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Medical Home: Is it the future of healthcare?
By James L. Holly, MD
Your Life Your Health
The Examiner
February 19, 2009

The Innovator's Prescription: A Disruptive Solution for Health Care, by Clayton M. Christensen, proposes a solution to the "problems" which our current healthcare system has. The following are some of the comments in the book's introduction:

- "In 1970…healthcare 7% of gross domestic product…In 2007…15%."
- "Health-care spending in the US regularly outpaces…overall economy…last 35 years…all goods and serves has risen…annual rate 7.2%...health care…rate of 9.8%"
- "…if federal...spending remains a relatively constant percentage of GDP…Medicare…will crowd out all other spending except defense within 20 years."
- "…costs of health care…forcing some of America's most economically important companies to becoming uncompetitive in world markets…"
- …if governments were forced to report…the liabilities they face resulting from…health care for retired employees, nearly every city and town in the US would be bankrupt…"
- "Health care is a terminal illness for America's governments and businesses…"
- "…many Americans have begun to look to a single-payer, government-controlled health systems…some governments with nationalized systems…(are) introduc(ing) competing private insurance plans…" (emphasis added)
- "…when caregivers make more money by providing more care, supply creates its own demand…"
- "…we need a system that is competitive, responsive, and consumer-driven, with clear metrics of value per dollar being spent."
- "…political dialogue on health-care reform centers on how to pay for the cost…This book offers the other half of the equation: how to innovate to reduce costs and improve the quality and accessibility of care."

Some of this prescription for our healthcare delivery system can be ignored. Perhaps the key concept in this book is that rather than focusing on how to design a system which we can afford, we need a healthcare system where the care is affordable. This subtle difference is profound. The concept of "afford" often focuses upon quantity, while the concept of "affordable" includes both the concepts of quality and expense.

However healthcare is structured there are quality elements which must be present in order to provide safety, standards, continuity and accessibility. In 1967, the American Academy of Pediatrics introduced the concept of "Medical Home." In 2007, the American Academy of Family Practice, the American College of Physicians (Internal medicine) and the American Osteopathic Association issued a joint statement in which

"Medical Home" was proposed as a solution to the dilemmas which we face as to access to quality healthcare while maintaining the continuity of health care.

In their joint statement, these organizations said, "The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family."

The following principles describe what a Patient-centered Medical Home would look like:

- Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home. The evidence for quality will be determined by:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Fundamental Shift – *Metanoia*

Change has been a part of the human experience since the beginning of time, but it was not until the 18th Century that the concept of progress – change in which the outcomes improve things – became a part of the collective ideals of society in general. The change, indeed, the progress, which needs to take place in healthcare will require that healthcare-provider organizations become "learning organizations." In the terms of Peter Senge's *The Fifth Discipline* a learning organization will have a "shift of mind":

> "The most accurate word in Western culture to describe what happens in a learning organization is one that hasn't had much currency for the past several hundred years…The word is *metanoia* and it means a 'shift of mind'…For the Greeks, it meant a fundamental shift or change…In the early… Christian tradition, it took on a special meaning of awakening

> shared intuition and direct knowing of the highest, of God. *Metanoia* was probably the key term of such early Christians as John the Baptist. In the Catholic corpus the word *metanoia* was eventually translated as 'repent.'
>
> "To grasp the meaning of *metanoia* is to grasp the deeper meaning of 'learning,' for learning also involves a fundamental shift or movement of mind…Learning has come to be synonymous with 'taking in information.'…Yet, taking in information is only distantly related to real learning.
>
> "This then is the basic meaning of a learning organization…continually expanding its capacity to create its future. For such an organization, it is not enough merely to survive. 'Survival learning' or what is more often termed 'adaptive learning' is important – indeed it is necessary. But for a learning organization, 'adaptive learning' must be joined by 'generative learning,' learning that enhances our capacity to create."

The Medical Home approach to healthcare will require a fundamental shift in the nature of provider organizations in which their learning will become "generative" – creating their future – and not just "adaptive – where they take in more informaiton about how things are around them at present. And, patient-centered care requires a fundamental shift in thnking of providers and in the relationship between patients and their primary care physicians. There must be:

- a higher degree of personalized care coordination
- access beyond the acute care episode
- identification of key medical and community resources to meet the patients' needs

The adoption of information technology for care management and quality improvement along with adequate payment methods are essential. In the long run, the Medical Home is likely to result in savings to patients, employers, and health plans. Increasing the emphasis on primary care could produce large dividends throughout the health care system.

Two trends are helping to build momentum around the medical home model:

1) a growing shortage of primary care clinicians due to adverse practice conditions; and
2) the increasing prevalence of chronic diseases among the U.S. population.

It is important to note, however, that the medical home model is not without controversy. The disease management industry has successfully carved a niche between primary care practices and chronic care patients by calling attention to physicians' lack of attention to patient coaching. Also, studies by RAND researchers and Dartmouth University have quantified the degrees of inaccuracy and misdiagnosis associated with chronic care patients treated in primary care settings. However, Vanderbilt studies and others confirm

that patients prefer coaching by their primary care physician, even while acknowledging that most provide little follow-up support for self-management. Some of the controversies about Medical Home are discussed in a December, 2008 article entitled, *The Patient-centered Medical Home Movement -- Promise and Peril for Family Medicine*.

Why Is the discuss of medical home important?

Primary care is essential for the effective and efficient functioning of America's health care delivery system. It is well established that having a regular source of care and continuous care with the same physician over time has been associated with better health outcomes and lower total costs. We know that states with more primary care physicians show more efficient and effective use of care, leading to lower overall health care spending. Data suggest that increased use of primary care physicians resulted in reduced hospitalizations and reduced spending for other non–primary-care specialist services with improvements in morbidity and mortality rates.

Most everyone agrees that the goal of health reform is personalized, coordinated, comprehensive care that is safe, affordable, and of high quality. Our current payment system encourages high volume, procedures, tests, and referrals. It does not reward the prevention of hospitalization, effective control of chronic conditions, or care coordination. T

Most methods of collaboration central to the medical home, though, are not paid for under much of the current fee-for-service system, such as e-visit consultations and chronic disease management. This lack of relative value placed on efficient, patient-centered care discourages many physicians and mid-level practitioners from providing such services.

Under the Medical Home model practices would:

- Ensure the ability to handle same-day appointments and walk-ins.
- Have Electronic prescribing connected to local pharmacies.
- Have interactive web sites moving patient self management to exciting new levels

  where patients could:

  1) access resources for preventative advice and chronic illness management, retrieve test results Access medical records,
  2) Process medication refills
  3) Schedule office visits
  4) Complete surveys
  5) non-urgent questions could be sent to their personal physician through online communication.

In the medical home primary, care is no longer a single physician craft but a complex set of tasks best managed by a multidisciplinary team. Since chronic illness management and lifestyle modification are central themes in the Medical Home, patients with similar problems could now be seen in groups led by physicians or other team members. The unique dynamics in group visits such as peer support could help with tackling tough problems such as obesity and diabetes.

Finally, critical in the Medical Home is the adoption of electronic health records (EHR). Without HER, medical home cannot and will not work. The tracking of performance measures for quality reporting through chart reviews is inaccurate and costly. Through the technology afforded in EHR's prospective data collection becomes a reality providing the physician with real-time quality measures for the purpose of benchmarking and improvement.

In keeping pace with the future of healthcare, SETMA is taking steps to form a Medical Home for all of our patients, starting with our Texan Plus patients. As part of that process, SETMA is also:

- Applying for NCQA certification of our diabetes treatment program
- Participating in the e-prescribing initiative
- Completing our affiliation with Joslin's Diabetes Center at Harvard
- Participating in the CMS project for reporting quality indicators for our care of Medicare and Medicaid patients.

These are daunting initiatives individually but collectively, they are challenging for they are complex and require us to rethink all that we do; but, for our patients and for our practice, they are the future.

Medical Home Part II: What is it?
By James L. Holly, MD
Your Life Your Health
The Examiner
February 26, 2009

Our February 17, 2009, column introduced the concept of Medical Home, but "What is it?" Two things are novel and may be the energy behind Medical Home. First, the patient and the healthcare provider enter into a collaborative relationship where the more the patient knows and understands about his/her health, and the more the patient accepts and takes responsibility for his/her health, the closer they come to forming a healthcare team which is defined by the concept of Medical Home. Second, Medical Home not only results from this team formation but also from the healthcare provider, who is identified by the patient as his/her principal healthcare provider, having information about the patient which is:

1. Comprehensive – this information goes beyond the routine medical, social, family and habits history and includes things such as the living condition, literacy, nutrition, etc., of the patient.
2. Accessible – this information must be readily accessible to the provider.
3. Considered in medical decision making for the patient – this information must be an active part of the patient's care and evaluation.

Historically, medical records and medical databases have looked more like a stick-figure than like a portrait of the patient. Electronic patient records have enabled that portrait to take on granularity and specificity so that the "picture" of the person is more personal. Now, Medical Home requires that that portrait take on the unique features of the patient which are personal, specific and unique. Creating the database for this information-set is the "first thing." Making that database interactive and dynamic is the "second thing." Using that database in an active and inter-active means in the care of patients is the "third thing."

Under the Medical Home model the provider has NOT done their job when they simply prescribe the care which meets national standards. Doing the job of Medical Home requires the prescribing of the best care which is available to the patient. For example, a year ago, the partners of SETMA formalized a 501-C3 not-for-profit foundation – The SETMA Foundation – which has as its purpose medical education and underwriting the care for patients who cannot afford care. Obviously, this fledgling foundation has limited assets but it is a beginning.

Recently, I saw a patient who has a very complex and fascinating healthcare situation. During his office-based hospital follow-up, I discovered the patient was only taking four of nine medications because of expense. I believe in this case, SETMA practiced Medical Home as the patient left the office:

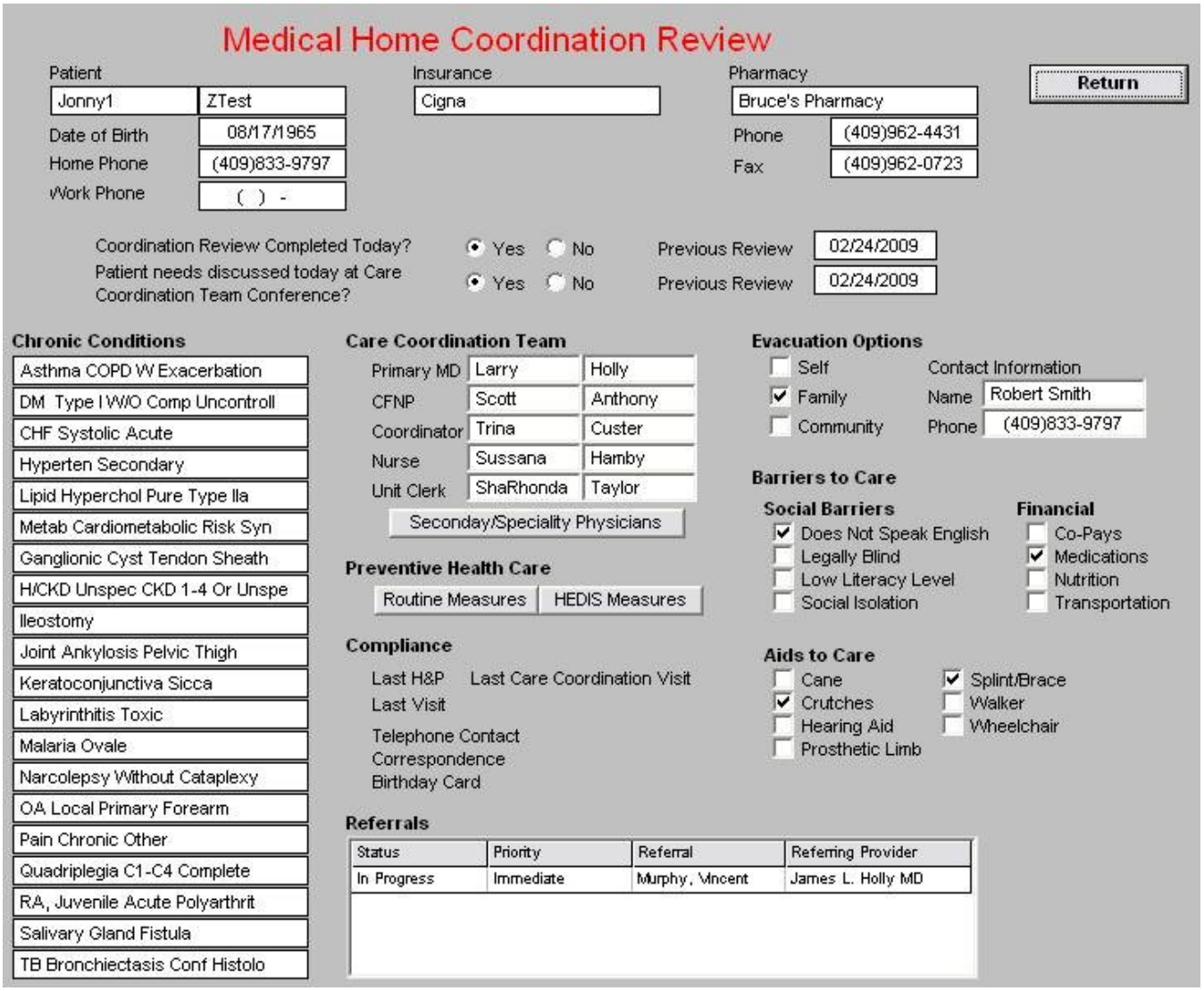
1. Appointment to SETMA's American Diabetes Association-approve diabetes-education program. The fees for the education program were waived. However, while talking to the patient's family, I discovered that the patient could not afford the gas to come to education meetings. The patient also left with a gas card with which to pay for the fuel to get the education which is critical to the patient's care.
2. My staff negotiated a reduced cost with the patient's pharmacy and made it possible for the pharmacy to bill The SETMA Foundation.
3. Because the patient cannot work at his job, the patient's care also involved counseling that we will coordinate an application for Social Security disability.

Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not, but are they a part of Medical Home? Absolutely. This patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with a smile and feeling that there is hope. It may be that the biggest result of Medical Home is hope.

Now, every healthcare provider doesn't have a foundation and even ours can't meet everyone's needs, but assisting patients in finding the resources to help our patients will be a part of medical home. And, when those resources cannot be found, Medical Home will be "done" by modifying the treatment plan so that what is prescribed can be obtained, for the ordering of tests, treatments, prescriptions which we know our patients cannot obtain is not healthcare even if the plan of care is up to national standards..

Medical Home Coordination Review

This is a quick look at what a Medical Home Coordination Review would look like. Almost all of the data will be collected from other data fields which already exist in our EMR. The final product will be interactive. Notice the team concept, along with the coordination of care initiatives, particularly for things such as evacuations and emergencies. This template will assume three kinds of coordination of care contacts: telephone, mail, and office visits, with a possible fourth, e-mail. The disease management tools are the ones being used in this patient (not a real patient). While the screen shot does not show the functionality, if you click on the Preventive Health and HEDIS buttons, a pop-up appears and tells you what measures are up-to-date and which ones are not.



As we have thought more about Medical Home, it occurs to us that the dynamic and the potential of Medical Home is found in its name. What is a "home:"

- It is a place where you need fear no harm from those who are with you.
- It is a place where your needs are met.
- It is a place you can go when you don't know what else to do.
- It is a place where you can be yourself and you can tell others how you really feel without fear of rejection.
- It is a place where others really want to see you succeed.
- It is a place where if you are away too long, someone is calling to find out if you are OK.
- It is a place where you are treating like family.

Coupled with excellence of care, Medical Home has the potential for leveraging great benefit for patients and providers from the healthcare delivery equation. Like the homes

in which we grew up, Medical Home will facilitate the success of the patient in a nurturing environment.

Goodbye Mr. Chips and Medical Home -- The value of a life given to the service of others

Recently, I saw the last few minutes of *Goodbye Mr. Chips*. Based on a novel by James Hilton and originally published in 1934 – Hilton was also the author of *Lost Horizon* which was about the mythical Shangri-La – the movie was released in 1939. Another version was released in 1969 starring Peter O'Toole. The novel, *Goodbye Mr. Chips*, is very similar to my favorite British novel entitled, *To Serve Them All of My Days*, by R. F. Delderfield, published in 1972.

I never see this movie without being deeply moved by the value of a life given to the service of others. The story is about Mr. Charles Chipping played by Robert Donat. Chipping comes to be called "Chips" by the boys in the boarding school where he teaches and where, during WWI, he becomes the headmaster. As he dies, Mr. Chips is dreaming of all his past students. He over hears two colleagues lament that he is dying alone and that he lived a lonely life without his own children. He awakens and says that he has not lived alone. He has had thousands of children, "All boys, he declares." In the last scene, young Peter Colley III, the youngest of a family of boys whom Chips had taught through the years, waves to him and says "Goodbye, Mr. Chips, goodbye."

Dr. Robert Culpepper and Medical Home

It occurred to me, as I was again moved by this dramatic scene, that Chips' attitude toward the boys is the same spirit and attitude which will be at the core of a Medical Home. And, in that regard, the new idea of a Medical Home really is only re-discovering the "old way" of medicine from 50 years ago. When I graduated form medical school in 1973, I called Dr. Robert Culpepper in Pineville, Louisiana. He had been my family's doctor from 1940 until we moved to Natchitoches, Louisiana in 1949. He lived in a fine home atop a beautiful hill which was on the way to my grandparent's home. Each time I passed that home through the years, I thought of Dr. Culpepper.

When I graduated from medical school, I wanted to let him know. When I called him, retired and now quite elderly, Dr. Culpepper, who had not seen my parents for over 24 years, said, "Larry, how are Bill and Irene," calling my parents by name. While in my mind, my parents were large, they were not wealthy or prominent people, yet he remembered their names and expressed personal interest in them, just like a "family" would. That is a response which reflects the dynamic of a Medical Home.

Medical Home is an old idea reinvented with technology attached – Generative Thinking

As we design electronic support for the implementation of this "new" idea (Medical Home), we shall remember that it is really quite old. It is like many things in which the

activity of creating the future is simply an effort to make that future resemble the best of the past. And, in that creating process, we must employ what Dr. Peter Senge calls "generative thinking" in his seminal work entitled, *The Fifth Discipline*.

Medical Home requires that patients become people and that those people have personal value to us beyond their financial contribution to our success. While this is most often the case with all physicians and healthcare providers, there are special obligations which its formalization in Medical Home imposes upon the provider, which if they are not systematized are often overlooked. This is why it is possible to have implemented all of the elements of Medical Home excellently without having become a Medical Home. Medical Home must have a foundation of excellence in the science of medicine but that excellence must be received in a personal setting.

As we understand what Senge calls "generative thinking," we with the collaboration of others will create this future we call Medical Home and in doing so we will create a future which produces our best result and which fulfills our best goals and ambitions as healthcare providers. Of generative thinking, Senge said:

> "This then is the basic meaning of a learning organization…continually expanding its capacity to create its future. For such an organization, it is not enough merely to survive. 'Survival learning' or what is more often termed 'adaptive learning' is important – indeed it is necessary. But for a learning organization, 'adaptive learning' must be joined by 'generative learning,' learning that enhances our capacity to create.
>
> "As I began my doctoral work…I felt that the solutions to the Big issues lay in the public sector. But I began to meet business leaders…These were thoughtful people, deeply aware of the inadequacies of prevailing ways of managing. They were engaged in building new types of organizations – decentralized, nonhierarchical organizations dedicated to the well being and growth of employees as well as success. Some had crafted radical corporate philosophies based on core values of freedom and responsibility…Gradually I came to realize why business is the locus of innovation in an open society. Despite whatever hold past thinking may have on the business mind, business has a freedom to experiment missing in the public sector."

"Medical Home!" A daunting concept. As SETMA moves into this new era of medicine, we will look forward to the health benefit to our patients, who really are like our professional family and we believe this will have great benefit to our community.

Medical Home Part III
Requirement Number 1 of 28
By James L. Holly, MD
Your Life Your Health
The Examiner
March 3, 2009

This is the third in a series of articles about Medical Home. Because of the newness of this concept a degree of repetitiveness is valuable in order to make sure we all understand what Medical Home is and why it has such great promise.

The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and well-functioning medical organization is the concept of "Coordination of Care." This is the intentional structuring, reviewing, facilitating and consistently practicing of a level of care which meets all current NCQA, CMS, national standards and HEDIS requirements for the demonstration of excellence.

The concept of "intentionality" is critical in this process. Rather than hoping the result is good, Coordination of Care plans, executes and reviews care to make certain that it meets the highest standards. In addition, patients are involved in this coordination by making them aware of the standards and giving them a periodic review, in writing, of how their care is or is not meeting those standards.

To quality as a Tier II Medical Home, a medical practice must meet 28 requirements. At present, SETMA is documenting its fulfillment of all of these requirements. Twelve of the documents are complete. Fourteen of the documents are in process sand two will be started this week. It is expected that within seven days all 28 documents will be finalized. SETMA expects to submit an application to NCQA for Medical Home status by the end of March.

The first requirement for qualifying to be a Medical Home relates to continuity of care and is described by CMS as, "The practice discusses with patients and presents written information of the role of the medical home that addresses up to 8 areas." The following is the document which fulfills the formal requirement for the first element of that application. This explanation of Medical Home which will be given to all of SETMA's patients who are enrolled in Medical Home.

Welcome to Southeast Texas Medical Associates (SETMA), LLP's
Medical Home
By James L. Holly, MD

"What did you welcome me to? " A Medical Home! This is not a new idea. The American Academy of Pediatrics (AAP) introduced the concept over thirty years ago, but in the past five years, the American Academy of Family Practice and the American College of Physicians (internal medicine) have joined the AAP in promoting the concept.

The Centers for Medicare and Medicaid services (CMS) and the National Committee for Quality Improvement (NCQA) have also joined forces to promote Medical Home.

The goal is to bring you better medical care. A Medical Home is not unlike your family home. It is a place where people care about you personally and where you can trust that your interests come first. It is a place you can go when you have a need. Like your home, a Medical Home is made up of a team, each member of which has a special role, but where no one person is more important than another. It is a place where the team makes certain that all of your needs are met.

In many ways, Medical Home is like the care you have been receiving from SEMTA for years. With the use of electronics, SETMA has been able to develop systems which protect you from medical errors and which can insure that you are receiving the care you need and deserve. Now a new dimension has been added which is the Care Coordination Team (CCT). This is a team of people who focus on your needs, whether they are ordinary, like every one else's, or whether they are special needs which are unique to you. The Care Coordination Team will make certain that you get the care you need as they assess any barriers which prevent you from obtaining that care, whether it is financial, access, understanding, transportation or other.

The Care Coordination Team will also develop a plan to make sure that your needs are cared for in an emergency such as when an evacuation is ordered. Medical Home is directed toward making certain that as we increase the "high tech" aspects of your quality care, we do not lose that "high touch" care we all experienced fifty or seventy-five years ago.

The CCT led by your personal physician will make certain that your care meets national standards and will share the elements of that standard with you so that you can be confident of the quality of care you are receiving.. Measured by HEDIS and the Consortium for Physician Performance Improvement standards, your care will be evaluated each time you come to the clinic and often at times when you don't come to the clinic. When you have complex problems, the team will meet to discuss how to make sure that your care is optimal. Before you come for an appointment the team will review the state of your care to make certain that it meets the highest standards.

HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.

HEDIS measures address a broad range of important health issues. Among them are:

- Asthma Medication Use
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Antidepressant Medication Management
- Fall Risk Assessment in the elderly
- Advising Smokers to Quit
- Many other measures of care

SETMA has incorporated HEDIS standards into our Medical Home Care Coordination Review (MHCCR). In addition to the LESS Initiative (Lose Weight Exercise Stop Smoking), to which you have become accustomed, and other educational materials on your medical conditions, you will receive a Medical Home Care Coordination Review (MHCCR) each time you come to the clinic. The MHCCR will include:

- The names and contact information for your Care Coordination Team members.
- The status of your HEDIS compliance and the status of your preventive care needs.
- A list of your current medications with descriptions of your directions in plain English
- The names and numbers of emergency contacts and your medical power of attorney
- The name and number of your pharmacy as everyone who provides you care are a part of your healthcare team.
- A list of the conditions for which you are being treated.
- Information about who we are to contact in case of a mandatory evacuation so that your Medical Home can be aware if you need help in being safe.
- An assessment of any barriers to care which you have, whether they are social, financial or other.
- Any special needs they have including mobility and safety.

The MHCCR will help you take charge of your own care and for you to initiate the obtaining of the care which you need but have not received. It will allow you to judge whether you are receiving excellent care. Of course you will continue to receive the encouragement to stay active, stay healthy, eat right, lose weight and avoid tobacco.

Medical Home will enable you to continue to receive:

- Same day appointments for urgent problems.
- Immediate attention in the ER for emergency conditions
- Response by telephone or e-mail to your questions or concerns.
- Follow-up by telephone for your results of testing when appropriate.
- And, all the other contact you have received in the past.
- 24 hour a days, seven day a week access to a SETMA provider for your healthcare needs.

In addition to this, you will receive calls and correspondence from the practice about issues of general medical interest and/or things related to your personal health concerns. We believe that Medical Home is going t make you feel "right at home" with your health care: safe, confident, secure and at ease.

Welcome to SETMA's Medical Home – welcome to **YOUR** Medical Home. Together, we will make your healthcare experience pleasant, satisfying, excellent and successful. Welcome to your healthcare team, of which you are not only the main focus, but now you are a dynamic and critical part.

Medical Home Part IV: Help and Hope in Healthcare
By James L. Holly, MD
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March 12, 2009

The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and highly-functioning medical organization is the concept of Coordination of Care. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current NCQA, CMS, national standards and HEDIS requirements for demonstration of excellence in the providing of care.

The concept of "intentionality" is critical in this process. This is contrasted with "incidental." In health care, most HEDIS compliance and coordination of care are done incidentally to a patient encounter as opposed to the having of a purposeful, provable and persistent fulfillment of national standards of care. Rather than hoping the result is good, Coordination of Care plans and reviews care to make certain that it meets the highest standards. The Medical Home intentionally fulfills the highest and best healthcare needs of all patients. In addition, the patient is involved in this coordination by making them aware of the standards and giving them a periodic review, in writing, of how their care is or is not meeting those standards. Patients are encouraged to know and to initiate the obtaining of preventive care on their own. Perhaps the ultimate judge of the success of Medical Home is when healthcare providers hear the following from their patients, "I am here today for preventive healthcare." Today, almost all healthcare providers would tell you that they have never had a patient present with that "chief complaint," or reason for scheduling an appointment.

To quality as a CMS Tier II Medical Home, a medical practice must meet 22 of 28 requirements. SETMA fulfills all 28. While Medical Home will ultimately qualify a practice for increased reimbursement from CMS and other healthcare payers, SETMA believes that this method of healthcare delivery is sufficiently promising to develop it with or without change in reimbursement and not only to apply it to Medicare, Medicaid or Medicare Advantage patients, but to all of our patients. It is obvious to us that SETMA's Medical Home will evolve over time. While we will be guided by CMS and NCQA requirements and by the experience of others, it is our expectation that ultimately, we will innovate, experiment and create a unique expression of Medical Home which will fulfill all of the requirements imposed by these agencies but which will also go beyond that as our vision, understanding and experiences increase.

As SETMA began to think about Medical Home, we had the following example set before us.. The following is a memo to the SETMA staff, by SETMA's CEO:.

> "My business philosophy is, 'I want it done right and I want it done right now!' Thus, if we are going to do Medical Home, I want it to be done right." Coupled with excellence of care, Medical Home has the potential

for leveraging great benefit for patients and providers from the healthcare delivery equation. Seeing the Medical Home as a reflection of the value and attitudes of "a home," make me think again that what I said this morning is right. I repeat it:

"In 2008, the partners of SETMA finalized a 501-C3 not-for-profit foundation – The SETMA Foundation – which has as its purpose medical education and underwriting the care for our patients who cannot afford it. In February, 2009, I saw a patient who has a very complex and fascinating healthcare situation. I saw him during his hospitalization and then for the first time in my office. What I discovered was that he is only taking four of his nine medications because he cannot afford them. I believe in this case, SETMA practiced Medical Home as he left this encounter with:

1. Appointments to SETMA's ADA-approved diabetes education program. The fees for the education have been waived. However, while talking to the patient and his wife, I discovered that he could not afford the gas to come to the meetings. He also left with a gas card with which to pay for the fuel to get the education which is critical to his care.
2. My staff negotiated a reduced cost for his medications with his pharmacy and made it possible for the pharmacy to bill The SETMA Foundation.
3. Because at 60 years of age and with his problems he cannot work at his job of a long-distance truck driver, his car also involved counseling him that even in the face of all of the abuse of the disability provision of Social Security, he can no longer work and I will coordinate his application for disability.

"Gas cards, disability, paying for medications – a part of a physician's responsibilities? Absolutely not! Gas cards, disability, paying for medications, a part a Medical Home? Absolutely!

This patient, who was depressed and glum in the hospital such that no one wanted to go into his room, left the office with a smile and feeling that there is hope. He left as if he had just had a visit to home. It may be that the biggest result of Medical Home is hope. This IS Medical Home!!"

Obviously , SETMA and/or The SETMA Foundation cannot meet everyone's needs, but that reality does not mean that we should not try to meet some of those needs. And we shall.

Often, as we reach a milestone in our life – say 65 years of age – or when we are faced with disappointment due to illness or disability, we long for simpler times when we were more certain of who we are and we were more secure in our lives. As time brings insecurity or anxiety about our health, we look for anchors which are familiar and encouraging. Many of us remember one of those anchors as the "ole timey" family "doc," who was more like a member of the family than a healthcare professional. One of

the hallmarks of our "coming of age' – either by birthday or disability -- is that we are now eligible for Medicare. And, because we are "of an age," there is a healthcare option to regain those "good old times;" those safe and familiar times.

It is called Medical Home. It is not a new idea; it is a new version of an old ideal. Medical Home combines the new technology of health care, whose benefit we all want, with the old philosophy of a healthcare provider being a family friend, which we all long for. Who ever thought that we could have both – high tech and high touch – the benefit of science and the blessing of sensitive, caring people? We can.

You will be hearing more and more about Medical Home in the coming years, but a few fortunate people can experience it now. Complex papers have been written about Medical Home but in essence it is defined by its name, "home:"

- Home is a place where you need fear no harm from those who are with you.
- Home is a place where your needs are met.
- Home is a place you can go when you don't know what else to do.
- Home is a place where you can be yourself and you can tell others how you really feel without fear of rejection.
- Home is a place where others really want to see you succeed.
- Home is a place where if you are away too long, someone is calling to find out if you are OK.
- Home is a place where you are treated like family.

Medical Home is where you and your needs come first. It is where you can expect the best care available but where you don't have to lose your individuality to get it. It is where people are "looking out" for your interests. It is where when you don't understand, you can ask and you will get an answer. It is where success is not measured by the value you are to the organization but by how valuable the organization is to you. It is where you are the focus; you are the core; you are the center of attention. It is where by design everything revolves around you and your needs.

In twenty years, Medical Home will be the standard of care for everyone, but by asking and looking, you can find a Medical Home today. If you want to feel special again; if you are weary of feeling like you are a bother to your healthcare system, find a Medical Home. There is no promise that everything that you want will come to pass, but there is a promise that everything you need will be made available to you and that when your problem cannot be resolved someone besides you will care.

Who would have thought that “coming home’ would be finding an “ole timey-like” healthcare provider who will also make sure that you are receiving the best and most up-to-date preventive care, the best of evidence-based care where you are the leader of your health care team and every member of that team wants to make you successful. You don’t have to wait twenty years – the reality is that some of us may not have twenty years to wait -- you can have Medical Home today. Just ask, no, insist that you be part of a Medical Home.

Stephen Foster’s melancholy words to Sewanee River, “There's where my heart is turning ever, there’s where the old folks stay,” often fill my heart with the yearning for simpler times. If you share that longing, Medical Home can help.

Medical Home Part V:
Healthcare Education and Delivery: Essential Changes Needed in Both
By James L. Holly, MD
Your life your Health
The Examiner
March 19, 2009

While SETMA has been thinking about the new organization, structure and dynamic of healthcare delivery, which is called "Medical Home," I have been simultaneously involved in meetings in which the education of healthcare professionals has been the central focus of discussion. Among many other community, business and consumer leaders, those meetings have involved the leadership of the various schools who train healthcare professionals. At most academic healthcare centers, those schools will include the following and others:

- School of Nursing,
- School of Dentistry,
- School of Biomedical Education which trains doctoral candidates in Biochemistry, Cellular and Structural Biology, Microbiology and Immunology, Molecular Medicine, Pathology, Pharmacology, Physiology, and Radiology,
- School of Health professions which trains healthcare professionals in Clinical Laboratory Sciences, Deaf Education and Hearing Science, Dental Hygiene, Dental Laboratory Sciences, Emergency Health Sciences, Occupational Therapy, Physician Assistant Studies, Physical Therapy, Respiratory Care., and
- School of Medicine.

One such academic center defines its mission statement as, "to serve the needs of the citizens of the state, the nation, and the world through programs committed to excellence and designed to:

- "educate a diverse student body to become excellent health care providers and scientists
- "engage in biomedical research focused on seeking information fundamental to the prevention, diagnosis and treatment of disease
- "provide compassionate and culturally competent state of the art clinical care
- "enhance community health awareness, education and practices thereby improving the wellness of the citizenry."

From this point forward, this discussion ceases to be attributable to anyone except this author and is not a reporting of anyone else's opinions, attitudes or thoughts. The ideal setting in which to deliver and to receive healthcare is one in which all healthcare providers value the participation by all other members of the healthcare-delivery team. In fact, that is the imperative of Medical Home. Without an active team with team consciousness and team collegiality, Medical Home is just a name which is imposed upon the current means of caring for the needs of others. And, as we have seen in the past, the lack of a team approached at every level and in every department of medicine creates inefficiency, increased cost, potential for errors and it actually eviscerates the potential strength of the healthcare system.

Why is this? Typically, it is because healthcare providers in one discipline are trained in isolation from healthcare providers of a different discipline. Oh, they are in the same buildings and often are seeing the same patients but they rarely interact. Even their medical record documentation is often done in compartmentalized paper records, which are rarely reviewed by anyone but members of their own discipline. This is where the first benefit of technology can help resolve some of this dysfunction. Electronic health records (EHR), or electronic medical records (EMR) help because everyone uses a common data base which is being built by every other member of the team regardless of discipline. While the use of EMR is not universal in academic medical centers, the growth of its use will enable the design and function of records to be more interactive between the various schools of the academic center.

And, why is that important? Principally, because more and more healthcare professionals are discovering that while their training often isolates them from other healthcare professionals, the science of their disciplines is crying for integration and communication. For instance, there was a time when physicians rarely gave much attention to the dental care of their patients, unless they had the most egregious deterioration of teeth. Today, however, in a growing number of clinical situations, such as the care of diabetes, physicians are inquiring as to whether the patient is receiving routine dental care as evidence-based medicine is indicating that the control of disease and the well-being of patients with diabetes is improved by routine dental care. Also, as the science of medicine is proving that more and more heart disease may have an infectious component, or even causation, the avoidance of gingivitis and periodontal disease have become of concern to physicians as well as dentist.

Disruptive Innovation

In addition, Medical Home places major emphasis upon issues which historically have been the concern of nurses. Physicians who use EMRs are discovering that the contribution of nursing staff can make the difference in the excellent and efficient use of this documentation and healthcare-delivery method. No longer is the nurse a "medical-office assistant" ancillary to the care of patients, but the nurse is a healthcare colleague central and essential to the patient's healthcare experience. As evidence-based medicine expands the scope of what *The Innovator's Prescription: A Disruptive Solution for Health Care* By Clayton M. Christensen labels as "empirical medicine" which ultimately leads to "precise medicine," it is possible for physicians and nurses to be a true-healthcare delivery team, as opposed to the nurses only being an aide to the physician. Christensen identifies the following "Levels of medicine" and makes the following judgments about the future of healthcare delivery:

- Intuitive Medicine -- "when precise diagnoses isn't possible…where highly trained and expensive professionals solve medical problems through intuitive experimentation and pattern recognition."
- Empirical Medicine -- "As patterns become clearer, care evolves into the realm of evidence-based medicine…where data are amassed to show that certain ways of treating patients are, on average, better than others."

- Precise medicine -- "when diseases are diagnosed precisely…therapy that is predictably effective ...(can) be developed and standardized."

Change wrought by Precision Medicine

- "…(when) we know what type of bacterium, virus, or parasite causes one of these disease…"
- "…(when) we know the mechanism by which the infection propagates…"
- "…predictably effective therapies can be developed…"
- "…therapies that address the cause, not just the symptoms…"

As a result, Christensen concludes:

- "….nurses can now provide care for many infectious diseases…"
- "…patients with these diseases only rarely require hospitalizations."

It is easily recognized in this emerging paradigm that all of the schools in the academic healthcare center are actively involved in patient care and in the training of those who will be healthcare providers. Yet, it seems that the farther and farther a person advances in biomedical education, the obvious union of their disciplines at their foundations seems to be lost and the more isolated from the whole these "specialists" and 'experts" become. This even creates problems within the various disciplines as egocentrism isolates one medical specialty from another. It is as a result of the need for the integration of healthcare disciplines at the delivery level, that the imperative becomes obvious for the restructuring of the training of the members of this healthcare team. And, the first change must come in the relationships between the leaders of the training programs who educate and mentor future healthcare scientist, teachers, caregivers and researchers. The educational leaders must model this integration for their disparate student bodies and that modeling will require the investment of the most precious and rare resource: time.

Glue? Adhesion and Cohesion

What is the model for this restructuring of the relationships between schools in the academic healthcare centers? It has been suggested that there is "glue" which unites the members of the various schools in an academic healthcare center, which will ultimately create this team. I would argue with that. Glue is an adherent. "Adherence" is described and simultaneously defined by the following:

- "Two dissimilar parts touching each other but not fused."
- "The union of separate parts; tending to adhere to or be connected by contact."

If propinquity is the principle motivation for the forming of a team, it will not survive the stresses and pressures which tend to make the team fly apart.
On the other hand, "cohesion" is "the bonding together of members of an organization/unit in such a way as to sustain their will and commitment to each other, their unit, and the mission," and it has been further defined as a "union between similar

plant parts or organs." Synonyms of "cohesion" are "harmony, agreement, rationality." Here is the source of the union of the various elements of the healthcare team in training. It is in the recognition of their commonness and in the acknowledgment of their being part of the same "organism."

Harmonics

The concept of "harmony" is valuable here also. Harmony is not the absence of discord; it is the presence of a common nature. The typical definition for a harmonic is "a sinusoidal component of a periodic wave or quantity having a frequency that is an integral multiple of the fundamental frequency." I smiled and chuckled aloud as I wrote this last sentence. It is a mouthful, but how is it related to our problem of healthcare delivery? If you have a room filled with tuning forks of different frequency and you strike one of the forks, all of the forks which are of the same frequency or a multiple of the same frequency, as the one struck, will begin to sound. Those which are intrinsically different will remain silent.

In a room of educators, some health science, some historians, some vocalists, some archeologists, etc., when the sounding is of excellent in healthcare delivery; when the sounding is of evidence-based medicine; when the sounding is of containing the cost of healthcare while maintaining the quality; when the sounding is of increasing the accessibility of healthcare by removing barriers of affordability, linguistics, literacy, etc; each member of the healthcare-education team, whether nurse, dentist, physician, scientist, physical therapist, laboratory technician or other, will begin to resonate, as they are all coherent, by their nature, to the process of sustained improvement in the delivery of healthcare. It is as if the healthcare-education team, as the healthcare-delivery team, has become a symphonic orchestra made up of instruments which are different in sounding method but which harmonize to produce an aesthetically satisfying result. Remember, the Greek word "symphonia" means "sounding together." So it is that the members of the healthcare-education and the healthcare-delivery team "resonate together" to produce the results we all desire.

Personal Pilgrimage

My personal pilgrimage in this process began my first year in medical school, but it was not in the class room. One day, as I was leaving the medical school with a classmate, the Dean's secretary ran up to us and said, "Larry, you must go downstairs. There is a meeting for the new health careers program and the Dean is there by himself." Reluctantly, I went and began a two-year participation in the School of Medicine's Health Careers Program and a life-time of desire to help young people pursue health careers. Every Saturday, we brought high school students, principally Hispanics, to the school of medicine and introduced them to health careers. I realized then that the recruitment of a diverse student body to the various elements of the health science center was not going to be done en masse but it was going to be done one student at a time. As a result, one of the missions of the SETMA Foundation is to help underwrite the education costs for students who qualify but cannot afford health-career education.

The second element to my pilgrimage was in Clifton, Texas, after graduation from Medical School. With the birth of my second child days before graduation and with him in neonatal ICU, I had to work in order to provide for my family. Monday after gradating on Saturday, I left for Clifton. I lived in the hospital around the clock with two days off in a month to take the state medical boards. I learned the value of a healthcare team from an LVN when one night, as I was preparing to treat a patient in the ER, she said, "I have noticed that our doctors do that this way." She was so kind. She didn't say, "Hey, stupid, didn't you learn anything in medical school?" Yet, over the next four weeks, my wealth of knowledge of physiology, pathophysiology, biochemistry, heart failure, etc., was augmented by a wealth of practical medicine taught to me by an LVN. What doctor cannot remember the same kind of experience with a nurse, or other healthcare team member who helped him/her through a patient encounter which was new? Why have we forgotten?

The third element of my pilgrimage was SETMA's migration to EMR. When SETMA was formed there was no uniformity in how medical records were created, filed or stored. Some dictated records, others hand wrote records. Some organized records alphabetically, others used a numeric system. On August 1, 1995, SETMA's medical-record-keeping illustrated all of the problems facing the future of healthcare in America. With the new millennium approaching, with all of the potential of 21st-Century technological care, SETMA was hamstrung by the use of mixture of a 19th –Century documentation system, i.e., pencil and paper, and a 20th-Century system, i.e., dictation and transcription. Neither system was capable of supporting innovation in healthcare delivery. In March of 1998, we purchased an EMR system.

Two events define our success with NextGen EMR and EPM. They occurred simultaneously. The first was our realization that this task was too hard and too expensive if all we were to get out of it was the ability to document a patient encounter electronically. It was this realization which pushed us past electronic patient records to electronic patient management. We realized that we had to develop the functionality for the EMR to enhance the quality of patient care, to increase the satisfaction of patients themselves and to expand the knowledge and skills of health care providers, if it was to be "worth it." It also had to expand the healthcare team to include all participants as active, valuable contributions to the delivery of healthcare. In the spring of 1999, we made this transition to electronic patient management and the investment of time and money suddenly was "worth it."

The second event occurred in May, 1999, and it set the tone for the next ten years of EMR implementation. In a moment of frustration at the new system, which at this point of development was cumbersome to use and yielded little more than an acceptable record of a patient encounter, one partner said, "We haven't even begun to crawl yet," speaking of our use of the EMR. SETMA's CEO said, "You're right, but let me ask you a question. When your oldest son first turned over in bed, did you lament to your wife, 'this retarded, spastic child can't even walk, all he can do is turn over in bed,' or did you excitedly announce to your wife, 'he turned over in bed!'?" He smiled and the CEO

dded, “If in one year, all we’re doing is what we are presently doing, then I’ll join you in your complaint. For now, I am going to celebrate the fact that we have started and that we are doing more than before.”

That celebratory attitude has given SETMA the energy and resolve to face hard times and the vision of electronic patient management has given us direction and substance to our goal. Today, we are not what we were, and we are not yet what we shall be, but we are on a pilgrimage to excellence which will never end. We started eight years ago at MGMA; where is the end? There isn’t one and that is
what helps us get up day after day, excited about the prospect of the future. Mostly what we celebrate today is the team which EMR has facilitated our forming.

Medical Home

Now, we come to Medical Home. As the healthcare education establishment is reorganizing itself to model the health-care-team concept for those they are teaching and mentoring, those in healthcare delivery are enjoying the opportunity to rethink our approach. Many of us have already experienced through the implantation the value of a healthcare team. Now with the power of the EMR, we have embedding HEDIS standards and other measures of quality into our EMR. We have designed a Coordination of Care review which allows us a snapshot at every visit as to where our patients are in their healthcare journey. We have completed a 408-page review of our practice and have been able to analyze what we are doing well and where we need to improve. Most of all, we have recognized how valuable the healthcare team is to our model of healthcare delivery and how central it is to Medical Home.

We value participants in healthcare delivery by what we pay them, but more essentially we value them by how we treat and relate to them. In the future, healthcare will undergo significant changes in monetary valuation of services which have been delivered. That will be forced upon us. However, our valuation of the contribution of others to our team is within our power to judge and acknowledge. How well and accurately we do, that to a great extent, will determine how we navigate the future.

Medical Home Part VI:
Evidenced Based Medicine Defines the Standard and the Structure of Care
By James L. Holly, MD
Your life your Health
The Examiner
April 16, 2009

On February 17, 2009, I attended a meeting in Houston at which the concept of "medical home" was discussed. In the ensuing eight weeks, SETMA has been engaged in an examination of the concept of medical home and the issues related to it. In that time, we have completed a review of our entire practice based on the 28 requirements of medical home published by the Centers for Medicare and Medicaid Services (CMS). In that review, we have examined and adopted the following standards for evidenced-based medicine:

1. **Healthcare Effectiveness Data and Information Set** (**HEDIS**) – published by he National Committee on Quality Assurance (NCQA), HEDIS measures are used by more than 90% of United States health plans to measure the effectiveness of care provided through their plans. HEDIS measures effectiveness of preventive care, acute care and chronic care based on the results of evident-based studies. In preparation for transforming SETMA into a Medical-Home model of healthcare delivery, we have embedded the HEDIS data set into our electronic medical record. As a result, it is possible for a provider at the point-of-service to evaluate whether the elements of HEDIS have been met. In addition, that information will be reported to the patient in two ways. First, at the point-of-service, the patient will be given a document which will review their Medical Home Coordination information and status. This review will include all HEDIS measures which apply to that particular patient and it will tell the patient whether each measure has been met or not. It will also let the patient know what needs to be done in order to meet HEDIS standards. Second, quarterly, SETMA will publish on its website, a summary of the SETMA's providers' HEDIS performance. This will not identify patients nor individual providers, but will let patients know how SETMA as a team is doing. Internally, SETMA providers will be given their performance and that performance will be compared to other SETMA providers.

   SETMA expects this function, and the introduction of the other four evidence-based standards of care into our EMR, to have a Hawthorne effect upon providers. What is that? There are three effects that observation and interaction has been shown to have upon people. The "placebo effect" is a well- known phenomenon that a patient's symptoms can be alleviated by an otherwise ineffective treatment, apparently because the individual expects or believes that it will work. The "Pygmalion effect" refers to self-fulfilling prophecy situations in which students performed better than other students

simply because they were expected to do by their teachers. It is possible for others to benefit from both of these effects.

The "Hawthorne effect" addresses a change in behavior, usually positive, resulting from the knowledge that one is being studied. This effect was first observed in a series of experiments conduced from 1924 to 1933. The term "Hawthorne" was coined as the site for the experimental studies took place at Western Electric Hawthorne Work, Chicago. The publishing of he HEDIS data in our EMR, the making of it possible for a provider to measure their own work at the time and place of service, and the knowledge that the result of that work is going to be posted in a public place will change behavior.

2. **National Committee on Quality Assurance (NCQA) --** Since its founding in 1990, NCQA has been at the forefront of advocating for improved healthcare delivery and providing standards to measure that improvement. The NCQA website makes the following comment:

> "NCQA consistently raises the bar. Accredited health plans today face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn NCQA's seal of approval. And even more stringent standards are being developed today. These standards will promote the adoption of strategies that we believe will improve care, enhance service and reduce costs, such as paying providers based on performance, leveraging the Web to give consumers more information, disease management and physician-level measurement….
>
> "….NCQA's programs and services reflect a straightforward formula for improvement: Measure. Analyze. Improve. Repeat. NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year."

SETMA is seeking NCQA recognition as a medical home and is also applying for NCQA recognition in diabetes care and in other clinic areas.

3. **National Quality Forum** (**NQF**) – this forum has published almost 500 evidence-based measures which have been recognized as standards of care. About 120 of those measures apply to primary care. In order to quality for Medical Home recognition by the NCQA, a practice must report on eight of these measures. SETMA will report on 43 of these measures and each year will add others until we are reporting on all of those which apply to outpatient,

ambulatory, primary care. Again, the results of this report will be published internally to our healthcare providers, will be reported to Golden Triangle Physician Alliance and Select Care of Texas, and will be posted on our website.

4. **Physician Consortium for Physician Performance Improvement** (**PCPPI**) – also based on evidence-based medicine the Consortium data sets have been developed to allow healthcare providers to evaluate and improve their own performance at the point of care. Since their publication over the past five to ten years, SETMA has embedded many of the data sets into our EMR for diabetes, hypertension, weight management, congestive heart failure, asthma, chronic stable angina, etc.

5. **Physician Quality Reporting Initiative** (**PQRI**) – first introduced in 2006 by CMS this evidence-based initiative defined 186 measures which could result in increased payments to providers and/or provider groups which reported on their performance of these measures and who exceed an 80% performance rate. The reporting is complex but due to our EMR, it is possible for SETMA providers to achieve this performance and reporting standard without interfering with patient care. There are 122 measures which apply to ambulatory, outpatient, primary care. To meet CMS standards, SETMA is required to report on 3 measures. Beginning in July, 2009, SETMA will report on 34 measures and each year will add others.

6. **Patient Centered Medical Home** (PCMM) – recognition as a Tier III Patient Centered Medical Home by NCQA requires the fulfillment of more than 50 standards including communication, education, access, collaboration, evidence-based standards of care, planning, and review and reporting. SETMA is activity re-designing workflow and functionalities and implementing new capabilities to meet the highest level of NCQA standards. We expect to submit an application for Medical Home in September and will publish the results of that application process on our website.

7. **E-prescribing –** it has long been a goal of quality-improvement in healthcare to make it possible for healthcare providers to submit prescriptions to pharmacies in an electronic format for safety, efficiency, convenience and excellence. Since January of this year, SETMA has been doing this. Patients and pharmacies like this service and it meets all of the standards of excellence which are required by CMS.

Teamwork

Yet, with these quality measures and functions as the foundation of the patient-centered Medical Home, the fundamental concept is built on the concept of a team. It is no longer the action of the super star but it is the collective and collaborative activity of the integrated team which will consistently and persistently achieve the results we all

desire. Because of this, a provider's commitment to the content of evidence-based medicine can be emasculated by resistance to the organization, structure and dynamic of evidenced-based medicine! In healthcare, the standard is practicing evidence-based medicine, BUT – and here is the rub – evidenced based medicine does not only address the content of care but the organization, structure and dynamic of care. You may be committed to evidence-based medicine but resist the organization, structure and dynamic of the team approached with shared responsibilities which has been proved to produce superior result.

Medical Home does not succeed on the basis of one person's performance, or on the basis of the "leader's" performance – it succeeds on the basis of the TEAM's performance and the TEAM is the "organism" of evidence-based medicine." Marshall McLuhan said, "Our Age of Anxiety is in great part, the result of trying to do today's jobs with yesterday's tools." Paper and pen and Dictaphones are yesterday's tools for patient care. Electronic records are the tools of the 21st century. In the same way, the team is now the unit of evidenced-based medicine, not the individual physician. Michael Jordan said, "Talent wins games, but it takes teamwork and intelligence to win championships." This is why an excellent physician may never achieve the depth and breath of excellence he/she desires because of the absence of utilizing the power and resources of the team.

Too often the terms "group" and "team" are used interchangeably. This is unfortunate because there is a big difference between the two. A group is a unit of co-workers who perform their jobs in the same location but are not interconnected and functioning with the entire practice in mind. As a result, a group often experiences re-work and process inefficiencies. A team, on the other hand, not only functions with the entire practice in mind but also understands where their job fits into the whole. Team members who are given the option to participate in a problem-solving possess a greater sense of trust and feelings of mutual respect. A medical home needs to function like a well-oiled machine in order to deliver the care required by patients in the 21st century. Every member of the staff must recognize their contribution to the patient's experience and the value of the contribution.

2009 is a pivotal year in the history of SETMA. It will be interesting to report in 2010 how we have done in this radical transformation of our practice.

Letter Approved by CMS for sending to Medicare Recipients about Medical Home March 2009

Dear_____(patient's name)

Often, as we reach a milestone in our life – say 65 years of age – or when we are faced with disappointment due to illness or disability, we often long for simpler times when we were more certain of who we are and felt more secure in our lives.

As time brings insecurity or anxiety about our health, we look for anchors which are familiar and encouraging. Many of us remember one of those anchors as the "ole timey" family "doc," who was more like a member of the family than a healthcare professional. One of the hallmarks of our "coming of age" – either by birthday or disability -- is that we are now eligible for Medicare. And, because we are "of an age," there is a healthcare option to regain those "good old times;" those safe and familiar times.

It is called Medical Home. It is not a new idea; it is a new version of an old ideal. Medical Home combines the new technology of healthcare, whose benefit we all want, with the old philosophy of a healthcare provider being a family friend, which we all long for. Who ever thought that we could have both – high tech and high touch – the benefit of science and the blessing of sensitive, caring people? We can.

You will be hearing more and more about Medical Home in the coming years, but a few fortunate people can experience it now. Complex papers have been written about Medical Home but in essence it is defined by its name, "home:"

- Home is a place where you need fear no harm from those who are with you.
- Home is a place where your needs are met.
- Home is a place you can go when you don't know what else to do.
- Home is a place where you can be yourself and you can tell others how you really feel without fear of rejection.
- Home is a place where others really want to see you succeed.
- Home is a place where if you are away too long, someone is calling to find out if you are OK.
- Home is a place where you are treated like family.

Medical Home is where you and your needs come first. It is where you can expect the best care available but where you don't have to lose your individuality to get it. It is where people are "looking out" for your healthcare interests. It is where, when you don't understand what your physician is telling you, you can ask and you will get an answer. It is where success is not measured by the value you are to the organization but by how valuable the organization is to you. It is where you are the focus; you are the core; you are the center of attention. It is where by design everything revolves around you and your healthcare needs.

In twenty years, Medical Home will be the standard of care for everyone, but by asking and looking, you can find a Medical Home today. If you want to feel special again; if you are weary of feeling like you are a bother to your healthcare system, find a Medical Home. There is no promise that everything that you want will come to pass, but there is a promise that everything you need in the way of medical services will be made available to you and that when your problem cannot be resolved someone besides you will care.

Who would have thought that "coming home" would be finding an "ole timey-like" healthcare provider who will also make sure that you are receiving the best and most up-to-date preventive care, the best of evidence-based care where you are the leader of your healthcare team and every member of that team wants to make you successful. You don't have to wait twenty years –you can have Medical Home today. Just ask, no, insist that you be part of a Medical Home.

Stephen Foster's melancholy words, "There's where my heart is turning ever, there's where the old folks stay," often fill my heart with the yearning for simpler times. If you share that longing, Medical Home can help. To make an appointment with me to learn how Medical Home can be a reality for you—please call
(telephone#)

James L. Holly, MD
CEO, SETMA, LLP
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Medical Home Part VII:
Reporting of Quality Measures Performance
By James L. Holly, MD
Your Life Your Health
The Examiner
April 23, 2008

"A test will be given next week," announces the teacher, instantly creating anxiety and apprehension in the class. "What will we be tested over?" What do we need to know? Relief sweeps over the class when the teacher announces, "It will be an open book test and here are the questions, you will be asked."

Excellent testing should be as educational of what the student should know, as it is evaluational of what he/she does know. Tests should indicate to the student what is important and test should not just be tools which shows the student what he doesn't know.

Often we associate test with a classroom setting in a formal educational program, but the reality is that all of life and all of our life experiences are a test of on sort or another. So it is with healthcare. Once a year by some health plans and less often by others, the performance of healthcare providers is measured. The testing tool is called HEDIS, which stands for "Healthcare Effectiveness Data and Information Set" HEDIS has various subsets of data collection. Some of the data evaluates health plan functions and some healthcare provider functions. It is the latter in which we are presently interested.

SETMA's Open Book Tests: HEDIS, NQF, NCQA, PQRI

HEDIS measures are developed by the National Committee on Quality Assurance (NCQA), which was formed in 1990. Annually, NCQA publishes an approximately 300-page *HEDIS Technical Specification for Physician Measurement*.

As SETMA has been developing its Medical Home, it occurred to us in that HEDIS and other measures of quality performance by healthcare providers are open-book test and in that the "professor" has given us the test questions, we should measure ourselves to see how we are doing. In addition, in that we have that data, we should share it with our patients and with our community. So, we shall.

While HEDIS is the major quality measure used in the healthcare industry, there are other significant ones including:

1. **Physician Consortium for Performance Improvement** – this measurement set for various conditions such as hypertension, diabetes, congestive heart failure and others have been developed by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Institute of Medicine (IOM) and the medical and surgical specialty societies. These data sets are intended as "open-book tests of provider performance, where the

questions have been given to the provider." The hope is that as providers measure their own performance that quality of care will improve. SETMA has embedded some of the Consortium's data sets into our EMR and we will report on the results of these as well as HEDIS.

2. **National Quality Forum (NQF)** – In 1998, A report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, proposed the formation of the Forum as a part of a national agenda for improvement in healthcare delivery. Formed in 1999, NQF's mission statement declared, "The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs." NQF's vision is that "the NQF will be the convener of key public and private sector leaders to establish national priorities and goals to achieve the Institute of Medicine Aims—health care that is safe, effective, patient-centered, timely, efficient and equitable. NQF-endorsed standards will be the primary standards used to measure and report on the quality and efficiency of healthcare in the United States. The NQF will be recognized as a major driving force for and facilitator of continuous quality improvement of American healthcare quality."

   As of October, 2008, NQF has endorsed 514 "national voluntary consensus standards." For NCQA recognition as a medical home a physician group must report to its providers and to an external agency their performance on at least 8 of these measures. SETMA has chosen 43 on which to report and our performance on these 43 measures will be posted to our website as well as reported to our providers.

3. **National Committee for Quality Assurance (NCAQ)** – As previously noted, NCQA published the HEDIS measures each year and provider's evaluation tools for health plan and provider groups. Principle among these is NCQA recognition as a Patient-Centered Medical Home. It is NCQA which requires a practice to report internally to healthcare providers and externally to health plans on at least 8 NQF-endorsed measures.

   NCQA has nine standards for measuring the qualification of a practice as a Medical Home. Each standard has multiple elements and each element has as many as 18 specific measures. NCQA recognizes three levels of Medical home depending upon how many standards, elements and measures the practice meets. SETMA will submit and application for Medical Home designation in September of this year.

   SETMA is required to report on three conditions for Medical Home recognition, we have chosen diabetes care, hypertension care and cholesterol care as our three conditions. In addition, because the core of Medical Home is

the "care coordination" function, SETMA will provide a document to our patients at the time-of-service which summaries the sets taken by SETMA to coordinate that patient's care. Also, that document will summarize for the patient their HEDIS and NQF measures status, with a list of the measures which have not yet been met. This report care to the patient on the provider performance will also function as a report to the patient of what is missing in their care.

4. **Physician Quality Reporting Initiative (PQRI)** -- The 2006 Tax Relief and Health Care Act required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). *The 2990 PQRI Measures Specifications Manual for Claims and Registry Release Notes* is a 442-page document which explains this program.

   PQRI has identified 14 measures and PQRI requires that a practice report on at 86least 3 individual measures or 1 Measures Group in order to be recognized by CMS. SETMA will report on three Measures Groups (Diabetes, Preventive Care, Rheumatology and Ophthalmology) which contain a total of 28 measures.

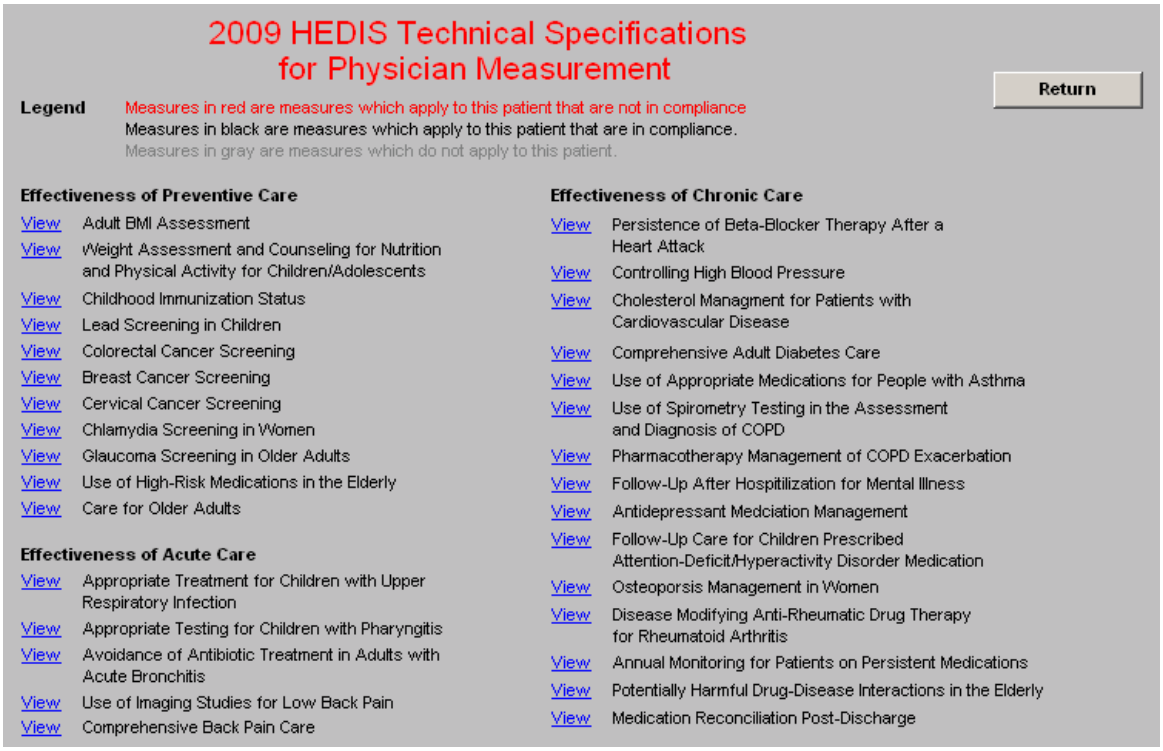
These are SETMA's providers', actually all healthcare providers in the United States, open-book tests. For the benefit of our patients and as a challenge to ourselves to fulfill the promise of excellent care, we will begin public reporting on all of these measures by the end of this year.

HEDIS measurers effectiveness of Care in Preventive, Acute and Chronic Care.

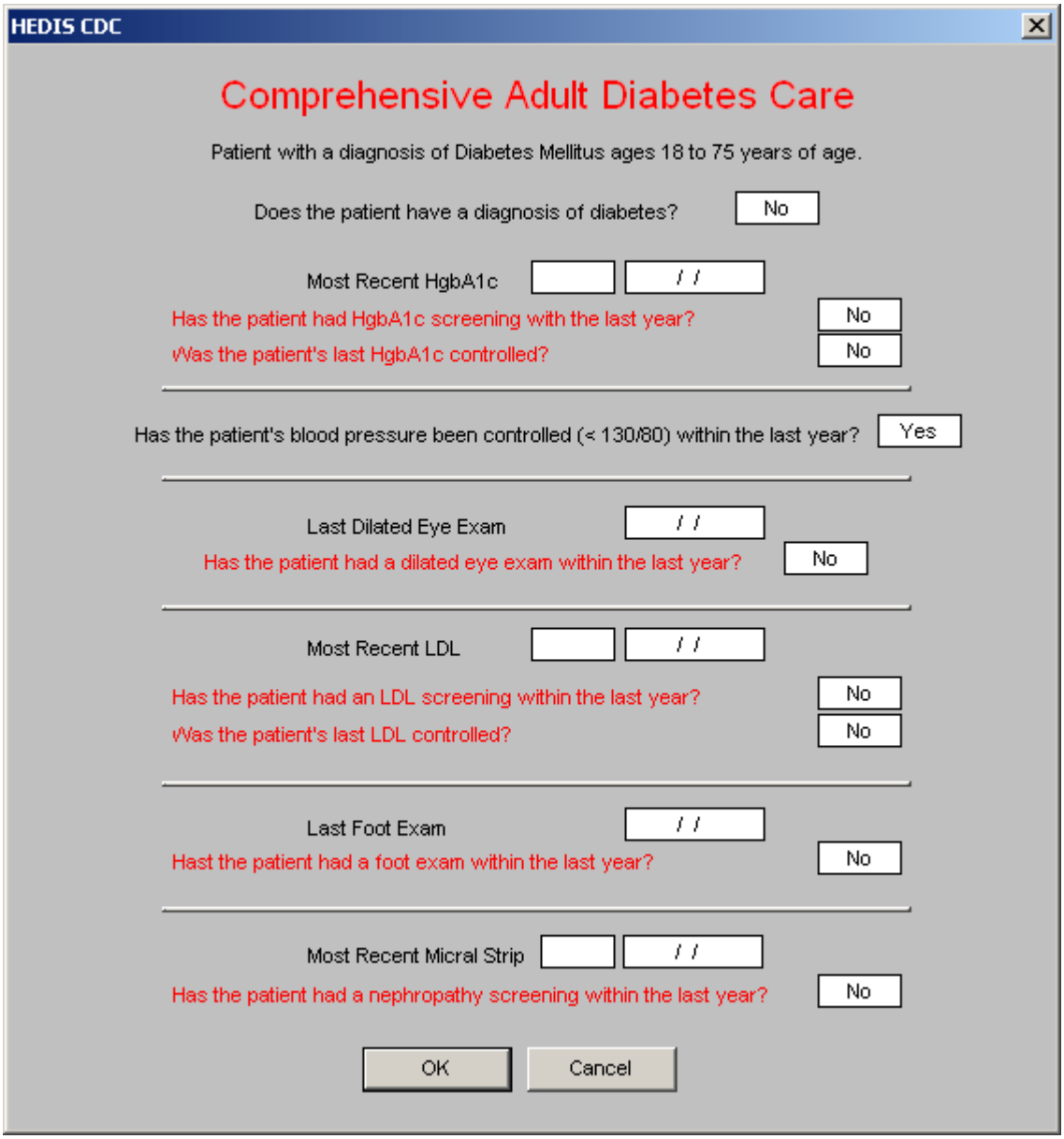
The following is the display in SETMA's EMR of the HEDIS Measures. This template lists all of the HEDIS measures for which providers are responsible. All of the activity and fulfillment of the HEDIS measures on this template are captured automatically.

At the top of the template is a section entitled, "**LEGEND**," which explains that:

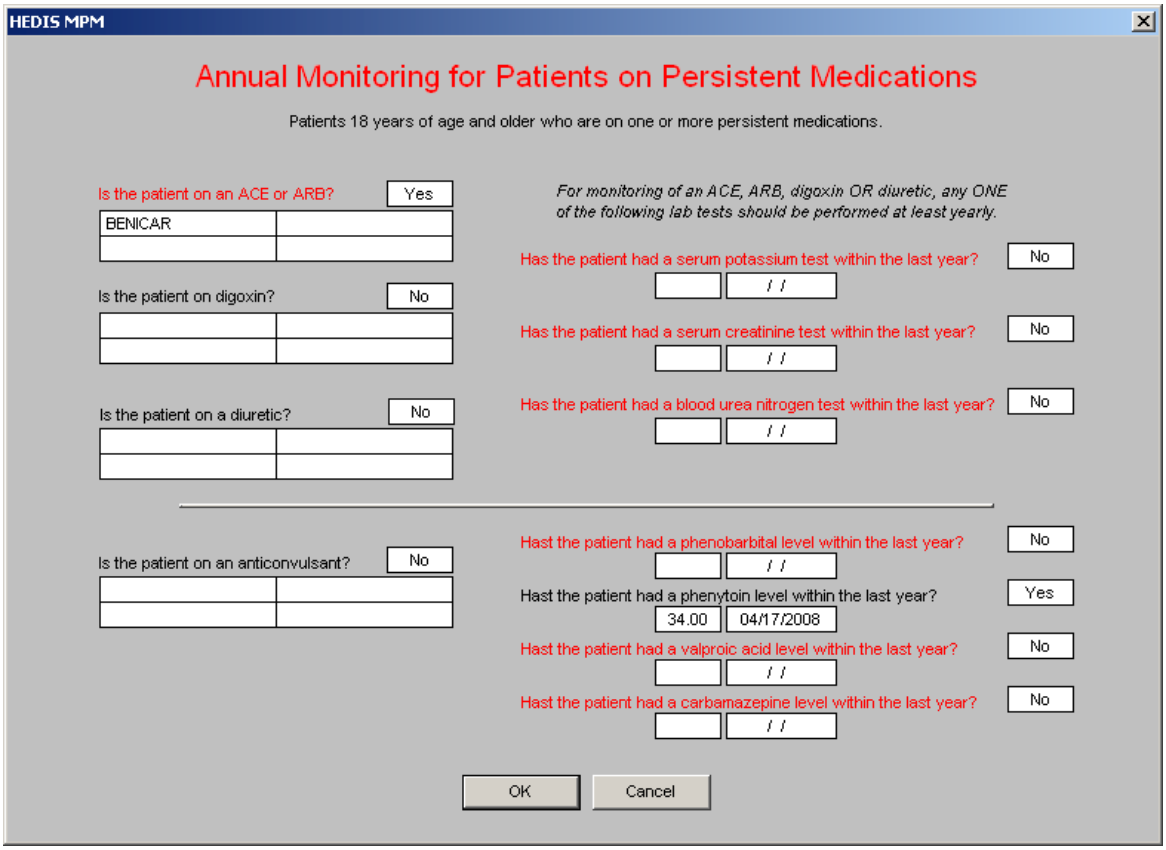
- measures which apply to the current patient and are not fulfilled appear in **RED**
- measures which apply to the current patient and are fulfilled appear in **BLACK**
- measures which do not apply to the current patient are **Grayed-out**



As illustration of each of the above, the following shows how the Comprehensive Adult Diabetes Care displays on the patient's electronic patient record. The data points within this template are captured automatically without the provider doing anything.


HEDIS CDC
Comprehensive Adult Diabetes Care
Patient with a diagnosis of Diabetes Mellitus ages 18 to 75 years of age.
Does the patient have a diagnosis of diabetes?
No
Most Recent HgbA1c
/ /
Has the patient had HgbA1c screening with the last year?
No
Was the patient's last HgbA1c controlled?
No
Has the patient's blood pressure been controlled (< 130/80) within the last year?
Yes
Last Dilated Eye Exam
/ /
Has the patient had a dilated eye exam within the last year?
No
Most Recent LDL
/ /
Has the patient had an LDL screening within the last year?
No
Was the patient's last LDL controlled?
No
Last Foot Exam
/ /
Hast the patient had a foot exam within the last year?
No
Most Recent Micral Strip
/ /
Has the patient had a nephropathy screening within the last year?
No
OK
Cancel

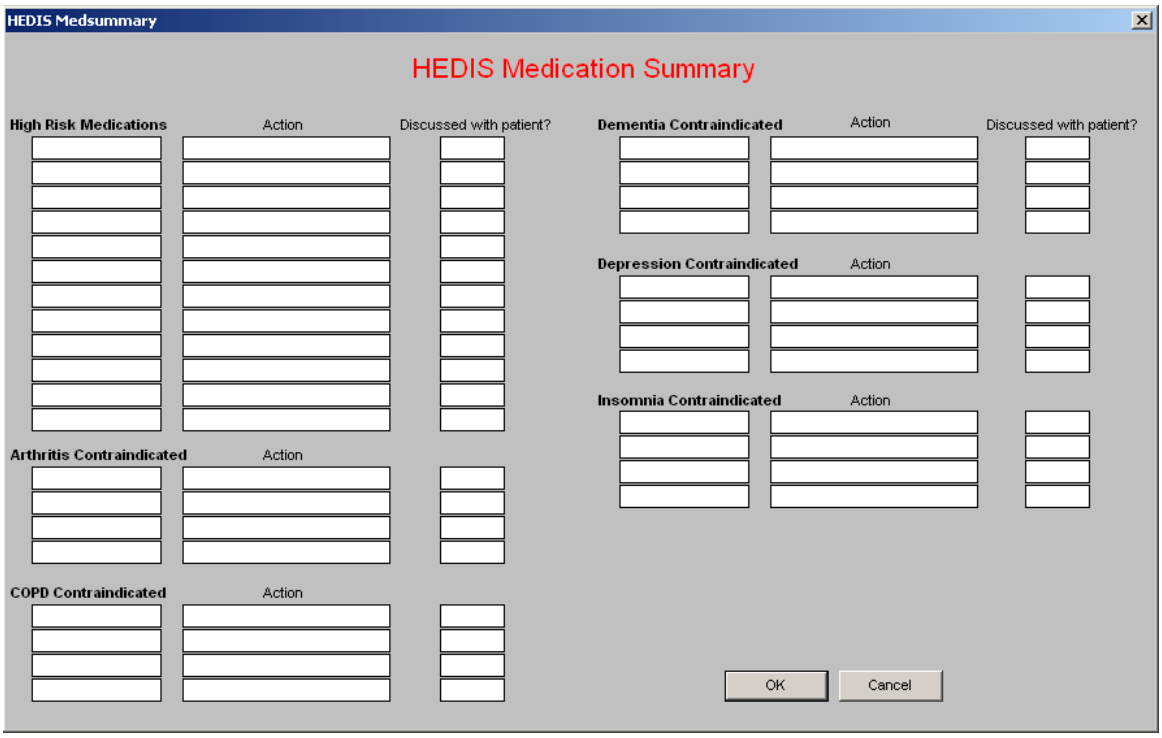
The following is a HEDIS measure entitled “Annual Monitoring for Patients on Persistent Medications”



The EMR program which SETMA has built searches for each of the mediations which are being monitored and indicates whether the designated test has been done.

In the care of the elderly, there are numerous medications which should not be used or if used should be done with cautions. This HEDIS Measure is entitled, “Potentially Harmful Drug-Disease Interactions in the Elderly.” SETMA’s EMR searches each patient’s record and alerts the patient as to whether or not the patient is on one or more of these medications.

If one of the medications is found, the provider is directed to address the medication and to discuss it with the patient. There are three options: “the medication has been changes,” “the medication ahs been discontinued,” or “the medication has been reviewed and needs to be continued.”



Every day, on every patient, SETMA providers can measure their own performance. Every day an audit will be done on HEDIS, NCQA, NQF, Consortium and PQRI data sets and reported to each SETMA provider. Quarterly, staring at the end of this year, SETMA will post these results on our website.

We want our patients to know that we take their healthcare seriously.

Medical Home Part VIII:
Why is Medical Home Called Patient-Centered Medical Home?
By James L. Holly, MD
Your Life Your Health
The Examiner
May 21, 2009

Amazing technological innovations have advanced the potential benefit of modern healthcare to a heretofore unimagined level. However, those same innovations unintentionally promoted a reimbursement methodology and an organizational structure of the delivery of healthcare which have to some degree abrogated the promise of those same technological advances.

As the science of medicine grew, due to capabilities and reimbursement, the focus of care delivery came to be on procedures, services and encounters rather than on the global health of the individual patient. And, technology was applied without regard to whether or not it was benefiting the patient long-term and/or creating health. The end-of-life, rather than being a time of reflection, reconciliation and resolution, often became a marathon of hospitalizations, surgeries and extraordinary interventions which neither improved the quality nor add to the quantity of life. Markets were created for "practice enhancement" and new "revenue streams," which focused upon the benefit of the provider without any realization that what often happened was that the health of the patient suffered.

In this system, the patient encounter was directed toward meeting the immediate expectations and interests of the patient without attention being given to the overall "need" and "health" of the patient. "Good medicine." in this system, was defined by a growing patient base, an increasing reputation of the provider as thorough and knowledgeable clinician and the financial success of the practice.

There is no doubt that the patient's welfare was important and that there was no intention of developing a system which was dysfunctional, but it happened. The patient was the focus but only as a snapshot in healthcare delivery, which delivery attended to the immediate, expressed needs of the patient and often not to the implications of evidence-based medicine for the patient's long-term benefit. The snapshot narrowed the focus of the healthcare system to "parts of the patient," rather than providing a detailed portrait of the patent which included hopes, dreams, and humanity, as well as physiology and anatomy.

Finally, the dysfunction in the healthcare system, which was created by innovations and advances, was recognized. Gradually, efforts were made to modify this system and to eliminate the dysfunction. Quality measures were published which allowed the care of one provider to be measured against the care given by another. Preventive care was emphasized, but remained difficult because preventive care was rarely if ever a primary reason for a patient seeing a provider and it was often not paid for by insurance companies including CMS. Efforts were undertaken to move the patient back to the

center of the healthcare equation. Providers began to be encouraged to emphasize points of care other than acute illness.

The compartmentalizing of care by many providers, most of whom were specialists, created a system of incoordination, where patients felt that the only "safe" way to get excellent care was through seeing many different caregivers, each of whom knew everything about one thing but rarely everything about the one patient. Because the payment for this system was based on procedures and studies, costs escalated. Patients associated "good care" with a delicatessen kind of medicine in which they got one of these, one of those and one of another. The care received in this system increasingly lost the focus on the patient as a whole and the health outcome of this system of care deteriorated.

As the demand for quality care increased and as the need for methods of measuring that quality in quantifiable and comparable ways grew, agencies and organizations stepped into the void. One solution to the healthcare-delivery conundrum was the introduction of Medical Home.

Seeing the Patient as a Whole and as the Whole Interest

The concept of a Medical Home is new to most healthcare providers as well as patients. An old idea, which has recently gained momentum, the ideal of Medical Home was adopted by the American Academy of Family Practice, which in 2002 published a monograph entitled *The Future of Family Medicine:: A Collaborative Project of the Family Medicine Community Future of Family Medicine Project Leadership Committee*. That paper concluded with 10 points which addressed the future of healthcare in America in general and family practice specifically. These will be addressed below.

The heart of Medical Home is the patient which is why NCQA's version is entitled Patient-Centered Medical Home. No longer will procedures, tests and things we do to patients be the focus of healthcare – although these will continue to be an important part of the delivery of health – now the patient will be front and center. And, the patient will be the center in all aspects of the healthcare experience:

- The patient will be "in charge," which empowers the patient to be responsible for their care and for their health. In this system, the patient can no longer "turn his/her care over to a provider" and passively expect "health" to happen. The patient has to determine that he/she wants to be healthy and has to determine to take the steps to make that happen. Both the patient and the provider become accountable in this system. The provider cannot do what the patient refuses to, but the patient can now require that the provider provide evidenced-based, quality-measured health care.
- The patient will no longer see the provider as a "constable" charged with imposing care upon the patient, but the patient will view the provider as a colleague, a counselor and a collaborator in the process of the patient retaining, regaining or maintaining health. And, in the end, rather than being a "miracle

worker" who can forestall the inevitable, in this system, the caregiver will compassionately and with care, with family, friends and others, the provider will help the patient through the final days of life. Sometimes this will be done in a healthcare facility but increasingly it will be done in the home.

- The patient's understanding of and education about his/her health condition and/or illness will be the goal of healthcare delivery, particularly in the primary setting. The marching orders for patient and provider will be to realize the truth of Dr. Elliott Joslin's (Founder of the Joslin Diabetes Center at Harvard University) statement, "The patient who has diabetes who knows the most about diabetes will live the longest." Length of life will be more associated with the knowledge and decisions of the patient than with the power and prescriptions of the provider.
- The patient will be encouraged, supporting and followed by the provider not only when the patient is in the provider's office but particularly when the patient is not. Perhaps nothing will be a more fundamental change in the delivery of health care than this point.

As providers modify their work flow, systems, organizations and structures to meet the new demands of Medical Home, they will discover that the complex workflow processes of Medical Home relate to patient convenience, compliance and/or capacity to receive care. These changes are identified by NCQA in many of the 9 standards, 30 elements and 183 data points which define NCQA's requirements for recognition as a Medical Home. Some of these are:

- Follow-up calls after a visit to see if the patient saw the specialist, had the, or got the medication filled.
- Pre-visit reviews to confirm that all information required for that visit is available
- Coordination of visits between multiple providers and/or other service points on the same day
- Evaluation of barriers to care – language, literacy, sight, hearing, transportation, finances, etc.
- Advanced planning so that the patient's desires are known and followed
- Ability for the patient to participate in their care by their documentation of part of their medical record on-line before their visit.
- Ability of the patient to initiate and participate in self education about their major health problems.
- Ability for the patient to document in their medical record the data related their conditions such as blood sugars, blood pressures, weight gain or loss, etc.
- Ability for the patient to communicate with their provider electronically which is efficient and effective.

Heretofore, the convenience of the practice or of the provider was the major consideration in the structure and organization of medical practices. It is a significant and necessary change to focus on the patient's convenience, compliance and capacity to receive the prescribed care. And, the work of the provider has not concluded simply by telling the patient what needs to be done. There must be an evaluation by the provider

and/or his/her staff as to whether that care can be obtained. As a great movie is not a finished product until the film editor has taken the work of the director and producer and spiced it together in an intelligible and deliverable final product, so the Medical Home team just take the work of the provider and make sure that it is package in an intelligible and deliverable final product Without these structural and functional changes, Medical Home can be just another administrative concept, which is a distinction without a functional difference.

Intentional and Incidental

The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and highly-functioning medical organization is the concept of Coordination of Care. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current measures endorsed by:

- National Committee for Quality Assurance (NCQA)
- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Physician Consortium for Performance Improvement (PCPPI)
- National Quality Forum (NQF)
- Physician Quality Reporting Initiative (PQRI)

The concept of "intentionality" is critical in this process. This is contrasted with "incidental." In health care, most HEDIS compliance and coordination of care are done incidentally to a patient encounter as opposed to the having of a purposeful, provable and persistent fulfillment of national standards of care. Rather than hoping the result is good, Coordination of Care plans and reviews care to make certain that it meets the highest standards. In addition, the content and the process of this Coordination pf Care is report to the patient so he/she can be confident that what should be done has been and,. Or so that the patient can request that what should have been done and hasn't been is done.

The Medical Home intentionally fulfills the highest and best healthcare needs of all patients. In addition, the patient is involved in this coordination by making them aware of the standards and giving them a periodic review, in writing, of how their care is or is not meeting those standards. Patients are encouraged to know and to initiate the obtaining of preventive care on their own. Perhaps the ultimate judge of the success of Medical Home is when healthcare providers hear the following from their patients, "I am here today for preventive healthcare." Today, almost all healthcare providers would tell you that they have never had a patient present with that "chief complaint," or reason for scheduling an appointment.

While Medical Home will ultimately qualify a practice for increased reimbursement from CMS and other healthcare payers, SETMA believes that this method of healthcare delivery is sufficiently promising to develop it with or without change in reimbursement

and not only to apply it to Medicare, Medicaid or Medicare Advantage patients, but to all of SETMA's patients.

It is obvious to us that SETMA's Medical Home will evolve over time. While we will be guided by CMS and NCQA requirements and by the experience of others, it is our expectation that ultimately, we will innovate, experiment and create a unique expression of Medical Home which will fulfill all of the requirements imposed by these agencies but which will also go beyond that as our vision, understanding and experiences increase.

Medical Home Example

As SETMA began to think about Medical Home, we had the following example set before us in February, 2009. In a memo to the SETMA staff, SETMA's CEO said:.

> "My business philosophy is, 'I want it done right and I want it done right now!' Thus, if we are going to do Medical Home, I want it to be done right. As I have thought more about this project, it occurs to me that the dynamic and the potential of Medical Home are found in its name. A 'home' is:
>
> - A place where you need fear no harm from those who are in the home with you.
> - A place where your needs are met.
> - A place you can go when you don't know what else to do.
> - A place where you can be yourself and you can tell others how you really feel without fear of rejection, judgment, or embarrassment.
> - A place where others really want to see you succeed.
> - A place where if you are away too long, someone is calling to find out if you are OK.
> - A place where you are treating like family.
> - A place where the safety of one in a crisis or danger is not satisfied until all are safe and secure.
>
> "Coupled with excellence of care, Medical Home has the potential for leveraging great benefit for patients and providers from the healthcare delivery equation. Seeing the Medical Home as a reflection of the value and attitudes of "a home," make me think again that what I said this morning is right. I repeat it:
>
> "In 2008, the partners of SETMA finalized a 501-C3 not-for-profit foundation – The SETMA Foundation – which has as its purpose medical education and underwriting the care for our patients who cannot afford it. In February, 2009, I saw a patient who has a very complex and fascinating healthcare situation. I saw him during his hospitalization and then for the first time in my office. What I discovered was that he is only taking four of his nine medications because he cannot afford them. I believe in this case, SETMA practiced Medical Home as he left this encounter with:

1. Appointments to SETMA's American Diabetes Association (ADA) approved diabetes self-management education (DSME) program. The fees for the education have been waived. However, while talking to the patient and his wife, I discovered that he could not afford the gas to come to the meetings. He also left with a gas card with which to pay for the fuel to get the education which is critical to his care.
2. My staff negotiated a reduced cost for his medications with his pharmacy and made it possible for the pharmacy to bill The SETMA Foundation.
3. Because at 60 years-of-age and with his problems he cannot work at his job as a long-distance truck driver, his care also involved counseling him that even in the face of all of the abuse of the disability provision of Social Security, he can no longer work and I will coordinate his application for disability.

"Gas cards, disability, paying for medications – a part of a physician's responsibilities? Absolutely not! Gas cards, disability, paying for medications, part of Medical Home? Absolutely!

"This patient, who was depressed and glum in the hospital such that no one wanted to go into his room, left the office with a smile and feeling that there is hope. He left as if he had just had a visit to home. It may be that the biggest result of Medical Home is hope. This IS Patient-Centered Medical Home!!"

There is a remarkable story told by a missionary to Indonesia. It is called the Pineapple Story and tells the experience of a missionary who fashioned his life for his convenience and for his comfort, only to discover that he was not able to fulfill his calling. It is so with Medical Home. While many of its elements will seem strange and unusual, even objectionable and inconvenient, through the process of developing a patient-centered medical home health care providers will rediscover their mission and their calling. In the end, both the patient and the provider will win – and that is good.

Medical Home Part IX
Radical Changes in Healthcare Delivery
A Slow and Continuing Process
By James L. Holly, MD Your
Life Your Health
The Examiner
May 28, 2009

The foundation of the Patient-Centered Medical Home has been laid in the first eight parts of this series which began on February19, 2009. In these first eight articles, we have reviewed the concept of, the content of and the changes in healthcare delivery which result from the introduction of Medical Home. Like any new idea which has validity, Patient-Centered Medical Home will not only result in changes based on the current standards required to achieve recognition but those changes will expand as they result in unintended consequences which will improve the processes of healthcare delivery.

This is illustrated in something as simple as patient education and provider examination. As SETMA's Registered Dietician reviewed SETMA's Medical Home Coordination Review tutorial – which when completed will be over 100 pages long – she commented that she hoped the day would come when patient education would be a part of the evidence-based measures which are the content of quality improvement resulting from the requirements of medical home recognition.

Here is part of that discussion

"I (Dr. Holly) will forward your ideas to NCQA, as I agree with you as to the importance of diabetes education and of the value of the Registered Dietitian in regard to the management of

- Hypertension (DASH – Dietary Approach to Stop Hypertension -- diet),
- Lipid management (low cholesterol, low triglyceride diets) and
- To the imperative of effective weight management in regard to diabetes, hypertension and lipid management.

"Another area in which I hope SETMA can influence NCQA for HEDIS measures and Medical Home, as well as NQF, Physician Consortium and PQRI is in regard to the measurement of the blood pressure in the treatment of hypertension. The following steps would improve the standardization of blood pressure values:

1. Repeating the blood pressure if it is elevated at any visit – already a part of Physician Consortium Hypertension Data set but not HEDIS, NQF or PQRI
2. Measuring the size of the bicep and calculating and documenting the size of blood pressure cuff which should be used and then which was used in taking the blood pressure. Not a part of any quality measure at present, but a critical step in accurate blood pressure measurement.

3. Documentation that the blood pressure was taken with the patient seated in a chair rather than on the examination table. Not a part of any quality measure at present, but an evidence-based standard in accurate blood pressure monitoring.

"Like patient participation in ADA approved Diabetes Self Management Education (DSME) and like patients receiving Registered Dietitian instruction for the DASH diet, and Weight and Lipid Management, each of these steps would raise the standard for treatment of hypertension and the measurement of the patient's blood pressure, which is one of the most "subjective" objective data points in the patient evaluation.

"June rapidly approaches as SETMA begins the practice of Medical Home, as does July when we will begin reporting data for PQRI. I am proud that you and other Diabetic educations and Registered Dieticians are part of the SETMA team."

"Standards and Guidelines for Physician Practice Connections Patient-Centered Medical Home"

This is the title of the National Committee for Quality Assurance's (NCQA) manual which describes the 9 standards, 30 elements and 83 data points which are part of the recognition process for Medical Home. As one examines this description of Medical Home, it involves many functions which are not currently part of how healthcare is delivered in America.

In education, a standard, or test, should teach as it examines, in other words, a student should come away from a test with a clear idea of what is important to know and how well the student knows that material. Typically, a test will be weighted to where the most important and often the most difficult material is given additional weight in the scoring of the test, i.e., the more important the material the higher a total score will be for knowing that material.

With the standards for recognition as a Medical Home, that is not always the case. For instance, often the elements and data points within each standard are weighted such that the potentially most valuable functions of the Medical Home are given the lowest value within the total score. Why would this be the case? Principally, it appears that it is because the most valuable functions of the Medical Home process are often the most novel and also often the most difficult to develop in the Medical home model of care delivery. Therefore, Medical Home recognition at the lowest level, Tier I, can be achieved without performing some of the most difficult functions of Medical Home, but are built into the standards as the impetus for practices to start moving toward fulfilling some of these more difficult and complex functions.

What are some of these functions?

Of the 9 NCQA Medical Home Standards, Standard Number 1is entitled "PPC 1: Access and Communication." In a total possible score of 100, this standard has a value of 9

points. Standard 1 has two elements; Element A has a weighted value of 4 points and Element B has a value of 5 points.

In order for a practice to receive all 9 points, it must fulfill 9 of 13 data points in Element A and 5 of 5 in Element B. The complexity of this Standard will be appreciated by noting that the 13 data points in Element A include the requirement that the practice has written processes for functions such as:

- Coordinating visits with multiple clinician and/or diagnostic tests during one trip.
- Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time
- Providing an interactive practice Web site
- Making language services available for patients with limited English proficiency
- Identifying health insurance resources for patients/families without insurance

The other 7 data points within Element A are more traditional medical practice functions. These 5 data points are all valuable and are therefore included to move practices forward in the radical change of healthcare delivery processes which is the goal of Medical Home. However, because they are relative new functions, all of them are not required at present but they give a medical practice a goal to pursue.

Standard Number 2

Standard Number 2 of the NCQA recognition process is entitled "PPC 2: Patient Tracking and Registry Functions." This standard has a weighted, total value of 21 paints within the 100 total potential points. There are six elements within this Standard and each element has multiple data points.

An illustration of the change in process which Medical Home generates is seen in Element F which is entitled, "Use of System for Population Management," and which has 7 data points. Element F has a total potential value of only 3 points. Again, this does not represent its potential value to a patient but it reflects the novelty of some of the functions defined in this element. Four of these data points are:

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

- Patients needing pre-visit planning (obtaining tests prior to visit, etc.)
- Patients needing clinician review or action
- Patients needing reminders for follow visits such as for a chronic condition
- Patients who might benefit form care management support"

Each of these data points is obviously valuable to the patient-care process, but each is also a relatively new function which is being introduced to the Medical Home practice. As a result, not all of these functions need to be present in order to qualify for a Medical

Home Recognition at present, but the goal is that any practice which gains Medical Home recognition will begin developing these functions.

Standard Number 3

One last point illustrates this principle. NCQA Standard 3 is entitled, “PPC-3: Care Management,” has 5 elements and has a weighted value of 20 points within the total of 100 points possible.

One of the requirements of Medical Home is for the practice to select three clinically important conditions upon which the practice will report to NCQA. SETMA has chosen diabetes, hypertension and lipid management. Element D of Standard 3 is entitled, "Care Management for Important Conditions.” There are 11 data paints in this element. In order to receive the full 5 points which is possible for Element D, the practice must demonstrate that 75% or more of patients seen in the three months prior to application have at least 4 of these 11 data points documented.

As you read Element D’s 11 data points, you would judge that they are extremely valuable to the patient’s care, but you would also judge that they are difficult to perform. They include functions such as:

- Conducing pre-visit planning with clinician reminders
- Writing individualized care plans
- Writing individualized treatment goals
- Following up when patients have not kept important appointments
- Reviewing longitudinal representation of patient’s historical or targeted clinical measurements.
- Completing after-visit follow-ups

These are valuable functions and it is the goal of Medical Home that they will be developed but because they represent significant resource allocation and personnel effort, they only represent 5 points out of 100 and only 4 of the data points have to be documented 75% of the time to gain those 5 points.

SETMA’s Goal and SETMA’s Assessment of the Medical Home Process Changes

SETMA is redesigning practice workflow with the intent of fulfilling all 9 standards, 30 elements and 83 data points of NCQA Medical Home recognition. However, we recognize that even for us some of them are difficult.

To do Medical Home “right,” it is our estimate that it will take a full-time care coordinator – which will be a new employee to a medical practice -- for every 1500 active participants in Medical Home. In addition, a MSW (social worker) will be required for every three care coordinators.

It is expected that it will take 12-24 months to initially create the new Medical Home database completely and thoroughly. After that it can be maintained and new patients added concurrent with initial care.

The above personnel need is calculated on the basis of a care coordinator giving ninety minutes of attention per year to facilitating, tracking and monitoring the care of each person in their unit. The MSW will be available for home assessments and counseling in more complex cases. It is expected that 20% of the Medical Home members will need this level of attention, giving the MSW 2.2 hours per year with each of this group.

Weekly care-coordination conferences will be held about active, unsolved coordination of care problems identified by healthcare providers, support staff, care coordinators or MSW. Those conferences can be held with lunch being provided so that it maximizes the time utilization of all members of the team.

A Final Thought

We don't believe for a minute that Medical Home is going to decrease the work of primary care providers and shorten their days. Increased satisfaction? Yes. Improved outcomes? Yes. Cost improvement? No doubt. Less work? In the words of the Scotsman, who was buying a used car from a customer, when he asked the man how much he wanted for the car, his response to the answer was, "Silly boy!!!"

Medical Home Part X
A Summation of the Beginning of a Journey
By James L. Holly, MD
Your Life Your Health
The Examiner
June 4, 2009

On February 17, 2009, four SETMA colleagues attended a physician-leadership conference in Houston to hear an introduction to the concept of a Patient-Centered Medical Home. Conducted by two representatives of the American Academy of Family Practice, the conference raised more questions than it answered. On February 19, 2009, the first of this series of ten articles on Medical Home, entitled, *Part I: Is it the future of healthcare?,* appeared in *The Examiner*. Thus began SETMA's 15-week journey through a maze of information, publications and discussions about what a "medical home" is.

The Beginning

On February 18, 2009, at 7:00 AM, I sent the following note to SETMA's team:

> "As I lay in bed last night thinking about the Medical Home, I got up and recorded a few thoughts some of which are below. This begins to answer for me the issue which I raised last night. If we accomplish what I have briefly outlined below and if we implement its use, after fleshing it out so that it is comprehensive, I think we will take all of the elements of Medical Home, all of which we already do and we will create the synergy which Medical Home promises. We are a very long way away, but this is a first step."

The question I asked last night, which was not answered, is, "If we are doing everything you say that a Medical Home should do, and if we are not now a Medical Home, which I am confident that we are not, what is missing?" No one could answer that question but it continued to plague me.

It became apparent, and it became the focus of SETMA's design, that there are two core issues to Medical Home

1. The patient is the central focus and it is the intent of Medical Home to engage the patient in their own care, empowering them with knowledge and ability to direct and evaluate the quality of that care.
2. The coordination of care must now be "intentional" rather than simply "incidental" to other forms of care. At each visit, the primary care provider must have as his/her goal, the organization and completion of care in three areas: preventive care, acute care and chronic care.

As a result, the February 18th note continued with the following comment:

"„The below is what is missing from our discussion last night. The "connector" for all of the elements of care which we are doing is the Medical Home Care Coordination Database and Review which we do not have."

CMS and NCQA Requirements for Medical Home Recognition

As part of our Medical Home initiative, SETMA reviewed the 28 requirements identified by the Centers for Medicare and Medicaid Services (CMS) for qualification as a Medical Home and did an extensive analysis of SETMA's fulfillment of those requirements. The result was a 419-page document which analyzed SETMA's care in light of CMS' requirements.

We had our challenge for the redesigning, restructuring and re-engineering of our wok flow and patient encounters to fulfill all of the elements of Medical Home. The enormity of that task became more evident as we reviewed the National Committed for Quality Assurance's (NCQA) standards for being recognized as a Medical Home. In their recognition process, NCQA identifies 9 standards, 30 elements and 183 data points.

Because participation in CMS's Medical Home program requires being recognized by an accreditation agency, SETMA chose to apply to NCQA for recognition as a Medical home. The intentional coordination of the patient's entire care and the inclusion in that collaboration of all of the standards, elements and data points of the NCQA model became the goal of our development of Medical Home.

After numerous meetings, reviews and discussions, SETMA's leadership felt that we could quality for a Tier 1 Medical home, which is the lowest qualifying level. However, we wanted to quality as a Tier III, which is the highest. In addition, rather than just fulfilling 75 out of a possible 100 points, in order to achieve a Tier III Medical Home, SETMA wants to achieved higher than a 95-point recognition. The task now was much larger. Rather than completing an NCQA Medical Home application in March, 2009, we decided to complete a remodeling of SETMA's healthcare delivery and to apply to NCQA in September, 2009.

At 7:45 AM, on February 18th, I sent the following note to SETMA's staff:

"I do not pretend that anything I wrote below is new. Such information is collected by many different parts of our system – there are even ICD-9 Codes for social situations such as "lives alone" etc.

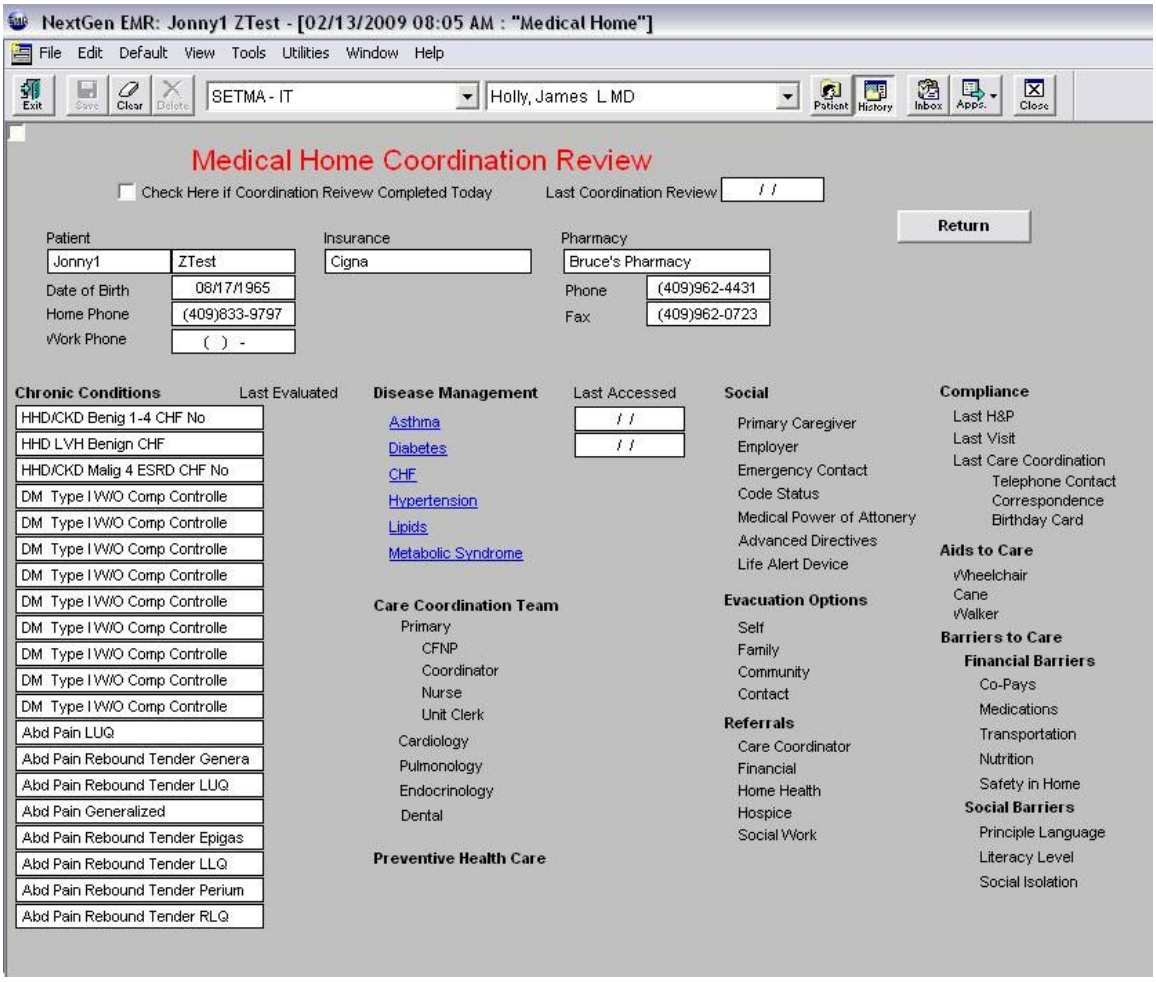
"The thing which I think is novel and which may be the energy behind Medical Home is where the healthcare provider, who is identified by the patient as his/her principal healthcare provider, has all of this information which is:

1. Comprehensive
2. Accessible
3. Considered in medical decision making for the patient

"Creating the database for this information is the 'first thing.' Making that database interactive and dynamic is the 'second thing.' Using that database in an active and inter-active means in the care of patients is the 'third thing.'

"Under the Medical Home model the provider has NOT done their job when they simply prescribe the best care which meets national standards of care. Doing the job of Medical Home requires the prescribing of the best care which is available to the patient."

At 10:13 AM, on that February 18th morning, the following preliminary view of the Medical Home Coordination of care



When compared with the layout and functionalities of the completed Coordination of Care Review template which is reviewed below, it will be seen how this process slowing began to give form and substance to the comprehensive coordination of patient care.

On April 14, 2009, I summarized some of our progress with the following note:

"Yesterday, I asked my assistant to tally the number of pages of materials which we have possessed in our Medical Home pilgrimage. I was amazed to learn that it is

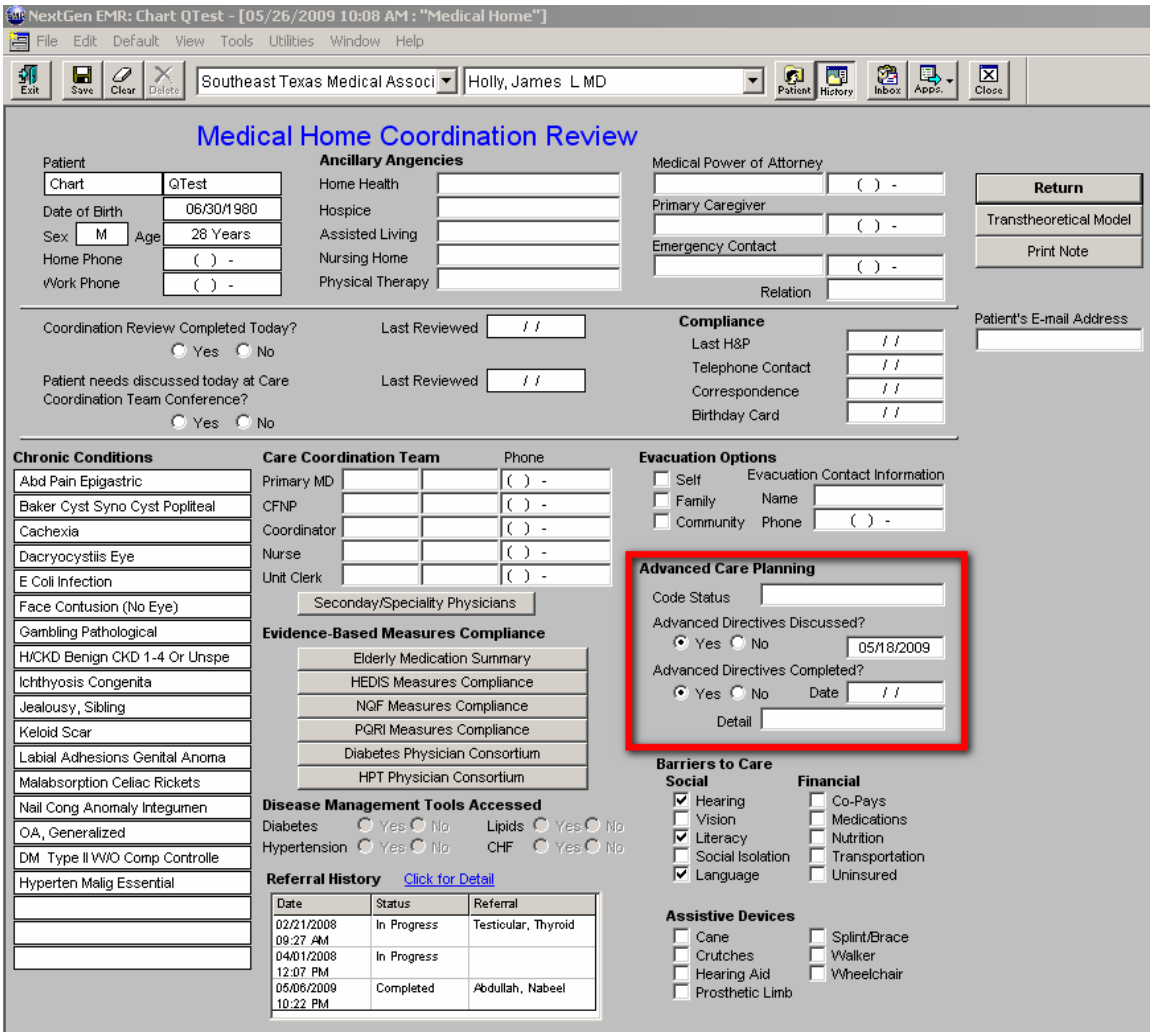
2,280 pages, contained in 9 notebooks with material from NCQA, CMS, NQF, and PQRI, along with over 600 pages of materials which have been produced and written by SETMA staff. This has been a prodigious effort and a Herculean project. We are virtually at the end of the beginning.

"…by the end of this year, at the very latest, we expect to have incorporated into our EMR and into our work flow evidence-based standards and structure of healthcare , with the capacity for each provider to daily evaluate their own performance at the point-of-care, from:

1. Healthcare Effectiveness Data and Information Set (HEDIS)
2. National Committee on Quality Assurance (NCQA)
3. National Quality Forum (NQF)
4. Physician Consortium for Physician Performance Improvement (PCPPI)
5. Physician Quality Reporting Initiative (PQRI)
6. Patient Centered Medical Home (PCMM) – in process, application to be submitted in September
7. E-prescribing"

As this is written, June 2, 2009, all of the above is complete and the data to support the NCQA application is being collected daily. The application for NCQA recognition will be completed in September, supported by the data which we began to collect on June 1, 2009.

The following is the Medical Home Coordination Review template. Comparing this with the preliminary template from February 18th lets you see how far we have come. This template has been in use for over a month and all of SETMA's are becoming experience in how to use it.



All of SETMA's healthcare providers and most of our nurses, and some all of our nurses have completed the review and study of a 99-page tutorial on how to effectively use this template in the performance of the Coordination functions of Medical Home. In addition, each has completed a comprehensive test on this tutorial indicating their knowledge of its content and of how to use this tool in the midst of seeing patients.

In addition, they have reviewed a shorter, 7-page tutorial, on how o complete the evidence-based preventive health care and patient evaluation measures required by NCQA, which have not traditionally been part of routine patient care, but which are a critical part of the intention improvement of patient care.

Auditing Provider Performance

For the next two-weeks, SETMA's information technology department staff (IT) is involved in installing and in being trained on the use of a robust "data mining" software tool which will enable providers to know "how they are doing."

When completed in two-weeks, all members of SETMA's healthcare team will receive a daily audit on the patient encounters from the previous day. This audit will include:

1. The number of elderly patients who are medications which have been identified as being potentially hazardous to the patient. This review will include the following information:

    a. Was the medication reviewed and discontinued?
    b. Was the medication reviewed and changed?
    c. Was the medication reviewed and needs to be continued?
    d. Was the medication and the action discussed with the patient?

2. HEDIS evidence-based quality measures. This audit will include a report of how many measures applied to each patient and how many were completed.
3. NQF evidence-based quality measures. This audit will report how many patients had all of their NQF measures fulfilled and how many did not.
4. PQRI evidence-based measures. This will be audited as for HEDIS and NQF.
5. Physician Consortium for Performance Improvement in Diabetes
6. Physician Consortium for Performance Improvement in Hypertension

These audits will be automated and will be reported to each provider at 6:00 AM. Each month, SETMA's aggregate data on all patients seen will be posted to our website so that all of our patients can know how SETMA is performing and how SETMA is improving in our quest to become an effective Medical Home.

There are other data points required by NCQA which are not a traditional part of healthcare providers' attention or documentation. Some of those were discussed in Part IX of this series. Our auditing will indicate to us how we are coming in areas such as having written "plans of care" and written "treatment plans" on our patients.

This is not an easy process, but the result will be improved and excellent care for all for our patients. That result is worth the energy, effort and resources which SETMA is putting into this process. We look forward to reporting to you in the fall that SETMA has been recognized by NCQA as a Tier III Medical Home. Until that time, we continue to work toward continuing to provide the best care to our patients, which is the only care they deserve.

The Place of Patient-Centered Medical Home
in the Future of Healthcare Delivery
By James L. Holly, MD
Your Life Your Health
The Examiner
July 23, 2009

In our ten-part series on patient-centered medical home, recently published in the *Examiner*, we have examined the concepts and content related to the old, now new, concept of Medical Home. The interest in this re-formation of healthcare delivery is accelerating, as is evidenced by the following.

The 795-page, U.S. House of Representatives' marked up heath reform bill has been made public (July 15, 2009). It includes language which begins the process of rewarding healthcare providers who are practicing Medical Home. The following is part of Section 224 entitled, "Modernized payment initiatives and delivery system reform," which addresses innovations which are hoped will bring increased value, improved quality and decreased cost to healthcare delivery in the United States. It states in part:

> "the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include **patient-centered medical home and other care management payments, accountable care organizations**, value based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. (emphasis added)

"…The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that seeks to—

A. improve health outcomes;
B. reduce health disparities (including racial, ethnic, and other disparities);
C. provide efficient and affordable care;
D. address geographic variation in the provision of health services; or
E. prevent or manage chronic illness; and

promotes care that is integrated, patient centered, quality, and efficient."

The bill further identifies the metrics on the basis of which permanent funding of Patient-Centered Medical Home will be considered by the Secretary of the Department of Health and Human Services. Addressing this point, the bill states that the secretary will implement a pilot program for the evaluation of cost and quality in order to determine:

"...the extent to which medical homes result in

1. improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients;
2. improvement in reducing health disparities;
3. reductions in preventable hospitalizations;
4. prevention of readmissions;
5. reductions in emergency room visits;
6. improvement in health outcomes, including patient functional status where
7. applicable;
8. improvement in patient satisfaction;
9. improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and
10. reductions in health care expenditures; and

"…the feasibility and advisability of reimbursing medical homes for medical home services under this title on a permanent basis."

SETMA's involvement in Patient-Centered Medical Home began at a lecture in February, 2009. Since that time, we have expended a great deal of time and energy in working toward the development of Medical Home functions within SETMA. The week of July 20th, representatives from SETMA will be attending a meeting in Washington, DC presented by the National Committee for Quality Assurance (NCQA) on Patient-Centered Medical Home. This conference is the last step in SETMA's preparation for applying for designation by NCQA as a Patient-Centered Medical Home.

Other interest in Medical Home and SETMA's involvement in this movement are:

1. July 14, 2009, SETMA made a two-hour presentation to the national sales meeting of a major electronic medical records vendor on Patient-Centered Medical Home. This EMR Company, NextGen, is making strides toward providing the functionalities needed to support the requirements of recognition by NCQA as a patient-centered Medical Home.
2. August 4, 2009, a group of physicians and staff visiting SETMA from Scott and White Clinic will be spending the day to review SETMA's preparation for becoming a patient-centered Medical Home.
3. August 18, 2009, a group of physicians and staff from SETMA will be visiting the Texas A&M University School of Medicine in College Station to discuss their interest in EMR and in Patient-Centered Medical Home.
4. September 18-19, SETMA has been invited to join a conference of family medicine leaders from around the country. Representatives of SETMA will participate in this conference of physician leaders in Dallas to discuss Patient-Centered Medical Home. The official title of the group is "Family Medicine Leaders in Large Multi-specialty Groups." They meet twice a year to discussion advancements in healthcare delivery. Large groups who are members of this group include: Scott and White, Marshfield Clinic, Geisinger, Oschner, Mayo, Group Health, Duluth Clinic, Austin Regional

Clinic, Kelsey Sebold, Park Nicolette, St. Johns Clinic and Sharp Reese Stealy.

5. November, 2009, SETMA will make a presentation to the NextGen User Group meeting in Washington, DC on Patient-Centered Medical Home and Chronic Disease Management.

These and other opportunities indicate the growing momentum for this transformative initiative in healthcare delivery.

In context, Patient-Centered Medical Home may represent another in innovative changes which have transformed how SETMA is delivering healthcare. The first was the formation in 1995 of the foundations of a multi-specialty medical group in Southeast Texas. It had never been successfully done and it has proved to be a benefit to our patients and community.

The second was the adoption of electronic patient records (EMR) in 1997. At the time, it seemed that this effort might be a very expensive and difficult experiment in futility, but it has proved to be a critical and necessary step toward the transforming of healthcare. At www.jameslhollymd.com under the section Your Life Your Health, there is a great deal of information about the process of our transforming SETMA through EMR.

The third was the realization in May, 1999 that an electronic means of documenting a patient encounter was an inadequate goal. What SETMA really wanted to do is to develop electronic patient management (EPM). EPM meant that the EMR would be a tool to provide leverage for improving the quality of care and thus the outcomes of healthcare delivery. It meant that it was imperative that we develop disease management tools which would standardize the care all patients received from SETMA.

It meant that the same data base, and consequently the same decision-making information would be must be utilized at all points of care. SETMA realized that continuity of care involved all providers using the same data base at every encounter with every patient. Thus SETMA developed the ability to use the EMR and thus EPM in the clinic, in the emergency room, in the hospital, in the nursing home, in physical therapy and in any other venue where our patients received care. Electronic patient management provided excellent continuity of care in that all data and the same information was available everywhere.

This was illustrated in 2000, when a patient was admitted to one hospital. The history and physical examination (H&P) was prepared in the EMR. Subsequently, a few hours later, the patient was transferred to another hospital. The patient's condition has rapidly changed, in this instance for the better. Instantly, the H&P from the first hospital was available at the second. A subsequent evaluation was done at the second hospital and four hours later, the patient's condition had changed so dramatically that even thought he had been in the ICUs of two hospitals, he was able to be discharged to home the same day.

The patient's record included:

- An H&P from the first hospital
- An H&P from the second hospital
- A follow-up note from the second hospital
- A discharge summary from the second hospital.

The quality and continuity of care was excellent, principally based on the availability of information and data at every point of care. The cost of the patient's care was efficiently managed without any sacrifice in quality. The patient's satisfaction was high in that he wanted to go home when it was safe. The patient's follow-up care was outstanding in that all of the information was available to his physician at his follow-up visit in the clinic.

The benefit of SETMA's EMR and EPM initiatives was seen in 2008, when SETMA was able to query our EMR to analyze the quality of care our patients with diabetes had received. The data reviewed that there had been steady and progress improvement in the outcomes of our care over the past eight years. The data showed that there were three points at which that care had dramatically improved within a year.

Review of this data showed that the dramatic improvements had come when:

1. SETMA created a diabetes disease management tool in the EMR which enabled us to leverage the power of the EMR for electronic patient management.
2. SETMA developed an American Diabetes Association accredited Diabetes Self-Manement Education program.
3. SETMA recruited an Endocrinologist.

Now we come to Patient-Centered Medical Home. SETMA believes this will be the next major innovation and advancement in healthcare. Done properly Medical Home can e transformative in healthcare delivery at least as much as EMR, EPM and effective continuity of care.

Currently, the only complete description of Medical Home is that of NCQA. In that description, there are 9 Standards, 30 Elements and 183 data points. SETMA has spent a great deal of time determining whether we are fulfilling each of these standards, elements and data points. For us, it is our apprehension that it is possible to meet all 183 data points and not to achieve the promise of Medical Home.

In our judgment, the success of Medical Home will be measured by:

1. how engaged the individual patient is in this/her own care
2. how effectively providers are in helping patients make life-style changes which actually improve health and prevent illness

3. how rational the healthcare choices are which are made by patients and families as healthcare choices will be made rationally by patients and families are surely care will be “rationed” by the health insurer which may become the government.
4. How consistently evidenced-based medical therapies are utilized with all patients.
5. Whether Medical Home does result in improved care, decreased cost and prevention of chronic disease.
6. How successful we are in education of people and in convincing people that if they make a change in their habits and/or choices that that change will make a difference in the quality and quantify of their lives.

A true Medical Home will go far beyond tradition interests and responsibilities of healthcare providers. A true Medical Home will have to begin to address the social, cultural, sometimes ethnic, financial, and even religious barriers to good health and rational healthcare choices and decisions.

Medical Home must engage the recipient as an active agent and as a responsible participant. The question is what do we do about the millions of people who will not cooperate with their own health and/or who either will not, or cannot begin to make healthy choices in their lives? Changes in the administration, financing or access to medical care cannot correct and make up for all of the "bad choices" people have made and/or continue to make in their lives.

In SETMA’s Medical Home initiative, we have begun to discuss, ‘How can we get people to make the right choices?’ The reality is that we can't threaten them. Of course, with smokers, we have been telling them that if they don't stop smoking we will not continue to care for them. As a result many have stopped. Yet, when you begin to deal with nutrition and activity habits, it is probably not possible to make that bargain.

Our frustration -- and it is a frustration -- has arisen from the fact that we KNOW how to help people improve their health. Nonetheless, many patients' health does not improve because they are unwilling or unable consistently to make the choices which are required to become healthy. What do you do with a person who knows, that if they continue to overeat and under exercise that they will die, and yet they don't change? What do you do with a person who knows, if they don't stop drinking alcohol, that they will lose their family and their life, but they don't? What do you do with a person who knows if they don't take their medication, they will become sicker, but they don't?

Healthcare problems for most people are not in their heart, their arteries, their intestines or their joints; the problem is in their heads. There is no simple solution, but a great deal of it has to do with hope and/or the lack of hope. Without hope, human beings begin to die. And, while it is true physically, it is also true mentally, emotionally and spiritually, human beings begin to die from the inside out. If our Medical Home is going to be anything but a form, it must address these non-medical issues.