Care Coordination and a hospital-care support team which is in the hospital twenty-four hours a day, seven days a week.
14. Aggressive end-of-life counseling with all patients over fifty, and active employment of hospice in the care of patients when appropriate.

Fourth, we determined to adopt a celebratory attitude toward our progress in EMR. In May, 1999, my cofounding partner was lamenting that we were not crawling yet with our use of the EMR. I agreed and asked him, "When your son first turned over in bed, did you lament that he could not walk, or did you celebrate this first milestone of muscular coordination of turning over in bed?" He smiled and I said, "We may not be crawling yet, but we have started. If in a year, we are doing only what we are currently doing, I will join your lamentation, but today I am celebrating that we have begun." These four seminal events have defined SETMA's EMR pilgrimage and are the foundation of our success.

Updated on March 29, 2012, "Fourteen Years ago Tomorrow"

Fourteen years ago, tomorrow, on March 30, 1998, the partners of SETMA signed a $675,000 contract to purchase an EMR system which would revolutionize our delivery of healthcare. There were only three of us and our accountant said, "You guys are surely now joined at the hip until death do you part." He laughed at our foolishness. Colleagues in the community said, "What a waste; all that money, and no benefit to the patient!"

Now, fourteen years later, SETMA is a national leader in the use of EMR to improve the quality of patient care and in the advancement of healthcare with electronics. SETMA's integration of EMR, laboratory data, hospital records, nursing home records and the new field of telemetrics, are all evidences that we made the right decision in 1997, which is when we decided to buy an EMR. No one is laughing any more and many lament the fact that they did not join us in this pilgrimage soon to be fifteen years ago.

With the use of an EMR, SETMA has become a recognized and accredited Patient-Centered Medical Home. SETMA has built a website which represents the cutting edge of EMR use. Thought leaders in healthcare transformation from across the nation, use SETMA's website as a source for creative and innovative ideas about the future of healthcare.

Work Force Innovations
Robert Wood Johnson Foundation's LEAP Initiative:
Are Work Force Innovations Imposed upon Existing Structures, or
Are Existing Structures Radically Changed
by the Process and the Impact of Transformation?
By James L. Holly, MD

I am haunted by the question, "Are there any other work force innovations at SETMA of which you are particularly proud?" When I first looked at the RWJF project, I was concerned as to whether SETMA's work would be valuable because we have not adopted some of the "new ideas" which have become very popular in the age of healthcare reform. We wondered if imposing new structures on existing organizations would essentially change those organizations or would they simply make them appear to be different. We came to believe that existing structures and organizations need a metamorphosis which would radically, dynamically and continually change the organization where the changes were not superficial but fundamental.

In fact, we have rejected reform as a method for the improvements which are necessary in healthcare. "Reform" by its nature results in only imposing upon existing organizations different structures without fundamentally changing those organizations' raison d'être. The national healthcare policy debate has been cast in terms of reforming of the system. I would argue that reforming is an inadequate goal, doomed to failure, and even if should succeed; reformation of the healthcare system will not produce the positive results which are legitimately desired by all participants in the debate. I would argue that if healthcare change is going to improve care, improve the quality of life, cover all Americans, and address the rising cost of care, we must have transformation of the healthcare system and not simple reformation.

Does the distinction between reformation and transformation of the system really make a difference? In order to examine this question, we must define our terms. The definition of "reformation" is "improvement (or an intended improvement) in the existing form or condition of institutions or practices etc.; intended to make a striking change for the better in social or political or religious affairs." Synonyms for "reformation" are "melioration" and "improvement." Another definition states, "The act of reforming, or the state of being reformed; change from worse to better."

On the other hand, "transformation" is defined as, "a marked change in appearance or character, especially for the better." "Metamorphosis," a synonym for "transformation," is the transliteration of a Greek word which is formed by the combination of the word "morphe" which means "form," and "meta" which means "change." "Metamorphosis" conveys the idea of a "noticeable change in character, appearance, function or condition." Metamorphosis is what happens when a caterpillar morphs into a butterfly. It does not simply impose a new structure upon an old form; it fundamentally changes the nature of the organism which rather than crawling around now can fly!

The Function of Reformation and of Transformation Radically Different

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.

Reforming Tools

Reforming tools are rules, regulations, and restrictions. Reform is focused upon establishing limits and boundaries rather than realizing possibilities. There is nothing generative (creative) about reformation. The “lethal gene” of reform is the inclination of organizations to resist the tools of reformation. Resistance requires more and newer tools, rules, regulations & restrictions with which to exert more pressure.

Reform does nothing to change the healthcare model of a patient going to a provider, expecting something to be done to or for the patient. In this model, the patient was and is passive. There is little patient responsibility for their own care, as to content, cost, or appropriateness.
This model offers no patient/provider leverage for improvement of care, health or cost.

Transformation, on the other hand changes the nature of the organization. Transformation is generative (creative) producing the energy and power for sustainable improvement. Transformation is not dependent upon external pressure, but is energized by an internal drive which is the nature of a “learning organization. Transformation is fueled by personal passion; it is self-sustaining, requiring no reward or recognition to continue.

Mental Images Define a Future you Intend to Create

Transformation creates mental images of what the future can be. These images are internalized by the individual and by the organization. The images morph into a personal and organizational vision, which produces a passion for creating a remarkable future. These mental images then create new images, which propel further innovation and transformation. The healthcare provider is no longer a “constable” attempting to impose health upon a patient – the provider is a counselor, a consultant, a colleague, empowering the patient to achieve the health status he/she has determined to have. The transformation is not sustain by external pressure but by internal passion. The “coming into being’ of the structures and functions demanded by the mental images is the generative (creative) process “forced” by transformation.

Provider and patient, with many others, are active team members, working together to preserve or improve the patient's health. All members of the team know and acknowledge that the “race of life is the patient's to run.” The patient and the provider must 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, patient-centered 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 and to personal relationships of mutual respect.

An Inconvenient Reality – without Humanity Science is Helpless

It may be an inconvenient reality but science is not the foundation of transformation. The tension which exists between technology and humanity is why technology must always be subservient to humanity. Yet. that subservience does not emasculate or eliminate the power of technology. Through acknowledging truth, privately and publicly, we empower sustainable change, making analytics a critical aspect of healthcare transformation. But the balance which humanity brings to the equation is that in the midst of health information technology innovation, we must never forget that the foundations of healthcare change are ‘trust’ and ‘hope.’ Without these, science is helpless!

Transformation will require the reestablishment of the trust which once existed between provider and patient. That cannot be done by fiat. Patients must be absolutely confident that they are the center of concern and of care. Patients must also know that they are principally responsible for their own health. These concepts are the genius behind Patient-Centered Medical Home and this trust cannot be achieved by regulations, restrictions and rules.

Patient and provider must lose their fear of death and surrender their unspoken idea that death is the ultimate failure of healthcare. Death is a part of life and it cannot forever be postponed. While the foundation of healthcare is that we will do no harm, recognizing the limitations of our capabilities and the inevitability of death can lead us to more compassionate and rational end-of-life choices. As primary care providers are the key to transformation of healthcare, primary care providers must be actively involved in the defining of public policy. To be successful, they

must be able to put their personal and pecuniary interests aside and support and promote policies which will create a sustainable future for healthcare.

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.

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 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.

Common Prejudice of Technology

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.

In May of 2010, I wrote an article entitled, Technology and Humanity: The Critical Balance in 21st Century Healthcare. In part that article stated: “Technology must never blind us to the human…In our quest for excellence, we must not be seduced by technology with its numbers and tables. This is particularly the case in healthcare. In the future of medicine, the tension - not a conflict but a dynamic balance - must be properly maintained between humanity and technology.

> "Technology can contribute to the solving of many of our disease problems but ultimately cannot solve the 'health problems' we face. It is my judgment that the major issue facing healthcare delivery today is that men and women, boys and girls have replaced the trust they once had in their physician with a trust in technology.
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> "The entire focus and energy of 'health home' is to rediscover that trusting bond between patient and provider. In the 'health home,' technology becomes a tool to be used and not an end to be pursued. The outcomes of pure technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.
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> "The challenge for our new generation of healthcare providers and for those of us who are finishing our careers is that we must be technologically competent while at the same time being personally compassionate and engaged with our patients. This is not easy because of the efficiency (excellence divided by time) of applied technology. A referral or a procedure is often faster and more quantifiable than is a conversation or counseling.
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> "As we move deeper into the 21st Century, we do so knowing that the technological advances we face are astounding. Our grandchildren's generation will experience healthcare methods and possibilities which seem like science fiction to us today. Yet, that technology risks decreasing the value of our lives, if we do not in the midst of technology retain our humanity. As we celebrate science, we must not fail to embrace the minister, the ethicist, the humanist, the theologian, indeed the ones who remind us that being the bionic man or women will not make us more human but it seriously risks causing us to being dehumanized. And in doing so, we may just find the right balance between technology and trust and thereby find the solution to true healthcare."

Winston Churchill's response to the sinking of the Titanic juxtapositioned technology and humanity. Upon hearing of the tragedy of the Titanic's sinking, Winston Churchill wrote to his wife and said, "The Titanic disaster is the prevailing theme here. The story is a good one. The strict observance of the great traditions of the sea towards women and children reflects nothing but honor upon our civilization...I cannot help feeling proud of our race and its traditions as proved by this event. Boat loads of women and children tossing on the sea – safe and sound – and the rest – Silence. Honor to their memory."

"Forty-eight hours later, Churchill added the following comment: "The whole episode fascinates me. It shows that in spite of all the inequalities and artificialities of our modern life, at the bottom, tested to its foundations, our civilization is humane, Christian and absolutely democratic. How differently Imperial Rome or Ancient Greece would have settled the problem. The swells, the potentates would have gone off with their concubines and pet slaves and soldier guards, and then the sailors would have had their chance headed by the captain; as for the rest – whoever could bribe the crew the most would have had the preference and the rest could go to hell. But such ethics can neither build Titanics with science nor lose them with honor."

Trust Rather than Technology

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 in to system 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.

Public policy can determine whether healthcare is reformed or transformed

First, that policy must acknowledge that governmental policy created the current conditions. Payment by "piece work" put the government's check book in providers' hands. The Providers only benefited; they did not create the system which rewarded over-utilization and expansion of services.

Second, the healthcare system must reward what is valued and what the system wants to promote. In that all of the transformative issues in healthcare are relational rather than technological, the system must promote relationships by rewarding efforts to restore the provider/patient relationship as the basis of care. Even specialist reimbursement should be increased for personal patient management even while the payment for procedures is decreased. The expertise of the specialist benefits patient care without necessarily requiring expensive procedures.

Third, public policy must place the patient at the center of concern in the healthcare equation, but also must place the patient at the center of responsibility. Patients cannot be allowed to be passive in their care and they cannot transfer their responsibility for their own care to anyone else.

Fourth, healthcare policy must pay for educational medical services but not in such a way as to create a new industry. Providers who create educational opportunities for their patients should be rewarded for doing so.

Fifth, as patients cannot be passive in medical decision making, they cannot be passive in the utilization of resources. No one would argue that a sick person should be denied care unless they can pay for it. However, if a patient continues an activity which adversely affects their healthcare, there should be consequences and those should be partially financial.

Sixth, one side of the healthcare debate argues that improved preventive care will produce dramatic savings in healthcare cost. The other side argues that dramatic decreases in care will be produced by tort reform. Neither is likely to be true. The transformation of healthcare delivery will result in improved preventive care and will result in fewer instances of patient dissatisfaction with their care and/or instances of patient injury, thus decreasing legal actions against providers. Neither, as a primary initiative, will transform healthcare.

Seventh, SETMA and many physicians, nurse practitioners and other healthcare professionals with whom I have contact are working toward transforming their practices of medicine to fulfill the promise of the metamorphosis of healthcare. They each and they all illustrate the final principle of transformation. To be lasting and to be effective, it will be done one practice at a time. At some point, we will reach critical mass and we will see the impact upon our community and upon our country.

Teams

While these concepts are necessarily philosophical rather than structural, the structures which result from the adoption of these ideals will support the Triple Aim with or without reward and regulations. Public policy will require some action to make changes in our healthcare system. What is imperative is that those changes which are directed at reforming the system do not ultimately prevent the transforming of the system.

The ultimate work force changes which will be transformative are those where vision and passion are shared between all members of the healthcare team. When that vision and passion is shared and when the images are shared, the organization will be radically changed. Work force adaptation to this internalized vision will be dynamic and relentless.

The uniqueness of SETMA's team approach may be that we recognize, respect and welcome the collegial partnership with nurses, nurse practitioners and others who traditionally worked "for" physicians rather than working "with" them in a collegial, collaborative, team approach to healthcare. The following quote defines SETMA's teams:

> "Most of us at one time or another have been part of a great 'team,' a group of people who functioned together in an extraordinary way – who trusted one another, who complemented each other others' strengths and compensated for each others' limitations, who had common goals that were larger than individual goals, and who produced extraordinary results. I have met many people who have experienced this sort of profound teamwork – in sports, or in the performing arts or in business. Many say that they have spent much of their life looking for that experience again. What they experienced was a learning organization. The team that became great didn't start off great – it learned how to produce extraordinary results." (p. 4)

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