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By James L. Holly, MD
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Medical Home – Series Two
Part I The Movie
By James L. Holly, MD
Your Life Your Health
The Examiner
July 7, 2011

July is one year since SETMA achieved National Committee for Quality Assurance (NCQA) recognition as a Patient-Centered Medical Home and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation as a medical home and for ambulatory care. It is also the first month in which clinics can begin applying for accreditation by The Joint Commission (JACHO) as a medical home. Currently, to my knowledge, SETMA is the only organization to have dual medical home designation. SETMA anticipates applying for Joint Commission accreditation as a medical home in January 2012; assuming success in that process, we will certainly be the only clinic to have NCQA, AAAHC and Joint Commission medical home credentials. This will allow us to learn from the different approaches and to comment on our recommendations for the best way in which to transform a practice into a medical home.

July, 2011, is 27 months since SETMA began the process of transforming our practice into a medical home on February 16, 2009. On that date, five SETMA colleagues attended their first medical home lecture. Over the following ten weeks, this column was occupied with our growing understanding of medical home; those articles are published on our website at www.jameslhollymd.com.

After functioning as a medical home for a year, it seems appropriate to re-examine our understanding of the concepts and principles of medical home and to access where we think we are in this process. This will include an honest assessment of what we think we understand and of what we think we still need to learn. This second series of medical home articles begins with "Medical Home – The Movie." It will be followed by articles on:

- Sign post for health
- Care Continuity
- Care Coordination
- Care Transitions
- Care Plans and Treatment Plan
- The Medical Home Team
- And others

The Movie

While on vacation this summer, I saw the movie *People Will Talk*. It is the story of a physician who is opposed by a colleague. Each has a different vision of healthcare. Released in 1951, *People Will Talk* portrays a physician who sees people as more than a disease and medicine as more than a science. The movie is a comedy, a musical, a drama and a suspense story all rolled into one. There are elements of the characters lives which are not consistent with modern

medicine. The main characters smoke, but this reminds us that the tobacco industry used movies and television as vehicles of addiction. The doctor's bride-to-be shoots herself, aiming for her heart, misses and without complication walks out of the hospital the same day as surgery. Of course that is not possible. A cadaver in the anatomy lecture hall has pink skin, make-up and well coiffed hair. But, in spite of these contradictions and absurdities, there is much to learn from this picture about patient-centered medical home.

The movie begins with a printed narrative which prepares you for the story. My favorite movies start this way, and along with narration and theme music, movies establish a great pattern for live. The narrative states:

> "This will be part of the story of Noah Praetorius M.D. That is not his real name. Of course...There may be some who will claim to have identified Dr. Praetorius. At once, there may be some who will reject the possibility that such a doctor lives, or could have lived. And, there may be some who will hope that if he hasn't, or doesn't, he most certainly should.
>
> "Our story is also -- always with high regard -- about Medicine and the Medical Profession. Respectfully, therefore, with humble gratitude, this film is dedicated to one who has inspired man's unending battle against Death, and without whom that battle is never won.... The patient."

Immediately, you know that this story is going to focus on "the patient," and that is also the focus of medical home. The following vignettes from the movie expand on the idea of the patient being the central focus and the most important person in medicine.

The movie opens with Dr. Praetorius waiting for his opponent to arrive in the medical school's anatomy lecture hall. As the medical students sit waiting, Praetorius says, "I cannot give you the lecture which you came to hear and I am not sure that you should hear the lecture which I am prepared to give." With the students' encouragement, he begins, saying,

> "Anatomy is more or less the study of the human body. The human body is not necessarily the human being. Here lies a cadaver. The fact that she was, not long ago, a living, warm, lovely young girl is of little consequence in this classroom. You will not be required to dissect and examine the love that was in her, or the hate. All the hope, despair, memories and desires that motivated every moment of her existence. They ceased to exist when she ceased to exist. Instead, for weeks and months to come, you will dissect, examine and identify her organs, bones, muscles, tissues and so on, one by one. And these you will faithfully record in your notebooks, and when the notebooks are filled, you will know all about this cadaver that the medical profession requires you to know."

Patients are not a disease and they are not a condition; they are human beings and if we are to conduct a medical home, we must see them as more than a patient; we must see them as persons with hopes and fears, loves and hates, beliefs and passions. This is clearly the first principle of patient-centered medical home. It is an effort for a new generation of healthcare providers to

capture an old attitude about those whose health needs attention, either because they want to retain it before it is lost, or they want to regain it after it has been lost. It is a frame-of-mind which sees patients personally rather than professionally.

The next medical home portrayal in *People Will Talk* follows a symphony rehearsal. Praetorius is the conductor of the medical students' symphony and after the evening rehearsal, he returns to his clinic to check on a patient. A science professor, a member of the symphony, has dinner with Praetorius and asked if there was anything interesting at the clinic. Dr. Praetorius declares, "A physician respects the confidentiality of his patients and does not discuss them with anyone." In the medical home, all care givers respect the confidentiality of patient information." One of the foundation stones of trust is confidence that personal information will not become public. That which you are certain will be held in absolute confidence can be shared with another.

Continuing with some generic details of a case, Praetorius speaks of his need to involve the family in the solution to one patient's health problem. This extends beyond science and the idea of "patient" and involves the person as a whole being. Realizing how intimate Dr. Praetorius is becoming in this case, his scientist friend responded, "Has it ever occurred to you that none of this is your business." Praetorius asks, "What is my business?" The scientist declares, "To diagnose the physical ailment of a patient and to cure them." The doctor rejoins, "Wrong; my business is to make sick people well. There is a vast difference between curing an ailment and making sick people well."

This is where "process" – the steps and actions taken in order to "make sick people well" – and "outcomes," which are defined by what "being well" is understood to mean, come together. "Making sick people well," is not defined by avoiding death but by helping people be a whole person – a well person – even while they face death. Repeatedly in the movie portrayal of the life of Dr. Patch Adams, this message is addressed.

Medical Home always involves addressing end-of-life issues, helping persons deal with their own mortality without them seeing death as a failure of life. Death is inevitable; how it is approached determines whether a sick person, who is incurable, can be made well even when dying.

In the second day of the movie's story, a number of medical home concepts are illustrated. As Dr. Praetorius arrives at his clinic, people are outside the clinic building laying in the sun and enjoying the fresh air. Medical home involves normal behavior, even while seeking health care. The first object of medical home is encouraging a patient to maintain wellness. In healthcare, we often place the person, as a patient, in an unhealthy environment. We put them at bed rest rather than keeping them mobile. We limit their food rather than maintaining their nourishment. Often, we them as "being" sick, rather than treating them as healthy people who have an illness. The difference can be the difference between getting well and not.

Realizing that nutrition is central to good health and to "getting well," Dr. Praetorius responses to a nurse who said, "I'd like all the patients to be served breakfast at the same time. I cannot operate the kitchen without more personnel if they are not," saying, "Then hire more people to work in the kitchen." The nurse persists, "But it is common practice in hospitals to serve all the

patients at one time." Praetorius declares, "Not in my clinic. No patient will be awakened from a health-giving sleep and forced to eat breakfast at a time which pleases culinary union." The nurse rejoins, "But is it a good economy." Our doctor concludes the discussion by stating, "Bad therapy is never good economy. If you have to economize, do it in the doctors' dining room."

Medical Home puts the patient first and designs processes for meeting the patient's needs and not the staff's. 1951 was a simpler time, but in the 21st Century, it is possible to regain some of that simplicity for the patient's safe. If one patient will eat at 10 rather than at 8 AM; medical home feeds him/her at 10. If another person will eat at anytime, he/she can be fed at the staff's convenience. There are great demands upon the time, energy and attention of nurses. There are great financial pressures on healthcare providers and organizations. But, in the face of these demands and pressures, we can remember that in order to "survive" their hospitalization, the patient should, "eat up," "get up" and "get out." The three elements of successful care in the hospital involve nutrition, activity and transition to home.

While on the subject, Dr. Praetorius turns to another nurse and says, "And I will not have all of the patients bathed at the stroke of a gong for the convenience of the nurses. One of the reasons I started this clinic is the firm convictions that patients are sick people and not inmates." The principle is the same. A bath is a task for a nurse, but to the patient – to the person of their charge – it is an important part of who they are and it has medicinal benefits.

The last scene we will review shows Dr. Praetorius entering a patient ward after the above conversations. He approaches the bed of a very sick patient who is dying, and said:

> "I bet I know what you are thinking, here comes Dr. Happiness; the good humor man. He tries to cheer me up and all I want to do is to hit him with an ice bag. Right?" The patient responds, "Wrong." Dr. Praetorius continues, "Not that I blame you. One of the few pleasures of being sick is the right to be miserable. And, don't let any doctor tell you differently."
>
> The patient said, "I was thinking it's not much fun getting old." And the doctor continues, "It's even less fun not getting old." She answers, "I want to die." Dr. Praetorius says, "You'd like that wouldn't you; just to lie around in a coffin all day with nothing to do."
>
> The patient asks, "Doctor, does it hurt when you die?" He answers, "Not a bit. Where did you get that idea?" The patient states, "They tell me there is so much pain." The doctor, asks, "Did anyone who actually died tell you that?" The patient laughed and said, "Of course not."

Dr. Praetorius then tells the patient about a personal experience he had as a child. He was sick and everyone thought he was going to die. He relates that he felt that he was floating on a cloud and looking down at a scene in a play. He said, "Dying was very pleasant, but when I got better, I had a severe headache and vomiting for three days. I never felt as good alive as I did while I was dying." This scene concluded with the dying lady smiling and saying, "You certainly make dying should like a pleasure, Doctor."

A complete review of this movie – its good and bad – would take a volume, but it does gives us a "feel" for what medical home is. In some ways it is impractical and in others it is imperative. I do know that I would love for every medical student to see this movie and *Patch Adams* and *The Doctor* and *Keys to the Kingdom*. The message of each of these films helps us empathize with others, who are sick. Each portrayal has weaknesses. In the case of *People Will Talk*, I think Dr. Praetorius portrays an inappropriately negative attitude toward nurses, but his ideas are instructive for us. I think it will take a life time to understand and to create a true Medical Home, but this is a start and the journey is worthwhile.

Medical Home – Series Two
Part II The Caution Lights
By James L. Holly, MD
Your Life Your Health
The Examiner
July 14, 2011

Have you ever been driving down the highway and suddenly you see a police car? What is your response? I always slow down, even if I am driving the speed limit and I would bet that you do too.. Nothing causes traffic to bunch up like a State Trooper driving the speed limit on an interstate highway. Recently, there is a new "caution" about how fast we drive, which is really effective. You're driving down a city street and suddenly you see a blinking sign which is displaying your speed. I dare you to say that you don't instantly take your foot off the gas pedal and/or put your foot on the brake.

This last happened to me recently. I confess, I took my foot off the pedal. I think it is sneaky but it is equally effective. When this happened to me recently, I thought, "What if we could have signs along the way in our life that flash a warning about the unhealthy decisions we are making?" Do any of you remember the Burma shave signs along the highway? With one or two words per sign, in a series of five or six signs, the message was given. What if those kinds of signs reflected your health facts?

As health care providers increase their use of electronic devices to monitor and measure healthcare status, what if you had a device which preceded you in the cafeteria line? When you picked up a dish which might have an adverse effect upon your health, your "personal health monitor" would flash your most recent cholesterol level with an alert, "caution this dish will make your cholesterol go up." That same monitor would keep a record of the number of steps you have taken during the day and when you sit down in front of the television, that number would flash on your monitor with a red alert, "All illnesses are caused by, or aggravated by a sedentary life style."

Fortunately or not, no such monitors exist and try as I might, I can't imagine how to design one. Of course, Dick Tracy could create one and probably in our future such devices will be available. But how is this related to Medical Home? Again, for better or for worse, home is where we learned our values. We learned concepts of right and wrong, good and bad, and it is in the home where most of us learned the values which would guide us for all of our lives.

So, it is with the Medical Home that we should learn our health values and it is in the Medical Home where our "mental monitor" of our choices should be created. Each of us has the "right" to make bad health choices, many of which choices, we learned in our homes. But, before our health is damaged and while we are still in the position of "retaining our health," the first job of Medical Home is to teach healthy choices and to encourage us to make such choices. Like any

value system, our "health choices" education is a collection of "dos" and "don'ts." And, all of these choices can be expressed positively or negatively.

- Do maintain an ideal body weight: don't get fat.
- Do exercise regularly and stay active; don't become a couch potato.
- Do avoid tobacco smoke; don't start smoking.

As we are so often dealing with health which has been lost that, we get stuck in a negative mode – stop that; don't do that; quit that – but as we continue to learn and to develop concepts of Medical Home, we want to establish a positive approach to health by creating a positive statement of health – do that; start this, keep doing it.

If you think about our "caution light" metaphor, you will realize that in order to have a caution which encourages us to avoid the negative, we must have a standard against which to measure, or "monitor" our conduct. It is that standard which Medical Home must be prepared to establish, to teach and even to preach to the members of the home. Well, what are those standards?

In the August 9, 2007, Your Life Your Health, we discussed, "*How to survive your hospital stay! "Get up," "Eat up" and "Get out*." The principle is that often patients are put at bed rest, which immediately results in negative health consequences; are placed on restricted diets or no diet, which immediately results in negative health consequences; and, are kept in the hospital too long, which immediately results in negative health consequences. In order to survive the hospital, patients should "get up" – get out of bed and stay active when possible – "eat up" – maintain their nutritional intake when possible – "get out" – do not extend their hospital stay for any reason other than absolute necessity.

While the circumstances of routine life are different than when a hospitalization is required, the principles are the same: "get up" – get off the couch and get active, which is important for you both physically, emotionally and mentally – "eat up" – in your Medical Home do what your mother advised you all of your life, eat your vegetables, limit between meal snacks, eat fruits and avoid inflammatory foods (fried foods, fatty foods, processed foods, sugar and excessive salt) – "get out" – get out of the rut in which you find yourself.

If we want to turn our Medical Home into a positive – "do this" – rather than a negative – "don't do that" – we can change the design of our health monitor. Instead of it flash at the end of the cafeteria line and tell us of the bad choices we have made; we can design it so that when we pick up the healthy dish, a cheer goes up, lights flash and a voice declares, "Good choice; keep it up." Preventive dieting would have the monitor produce an electric shock (not a big one, just a little one) when we pick up a dish of the wrong food. That's supposed to be funny but it may not be a bad idea. It would certainly get our attention. And, the intensity of the shock could be proportionate to the risk of the dish selected.

Medical Home – Mentoring Healthy Choices

Beginning with infants, youths, adolescents and young adults, Medical Home must be mentoring good health. Before the consequences of bad choices trigger genetic predispositions resulting in poor health, Medical Home must be teaching and preaching healthy living. Start with the two biggest components of healthy living: nutrition and exercise.

The Mediterranean Diet must be taught. Before taste buds develop appetites for refined sugar, processed flour, white breads, and fried foods; fresh fruits, vegetables, olive oil, fish and poultry must become the preferred foods. (For more information on the Mediterranean Diet see Your Life Your Health at www.jameslhollymd.com under the icon ***Nutrition***, May 12 and May 19, 2005.)

In a seven part series in Your Life Your Health (see at www.jameslhollymd.com under the icon, ***Nutrition***) entitled "*Chronic Illness: The Effects of Exercise and Diet,*" the following summary is found in Part I, published July 20, 2006:

- Modern chronic diseases, including cardiovascular diseases, Type 2 diabetes, cardiometabolic risk syndrome, and cancer, are the leading killers in Westernized society and are increasing rampantly in developing nations.
- Obesity, diabetes, and hypertension are now even commonplace in children.
- Overwhelming evidence from a variety of sources, including epidemiological, prospective cohort, and intervention studies, **links most chronic diseases seen in the world today to physical inactivity and inappropriate diet consumption**.
- Modifying the lifestyle of children is paramount to reducing chronic disease risk.
- The evidence is overwhelming that **physical activity and diet can reduce the risk of developing numerous chronic diseases**, including CAD, hypertension, diabetes, metabolic syndrome, and several forms of cancer, and in many cases in fact reverse existing disease.

If our health monitor indicates how important an element of health maintenance is, then the frequency with which Your Life Your Health deals with a subject should reflect the element's importance. The following articles can be found at www.jameslhollymd.comunder the icon entitled ***Exercise***. These twenty articles are only a few of those published in this column over the past twelve years about exercise:

- Exercising the Heart Part V
- Exercising the Heart Part IV: A Merry Heart as Medicine
- Exercise of the Heart Part III: Loving Others
- Exercise and Your Heart Part II
- Exercise and Your Heart Part I
- Exercise, Weight Loss and Fat
- Exercise: AHA's Statement on Exercise and Physical Activity Part II
- Exercise: AHA's Statement on Exercise and Physical Activity Part I

- Exercise: Progressive Resistance Training (PRT) and Health
- Exercise -- Walking For Health
- Exercise: SETMA's Exercise Prescription Part II
- Exercise: SETMA's Exercise Prescription Part I
- Exercise: It's Never Too Late To Start
- Exercise -- Aging & Inactivity
- Obesity: Fat and Fit
- Exercise: Physical Inactivity; The Consequences of Being a Couch Potato
- Exercise: Getting Started Part III
- Exercise: Getting Started Part II
- Exercise: Getting Started Part I
- Exercise: Something Is Better Than Nothing

The key to exercise as an element of health is reflected in the following quote from a February 5, 2004 Your Life Your Health article. It is still valid today:

"Getting started." There are two maxims by which I have lived:

1. "There are many things which I have started which I did not finish, but I have never finished anything which I did not start.
2. "I would rather fail a thousand times trying than succeed once doing nothing.

"These are not unlike the more eloquent words of President Theodore Roosevelt, who said:

"It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, and comes short again and again, because there is no effort without error and shortcoming; but who does actually try to do the deeds; who knows the great enthusiasms, the great devotions, who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat.

Exercising for health is like that. It is possible to fail, but failing is far superior to never trying. The good news about failure is that you can always start over. The bad news about never starting is that you have never changed."

The foundation of Medical Home is health and the foundation of health is nutrition and activity. If we are to have a monitor which mentors us in health, it might be enough to have a small transistor (now that's old technology) which simply whispers in our ear – eat right, keep moving, get up, get out, think, read, be involved in the lives of others.

Medical Home Series Two
Part III The Baton
By James L. Holly, MD
Your Life Your Health
The Examiner
July 21, 2011

In October, 1999, four years after the founding of SETMA; nineteen months after SETMA had puchased the EHR which we continue to use today; nine months after SETMA started using the EHR to see patients; and. soon to be twelve years ago, we published a pamphlet for our patients entitled, *More Than A Transcription Service: Transforming Healthcare with Electronic Medical Records*. (A short form of this paper can be found at www.jameslhollymd.com in Your Life Your Health May 1, 1999. The link is http://www.jameslhollymd.com/)

We shared this booklet with our patients and colleagues as it described the future of healthcare, which SETMA wished to participate in bringing into existence. In the last paragraph of this paper (in the original the following was the last paragraph but in the edition of this paper which was presented in May, 2000, at TEPR, it appears on page 7), we said:

"Healthcare providers must never lose sight of the fact that they are providing care for people, who are unique individuals. These individuals deserve our respect and our best. Healthcare providers must also know that **the model of healthcare delivery, where the provider was the constable attempting to impose health upon an unwilling subject, has changed. Healthcare providers progressively are becoming counselors to their patients, empowering the patient to achieve the health the patient has determined to have.** This is the healthcare model for the 21st Century and the computerized patient record is the tool, which makes that model possible." (Emphasis added) (October, 1999, *More Than A Transcription Service*, for the full article see http://www.jameslhollymd.com/)

"Healthcare providers progressively are becoming counselors to their patients, empowering the patient to achieve the health the patient has determined to have: this is the core concept of medical home. It is an expression of the centrality of the patient to medical home and of the active involvement of the patient in their care. This differs from the traditional concept of the patient being a passive recipient of care directed solely by the healthcare provider. No longer a spectator to their own care, Medical Home patients participate in determining their goals, in designing processes for addressing those goals and in achieving those goals.

A second element of Medical Home illustrated by SETMA's early experience is that while no provider can know everything about a patient – patients and providers do not share the same experiences and often don't have the same "data dictionary" with which to understand those experience. The words patients and providers use and the values they place on symptoms may differ. Yet, the provider must know enough in order to consult effectively with the patient about their health. The same May, 1999, monograph referenced above, said:

> "Recently, the mother of a prominent citizen in our community became our patient. After completing an extensive history and physical utilizing the computerized patient record, I asked this lady, 'Do you think I now know you well enough to make appropriate decisions about your healthcare?'" She responded, 'You know more about me than the doctor who has taken care of me for twenty years. He has never asked me all those questions.' This testimonial can be repeated multiple times. EHR creates tremendous confidence in the patient that an accurate and complete database is available to the healthcare provider.
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> "As an extensive database is created on each patient, the patient's confidence in the provider's decision making increases. As the computerized patient record is 'sold;' to the patient, the patient becomes the provider's greatest ally in producing an excellent record, which is complete and accurate. Also, when the encounter is completed and a copy of the record is given to the patient:
>
> - "The patient is able to review the record, further gaining confidence that "if my doctor knows all of this about me, he/she must be making the right decision."
> - "If any data is inaccurate or has become invalid, the patient can correct the record, becoming a partner with the provider in the process of producing a complete, accurate, valid and current medical record."

In a future article on medical home, we will discuss the place of the record in the continuum of care issues surrounding medical home, but this episode illustrates the power of a database which is available at every point of service. In addition, documenting every encounter in the same database whether inpatient, outpatient, emergency department, nurse home, hospice, home health, physical therapy, etc, allows the patients medical record to morph from at best a **silhouette** into a granular **portrait** of the patient's health and condition.

The Baton

The following experience further illustrates SETMA's early efforts at using a "healthcare baton." I remember the morning. I arrived in the hospital at 5 AM to begin morning rounds. I always walked through the emergency department to see if any of our patients were there. This event transpired in November of 1999. The contemporaneous record of this event from *More than a Transcription Service* states:

> "Recently, an elderly patient of mine came to the emergency room at 5:30 AM. I met her there as she walked in. When she sat down in the exam room, she pulled out of her purse a copy of her computerized patient record from her last visit to my office. It was complete and had all of her past history, allergies, medications, diagnoses and physical examination. I have known this patient for twenty-five years, but this record was more complete than my memory. I was able to quickly assess her condition and safely allow her to return home, without further testing. After dictating an emergency room encounter

note (we were still six months away from having our EMR in the hospital), which would appear as if I had spent hours with the patient rather than a few minutes."

This event accelerated the effort to deploy SETMA's EMR into the hospital, the emergency department, indeed, into all points of service. It showed us how important it is to have the patient's data available every where.

Another element of Medical Home involves the patient's access to their health information. In a September 21, 2001, *Your Life Your Health* article, the following appeared:

> "The Health Information Coalition (a local organization designed to integrate care in Southeast Texas) shares SETMA's philosophy about health information. In fact, '*Your Life -- Your Health'* is derived from this philosophy. In the past, healthcare providers were viewed as and often functioned as 'constables' attempting to impose health and healthcare upon unwilling or partially willing subjects, who are called patients. In the 21st Century, much of the mystery of healthcare information is being removed by the easy access which so many have to so much information. Therefore, there has been a shift from healthcare providers being 'constables' to their being 'counselors' who empower patients to achieve the health which they have determined to have. Previously, patients were 'told' what to do and they either complied or didn't. Today, healthcare providers are inviting 'people' to take charge of their own health. Healthcare providers are encouraging patients to adopt healthy habits, avoid unhealthy activities and recognize the danger signs of approaching illnesses.
>
> "Preventive health is really becoming 'pro-active' health where the patient and the provider collaborate to make good choices to retain or regain as good a state of health as is possible for every individual. SETMA and the Health Information Coalition is the vanguard of Pro-active Health. The Coalition will soon announce a new service to Southeast Texans called First Nurse. Watch for the announcement and learn how First Nurse will benefit your family.
>
> "In order for this paradigm shift to succeed, patients must have more access to their healthcare provider and healthcare providers must have an expanded ability to communicate with the patients who entrust their health to them."

This was written in 2001, eight years before anyone at SETMA had heard the term "Medical Home." (see the full article at www.jameslhollymd.com *Your Life Your Health*, '*So Much Information; so many experts; who to believe*," September 21, 2001) These key concepts about Medical Home are reflected in this 2001 article:

1. Health and wellness are critical to the functioning of a medical home
2. Preventive Health is imperative to the medical home
3. Patients taking charge of their own care are central to the medical home
4. Patients having access to their own healthcare information is part of medical home

5. Patients having increased access to their providers in the office, outside of the office, on the telephone, through a Health Information Exchange and through a secure web portal are all part of medical home.

These ideas, which have been a part of SETMA's care for the past sixteen years and which became a part of our written philosophy twelve to fourteen years ago, are now symbolized by **THE BATON**. SETMA's new posters, entitled "SETMA's Healthcare Philosophy," which are displayed in our offices, reflect:

- The patient is in charge of their own care 8,760 hours a year – full time.
- The "healthcare race" belongs to the patient, not to the provider – the patient is responsible for success in healthcare.
- The provider is a coach, a counselor, a consultant, a colleague to the patient; the provider is not the boss.
- The plan of care and the treatment plan, developed with the patient and agreed to by all members of the medical home team, is the tool – The Baton – which enables the patient to lead his own healthcare team.

Increasingly, The Baton will be the symbol of the medical home's transfer of care responsibility from the provider to the patient. (For more on The Baton see *Your Life Your Health*, March 12, 2010). The Baton illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan – the "baton" – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display continually reminds the provider and will inform the patient, that to be successful, the patient's care must be **coordinated**, and must result in **coordinated care**. As SETMA has expanded the scope of our Department of Care Coordination, we know that coordination begins at the points of "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute that plan.

Medical Home Series Two
Part IV A Metaphor for Medical Practice
The Foundation is Health and Wellness
By James L. Holly, MD
Your Life Your Health
The Examiner
July 28, 2011

Whether you call it a "heath home" or a "medical home," the name is a metaphor for the design and content of primary healthcare in the twenty-first century. Being a metaphor, the name implies a resemblance between the structure and function of a "home" and the organization and activities of a "medical practice" organized around the concept of "home."

By its nature a home is a place where the members of a family live and where they nurture one another. A home is a place where food and activities -- physical, intellectual, spiritual -- are designed to promote health and wellness. In this way, a home is a precise metaphor for excellent healthcare as the primary intent of the "medical home' is not to treat disease but to promote health and to model and to encourage wellness. While, like the "home," where those who become ill are cared for, the primary design, object and focus of the "medical home" is the promotion of health and of wellness. So the "medical home," while being excellent in the care of those who have become ill, never loses its focus on wellness.

SETMA's first series of articles on Medical Home (published in the *Your Life Your Health* between February and May, 2009), included the following February 26, 2009 attempt to describe the "medical home" metaphor. That article stated that the "medical home" is a place:

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

That article further stated, "The Medical Home requires that patients become people to the healthcare provider and that those people have personal value beyond their financial contribution to the practice's success…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."

Health and Wellness

Healthcare very often focuses upon what has been lost – health and wellness – because that loss is what motivates patients to seek care. Although the most common search on the World Wide

Web is for health information and often for keys to staying healthy, I have never had a patient make an appointment to ask, "How can I stay healthy?" We often over look the fact that many of our efforts to promote health and wellness are actually examples of how much "natural" supports of health and wellness have been lost. The perfect example is "wellness centers" or exercise "studios." These ubiquitous centers are a testament to how unhealthy our lifestyles have become. We have treadmills to substitute for our lack of walking in our daily life. We have spent several generations creating means of making physical activity unnecessary – first bicycles and then automobiles, now human conveyor belts at airports or escalators at the mall and now we spend billions of dollars compensating for the unhealthy effects of these technological advances. All of these "conveniences" contribute to our sedentary life style and thus to our loss of health and wellness.

Lifestyle Wellness

Wellness can be and should be promoted without gymnasiums and treadmills. In a 2004, study of the Amish, we were reminded of the value of "activities of daily living." The Amish reject modern conveniences. They don't use telephones or computers and they don't use automobiles; they walk. And, how they walk! If they want to talk to a neighbor, they walk over to the neighbor's house. They don't "go to the track, or to the gym." They don't log their miles, or pace. They don't use heart rate monitors. They don't exercise as a discipline. They exercise as an "activity of daily living."

The study of Amish men and women was published January, 2004 in *Medicine and Science and Exercise*. The result of a project at the University of Tennessee, the study documented that Amish men are six times more active than the average American. While the average American takes 2-3,000 steps a day; Amish men take an average of 18,425 steps a day and Amish women take an average of 14,196 steps a day. One Amish man took over 51,000 steps in a day, which is equivalent to walking 25 miles.

Purposeful Activity

The study documented that in a week Amish men perform:

- 10 hours of vigorous physical activity (tossing bales of hay, shoveling,
- digging and plowing)
- 43 hours of moderate activity (gardening, feeding animals)
- 12 hours of walking

Amish women weekly perform:

- 3.5 hours of vigorous physical activity
- 39 hours of moderate activity

- 6 hours of walking

What is the result? The Amish have a 4% incidence of obesity and 26% were overweight as opposed to a 31% obesity and 64% overweight in the general American population. And, this is in spite of the very high-calorie, high-fat-content diet which the Amish typically consume.

The Amish finding falls in line with a theory espoused by University of Wisconsin professor William Morgan who stresses the need for "purposeful activity" in exercise. Mr. Morgan calls for a paradigm shift in physical activity, criticizing the current trend of "peddling treadmills to nowhere." He says that when people exercise for a purpose, there is higher adherence to an exercise program. Purposeful activity includes mowing the lawn, cleaning the house, or even walking the dog. The Amish have that skill down pat. "The cows have to be milked," says Mr. Morgan. "You can't say, 'It's rainy. I'm going to skip today.'"

Activities of Daily Living and Exercise

Can something as simple as walking further to get the mail or the newspaper make a difference in your health? Absolutely! In another study, published in the May, 2004 issue of *Medicine & Science and Exercise*, the official journal of the American College of Sports Medicine, it was reported that middle-aged women who took at least 10,000 steps per day on average were much more likely to fall into recommended ranges for measures of body composition such as total body weight and body fat percentage. Conversely, inactive women – those taking fewer than 6,000 steps per day – were more likely to be overweight or obese and have higher waist circumferences, a strong predictor of increased risk of cardiovascular disease.

Treatment of every disease known to man

The treatment for virtually every illness known to man, including diabetes, heart disease, respiratory disease, congestive heart failure, cholesterol, etc., begins with activity. And, not only are these conditions effectively treated by activity, but **they are also effectively prevented by activity.** The reality is that the causes of all of these diseases can be traced directly or indirectly to sedentary life styles.

In the November, 2005 issue of *Journal of Applied Physiology,* a review article was published entitled, *Effects of exercise and diet on chronic disease*. The following is a summary:

- Modern chronic diseases, including cardiovascular diseases, Type 2 diabetes, metabolic syndrome, and cancer, are the leading killers in Westernized society and are increasing rampantly in developing nations.
- Obesity, diabetes, and hypertension are now even commonplace in children.
- Overwhelming evidence from a variety of sources, including epidemiological, prospective cohort, and intervention studies, links most chronic diseases seen in the world today to physical inactivity and inappropriate diet consumption.
- Modifying the lifestyle of children is paramount to reducing chronic disease risk.

- The evidence is overwhelming that physical activity and diet can reduce the risk of developing numerous chronic diseases, including CAD, hypertension, diabetes, metabolic syndrome, and several forms of cancer and in many cases in fact reverse existing disease.

(For more information, see the seven-part series entitled "*Chronic Disease: The Effects of Exercise and Diet*," at www.jameslhollymd.com, *Your Life Your Health* under the icon "*Exercise*."

In a column entitled "The Consequences of being a couch potato," (February 26, 2004, *Your Life Your Health*). Three questions were asked and answered:

- **Question**: Which will do more for the improvement of your health? Visiting the doctor or visiting the gym?
- **Question**: Which will do more for the improvement of your health? Taking a pill or taking a walk?
- **Question**: What can medicines do to help you avoid the consequences of your inactive lifestyle? **Nothing!**

Aerobic Activity – How Much Is Enough?

Placing exercise at the core of a health and wellness program is appropriate. In 2007, the American College of Sports Medicine and the Centers for Disease Control and Prevention updated the 1995-published national guidelines on Physical Activity and Public Health. The update stated that to promote and maintain health, all healthy adults aged 18-65 years need moderate-intensity aerobic physical activity for a minimum of 30 min on five days each week or vigorous-intensity aerobic activity for a minimum of 20 min on three days each week. Also, combinations of moderately and vigorous-intensity activity can be performed to meet this recommendation. (For more information, see the series entitled "*Physical Activity and Public Health: 2007 Updated Recommendation for Adults*," at www.jameslhollymd.com, Your Life Your Health)

Muscle-Strengthening Activity

To promote and maintain good health and physical independence, adults will benefit from performing activities that maintain or increase muscular strength and endurance for a minimum of two days each week. It is recommended that 8-10 exercises be performed on two or more nonconsecutive days each week using the major muscle groups. To maximize strength development, a resistance (weight) should be used that allows 8-12 repetitions of each exercise resulting in volitional fatigue. Muscle-strengthening activities include a progressive weight-training program, weight bearing calisthenics, stair climbing, and similar resistance exercises that use the major muscle groups.

Clarifications to the 1995 Recommendation

Although fundamentally unchanged from the 1995 recommendation, the updated recommendation is improved in several ways. First, the recommended frequency for moderate-

intensity physical activity has been clarified. The 1995 document simply specified "most, preferably all days per week" as the recommended frequency while the new recommendation identifies five days per week as the recommended minimum.

The updated recommendation now clearly states that the recommended amount of aerobic activity (whether of moderate- or vigorous-intensity) is in addition to routine activities of daily living which are of light intensity, such as self care, casual walking or grocery shopping, or less than 10 min of duration such as walking to the parking lot or taking out the trash. Few activities in contemporary life are conducted routinely at a moderate intensity for at least 10 min in duration. However, moderate- or vigorous-intensity activities performed as a part of daily life (e.g., brisk walking to work, gardening with shovel, carpentry) performed in bouts of 10 min or more can be counted towards the recommendation. Although implied, this concept was not effectively communicated in the original recommendation.

SETMA's Medical Home, Which Is Your Medical Home and Wellness

SETMA's Medical Home actively promotes health and wellness. While recognizing that it is the patient's responsibility to "get started," SETMA's Medical Home helps you maintain your health in the following ways::

1. **The LESS Initiative** – The acronym stands for "lose weight," "exercise" and 'stop smoking," These lifestyle changes are valid for healthy people and unhealthy people. With a personalized weight management assessment, a personalized exercise prescription and an assessment of smoking status, SETMA's LESS Initiative is the starting point of our wellness program. Remember, the Agency for Healthcare Research and Quality (AHRQ) has accepted SETMA's LESS Initiative as a valuable and creative healthcare innovation, making it available to all physicians in America.
2. **Preventive and Screening** – Provider compliance with standards of preventive care and of screening for illnesses supports our patients' determination to be healthy. It encourages healthy living and discovers illness or the potential for illness while health and wellness can still be recovered.
3. **Wellness Assessment** – This peer reviewed and evidence-based assessment allows patients to see the relationship between rest, eating habits, etc., and wellness. And, it recommends to the members of our Medical Home lifestyle changes which can support wellness and health.
4. **Stress Assessment** – Stress relief is more than a pill. To determine the sources of stress and to recommend a solution is a key part of SETMA's wellness program.
5. **Diabetes Prevention** – The best way to treat diabetes is "don't get it." Screening at-risk or high-risk patients for diabetes allows early intervention to delay the onset of diabetes and hopefully to prevent its onset completely.
6. **Hypertension Prevention** – Without preventive, lifestyle steps being taken, 90% of 55 year-olds without hypertension will develop high blood pressure in their lifetime. Evidenced-based medicine gives guidance for blood pressure wellness and the prevention of disease. SETMA's Medical Home identifies those life style changes and promotes patient adherence with the same.

Nothing New

In addition to exercise and activity, there are other elements to a Medical Home health and wellness program. But, without an exercise, and an activity program, all of the other elements are relatively of little benefit. Working with diabetes, thirty years before insulin was discovered, and recommending a plan of care and treatment plan for patients with diabetes which emphasized exercise 100 years before his ideas were confirmed by random controlled studies, Dr. Elliot Joslin said, “It is better to discuss how far you have walked than how little you have eaten.” Dr. Joslin’s recognition of the value of exercise in health and wellness was not isolated. SETMA’s exercise prescription includes the following quote, “"Those who think they have not time for bodily exercise will sooner or later have to find time for illness." (Edward Stanley, Earl of Derby; *Conduct of Life*, address to Liverpool College, 20 December, 1873).

The Medical Home reality is that you can be healthy and well, but you will have to walk, jog, run, bike, swim…..

Medical Home – Series Two
Part V Continuity of Care
By James L. Holly, MD
Your Life Your Health
The Examiner
August 4, 2011

In this second series of articles on Medical Home, we are reviewing what SETMA has learned since starting our pilgrimage to Medical Home in February, 2009. Having received National Committee for Quality Assurance (NCQA) Tier III Patient-Centered Medical Home recognition in 2010 and Accreditation Association for Ambulatory Heath Care (AAAHC) accreditation for Ambulatory Care and for Medical Home in August 2010 for one year and recertification in 2011 for three years, SETMA has continued to learn and to transform our organization into a "functioning" medical home.

Published in 2009, SETMA's Medical Home Series One is an eleven-part examination of what we were learning about Medical Home when we started this process. Those articles are posted on www.jameslhollymd.com under *Your Life Your Health* and can be found by clicking on the icon entitled, *Medical Home*.. Parts 1-IV of Series Two are:

- Part I – *The Movie*, July 7, 2011 – this reviews the Medical Home concepts which are seen in the 1951 movie, *People Will Talk*.
- Part II – *The Sign Post*, July 14, 2011 – this reviews the idea that Medical Home is a series of sign post along the avenue of life showing us how to maintain health and wellness and how to regain them, if we lose our health.
- Part III – *The Baton*, July 21, 2011 – this reviews the concept of "the baton" and of "the baton" posters in our lives. It reviews the foundations of SETMA's Medical Home which are found in our analysis and design of our practice beginning in 1995.
- Part IV – *The Metaphor*, July 28, 2011 – this reviews the metaphorical nature of the name "Medical Home" and its foundation principle of health and wellness.

Continuity of Care

Now, we come to Continuity of Care. Regardless of the standard of evaluation of a practice as a Medical Home – **AAAHC** (founded, 1979 and began accredited Medical Home in 2009), **NCQA** (founded 1990 and began recognizing Patient-Centered Medical Homes in 2009) **URAC** (formerly called the Utilization Review Accreditation Commission, founded 1991 and began accrediting Medical homes in 2011), or **Joint Commission** (formally called the Joint Commission on Accreditation of healthcare Organizations and abbreviated as JCAHO was founded in 1951 and began accrediting Medical Homes in July, 2011) – the establishment, support and maintenance of continuity of care is critical to its definition and function

The elements of continuity of care are:

1. Data connection and data sharing over the entire healthcare experience of the patient whether that involves different visits with the same provider, care by multiple providers, multiple locations of care, or multiple disciplines of care such as physicians, nurse practitioners, physical therapist, social workers, nutritionists, hospices, home health, case managers, pharmacists, etc.
2. Uninterrupted care of and attention to an acute or chronic problem until it is resolved or stabilized. This means that follow-up care always includes review, evaluation of and needed adjustments to previous care.
3. All care givers having adequate knowledge of a patient's overall health and of all conditions requiring attention. The association of continuity of care with the patient being seen by the same healthcare provider assumes that the same provider can and does know more about the patient than a new or different provider, depending upon the quality and granularity of the patients health record that may or may not be the case.
4. The foundation of the patient's care is a record which is longitudinal, cumulative, granular, accurate, accessible, available, confidential and thorough. Electronic patient records is the only method of medical-record keeping which can build on previous examinations and evaluations, continually transforming the "picture" of the patient from a silhouette, longitudinally into a true, granular portrait of the patients health and person.
5. All members of the healthcare team know the patient and have a personal interest in the patient's health and welfare. While the concept of medical home currently depends heavily upon a patient's identification of a "personal healthcare provider" as the principle conduit of continuity of care, the concept also recognizes the healthcare team as an essential foundation for the improved care given in the medical home. An essential part of the development of the medical-home model will be the clarification of the tension between care by a personal provider and care by a healthcare team.
6. Effective transitions of care are established and they function to transfer care from one point of care or provider to another provider or point of care. Transitions of care will be dealt with later in this series but they are critical to the maintaining of the continuity of care when the patient moves from one venue of care, i.e., inpatient hospital, to another, i.e., outpatient or ambulatory care. Like the universal joint in an automobile power train, the transition of care allows for the power, the standard of care and the content of care, created by and in one venue of care to be incorporated into and to be maintained in another venue..
7. The patient is included as a critical member of the medical home team. All other members of the team respect and support the autonomy, confidentiality and priority of the patient in decision making and in executing the medical home's plan of care and treatment plan. This requires that enhanced communication be present between the patient and provider including secure web portals, health information exchanges, telephone communication and after-hours access to care.

Tension between the personal healthcare provider and the healthcare team

All accrediting and recognition agencies for Medical Home associate continuity of care with the person of a healthcare provider, requiring that every effort be made to see that the same provider see the patient each time. At SETMA, we track this information and 61% of the time we fulfill this goal.

The American Academy of Family Practice (AAFP) defines Continuity of Care as:

> "…the process by which the patient and the physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.
>
> "Continuity of care is a hallmark and primary objective of family medicine and is consistent with quality patient care. The continuity of care inherent in family medicine helps family physicians gain their patient's confidence and enables family physicians to be more effective patient advocates. It also facilitates the family physician's role as a cost-effective coordinator of the patient's health services by making early recognition of problems possible. Continuity of care is rooted in a long-term patient-physician partnership in which ***the physician knows the patient's history from experience*** and can integrate new information and decisions from a whole-patient perspective efficiently without extensive investigation or record review." (Emphasis added)

The phrase "knows the patient's history from experience," reflects the Medical Home accreditation agencies' ideal that "continuity of care" principally takes place through the person of a particular and previously identified healthcare provider with whom the patient has a relationship. As will be discussed below, in SETMA's judgment, this is increasingly becoming an inadequate understanding of the process of medical home and of continuity of care.

The AAFP's definition of "continuity of care" concludes with its association with "coordination of care."

> "Continuity of care is facilitated by a physician-led, team-based approach to health care. Thus, the American Academy of Family Physicians supports the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordination of care with other health care professionals."

In the Medical Home, the team leader is the personal provider, while care is provided by a team. As more accrediting agencies enter the Medical Home arena definitions change. The Joint Commission also accredits Medical Homes operated exclusively by Nurse Practitioners while the 2009 version of NCQA's Medical Home standards did not recognize Nurse Practitioners as team leaders in Medical Home but do so in their 2011 standards. Standards are evolving and changing as we all learn more about Medical Home.

The AAFP's policy statement on Medical Home states:

> "The (AAFP) believes that everyone should have a personal medical home that serves as the focal point through which all individuals-regardless of age, sex, race, or socioeconomic status-receive acute, chronic, and preventive medical services. Through an on-going relationship with a family physician in their medical home, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians. (2006) (May 2011 Board)"

In reality, of all of the elements of "continuity of care" only one is related to a personal relationship with a particular provider. While few things in medicine are as enjoyable as a personal relationship over a long period of time with a patient and with multiple members of the patient's family, the quality of care is driven far more significantly by an accurate, thorough and available electronic health record.

This is demonstrated by SETMA's experience with its expanding use of the EHR. When SETMA began using the EHR in the hospital to complete the Admission History and Physical Examination and then the Discharge Summary, we developed the ability to complete daily progress notes in the hospital. (As will be discussed later, the name of the discharge summary has been changed to Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. This name change relates directly to the function of this document as the principle vehicle for effective Transitions of Care.)

In August of 2007, one provider in SETMA used the inpatient, daily-progress note function for over 2,500 daily hospital visits. While the hurdles of sharing critical data made this function labor intensive, it also had enormous value. Some of that value related to continuity of care. The benefit was seen in:

- Comprehensive documentation of a patient's inpatient care.
- Continuity of care – follow-up of inpatient care in the outpatient setting is dependent upon the availability of the inpatient record in the outpatient setting and is also dependent upon the completeness of that inpatient record.
- Cost savings realized when the inpatient record and outpatient record are in the same data base, eliminating redundant care and making it possible to schedule appropriate outpatient follow-up without extending a hospital stay just to make sure something gets done.
- Completion of the patient's "electronic" healthcare portrait, as now ALL patient encounter information is integrated into a single data base whether Nursing Home, In-patient Hospital, Out-patient hospital, Clinic, Physical Therapy or Home.

Documentation of a patient's care in the hospital should contribution to the portrait of that patient's health. Sometimes for a variety of reasons that portrait is more like a silhouette. As a silhouette, the medical record accurately depicts the outlines and contours of a patient's health,

but is not a granular, detailed, specific and precise picture of the patient's health status. This tool (the Electronically produced Daily Progress Note) – and it is only a tool – when fully developed will allow for a dynamic portrait to grow throughout the patient's hospitalization, such that by the time the patient leaves the hospital, the portrait will be complete and it will have evolved over the entire hospitalization.

Patterns of Change Rather than Static Snapshots

In a piece on "Clinical Inertia," which SETMA contributed to HIMSS' Quality 101 website, the power of the EHR to produce a patient portrait is addressed. In his book, *The Fifth Disciple*, Dr. Peter Senge, summarizing systems thinking, almost seems to have healthcare in mind. He describes systems thinking as, "a discipline of seeing wholes…a framework for seeing interrelationships rather than things, and patterns of change rather than static 'snapshots.'" Historically, medical records have been silhouettes of a patient's condition with little connection between the past and the future. Electronic Health Records (EHR) has changed that, or at least EHR has the potential of making that changing. With the cumulative data capacity of EHR, which provides a longitudinal portrait of the patient, patterns of change can be viewed seasonally and progressively.

The application of these concepts to medicine provides an elegant framework with which to study the design of the tools used to effect change in behavior of patients and physicians, and to shift the focus from information and experience to evidenced-based outcomes and data analysis over time. The most significant shift of mind in healthcare requires that the patient be seen as a whole and this requires a different kind of medical record than was found in the 18th, 19th and 20th centuries.

Continuity of Care is a central focus of patient-centered medical home because it requires and allows the patient to be seen as a whole person and it requires and allows for the patient's care to be seen as a continuum rather than as unrelated episodes. Our understanding of continuity of care will evolve over time and the processes to create and maintain continuity will also mature. What we know now is that it is critical to excellent care in the medical home.

Medical Home – Series Two
Part VI Care Transitions
By James L. Holly, MD
Your Life Your Health
The Examiner
August 11, 2011

While this is titled *Series Two on Medical Home*, the first being eleven-articles long and beginning in February, 2009, this is actually the third series. The second started July 29, 2010 and ran through September, 2010. It is entitled, "A New Day in Healthcare for you and for us." Along with occasional individual pieces on medical home, SETMA's documentation of our growing understanding of and experience with Patient-Centered Medical Home now exceeds fifty articles posted on www.jameslhollymd.com at Your Life Your Health under the icon entitled Medical Home.

One of the principle elements of continuity of care is in effective "transitions of care." There are few places where the ideals of Patient-Center Medical Home (PC-MH) are as clearly needed and as clearly seen as in the "transitions of care" from one setting of care to another, such as:

1. Hospital inpatient to Ambulatory Outpatient.
2. Ambulatory outpatient clinic to ambulatory outpatient home
3. Hospital inpatient to long-term, residential care (Nursing Home)
4. One provider to another

It is at these points where the quality of care is most often diminished, or even lost. It is by examining these points that the "organizational domain" of the future of healthcare can be transformed.

In SETMA's Model of Care (for a full description of this model see SETMA's presentation to the Federal Government's Office of National Coordinator (HIT, HHS) at the following link: http://www.jameslhollymd.com/The-Future-of-Healthcare.cfm), Care Transitions involves:

- Fulfillment of the Physician Collaborative for Performance Improvement (PCPI) Transitions of Care Quality Metric Set which has fourteen data points and four action items.
- Post Hospital Follow-up Call which is a 12-30 minute call which takes place the day after the patient leaves the hospital which is made by members of SETMA's Care Coordination Department.
- Plan of Care and Treatment Plan, which is symbolized by the "baton."
- Follow-up visit with primary provider in less than seven days of discharge and usually within three.

Over the past fourteen years, SETMA has developed numerous tools, (follow this link for a review of this history http://www.jameslhollymd.com/Care-Transitions_files/fullscreen.htm)
which enables us to do "medical home," to address each element of the transitions of care listed above, and to sustain an effort to impact hospital preventable readmission rates.

Transitions of Care Quality Metrics Set

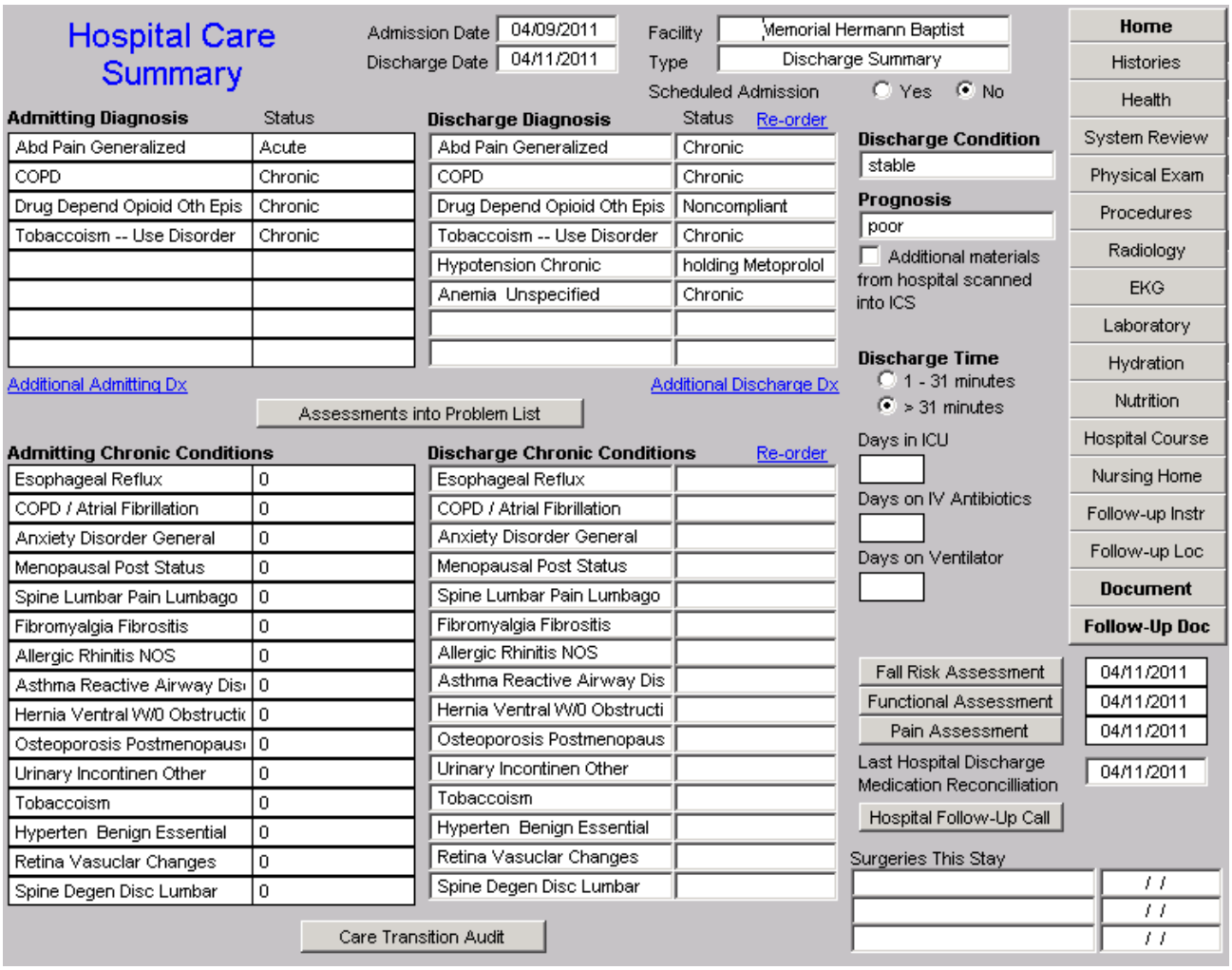
In June, 2009, the Physician Consortium for Performance Improvement (PCPI) of the American Medical Association published a quality metric set on Transitions of Care which involved 14 data points and 4 actions. Because SETMA had been completing hospital history and physicals and discharge summaries in the EHR for ten years, we were prepared to deploy this measurement set. Since July, 2009 we have successfully completed the measurement set on over 7,000 patients discharged from the hospital.

After a fifteen-month experience with Transitions-of-Care quality metrics set, in September, 2010 members of SETMA's team attended the National Quality Forum workshop on Care Transitions in Washington. During that conference, it occurred to SETMA that the name "discharge summary" for the hospital-care summary was outdated and not helpful. The document had become almost an administrative function, often completed weeks after the patient left the hospital. It was not the critical element in the patient's moving from their inpatient or emergency department care to the ambulatory or other setting. The document had little function in transitions of care and was not a functional part of the medical-home model-of-care.

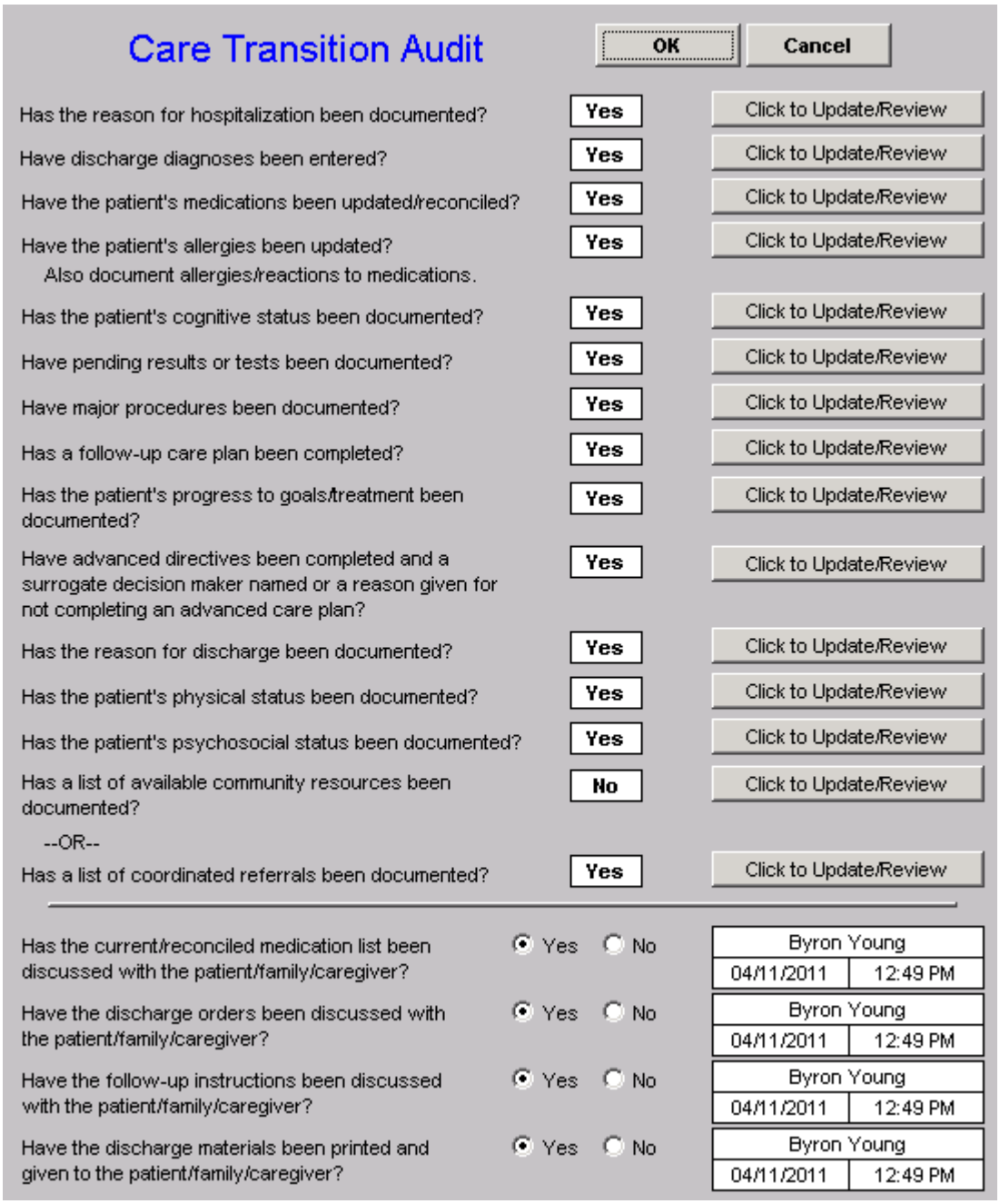
SETMA immediately changed the name to "**Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan**." This is a long and perhaps awkward name, but it is extremely functional, focusing on the unique elements of Care Transition. It also fulfills the medical home need for preparing the patient to care for him/her self, for medication reconciliation and for having a written plan of care and treatment plan which is given to the patient at the time of their leaving the hospital. From June, 2009 to August, 2011, SETMA has a 99.1% rate of completing this document at the time the patient leaves the hospital. As noted above, during this time we have discharged over 7,000 patients from the hospital.

Hospital Care Summary

SETMA saw these care-transition steps as part of our transformation into a medical home because the Hospital Care Summary is actually a suite of templates with which the care-summary document is created. (For a full description of this see the following on SETMA's website: **Electronic Patient Tools; Hospital Care Tools; Discharge Summary Tutorial**) The following is a screen shot of the master discharge template entitled "**Hospital Care Summary.**" This screen shot is from the record of a real patient whose identify has been removed.



At the bottom of this template there is a button entitled, "**Care Transitions Audit**." Once the templates associated with the Hospital Care Summary have been completed, the provider depresses this button and the system automatically aggregates the data which has been documented and displays which of the 18-data points have been completed. The elements in black have been completed; any in red have not.



If an element is incomplete, the provider simply clicks the button entitled "**Click to update/Review**." Instantly, the place where the missing information can then be added appears and the measure can be fulfilled. This fulfills one of SETMA's principles of EHR design which is, "**We want to make it easier to do it right than not to do it at all**."

At appropriate intervals, usually quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "**Public Reporting**," along with over 200 other quality metrics which we track routinely. This reporting is done by provider name. The following is the care transition audit results by provider name for

2010. This presently is posted on our website. The audit is done through SETMA's COGNOS Project which is described in detail on our website under **Your Life Your Health** by clicking on the icon entitled **COGNOS**.

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	95.0%	100.0%	82.4%	88.9%	93.5%	92.9%	90.7%	93.7%	95.0%
Aziz	98.4%	100.0%	95.2%	94.7%	96.7%	98.2%	95.6%	97.2%	95.6%
Colbert	100.0%	100.0%	50.0%	50.0%	83.3%	100.0%	66.7%	100.0%	100.0%
Cricchio	91.7%	94.4%	94.4%	91.7%	94.4%	91.7%	88.9%	88.9%	91.7%
Curry	99.1%	100.0%	97.2%	95.3%	96.2%	100.0%	95.3%	98.1%	98.1%
Deiparine	97.7%	100.0%	90.0%	95.8%	97.2%	96.3%	95.6%	96.3%	97.4%
Groff	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.2%	99.5%	94.1%	95.0%	95.9%	98.2%	94.1%	95.4%	96.3%
Henderson	84.0%	100.0%	64.0%	96.0%	96.0%	96.0%	88.0%	92.0%	92.0%
Holly	94.2%	99.7%	87.3%	94.0%	96.8%	91.8%	91.2%	91.3%	93.9%
Leifeste	97.6%	100.0%	88.0%	95.3%	98.6%	95.5%	95.9%	96.6%	96.4%
Murphy	98.7%	99.6%	95.7%	94.5%	95.3%	98.7%	95.3%	97.9%	94.5%
Qureshi	90.4%	100.0%	84.6%	96.2%	98.1%	90.4%	92.3%	94.2%	88.5%
Satterwhite	98.3%	100.0%	90.4%	90.4%	94.8%	99.1%	93.9%	93.0%	98.3%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.3%	99.7%	87.2%	93.9%	96.5%	95.5%	97.1%	95.2%	97.1%
Vardiman	96.9%	100.0%	88.8%	91.8%	96.9%	98.0%	93.9%	98.0%	95.9%
Young	86.8%	100.0%	73.6%	88.7%	86.8%	86.8%	86.8%	83.0%	86.8%
SETMA Totals :	96.4%	99.8%	89.1%	93.8%	96.4%	95.1%	93.7%	94.6%	95.4%

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

The public reporting of quality metrics goes beyond the requirements of any medical home requirement which only requires the ability to report and to report to an external agency on 10 quality metrics.

Once the Care Transition issues are completed, the Hospital-Care-Summary-and-Post- Hospital-Plan-of-Care-and-Treatment-Plan document is generated and printed. It is given to the patient and to the hospital. The complexity of Transitions of Care is illustrated by this analysis of how many different places this document can be needed. It can go from:

1. Inpatient to ambulatory outpatient (family) -- The "baton" in a printed format is given to the patient or in the case of a minor or incompetent adult to a parent or care giver. The "plan of care and treatment plan" -- "the baton" -- is reviewed with the patient, parent and/or family before the patient leaves the hospital.
2. Inpatient to ambulatory outpatient (clinic physician) -- for patients who are seen at SETMA, the "the baton" is created in the EHR and is immediately accessible to the follow-up SETMA provider. The provider is alerted by appointment when he/she is to see the patient and that the "baton" is available for review.
3. Inpatient to ambulatory outpatient (follow-up call) -- after the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (HCSPHPCTP) is completed, a template is completed and sent to the Department of Care Coordination. This template is

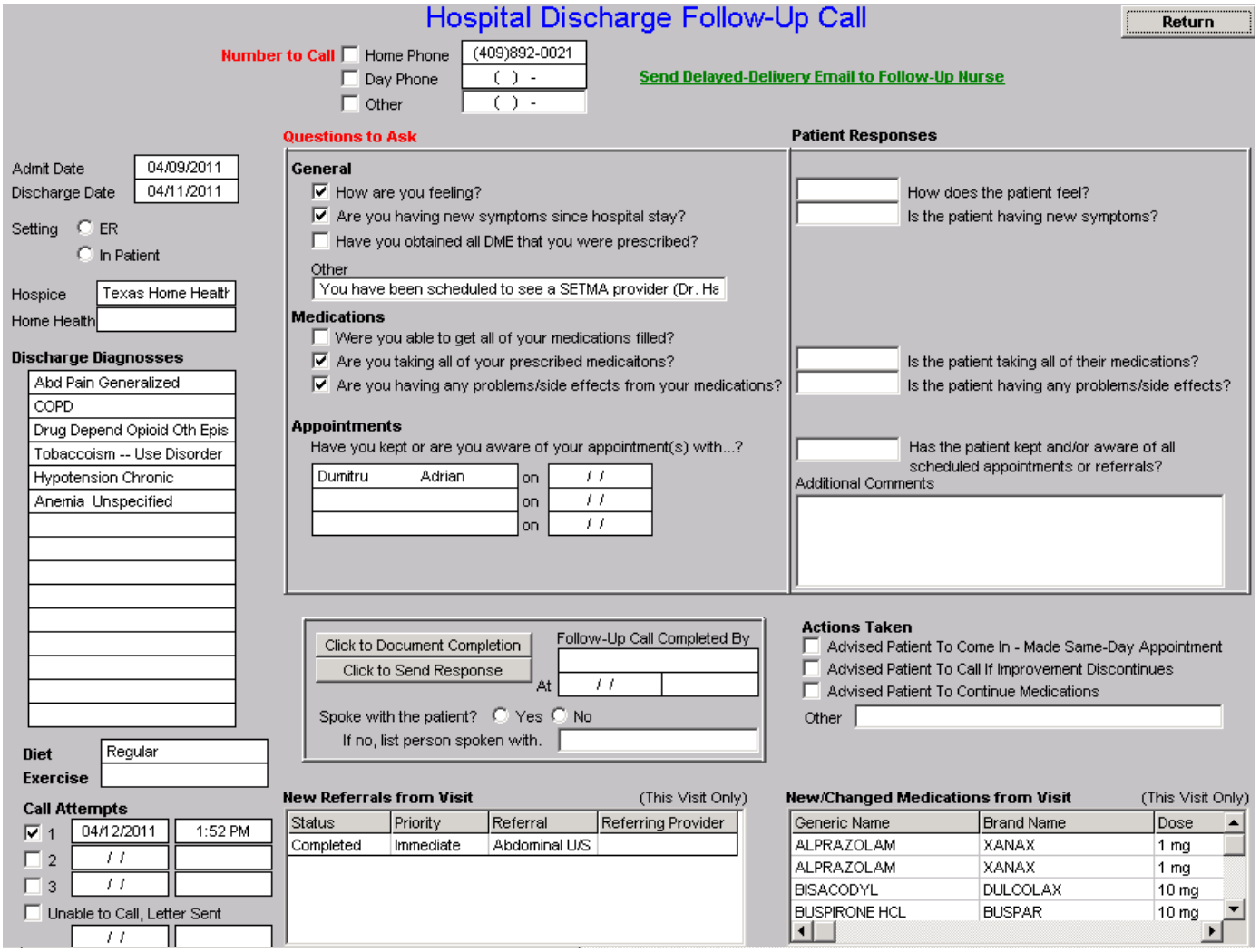
in the EHR where the HCSPHPCTP also resides. Both are immediately accessible to the Department. The "follow-up call from the hospital" call request is delayed for one day so that the call is made the day after the patient leaves the hospital.

4. Emergency Department to ambulatory care -- the same process as in "1" above.
5. Inpatient to Nursing Home -- the "baton" with a special set of Nursing Home orders is given to the patient or family and a copy is sent to the Nursing Home with the transportation to the Nursing home.
6. Inpatient to Hospice -- the same as with number "6"
7. Inpatient to Home Health -- the same as number "5" and "6" above. If the patient is seeing SETMA's home health, they have access to SETMA EHR and thus to the "baton."
8. Inpatient to outpatient out of area -- "Baton" given to patient and family and also posted to web portal and HIE. Token sent to health provider in remote area which allows one time access to this patient's information.

With this infrastructure and with this care coordination, continuity of care and patient support functions, SETMA is ready to make a major effort to decrease preventable readmissions to the hospital. The document generated once the care transition issues are met in part includes reconciled medications, follow-up appointments with time, dates, address and provider name and any referrals which have been initiated as a result of the hospitalization.

Hospital Follow-up Call

After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:



During that preparation, the provider checks off the questions which are to be asked the patient in the follow-up call. The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called. This call is a beginning of the "coaching" of the patient to help make them successful in the transition from the inpatient setting to their next level of care. After the call is completed, the answers to the questions are sent back to the primary care provider by the care coordinator. If the patient has any unresolved issues or is having any problem, he/she is given an appointment that same day.

The Care Coordination call takes 12-30 minutes with each patient and engages the patient in eliminating barriers to care. Recently, a complex case took one hour and twenty minutes but all

transitions of care issues were successfully fulfilled avoiding the risk of readmission and losing the care plan which had been established at the time of discharge. If appropriate, an additional call is scheduled at an appropriate interval. If after three attempts, the patient is not reached by phone, the box in the lower left-hand corner by "**Unable to Call, Letter sent**" is checked. Automatically, a letter is created which is sent to the patient asking them to contact SETMA.

Follow-up Visit with Primary Care Provider

The Transition of Care is complete only when the patent is seen by the primary care provider in follow-up. Many issues are dealt with in this follow-up visit, but one of them is another potential referral to the Care Coordination Department. If the patient has any barriers to care, the provider will complete the Care Coordination template. It takes three clicks and the Department will work with the patient to meet their healthcare needs.

Care Transition is the heart of the continuity of care of the patient-centered medical Home. It fulfills many of the elements of the National Priorities Partnership in which the National Quality Forum identified Priorities for the 2011 National Quality Strategy. These are:

- Wellness and Prevention
- Safety
- Patient and Family Engagement
- Care Coordination
- Palliative and End of Life Care

Medical Home – Series Two
Part VII Care Coordination
By James L. Holly, MD
Your Life Your Health
The Examiner
August 18, 2011

One of the "catch phrases" in medical home is that the care is "coordinated." While this process traditionally has referred to scheduling, i.e., that visits to multiple providers with different areas of responsibility are "scheduled" on the same day for patient convenience, it has come to mean much more to SETMA. Because many of our patients are elderly and some have limited resources, the quality of care they receive very often depends upon "coordination." It is hard for the frail elderly to make multiple trips to the clinic. It is impossible for those who live at a distance on limited resources to afford the fuel for multiple visits to the clinic.

As with most issues of quality care in the 21st Century, a **process** has an **outcome** and a metric may measure one or the other. **Coordination of Care** is the process an organization goes through to assure that patients receive the care they need and **Coordinated Care** is the outcome, i.e., the experience and perception the patient has when the care has been organized for continuity, for convenience and for compliance.

The Agency for Healthcare Research and Quality (AHRQ) of Health and Human Services (HHS) published the following definition of Care Coordination:

> "Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."

Care Coordination involves the following six elements:

1. Collaboration
2. Convenience
3. Comprehensiveness
4. Connection
5. Communication and Continuity

1. Collaboration

No longer is the patient the passive recipient of the instructions and care of the healthcare provider; the patient is now an active part of their own healthcare team. Communication in the medical home is not a monologue by the provider to the patient but it is a dialogue (see below). It is a dialogue where the provider recognizes and acknowledges that the "healthcare race is the patient's to run," and that what they need is not a coach that tells them what to do but a team mate with whom plans and activities can be and are discussed.

The physician, as a constable, imposing care upon and coercing change by the patient, is no longer an acceptable model of care. The physician as a collaborator, as a colleague and as a consultant to the patient is the medical-home model. This is the patient-centeredness of medical home. Not only is the welfare of the patient central but the participation and personal responsibility of the patent is central to medical-home care. The patient accepts responsibility for his/her own health and works with the healthcare team to establish a plan of care and a treatment plan which the patient is prepared to carry out and which the patient is capable of carrying out. This is medical-home care.

2. Convenience

Initially, the idea of convenience in the scheduling of appointments, particularly multiple appointments, was the extent of SETMA's understanding of this element of coordination. Eventually, "convenience" was translated into the understanding that coordinated care means more than just making patients comfortable; it meant and it resulted in:

1. Convenience for the patient which…
2. Results in increased patient satisfaction which contributes to…
3. The patient having confidence that the healthcare provider cares personally which…
4. Increases the trust the patient has in the provider, all of which…
5. Increases compliance in obtaining healthcare services recommended which…
6. Promotes cost savings in travel, time and expense of care which…
7. Results in increased patient safety and quality of care.

This requires intentional efforts to identify opportunities to:

- Schedule visits with multiple providers on the same day, based on auditing the schedule for the next 30-60 days to see when a patient is scheduled with multiple providers and then to determine if it is medically feasible to coordinate those visits on the same day.
- Schedule multiple procedures, based on auditing of referrals and/or based on auditing the schedule for the next 30-60 days to see when a patient is scheduled for multiple providers or tests, and then to determine if it is medically feasible to coordinate those visits on the same day.
- Scheduling procedures or other tests spontaneously on that same day when a patient is seen and a need is discovered.
- Recognizing when patients will benefit from case management, or disease management, or other ancillary services and working to provide the resources for those needs.

Convenience is a process not an outcome of coordination of care.

3. Comprehensiveness

The Coordination of Care in the medical home is not only collaborative and convenient, it is comprehensive. The medical home does not simply coordinate the primary care needs; it coordinates all of the care the patient receives. This includes evaluating the care recommendations of other providers. Those recommendations are not only evaluated as to whether everything is done which should be done, but also to determine whether what is

recommended should even be done. Often, the safety of a patient can be compromised by the recommendation of care which is inappropriate, unnecessary or excessive. These are all parts of the medical-home paradigm.

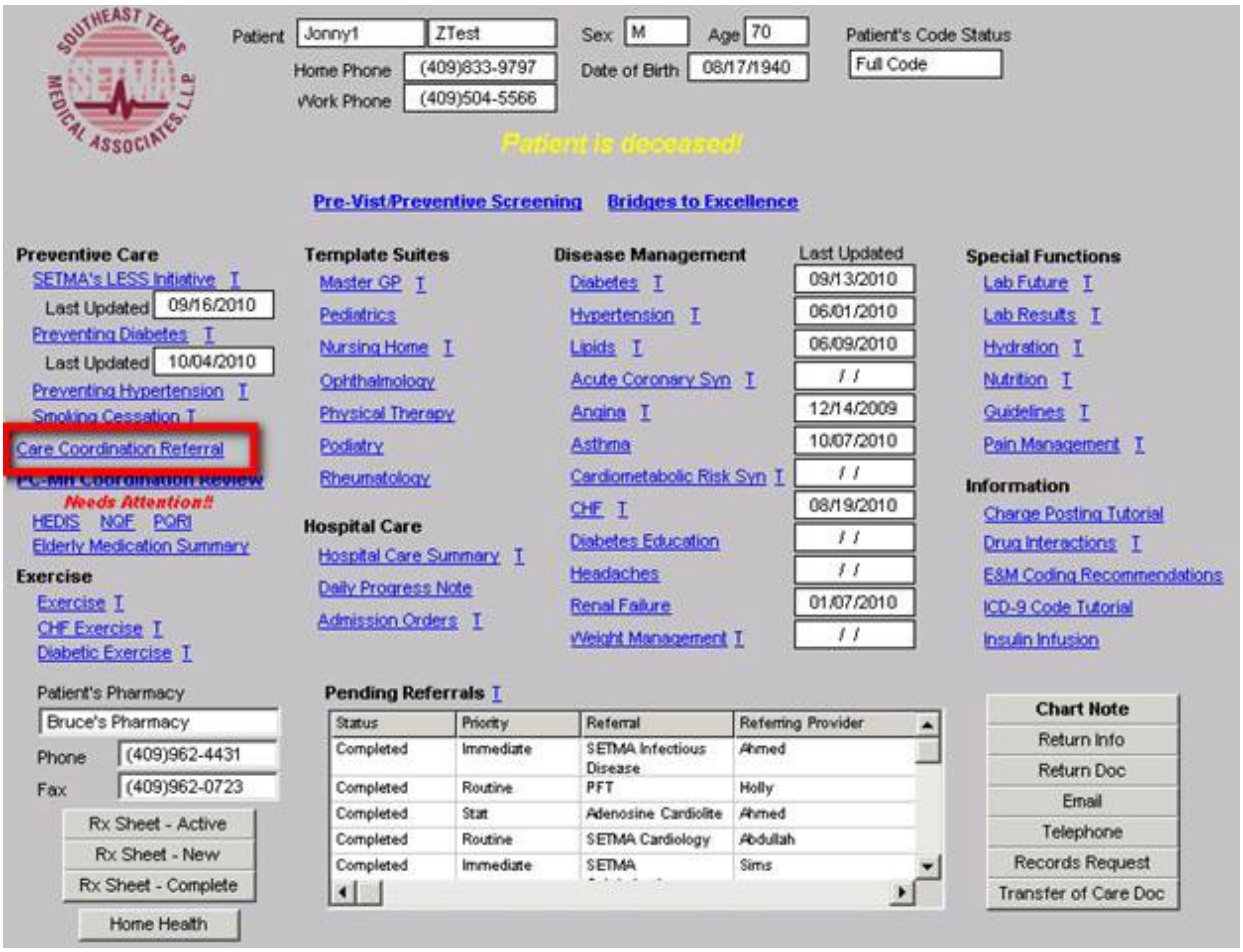
The inclusion of evaluations, assessments, testing and procedures from all points of care contributes to the comprehensiveness of the patient's electronic health record. For instance, at SETMA, laboratory results from a hospital stay are entered into the patient's ambulatory record. Those results interact with SETMA's disease management tools and with all quality metrics. This eliminates duplication of testing and continuity of care, both of which promote the cost effectiveness of care.

Care at other clinics is integrated into the medical-home patient's cumulative medical record. Diagnoses established elsewhere are displayed in the patient's chronic problem list and become an active part of the patient's follow-up care. Care recommended at another clinic is followed-up both for appropriateness and outcomes once the recommended care is completed. This eliminates the segmentation of the patient's care where one clinic only knows that part of the patient's health picture.

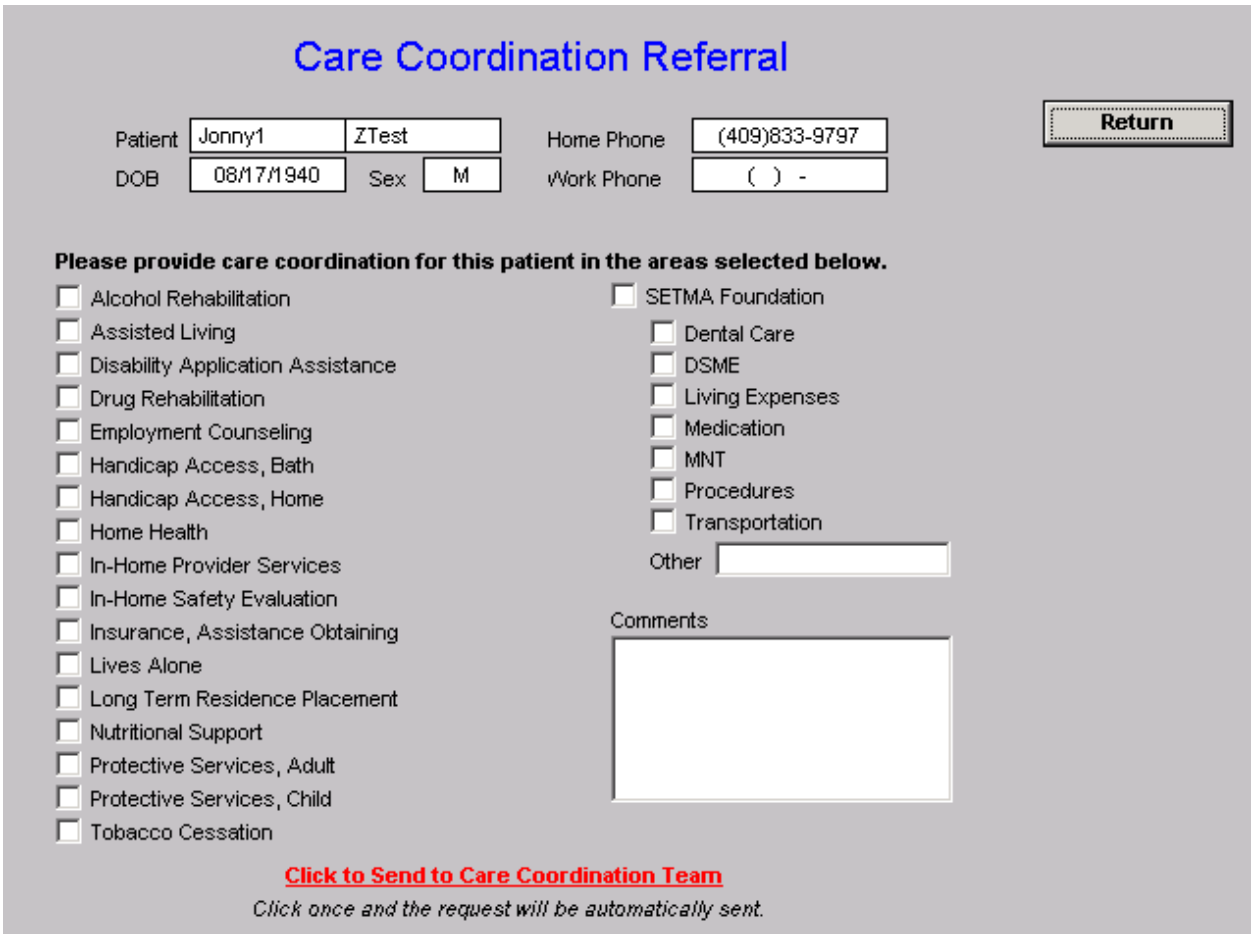
4. Connection

"Connections" has to do with providing or helping patients find the resources for the care needed. Patients who need help with medications or other health expenses are connected with the resources to meet those needs. In this way, Medical Home provides the healthcare professional with the opportunity to be more involved with the patient than ever before.

At SETMA not only are barriers to care evaluated, but a "care coordination referral" can be initiated by the provider. The Care Coordination Referral can be made by simply clicking the button in red on the template below:


Patient Jonny1 ZTest
Sex M Age 70
Patient's Code Status
Full Code
Home Phone (409)833-9797
Work Phone (409)504-5566
Date of Birth 08/17/1940
Patient is deceased!
Pre-Visit/Preventive Screening
Bridges to Excellence
Preventive Care
SETMA's LESS Initiative I
Last Updated 09/16/2010
Preventing Diabetes I
Last Updated 10/04/2010
Preventing Hypertension I
Smoking Cessation I
Care Coordination Referral
PC-MH Coordination Review
Needs Attention!!
HEDIS NQF PQRI
Elderly Medication Summary
Exercise
Exercise I
CHF Exercise I
Diabetic Exercise I
Template Suites
Master GP I
Pediatrics
Nursing Home I
Ophthalmology
Physical Therapy
Podiatry
Rheumatology
Hospital Care
Hospital Care Summary I
Daily Progress Note
Admission Orders I
Disease Management
Last Updated
Diabetes I 09/13/2010
Hypertension I 06/01/2010
Lipids I 06/09/2010
Acute Coronary Syn I / /
Angina I 12/14/2009
Asthma 10/07/2010
Cardiometabolic Risk Syn I / /
CHF I 08/19/2010
Diabetes Education / /
Headaches / /
Renal Failure 01/07/2010
Weight Management I / /
Special Functions
Lab Future I
Lab Results I
Hydration I
Nutrition I
Guidelines I
Pain Management I
Information
Charge Posting Tutorial
Drug Interactions I
E&M Coding Recommendations
ICD-9 Code Tutorial
Insulin Infusion
Patient's Pharmacy
Bruce's Pharmacy
Phone (409)962-4431
Fax (409)962-0723
Rx Sheet - Active
Rx Sheet - New
Rx Sheet - Complete
Home Health
Pending Referrals I
Status Priority Referral Referring Provider
Completed Immediate SETMA Infectious Disease Ahmed
Completed Routine PFT Holly
Completed Stat Adenosine Cardiolite Ahmed
Completed Routine SETMA Cardiology Abdullah
Completed Immediate SETMA Sims
Chart Note
Return Info
Return Doc
Email
Telephone
Records Request
Transfer of Care Doc

This is the Care Coordination Referral template



This template allows the provider and/or nurse to send an e-mail to the Department of Care Coordination, which helps find resources for a patient's special needs. Several functions are included with this template:

1. If a provider completes three or more referrals in any given encounter, an e-mail is automatically sent to the Director to allow for the coordination of those referrals to increase convenience and compliance.
2. The first column allows for the provider to indicate the special needs which the patient has and which would or might benefit from a follow-up contact from the Care coordination team.
3. A comment box is present which allows for a description of a need not covered by those listed.
4. The second column allows for the provider to indicate that the patient has financial needs and the service for which that need exists.

Once the provider or nurse checks the needs which exist, the red button entitled "Click to Send to Care Coordination Team" is launched. The button will turn to green which indicates that the e-mail has been sent to the Director of Care Coordination.

5. Communication and Continuity

To be a medical home, a practice must provide communication with a personal physician who accepts primary responsibility for the patient's care. This is more than a friendly affect when the patient is seen in the clinic. It means answering inquires about health from the patient at times other than when they are seen in the clinic. It means providing telephone access with same-day response; e-mail contact through a secure web portal with same day access; it mean eliminating a patient's anxiety about whether or not their healthcare provider cares about them by the provider or a medical-home "team mate" being available to the patient twenty-four hours a day, seven days a week.

It may mean in some cases that the patient has the provider's home telephone number, or cell phone number. It means doing whatever is necessary for making sure the patient knows how to access care when it is needed. The reality is that the more confident a patient is that they can reach their provider when needed; the less likely the patient is to pester the provider over trivial or unimportant matters.

Continuity of care in the modern electronic age means not only personal contact but it also means the availability of the patient's record at every point-of-care. During SETMA's on site survey by the Accreditation Association for Ambulatory Health Care, one surveyor said that his standard for judging medical records is, "Could I pick up this chart and provider excellent care for a patient whom I had never seen?" His answer after reviewing dozens of SETMA charts was, "I could easily treat any of these patients as the records are legible, complete and well organized." Because:

- all of the patient's health needs are clearly documented;
- all preventive and screening health needs are constantly and automatically audited;
- every patient's laboratory results, medications and diagnoses are interactive;

Every patent can be confident that all of their health needs are being addressed, can be addressed and will be addressed, no matter who the provider is that they see.

Coordination of care requires enhanced communication between the medical home and the patient. This communication can be initiated by the patient, the patient family, the patient care giver or the healthcare provider. Telephone calls initiated by the clinic to the patient following hospitalizations or complicated outpatient visits, allows for continuity of care, convenience of care and for assuring comprehensive care which is safe and appropriate. The availability of a web portal which allows a secure electronic connection between the patient, their record and their provider adds to the coordination of care through communication. This is further enhanced by a health information exchange so that communication between providers and points of care

are seamless, efficient and effective. The ability of the patient to review parts of their medical record and to recommend corrections or additions

Activities of SETMA's Care Coordination Department

Currently, these are the responsibilities of SETMA's Care Coordination Department:

1. Follow-up calls on all patients discharged from the hospital
2. Follow-up clinic calls as requested by the providers
3. SETMA Foundation referrals
4. Contact patients with 3 or more referrals
5. Infectious disease reporting to the state
6. Contact patients that no showed with Diabetes and Hypertension
7. Meet with patients in the clinic as requested by providers to give immediate help with needed care.
8. All complaints are directed to our office for resolution
9. Development and deployment of effective patient satisfaction surveys

Time, energy, and expense are conserved with these efforts in addition to increasing compliance thus improving outcomes. In order to accomplish this and to gain the leverage, synergism and advantage of coordination, a system is necessary which brings us to a new position designed by SEMTA entitled, Director of Coordinated Care..

Integration of Care

The medical home sees the patient as a whole and not as a collection of isolated and disconnect disease processes. While this is not new and has always been the ideal of health care, it becomes a significant focus and objective of the patient-centered medical home. Not only is the patient the major focus of the attention given, but all elements of the patient's needs are attended to and future needs are anticipated and addressed. No longer is a patient encounter simply used to address current needs but potential future needs are identified and addressed.

For instance, the young person who is seen for an upper respiratory condition but who is moderately obese, and who has a family history of diabetes, has his disease-risk addressed. In addition, recommendations are made for diabetes prevention and wellness including exercise, weight reduction, avoiding tobacco and others. Future contacts are scheduled, with or without a clinic visit, for assessing whether the patient has made the changes necessary to maintain their health.

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 of care 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." At

that point, you know that the patient has taken charge of their own care which is the ideal of medical home.

Medical Homes Series Two
Part VIII Patient Centered:
What Does That Mean?
Your Life Your Health
The Examiner
August 25, 2011

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. Often the patient became an object of care, i.e., the opportunity to perform a procedure, surgery or test, rather than the health and wellness of the patient being the principal focus. In addition, the patient is often the passive recipient of care rather than an active participate in their own care.

As the science of medicine grew, due to capabilities and the method of 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 added to the quantity of life. Markets were created for "practice enhancement" and new "revenue streams," which focused upon the benefit to the provider without any realization that what often happened was that the health of the patient suffered, or at the very least did not benefit.

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 a thorough and knowledgeable clinician and the financial success of the practice. And, often the patient was passive and was not actively involved in care planning and execution.

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 given by 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 in-coordination, 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.

In February, 2009, SETMA began the process of developing a Medical Home within SETMA and in reality to transform the entire practice into a Medical Home. In April, 2010, we submitted our application to the National Committee for Quality Assurance (NCQA) for recognition as a Patient-Centered Medical Home and in June, 2010, applied to Accreditation Association for Ambulatory Heath Care (AAAHC) for accreditation for Medical Home and for Ambulatory Care. In July, 2010, we received NCQA recognition as a Tier III Medical Home, their highest, and in August, 2010, SETMA received a one-year accreditation by AAAHC and in August 2011, we received a three-year AACH accreditation for Medical Home and Ambulatory Care.

In 2012, SETMA will submit applications to The Joint Commission and to URAC, two other agencies which endorse Medical Home applications. At the end of that process, SETMA will possess all four Medical Home recognitions and accreditations, which will allow us to comment intelligently about the entire process and about how it can be improved.

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 care – now the patient and the patient's health will be front and center. And, the patient will be the central 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, supported 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. Some of the standards which define patient-centeredness in medical home are:

- Follow-up calls after a visit to see if the patient saw the specialist, had the test, 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 end-of-life 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 to 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 takes the work of the provider and makes sure that it is packaged 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.

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 that SETMA's Medical Home will continue to evolve over time. While we will be guided by accreditation and recognition guidelines and requirements (SETMA has NCQA Recognition as a Medical Home and AAACH accreditation as a Medical Home), we will also be guided by the experience of others. We will continue to 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.

SETMA's Medical Home will be different from others but it will be the same in that it will fulfill the mandate for patient's to be engaged in their own care and for patients' desire and wishes to be given consideration in their health care.

Medical Home Series Two Part IX
Telling The Truth and Collaboration
By James L. Holly, MD
Your Life Your Health
The Examiner
September 8, 2011

The foundation of SETMA's Medical Home transformation was our facing of the truth about how we practice medicine. Nothing has changed about that. Former Notre Dame Philosophy professor, Tom Morris, applied Aristotle's four cardinal virtues to American business in writing, *If Aristotle Ran General Motors*. One of those virtues is truth, of which, Morris said in part:

> "There is probably no greater source of wasted time and energy in modern corporate life than the distraction that arises when truth is not readily available in the workplace and speculation, gossip, and rumor rush in to fill the void." (p. 30)
>
> "Human beings can't do without truth."
>
> "...the Spanish-born Roman poet Martial wrote in the first century, 'Conceal a flaw and the world will imagine the worst.' Whenever you confront a problem, you confront the need for truth. The people who work with you can't be their best if they are busy imaging the worst:
>
> - concerning the state of the company
> - what you think of their performance, or
> - what the future might hold. (31)"

As SETMA began the process of becoming a Medical Home, we determined that we did not want to achieve Medical Home simply by jumping through hoops but by fundamentally changing our healthcare-delivery model to gain the benefits of the ideals of Medical Home. When we started using NexGen EMR in 1999, it took us only three months to determine that it was too hard and too expensive if all we gained from it was an electronic means of completing a patient encounter. Therefore, we morphed from EMR to EPM (electronic patient management). All of our progress in disease management, evidenced-based medical management, population management and restructuring of our delivery model has been achieved as a result of that transition from EMR to EMP.

Early in the process of becoming a Medical Home, SETMA saw the potential of bringing about another major advancement in our delivery of healthcare. It has been and it is our intent to gain that advantage through taking seriously the spirit, intent, dynamic and potential of Medical Home. We believed that it would take five years before we would have the answer to this particularly question and before we would know whether we made the caliber of transition via Medical Home as we did via electronic patient management. That questions was being asked April, 2, 2009. Now, twenty-eight months later, the evidence is in; Medical Home is a major

step forward in healthcare delivery for SETMA. Thirty-two months from how, five years will have passed since we started this process. We now believe we will have passed the test.

In the past 28 months, we have learned a number of things about Medical Home. Perhaps the most remarkable is that when we started the Medical Home process NCQA would not include nurse practitioners in their Medical-Home recognition program, when the practice was an MD-led organization. This was a mistake as the BEST medical-home care-givers are Nurse Practitioners. In fact, it was like pulling teeth to get physicians to do the care which is the foundation of Medical Home, while nurse practitioners did it as a result of their training, experience and personal motivations.

We have come a long way since the Spring of 2009. At that time, we would not have qualified for a Tier I Medical Home. In the Summer of 2010, we were recognized as a Tier III. In 2009, we did not consistently demonstrate and document that we used evidence-based algorithms in treating our patients. In fact, we had partners who refused to use our disease management tools and who even told their nurses "Do not complete the diabetes templates," or "We don't use that part of the EMR." As a result, we were deficient in our ability to prove what we were actually doing. Other partners did not refuse to use those tools; they just neglected to do so. Fortunately, that is no longer the case.

None of the above is to say that we were not practicing good medicine. It was only to say that if we could not prove that we were practicing good medicine; and, if we are not learning, based on random-controlled studies and evidence-based medicine, which are the results of those studies, we will not be recognized for our efforts no matter how good they are. We no longer have partners or providers who refuse to use disease management tools and we now not only are but we can prove that we are, practicing excellent medicine.

We now document our awareness of, attention to, and performance in regard to evidence-based medicine by using the disease-management tools for diabetes, hypertension, lipids and CHF which have evidence-based standards and goals embedded in them. These standards are automatically aggregated and reported with the single clinic of a button. By paying attention to the alerts which are built into our system for preventive measures and for HEDIS compliance, we advance quality care. As we pay attention to the reports which we create about the measures endorsed by the National Quality Forum, we improve our care. We recognize that NCQA's HEDIS measures are designed to examine three things:

a. Effectiveness of Preventive Care
b. Effectiveness of Acute Care
c. Effectiveness of Chronic Care

Our system presently displays all of the HEDIS measures and automatically tracks our performance on those measures. Self-monitoring original was awkward so we completely

redesigned the presentation to make it easy to know what HEDIS measures apply to our patients and whether or not those measures have been met as of the current treatment date.

Because our partners were willing to modify their practice patterns, we have been able to remodel SETMA into a leader in 21st Century medicine. We led in the adoption of EMR; now as we lead in the Medical Home movement, we will improve the care all of our patients are receiving; we will secure our future; and, we will continue to fulfill our motto: Healthcare where your health is the only care.

Change always comes in the midst of challenges and often in the midst of crisis and sometimes in the midst of tragedy. SETMA started the process of becoming a Patient-Centered Medical Home at the same time that we were experiencing the loss of our friend and partner, Dr. Mark Wilson. Organizations often slow down and stop transformation at such times, but SETMA did not.

I wrote in March, 2009 words which are as true today as then:

"….I am proud of SETMA…**but the pride that I have in the partners of SETMA knows NO BOUNDS**…it is not possible for me to mourn my friend's death and my loss of him without being filled with gratitude to Drs. Aziz, Anwar, Colbert, Halbert, Murphy and Leifeste. They are men of honor, of integrity and of character, and they have proved each of those traits by their conduct through this very difficult time.

"I stand and I salute them. I say to them, thank you, and thank you. May God bless you and your families forever for your good deeds in your care of Dr. Wilson. Words are inadequate but words are demanded to say to each of you, Muhammad, Imti, Bobbie, Dean, Vince and Alan, I admire you and respect you. You deserve the best that it is possible for you to receive. I shall never forget what you have done; it shall always stand as the greatest evidence of what SETMA is all about.

"Mark and I are the founding partners of SEMTA, but in the last 19 months (From August, 2007 when Dr. Wilson announced his illness) each of you has joined the foundation of SETMA. You shall now and forever in the future be founders of this great and prospering organization. Dr. Wilson expressed his pride in you often and he would embrace what I have said."

That kind of perseverance is what has brought us to where we are. It will take us to where we want to be. As our Medical Home matures, we will grow and expand our understanding of this revolutionary concept and its foundation will be our collaboration.

Tom Morris addresses collaboration; he said:

> "...Tomas Hobbes (1588-1679) said, 'Knowledge is power...Too few executives seem to see that the sharing of knowledge yield more than shared power. It typically results in greatly expanded power. (p. 36)

> "As knowledge is shared, it expands. And as knowledge expands, power expands. Why should you run a forty-watt company when you could all be blazing with light? Share your knowledge and multiply your power. (p 37)
>
> "In my book *True Success: A New Philosophy of Excellence*, I stressed the importance of this sort of clear vision for effectively launching any quest for success." (p 56)

From these ideas and from our desire to improve our practice, we can observe that **the ultimate corporate reality is when we are able to tell ourselves the truth about ourselves and when we are willing to acknowledge that others already know that truth about us**. It is as the lead character says in one of my favorite moves, *My Cousin Vinny*. When addressing a witness, Vinny Gambini said, "Go ahead, you can tell them (the jury), they already know." Facing the truth about ourselves, which truth others already know, is the foundation for growth, development and maturity.

Finally, Morris addresses the concept of collaboration:

Peer Relation	Stance	Key Characteristics
Combative	**Fighting**	**Aggression, resistance, damage**
Competitive	**Striving**	**Rivalry, mixed motivations**
Cooperative	**Agreeing**	**Acquiescence, obedience**
Collaborative	**Partnering**	**Synergistic interaction**

Morris continued:

"The point is that collaboration is not the same thing as cooperation. Recall that I just characterized cooperation as a multiplication of hands to get a job done. **Collaboration is a multiplication of heads as well**. (p. 61)

"At their best, collaborators don't think exactly alike but are sufficiently in harmony with one another that their differences create new insight, and each is taught by the other.

"Collaboration is all about teams and basic transformation. It is about community, creativity, learning, building and pioneering. A collaborative model of excellence sees this highly sought after human state of maximum achievement in relational terms.

"Synergy ideally creates properties which either do not or cannot characterize the related individuals alone who are synergistically interacting. (p. 61)

"At the deepest level, collaboration is not just one of many alternatives possible means to excellence but rather an inevitable component of any form of excellence truly worth having." (p. 62)

SETMA is a team and as the partners, providers and management synergize their energy, their talents and their passion with that of their colleagues, we can take Medical Home, transform ourselves and change the future of the healthcare we delivery.

Medical Home Series Two Part X Quality, Coordination and Cost of Care
CMS Medical Home Feedback Report – SETMA's Performance
By James L. Holly, MD
Your Life Your Health
The Examiner
September 22, 2011

The promise of Medical Home is that patient safety will improve; that the quality of care received by patients will be consistent and excellent, and that the cost of care will be reduced while the quality of care is maintained. There is a large and growing body of academic medical literature on the Patient-Centered Medical Home. While not a part of the peer-reviewed literature, SETMA alone has produced over fifty articles on Medical Home in the past thirty-one months.

All of us involved in Medical Home have been eager to have objective data on treatment outcomes and cost on Medical Home and particularly to have that information in contrast with medical practices not pursuing the principles of Medical Home.

In January 2011, SETMA was invited to participate in the Medical Home Study conducted by RTI International (RTI) with funding from the Centers for Medicare and Medicaid Services (CMS). The study compared patterns of care between clinical practices that have received National Committee for Quality Assurance (NCQA) recognition as a medical home and clinical practices with similar characteristics that have not received NCQA medical home recognition. The only compensation the 312 Medical-Home practices received for this participation was that RIT prepared reports summarizing information for each practice providing comparative information with two groups: a bench mark group of non-Medical Home practices and mean (average) performance of the NCQA-recognized, Medical-Home group.

RTI used Medicare fee-for-service (FFS) billing data as the information source for their study. The limitations of that methodology will be discussed later. For practices with multiple sites, a report was produced for each practice site.

Three data categories are presented:

1. Clinical quality of care measures - Summary information about selected quality of care

measures, such as LDL-C, HbA1c, and influenza vaccination.

2. Coordination and continuity of care measures - Summary information for selected utilization measures, such as emergency room (ER) visits and hospitalizations for ambulatory care sensitive conditions, percentage of your Medicare FFS patients that had a follow-up visit within 2 weeks of a hospital discharge, percentage readmitted within 30 days of a hospital discharge, and rates of medical and surgical specialty use.

3. Medicare payments - Summary information on the share of care that you provide your Medicare FFS patients, total Medicare payments per beneficiary, and average Medicare provider payments by type of service.

The study analyzed patterns of care, health outcomes, and costs of care for Medicare fee-for-service (FFS) beneficiaries receiving healthcare services from clinical practices that are National Committee for Quality Assurance (NCQA)-recognized medical homes. In particular, the study was interested in determining if there are particular attributes of medical homes that are more favorably related to better outcomes of care. The information from these analyses will be used by CMS to help design Medicare and Medicaid medical home demonstrations.

SETMA's Results Against the Benchmark

Obviously, in January, 2011, our hearts where in our hands when we agreed to participate in this study. Who was to know how it would turn out? On June 30, 2011, SETMA received a communication from RTI, which in part stated:

> "Thank you again for agreeing to provide feedback on a draft of the Patient-Centered Medical Home Study Practice Feedback Report. Your input will help us improve the report template before the final reports are prepared and distributed."

The key word was "draft," which meant one thing to RTI and another to SETMA. After reviewing the data in the "draft" report, I responded:

> "I have reviewed your reports. Your data is seriously flawed. I am going to send you data on the same periods for the same measures. We use IBM's COGNOS Business Intelligence software which is very accurate. Look forward to our discussion."

RRI answered:

> "…the data presented in the feedback report template are 'not' real data for your practice. The purpose of this exercise is for you to take a look at a mock-up of a template that would be similar to the one you would receive (and that would contain your real data), so that we can get your opinion on the format and content of the report. But the numbers shown in the tables and graphs that you have right now are completely made up just for illustrative purposes-just to show how the tables and graphs would look."

That part of our conversation was concluded when I said:

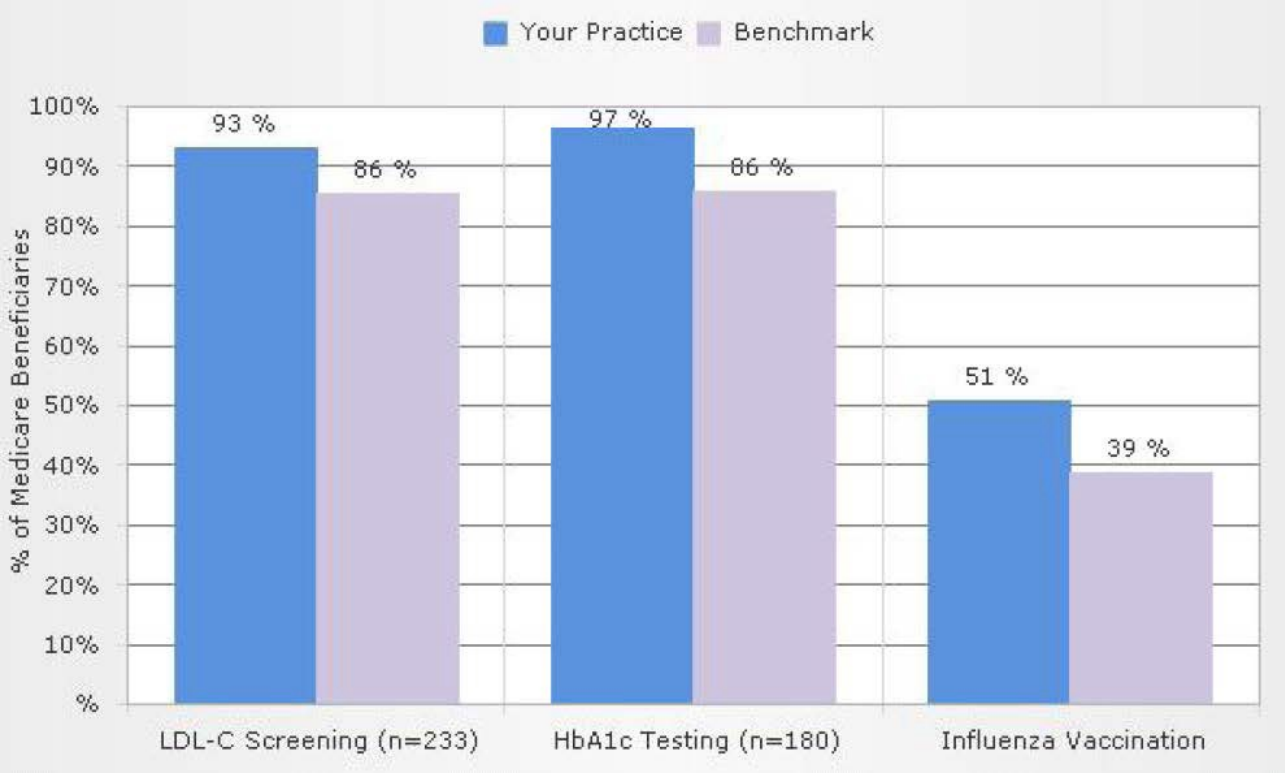
> "I am laughing out loud. Smile. I had no idea."

With that "clarification" of what "draft" meant, we waited, not patiently, for the "real" results to arrive. They did on September 2nd. What a relief. The results were very good. They gave us

confirmation of SETMA's Model of Care and of the efforts in which we have been engaged for 17 years.

Quality of Care

The following quality comparison was between SETMA and a benchmark which was developed from The benchmarks are from a predictive model that uses the comparison group performance and models the relationship between the outcomes and practice characteristics such as average health status of beneficiaries assigned to the practice, size of practice, type of practice, etc. As can be seen, SETMA outperformed the benchmark in all three areas of interest.



The data on influenza immunizations was worrisome, as even though we out performed the benchmark, the data we have on our practice is different. I wrote RTI and said:

> "Patients have learned to get influenza immunizations at many different places, i.e., pharmacies, hospital, emergency department, the VA, other clinics, etc. SETMA captures the overwhelming majority of these but they are not billed by us to CMS thus according to the process of this audit would not appear to be counted.

"The following are our results for **FFS Medicare** plus **all Medicare (FFS, Medicare Advantage and Dual Eligible**) during four periods:

- The first column is the same period you measured (July 1, 2009 to June 30, 2010) and is just the FFS Medicare.
- The second column is the same period you measured (July 1, 2009 to June 30, 2010) except it is all Medicare seen each clinic whether FFS or Medicare Advantage or Dual Eligible.
- The third column is the same group you measured for the year July 1, 2010 to June 30, 2011.
- The fourth column is all Medicare patients for July 1, 2010 to June 30, 2011 whether FFS or Medicare Advantage or Dual Eligible.

SETMA's Audited Influenza Immunization Statistics for two years and two different populations

to compare with the Statistics attached above from the CMS study

Clinic	7.1.09 – 6.30.10 CMS Study	7.1.09 – 6.30.10 All Medicare	7.1.10 -- 6.30.11 CMS Study	7.1.10 – 6.30.11 All Medicare
SETMA 1	54.3%	57.5%	57.5%	61.2%
SETMA 2	57.4%	73.7%	71.1%	83.0%
SETMA W	53.0%	62.2%	60.2%	68.9%

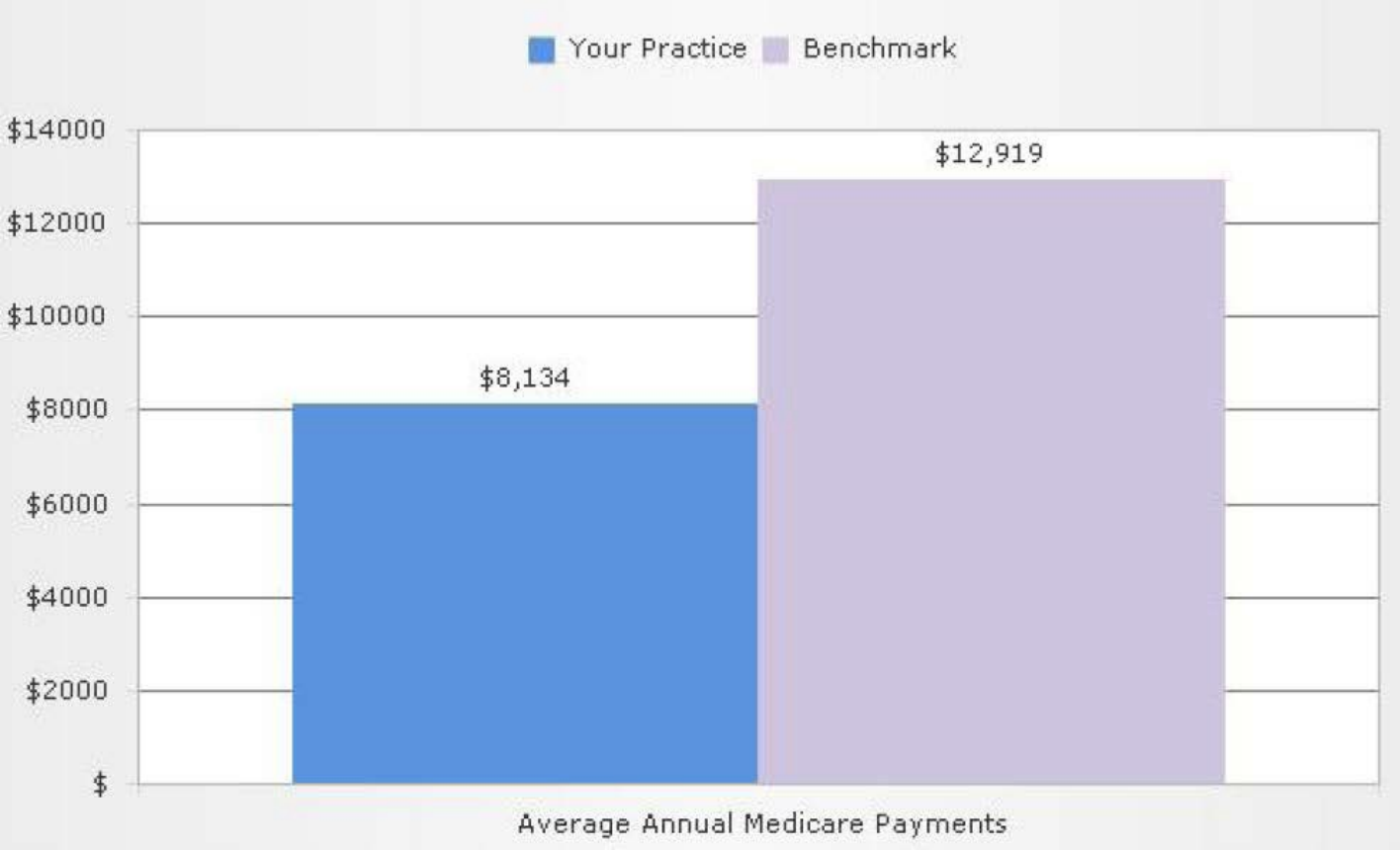
If a patient refused an influenza vaccine, they were included in the denominator but if they were allergic to the vaccine, they were excluded from the denominator.

The following is the answer which RTI International sent back:

> "**I have always had reservations about reporting influenza vaccination from Medicare claims data. And, your data shows why I am hesitant.** We simply do not capture in our rates vaccinations provided to Medicare FFS beneficiaries that are not subsequently billed to Medicare. **You clearly have a more robust system for capturing the actual rate of receipt among your patients.**" (Emphasis added)

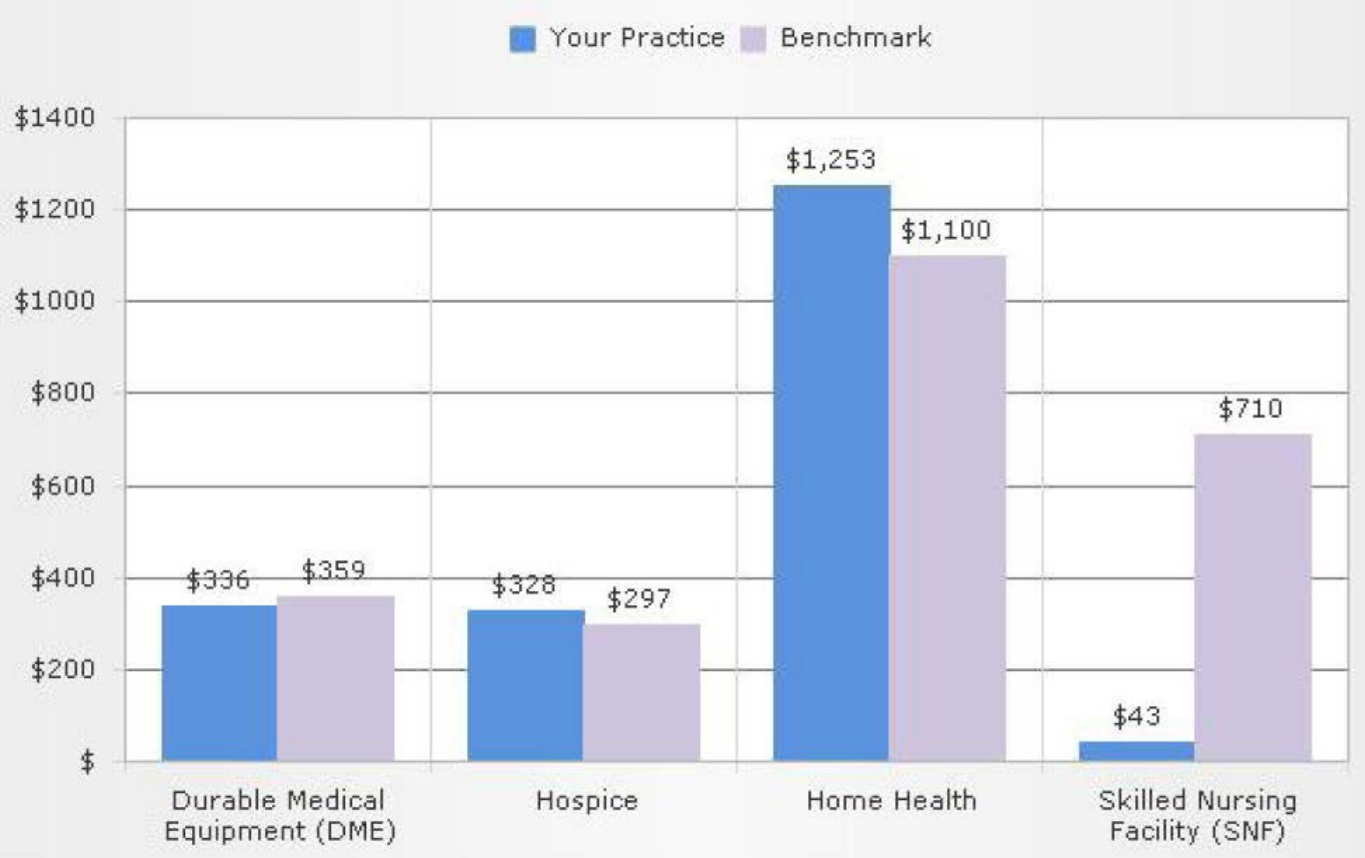
Cost of Care

The area of our practice which we had never seen, as had no other medical practice, is the total cost to Medicare for the patients we see under CMS' Fee-for-Service.



Dividing our cost of $8134 by the benchmark's cost of $12,919, SETMA has a 37.04% lower cost than the benchmarks while our quality of care is higher than theirs.

Looking at the cost of care for Durable Medical Equipment (hospital beds, oxygen, etc), Hospice, Home Health and Skilled Nursing, the results are similarly good. While our Home Health use is slightly higher than the bench mark, if you add the Home Health and the Skilled Nursing Care, the benchmark is $1810 and SETMA is $1296 SEMTA is 28.4% lower than the benchmark.



One of the most important targets for improving care and controlling the cost of care is in decreasing preventable readmissions to the hospital. The following graph shows CMS' estimation of the potentially avoidable inpatient admission payments for SETMA and for the benchmark. The benchmark is $2259 and SETMA is $962. SETMA is 57.42% below the benchmark.

The finally part of the study, which we will review today is the following graph which shows the trend of SETMA's performance.

Medical Home Series Two Part XI Continuation of Quality, Coordination and Cost of Care
CMS Medical Home Feedback Report – SETMA's Performance
By James L. Holly, MD
Your Life Your Health
The Examiner
September 29, 2011

Last week, we discussed CMS's Medical Home study which analyzed patterns of care, health outcomes, and costs of care for Medicare fee-for-service (FFS) beneficiaries receiving healthcare services from clinical practices that are National Committee for Quality Assurance (NCQA)-recognized medical homes. In particular, the study was interested in determining if there are particular attributes of medical homes that are more favorably related to better outcomes of care.

The data we examined last week showed SETMA contrasted with benchmarks. The results we will review this week include the mean (average) results from 312 practices which have earned recognition by NCQA as Patient-Centered Medical Homes. It is noteworthy that SETMA has 3,682 patients in the study and the total of 312 practices is 146,410, which means that the average practice has 470 patients in the study.

Table 1 below under the heading "Quality of Care," shows that SETMA II out performs both the benchmarks and the mean of the 312 Medical Home practices. You will remember the discussion of the low influenza immunization rates being due to the methodology of this study which depends upon charges sent to CMS. In that many patients get their flu shots from a source other than SETMA, thus the methodology of the CMS study will skew the influenza results.

Coordination and Continuity of Care

The next category of results on Table 1 addresses how often the patient is seen by their primary care provider or his/her representative. And, indirectly, this category addresses the effectiveness of that care by looking at hospital admissions, readmissions, emergency room visits, primary care visits, medical specialty visits (cardiology, etc.), and specialty care visits (orthopedists, general surgery, etc.).

The Medical Home mean outperforms the benchmarks for every measure and SETMA has a statistically significance variance only with the mean of Medical Homes in regard to the number of ER visits. However, even in that measure, SETMA still out performs the benchmarks significantly. Table 2 shows SETMA's performance over time. Three time periods are measured and shows that SEMTA is improving in the area of ER visits. Table 1 also shows that at present SETMA's cost of emergency department care is only 50% of the benchmarks.

Table 1

Measure	Your Practice (N benes=3682)	Benchmark (N benes= 124,210)	Your Practice versus Benchmark	Average across all study NCQA Medical Homes (N benes =146,410 N practices=312)
Quality of Care (% of beneficiaries)				
LDL-C Screening (n=233)	93 %	86 %		85 %
HbA1c Testing (n=180)	97 %	86 %		90 %
Influenza Vaccination	51 %	39 %		50 %
Coordination and Continuity of Care				
Hospitalization (rate per 100 beneficiaries)	24.5	47.4		16.9
Follow-up within 2 weeks of hospital discharge (rate per 100 hospital discharges, n=114)	56.5	40.4		57.3
30-day hospital readmission (rate per 100 hospital discharges, n=114)	17.5	30.9		13.2
ER Visits (rate per 100 beneficiaries)	47.4	80.5		32.3
Primary Care Visits (rate per beneficiary)	4.3	4.5		4.3
Medical Specialist Visits (rate per beneficiary)	3.3	3.9		3.0
Surgical Specialist Visits (rate per beneficiary)	0.6	0.8		0.5
Annual Payments (Average $ per beneficiary)				
Durable Medical Equipment (DME) Payments	$336	$359		$238
Hospice Payments	$328	$297		$148
Home Health Payments	$1,253	$1,100		$283
Physician Payments	$2,780	$3,160		$2,033
Outpatient Department Payments	$905	$1,373		$904
Skilled Nursing Facility (SNF) Payments	$43	$710		$299
Acute Care Hospital Payments	$1,947	$4,929		$1,613
Total Medicare Payments	$8,134	$12,919		$5,715
Physician Payments by Type of Service (Average $ per beneficiary)				
Office Visit Physician Payments	$410	$434		$373
Hospital/ER Visit Physician Payments	$203	$415		$119
Specialty Visits & Consultation Physician Payments	$138	$164		$151
Imaging & Laboratory Physician Payments	$727	$806		$453
Other Physician Payments	$965	$933		$710
Potentially Avoidable Payments based on Ambulatory Care Sensitive Conditions (ACSCs)(Average $ per beneficiary)				
Potentially Avoidable Inpatient Hospital Payments	$962	$2,259		$790
Potentially Avoidable ER Payments	$183	$214		$111

Annual Payments

The third group of comparisons on Table I is “Annual Payments”. There are eight categories of payments including DME, Hospice, Hospice and Skilled Nursing, which were discussed last week in comparison to benchmarks. In almost all areas, SETMA out performs the benchmark and collectively equals the performance of other Medical Homes.

The other four categories are Physician payments, Outpatient Department payments, Acute Care Hospital Payments, and Skilled Nursing Facility payments. SETMA's "total Medicare" payments" is 37% below that of the benchmarks but is higher than the mean of the Medical Homes.

Table 2

Measures	Your Practice Time Period 1: July 2007 – June 2008 (N benes=390)	Your Practice Time Period 2: July 2008- June 2009 (N benes=421)	Your Practice Time Period 3: July 2009- June 2010 (N benes=446)	Your Practice % Change (July 2007- June 2010)	Average % Change across all study NCQA Medical Homes (N benes=146,410 N practices=312)
Quality Of Care Measures (% of beneficiaries)					
LDL-C Screening	97 %	90 %	93 %	-4.1 %	3.5 %
HbA1c Testing	98 %	95 %	97 %	-1.0 %	1.5 %
Influenza Vaccination	32 %	34 %	51 %	59.4 %	20.2 %
Potentially Avoidable Hospitalizations / ER Visits based on Ambulatory Care Sensitive Conditions (ACSCs)					
Potentially Avoidable Hospitalizations (rate per 100 beneficiaries)	7.4	9.5	6.7	-9.5 %	-2.2 %
Potentially Avoidable ER Visits (rate per 100 beneficiaries)	13.6	17.6	11.9	-12.5 %	-5.2 %
Average Annual Payments ($ per beneficiary)					
Average Total Medicare FFS Payments	$6,430	$7,464	$8,703	35.4 %	12.0 %

SETMA's average total Medicare FFS increased by 13.4 percent from the first measurement to the second period and then by 14% from the second period to the third. This was significantly higher than the average across all of the Medical Home practices.

Conclusions for SETMA from the CMS Study

We are pleased with the study's results as to "**quality."** SETMA's Model of Care is discussed on our website (www.jameslhollymd.com) at the following links: *SETMA Model of Ca*re http://www.jameslhollymd.com/SETMA_Model_of_Care.cfm and *The Future of Healthcare - SETMA's View* (08.14.2010, Your Life Your Health) http://www.jameslhollymd.com/. SETMA's tracking, auditing and analyzing of quality metrics performance and our public reporting by provider name are bearing fruit. There are places where we can improve but we are moving in the right direction and we are following the right steps.

As to "**Coordination and Continuity of care**," we are doing a good job. We need to decrease the utilization of the emergency department by our patients, although our costs are very low. Most of the lower cost results from the fact that the overwhelming majority of SETMA's patients that go to the emergency room do so because they require admission. SETMA's "transitions of care" is working well. That is discussed in many places, most recently in this series part VI entitled, "Care Transitions" http://www.jameslhollymd.com/which contributes to our decreasing avoidable readmission rates.

While the CMS study measures the patient "follow-up within two weeks of discharge" and while SETMA performs better than the benchmarks and equally to the mean of Medical Homes, the study did not measure other elements of SETMA's care transition such as the completion of the "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan" (this was originally called the "Discharge Summary," but that name was changed to reflect the documents function.) The CMS Study did not address the "passing of The Baton," which is the critical part of the Care Transitions from inpatient to outpatient care and from a clinic visit to continuing care of the patient by patent at home. (http://www.jameslhollymd.com/is the link to a detailed explanation of "the baton.") And, the CMS Study did not measure the Hospital Following-up Telephone Call which is the first step in SETMA's Department of Care Coordination's "healthcare coaching" for SETMA's healthcare team.

Coupled with "coordination of care" the CMS Study looked at "Continuity of care." SETMA's approach is discussed in Medical Home Series Two Part V and is found at http://www.jameslhollymd.com In this article the elements of continuity of care are discussed and they are:

1. Data connection and data sharing over the entire healthcare experience of the patient whether that involves different visits with the same provider, care by multiple providers, multiple locations of care, or multiple disciplines of care such as physicians, nurse practitioners, physical therapist, social workers, nutritionists, hospices, home health, case managers, pharmacists, etc.
2. Uninterrupted care of and attention to an acute or chronic problem until it is resolved or stabilized. This means that follow-up care always includes review, evaluation of and needed adjustments to previous care.
3. All care givers having adequate knowledge of a patient's overall health and of all conditions requiring attention. The association of continuity of care with the patient being seen by the same healthcare provider assumes that the same provider can and does know more about the patient than a new or different provider, depending upon the quality and granularity of the patients health record that may or may not be the case.
4. The foundation of the patient's care is a record which is longitudinal, cumulative, granular, accurate, accessible, available, confidential and thorough. Electronic patient records is the only method of medical-record keeping which can build on previous examinations and evaluations, continually transforming the "picture" of the patient from a silhouette, longitudinally into a true, granular portrait of the patients health and person.
5. All members of the healthcare team know the patient and have a personal interest in the patient's health and welfare. While the concept of medical home currently depends heavily upon a patient's identification of a "personal healthcare provider" as the principle conduit of continuity of care, the concept also recognizes the healthcare team as an essential foundation for the improved care given in the medical home. An essential part of the development of the medical-home model will be the clarification of the tension between care by a personal provider and care by a healthcare team.
6. Effective transitions of care are established and they function to transfer care from one point of care or provider to another provider or point of care. Transitions of care will be dealt with later in this series but they are critical to the maintaining of the continuity of care when the patient moves from one venue of care, i.e., inpatient hospital, to another, i.e., outpatient or ambulatory care. Like the universal joint in an automobile power train,

the transition of care allows for the power, the standard of care and the content of care, created by and in one venue of care to be incorporated into and to be maintained in another venue.

7. The patient is included as a critical member of the medical home team. All other members of the team respect and support the autonomy, confidentiality and priority of the patient in decision making and in executing the medical home's plan of care and treatment plan. This requires that enhanced communication be present between the patient and provider including secure web portals, health information exchanges, telephone communication and after-hours access to care.

There is a tension between the current concepts of continuity of care and the concepts of a healthcare team and the contribution that a continuity-of-care record (electronic health records) makes to the overall coordination and continuity of care. While a personal relationship with a primary provider is currently the standard of Medical Home, it cannot compete with a robust, longitudinal health record which is available at all points of care. SETMA's electronic health record is used in the clinic, nursing home, emergency department, inpatient, home health, hospice, physical therapy and providers' homes. At every point of care, the patient's care is documented in the same data base contributing to a continuity of care which is otherwise not possible. SETMA has referred to this as morphing a patient's record from its current status as a silhouette by which the patient can be recognized albeit without detail into a portrait which is a granular representation of the details of a patient's condition, care and needs.

CMS Study, SETMA and Cost

There are bright spots in the CMS data for SETMA as to the cost of the care which we deliver. Analytically, it must be understood that there are inverse relationships between elements of cost, i.e., as one element goes up, another will come down. It should be expected that as Home Health and Hospice costs go up, inpatient cost will come down. Also as Home Health and Hospice go up, DME cost will go up. The decreasing of Specialty referrals, both Medical and Surgical, should be associated with a direct decrease in cost of care. The balance is that quality and patient satisfaction must be attended to so that cost control is not achieved at the expense of either or both.

Similarly, there are interactions between "coordination" and "continuity" of care and cost of that care. As the former two become more robust and significant in the Medical Home care model, the cost of care will be expected to decrease. One of the results of this CMS Study is that it demonstrates that these expected results with Medical-Home care actually exist.

This cost analysis also suggests that a collaborative effort between a Patient-Centered Medical Home and coordinated-specialty care can contribute to an increase in quality and simultaneously to a decrease in cost. This requires intense coordination and real continuity of care and it actually expands the Medical-Home Model into a Medical-Neighborhood Model, which sometimes is referred to as an Accountable Care Organization.

Without doubt this is a process in the midst of which we find ourselves! With perseverance and attentiveness, the result will be ever increasing quality and safety while increasing patient satisfaction and decreasing cost.

Medical Home Series Two Part XII
National Quality Forum and Care Coordination
By James L. Holly
Your Life Your Health
The Examiner
October 6, 2011

As SETMA continues to grow as a patient-centered Medical Home, we continue to think about the concepts associated with "Care Coordination," which is a process and "Coordinated Care," which is an outcome, or, stated a different way, which is the result of "Care Coordination." Since 2009, we have published a number of articles about *Care Coordination*. These can be found by going to www.jameslhollymd.com and accessing *Your Life Your Health* and clicking on the icon entitled *Care Coordination*. There you will find the following articles and their dates of publication:

- A New Day in Healthcare for You and For Us - Part VI - Meaningful Use September 23, 2010
- Care Transitions: The Heart of Patient-Centered Medical Home May 24, 2011
- Medical Home - Series Two: Part VII Care Coordination August 18, 2011
- Medical Home Part III: Requirement Number 1 of 28 March 03, 2009
- Medical Home Part IV: Help and Hope in Healthcare March 12, 2009
- Patient-Centered Medical Home - Care Coordination and Coordinated Care January 20, 2011

A related set of articles specifically addressing *Transitions of Care* which is directly relate to *Care Coordination*. The *Transitions of Care* articles can be found by going to www.jameslhollymd.com and accessing *Your Life Your Health* and clicking on the icon entitled *Care Transitions*.

- Concierge Medicine and the Future of Healthcare January 27, 2011
- Medical Home - Series Two: Part VI Care Transitions August 11, 2011
- Passing the Baton: Effective Transitions in Healthcare Delivery March 12, 2010
- Patient-Centered Medical Home and Care Transitions: Part I April 21, 2011
- Patient-Centered Medical Home and Care Transitions: Part II April 28, 2011
- Reducing Preventable Readmissions to the Hospital March 31, 2011
- SETMA and the National Quality Forum November 11, 2010
- The Future of Healthcare - SETMA's View October 14, 2010
- **The Baton** - this is the pictorial representation of the patient's plan of care and treatment plan March 12, 2010
- HIMSS Quality 101 Care Transitions
- NQF's Transition of Care Conference in Washington, DC - Summary of Comments September 2, 2010

SETMA's understanding of both the process and the outcome of coordinating patient care was recently expanded by the review of two documents published by the National Quality Forum (NQF). The NQF is described in the November 11, 2010 article entitled "SETMA and the National Quality Forum," referenced above. The NQF publications are:

1. NQF Quality Connections, Care Coordination, October, 2010
2. Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report, NQF, 2010.

The Problem

The NQF states, "…the average Medicare patient sees two primary care physicians and five specialists a year…patients with multiple chronic conditions may see up to 16 physicians a year. For one-third of patients, the assigned primary physician changes yearly…clinicians are unaware of a patient's history. The challenge of coordinating basic information …test results, allergies, prescription medications diagnosis…is extreme."

"The Problem" is magnified when patient care is documented by paper, in the worse case handwritten illegibly, and in the best case transcribed, which while it is legible, it is made up of isolated, unconnected instances of care which are not interactive with one another. Furthermore, these records, like hospital, home health, hospice, physical therapy, pharmacy and other patient-care records are "geographically bound." They are located in one place and when that place is not available, the patient information is not available.

One solution to "The Problem" is electronic records, which are legible, can be made available at multiple locations simultaneously, can always be available, and which can be interactive. But, the potential benefits which are available through electronic records are often not realized because the electronic record is not connected to points-of-care other than the provider's office. In addition, one electronic solution, which is used by one provider, is not interoperable with another electronic solution used by another provider, who sees the same patient. Both providers use electronic records but neither electronic record can communicate with the other, thus recreating the same dysfunction which paper records had. And, worse yet, the electronic record used by one provider is not available to that provider at any points-of-care other than his/her office. Thus, the same provider creates different records for the same patient in different locations, thus accentuating "The Problem" while using electronic records.

Electronic Solutions for "The Problem"

There are three major opportunities for solving "The Problem" with electronic records. The most obvious benefit comes when a patient is seen at every point-of-care utilizing the same electronic record. This was the ideal which led SETMA to make the electronic health record which we use available in the clinic, hospital, emergency department, nursing home, hospice, home health, physical therapy, provider's home and at ALL points-of-care. Not only is a patient's health record available at the clinic where the patient routinely gets care, their

healthcare is available at all SETMA clinics. When the patient's care is documented in the same electronic record at all points-of-care the problems of medication reconciliation, care transitions, data aggregation, screening and preventive care measures and health record reconciliation problems are all decreased tremendously. It is one thing to have problems with multiple providers communicating with each other; it is a more fundamental problem when a single provider has difficulty communicating with his/her own self at different points-of-care.

The next level of solving "The Problem" is when electronic communication is possible between the patient and his/her primary care provider. This is most efficiently done through a secure web portal. 'Secure" means that the information transmitted electronically is protected by passwords and "fire walls," which prevent confidential and sensitive health information from being accessed by those who have no right nor need to see that information. "Web portal" means that there is a website which the patient can access to:

a. Review medications, tests, procedures and other healthcare information.
b. Communicate with their healthcare provider to ask questions or to give the provider updated health information.
c. Maintain their own personal health record which empowers the patient to know their health record and to coordinate what is in that record.
d. Anticipate a visit for routine or acute healthcare by completing part of their clinic visit prior to arriving at their provider's office. This allows a thoughtful, thorough record to be given to the provider which can be made a part of the patient's permanent record. Most people can read faster than another person can talk which means that a record is now accurate, complete and in the patient's voice.
e. An electronic, reusable record of the patient's care can be available to the patient routinely.

SETMA has deployed solution to the web portal name NextMD. It allows SETMA providers to communicate with patients in a HIPPA compliant method and allows patients to actively participate in their own care. If you are a SETMA patient, use a computer and have not signed up for the NextMD program, call our office and ask for directions.

The third level of connectivity which promotes coordination of care through electronics is a Health Information Exchange (HIE). An HIE is simply an electronic method where multiple healthcare providers – hospitals, home health, physical therapy, pharmacies, nursing homes, healthcare providers – who give care to the same patient, can overcome the barriers discussed above. A community-wide and particularly a region-wide HIE provides great safety to patients. When all pharmacies are reporting to a common HIE, there is decreased danger of a patient being on conflicting medications and in the instance when a patient becomes dependent upon medications and begins to take more than they should, it will be instantly known to all provides who are caring for that patient. The HIE provides opportunity for:

a. All care given to a single patient by multiple providers to be available to all care givers.
b. A common medication list which is updated by all providers so that medication errors and conflicts can be reduced and eventually eliminated.
c. All providers giving care to a patient has the patient's history remote and recent available at the point-of-care.
d. Repetition of care is eliminated because all care becomes transparent to all care givers

eliminating the need for repetition of tests due to either it not being know that the test was done or the results not being available This is particularly valuable between hospitals and their emergency departments. If a patient is seen at one emergency room one night and has a CT of the brain and is seen at another emergency room a few night's later, with no change in condition, the CT results is available and repeating the tests can often be avoided.

With an HIE in place all of the elements of "The Problem" identified by the NQF above are solved. While it is still ideal that the same provider sees a patient regularly, electronic health records connected to a secure web portal and an HIE goes a long way to increasing patient-care safety and continuity. The NQF Quality Connections report, addressing "The Problem" concluded, "The resultant lack of commutation among providers often means that critically important information is never conveyed, or is lost or ignored, to the patient's detriment." Electronic health records, used by a provider at all points-of-care of a patient connected with a secure web portal and an HIE eliminates this potential danger.

SETMA has solved this area of care coordination through the Southeast Texas Health Information Exchange (SETHIE). SETHIE is already functioning with Baptist Hospital and in the next few months, it is hoped that it will expand to other area hospitals and to other healthcare providers. Once it is completely in place, SETHIE will provide care coordination at the highest standard with any healthcare system in the nation.

Care Transitions – Plan of Care and Treatment Plan

Care Transitions is a major part of Care Coordination and when it is absence, "The Problem" is accentuated. NQF said, "Even for patients without chronic conditions, the transfer of care responsibility from one clinician to another – the "hand off" – is rife with error. Follow-up care for patients discharged from an acute care hospital, or sent home from a practitioner's clinic after a diagnosis also presents a problem area, when patients are not fully instructed on what they should eat or avoid eating (and when), what medications they should take, or when to return to visit the clinician."

As "The Problem" is solved by effectively using electronic records at all points-of-care, coupled with a web portal and HIE, this element of "The Problem" is addressed by a personalized, written "Plan of Care and Treatment Plan" which is give to the patient at each point-of-care. For those patients who are computer literate, this "hand off" can be made via the web portal but for those who do not have access to the use of, or the knowledge of the use of computers, this will have to be done by a printed plan of care and treatment plan.

The plan of care and treatment plan must identify:

a. The patient's current condition
b. Specifics of that condition – history, physical, test results, procedure results, etc.
c. Goals of care
d. Where the patient is in progress toward that goal.
e. What changes the patient should make in order to pursue those goals.
f. A medication list with names, dosages and instructions for taking medications which are to be continued and the names of medications which are to be stopped.

The NQF makes the following comment about the plan of care: "A critical construct of coordinated care is the 'plan of care' – the written plan that anticipates routine needs and tracks progress toward a patient's goals. A proactive plan of care that emphasizes self-management, goals and support should serves as a central care coordinating mechanism for all patients, families and care team members…the plan of care becomes an important guidepost between clinician-driven care and patient self-management. The plan of care is…vital during handoffs and transition of care, because it can serve as the main communication document between clinicians and care settings and outline elements such as the medication list, follow-up steps, identification of care problem and resources for nonclinical care."

SETMA's plans of care and treatment plans include these elements and more. As we learn, this part of our care coordination will improve, also.

Medical Home Series Two Part XIII
National Quality Forum and Care Coordination Part II
By James L. Holly
Your Life Your Health
The Examiner
October 13, 2011

A Dialogue versus Two Simultaneous Monologues

Last week, we began a discussion of Care Coordination as defined and described by the National Quality Forum (NQF) in 2010. Because the Plan of Care is an important element of Care Coordination, NQF added the following comment to that discussion: "Integrated with the plan of care, but distinct from it, is the critical role of the 'feedback loop' in coordinated care."

The "feedback loop" includes communication but communication with an open dialogue between the provider, the healthcare team, the patient and their family. A "dialogue" is by definition "a discussion." Often in human relationships people carry on two simultaneous monologues without ever really communicating. Perhaps no human enterprise has been more filled with monologues than healthcare. However, when both provider and patient are listening to one another with respect and interest, it is possible to create understanding and in the case where a healthcare action has to result from the conversation, a plan of care can result.

Medical Ethics and Patient Rights

An illustration of the value and power of a dialogue between patient and provider occurred in my practice twenty-five years ago. A patient I was caring for had been admitted to the hospital. He needed a blood transfusion but explained to me that his deeply-held religious convictions prevented him from receiving human blood. After stating this, he began to explain to me why he believed that. I interrupted him and said, "You have the right to your belief and I respect that right. You are competent to make the decision which you have made, and you understand and accept the potential consequences of your choice. We have two choices, we can leave the conversation where it is and I will respect your choice, or you can continue to explain to me why

you believe as you do and I will expect equal time to explain to you why I don't believe that."

He smiled and said, "Let's leave it where it is." This patient and I had a long and mutually satisfying relationship even though we both knew that we disagreed with each other. The key here is that it is not necessary for a patient to justify, or explain their preferences in treatments. If a patient is mentally and legally competent to make choices, patient-centered, care coordination requires the healthcare provider to respect the patient's choice and decisions. In addition, after making certain that the patient understands and accepts the risks of their choices, it is incumbent upon the healthcare provider to support those choices in a non-judgmental and positive manner.

However, consistent with medical ethics, if the healthcare provider feels that he/she cannot or should not provide the care which the patient wants, and which care is legal, then the provider can transfer the patient's care to another provider. Either way, the patient has the right to make choices, even if the choice made is personally objected to by the healthcare provider.

Content of a Dialogue

For a dialogue to be effective, all parties to the conversation must have the same information such as in "consultation notes, progress reports, sharing decision making and maintaining privacy with access to information." Communication, which is the intent of this dialogue, must "involve health literacy, translators, and expert panels as appropriate and should be culturally competent" (NQF, *Quality Connections*, "Care Coordination," p. 3, 2010)

As healthcare providers encourage their patients to have a personal health record (PHR) and as providers help facilitate patients' ability to have such through web portals, it is important to affirm that the patient has the right to access to everything that is in his/her medical record. Some of the means to that end are:

1. The patient should receive a printed copy of his/her encounter record at each visit with his/her healthcare provider.
2. The patient should have electronic access to part of his/her health record – medications, laboratory tests, procedure summaries, etc. – through a web portal.
3. The patient should be able to obtain a reusable, electronic version of his/her health record upon request.
4. The patient should know what his/her treatment goals are and how those goals are measured.
5. The patient's agreement must be sought and obtained if the ultimate value of this transparency is to be achieved.

This level of transparency between the patient and the healthcare provider is a new concept in healthcare structurally, but has always been a part of creative, dynamic healthcare relationships, which create trust and confidence in the provider. This level of transparency will also increase the collaboration of patients in their care. In this case concurrence is both a part of the process and of the desired outcome.

Interrogatives: An Effective Part of Dialogue

One of the most effect means of assessing the effectiveness of patient-provider communication is "teach back," where the provider asks the patient to teach the provider what he/she has just learned in the patient-provider encounter.

In the book, *The Influencer*, the author examined a school in which certain teachers routinely had excellent results and where others routinely had poor results. The difference turned out to be the difference between a monologue and a dialogue. The teachers who routinely had poor results lectured to their students without any interaction or dialogue. The teachers who routinely had excellent results combined lecture with questioning of the students. The questioning reinforced the lecture and the dialogue allowed the students to test their knowledge. It turned out that the "feed back" from the students not only helped the students learn but it also helped the teachers teach.

None of this should be surprising because healthcare providers and patients learn in the same way. Recently, I made presentations to three national organizations concerned with continuing medical education (Society for Academic CME; National Institute for Quality Improvement and Education, and The National Task Force on CME/Provider/Industry Collaboration). All of the participants understood that lectures were among the poorer teaching methods. In one of my presentations, I said, "A *dialectic* approach – a dialogue -- is substituted for the traditional *didactic* – pedagogical – CME method. As Medical Home engages the patient in a discussion about their health, Joslin engages providers in a discussion about evidence-based medicine."

This was illustrated by a humorous story which I was told by a friend. An elderly gentleman was driving around town at 2 AM. He could barely see over the steering wheel. The police observed him for a while and then stopped him and asked where he was going at that hour. He said, "To a lecture." Incredulous, the police said, "What kind of lecture?" The elderly gentleman said, "A lecture on alcohol, tobacco and sleep depravation." "Who is giving such a lecture at this hour, the officer asked? The old man, smiled and said, "That would be my wife."

It is probable that the old man was not going to profit from the lecture he was going to receive. And, it is probable that our patients are going to benefit more from a conversation with us than they will a lecture. Dialogue, dialectic, teach-back, and interrogative -- whatever term you want to use, the principle is that successful communication will be the result of a dynamic exchange between a healthcare provider and a patient. And, the patient is more likely to carry out a plan of care which they have helped develop and to which plan they have agreed.

Plan of Care: Reviewing Elements of Plan

The great value of a written plan of care and treatment plan is to provide the patient and the patient's family with a means of reviewing what they learned during the visit to the clinic. Without the written plan of care which is identified on each page with the patient's name and which has the patient's personal laboratory and procedure results, little will be accomplished, as

in a very short time, humans forget 90% of what they have heard. And, what a person remembers of what he/she only received audibly is not accurately what was said. With a written plan of care to review, the probability of real learning taking place is greatly enhanced.

Furthermore, as healthcare providers we are committed to life-time learning, we want our patients to become students. The more the patient learns, the more they participate effectively in their own care. Having had a dialogue with their healthcare provider and having received a printed copy of their plan of care, the patient is prepared to accept responsibility for their own care 8,760 hours a year.

This principle was illustrated for SETMA twelve years ago. A mother brought her five-year-old child to the pediatrician at SETMA. At SETMA, every patient is given a **LESS Initiative**. The Agency for Healthcare Research and Quality which is a part of Health and Human Services has published SETMA's **Less Initiative** on their Innovation Exchange. The Initiative encourages each patient to Lose Weight if needed, Exercise and Stop Smoking. It consists of a weight management assessment for each patient, in which patients are given their BMI, BMR, and Body Fat content, with explanations of each and with a plan for how to increase the BMR in order to achieve improved weight. Each patient is given a personalized exercise prescription with an explanation of his/her personal maximum heart weight and how to start an exercise program which includes stretching, strengthening and aerobic conditioning. Finally, the **Initiative** includes an assessment of smoking and in the case of children, passive, second hand, or environmental smoke exposure.

When the mother returned home, she left the **Less Initiative** on the truck seat. Shortly after their return, the father got into the truck to go buy another pack of cigarettes. He saw the paper with his son's name on each page. He began to read. Forty-five minutes later, the father walked back into the house having never left the drive. His eyes were red because he had been crying for forty-five minutes. In alarm, his wife asked what was wrong. He responded that he had never realized what his smoking was doing to his son. If a person does not smoke, but is exposed to second-hand smoke, the **LESS** presents evidence of the harm that smoke is doing. The father has not smoked since. The dialogue with the pediatrician and the personalized document dramatically impacted this family.

Example of Feedback Loop

Few things are as new; it seems, to the "medical home" model of care, as is this concept of a "feedback loop." Most physicians were trained to have a monologue with patients: telling them what they have; how it is to be treated; and, what they are to do until their next visit.

In September, 2010, I saw a patient for the first time whose father, mother, sister and two brothers had diabetes. I thought, "Aha, I wonder if she has diabetes?" Upon testing, diabetes was proved. The day following the clinic visit, I called the patient and reviewed the diagnosis,

condition and plan of care and treatment plan with the patient, which included medication, further evaluation with ophthalmology, endocrinology and diabetes self-management education and medical nutrition therapy.

The patient agreed to all of the plans, but as I hung up, I thought to myself, “This patient is not buying any of it.” Using SETMA’s Clinic Follow-up Call template, I scheduled a call from our Care Coordination Department for three days hence. The call was made and I received the report: the patient appreciated the visit and the call, but was not going to do the education, take the medication or have any of the other evaluations. In this case the “feedback loop” was disappointing but demonstrated the work needed in order to get this patient to accept treatment. That was a year ago; at present, the patient has been unwilling to pursue a treatment plan which is appropriate. Tragically, this can be done for ten or more years but then the complications set in and they are irreversible. We don’t always win with our patients but effective communication will increase our win/lose ratio and when we do lose, it is because of a conscious, informed, and documented decision by the patient.

Communications between Healthcare Team Members

NQF states, "Communication among primary care providers, hospital providers, specialist and nonclinical resources in the community is critically important to optimal care. Communication has become a vehicle of many hospital programs to improve transitions and reduce medical errors and re-hospitalizations." SETMA's Care Transitions program which includes post hospital calls has resulted in decreased readmissions and improved patient safety and satisfaction. (See Patient-Centered Medical Home and Care Transitions: Part I April 21, 2011 and Patient-Centered Medical Home and Care Transitions: Part II April 28, 2011 at www.jameslhollymd.com under Your Life Your Health) Also, SETMA's program design, which includes the principle that the last act of the post-hospital transition of care is the patient being seen in the clinic by their primary care provider, has "closed the loop" on hospital care transition.

This element of communication is increasingly important as more and more hospitals are employing hospitalists who take care of indigent and unassigned patients admitted to the hospital. Many of the hospitalists work for larger companies most of whom do not have a clear plan for care transitions making the patient seen by them vulnerable at the time of transition to ambulatory care. This is an important area for work to be done to improve patient safety, continuity of care and care coordination.

Medical Home Series Two Part XIV
Medication Reconciliation: AMA, NQF, ISMP
By James L. Holly
Your Life Your Health
The Examiner
October 20, 2011

Why is medication reconciliation a subject worthy of special consideration in a medical home setting? To answer that question, consider active conversations which went on among high school students during the 1940s, 1950s and 1960s. Whereas Latin was and still is a part of a classical education – one of my granddaughters will graduate from high school having had four years of Latin – these discussions were about how the study of Latin would help a student who is interested in medicine as a career. Little did those students know that essentially the only place where Latin was of any use was in writing prescriptions. Some of the common Latin prescription abbreviations used on prescriptions by physicians included:

- ac (ante cibum) means "before meals"
- bid (bis in die) means "twice a day"
- gt (gutta) means "drop"
- hs (hora somni) means "at bedtime"
- od (oculus dexter) means "right eye"
- os (oculus sinister) means "left eye"
- po (per os) means "by mouth"
- pc (post cibum) means "after meals"
- prn (pro re nata) means "as needed"
- q 3 h (quaque 3 hora) means "every 3 hours"

Perhaps, we should include *ad nauseam* in this list? Fortunately, the use of Latin abbreviations in medicine is decreasing and hopefully will soon be eliminated.

There was a time, actually quite recently, when the "magic and mystery" of medicine was considered part of the art of medicine and often actually probably made people "feel" safer. Patients had enormous trust in their physicians and looked upon them as their most favored and MOST trusted counselors. Prescriptions written in Latin were reassuring to the patient who believed that their very-well-educated physician knew more than they did because he or she could write a prescription which they, the patient, could not understand. Most patients took one or two prescriptions a year. Today that number ranges from 25 to 44 prescriptions a year for patients 65 years-of-age and older, depending upon the State in which the patient lives. Medication regimes are much more complicated and are changed much more frequently.

There were not many medications in the 1940s. In the *Health Care financing Review* (Winter, 1996/ Volume 18, Number 2, p. 15), it is stated, "Many of the changes in clinical medicine by the early 1960s were the result of pharmaceuticals: the antibiotics, psychotropics, tranquilizers, hormones, and other drugs. It was estimated that 90 percent of the drugs prescribed in 1960 had

been introduced in the previous two decades and that 40 percent of the prescriptions could not have been filled in 1954."

The good news was progress increasingly made valuable and useful pharmaceuticals available for treating patients. The bad news was that more and more people were taking multiple medications, some with complicated "sig" codes (written instructions in Latin) and others with an increasing number of serious interactions. The first pitfall in dealing with these interactions is "to rely upon your memory in assessing medication interactions." There are too many of them for any one person to remember all of them.

The following developments created an environment where accurate medication lists in provider records and accurate understanding by patients of what medications they were to take as well as when and how to take them became imperative:

- The number of medications grew, – today there are over 10,000 prescription medications and over 300,000 over-the-counter drugs.
- The "magic and mystery" of the medical profession decreased both because of an increasingly knowledgeable populace and because of a decreasing trust in physicians.
- More and more people were taking more and more complex medications
- Medications had increasingly serious and dangerous side effects and interactions.
- Technology created these new medicines and it would take technology to keep track of them.

A major sociological shift took place in the United States as well. Demand increased to take all of the magic and mystery out of medicine. Hospitals required that abbreviations, particularly Latin abbreviations not be used in hospital records. Medication lists given to patients were required to be written in English instead of Latin abbreviation, i.e., instead of "Sig: 1 po qid," medication directions were required to be written in "Directions: one tablet by mouth four times per day."

As early as the mid, 1970s, healthcare professionals and organizations like the Institute for Safe Medication Practices (ISMP), which describes itself as "A Nonprofit organization educating the medical community and consumers about safe medication practices," began to raise the alarm about the need for safe medication practices. In a 2007 publication entitled, *Protecting U. S. Citizens From Inappropriate Medication Use*, ISMP stated, "3.4 billion prescriptions (were) dispensed in 2005…an increase of nearly 60% since 1995…81% of adults…take at least one medication…and 27% take five."

Magic and Mass: The magic of medicine was gone and the mass of medicines had increased. Both are good things but both require new skills and attentiveness by providers. Medication reconciliation is the most important result of these changes. And, it is still a fact that one of the two most difficult tasks facing all healthcare providers is maintaining an accurate and up-to-date medication list on all patients.

In 2010, the National Quality Forum (NQF) published a study entitled *Preferred Practices and Performance Measure for Measuring and Reporting Care Coordination: a Consensus Report*. One of the critical quality measures is Medication Reconciliation. One of those measures is

described as: 'The plan of care document should include essential clinical data documenting the patient's current state, including, but not limited, to problem lists, medication lists, allergies and risk factors, age-appropriate standardized clinical assessments and screening tests; immunizations status…". Repeatedly, medication reconciliation is included as an essential part of care transitions at every point whether the transfer of care was made from clinic to home, hospital to ambulatory care, emergency department to nursing home, hospital to hospice, hospital to skilled nursing facility, hospital to long term acute care or other transitions.

Physician's Role in Medication Reconciliation (all of the following information is from this AMA monograph)

In 2007, the American Medical Association published its monograph entitled, *The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles*. The preface gives this warning to physicians: "Medication Reconciliation is essential to optimize the sage and effective use of medications. It is one element in the process of therapeutic use of medications and medication management for which physicians are ultimately held legally accountable…" The document then gives illustrations of harm to patient and legal disasters for physicians when transitions of care were made without effective medication reconciliation.

The AMA documented that in between 2004 and 2005, "in the United States 701,547 patients were treated for an adverse drug event (ADE) in emergency departments and 117,318 patients were hospitalized for injuries caused by an ADE. Insulin, warfarin and other drugs that require monitoring to prevent overdose or toxicity were implicated in one of every seven ADEs treated in emergency departments."

Over-the-counter drugs

The report stated, "Interactions between prescription medications and over-the-counter (OTC) drugs, herbal preparations or supplements are a growing concern, as concurrent sue can lead to serous adverse reactions." And, "in all settings of care, drug-drug interactions are significant but undetected cause of ADEs."

Steps and Principles of Medication Reconciliation

Steps:

1. Assembling the list**S** of medications – notice the word is "lists," not list. In a recent meeting about a regional health information exchange (HIE) an alarm was raised by the potential need to reconcile medication lists from five to ten locations. The response was that the good news was that for the first time, all providers would know that patients were getting medication from multiple sources and providers would have access to the "real" lists for medication reconciliation.
2. Ascertaining accuracy (review and compare prior and new lists)
3. Reconciling medications and resolving discrepancies
4. Formulating a decision, i.e., making a medical judgment, with respect to the patient's condition and medications.

5. Optimizing care to best meet the patient's needs with this information.
6. Checking the patient's (and/or caretaker's) understanding of their medications
7. Documenting changes and providing the patient with a copy of his or her current medication list.

Principles

1. Medication reconciliation is a necessary component of safe medication management. The process is ongoing and dynamic
2. The medication reconciliation process should be patient-centered.
3. Shared accountability between healthcare professionals and patients is essential to successful medication reconciliation outcomes.
4. All patients should have an accurate medication list for use across sites of care and over time.
5. The medication list should not be limited to prescription drugs.
6. Within all settings, the medication reconciliation process should happen at every medication encounter, regardless of the care location.
7. Across all setting, the medication reconciliation process must happen at every transition in the patient's care, regardless of the care transition.
8. The process of medication reconciliation is interdisciplinary and interdependent – and reliant on a team approach.
9. Physicians are ultimately responsible both ethically and legally for the medication reconciliations process.
10. Some medication information may be emotionally or legally charged, but nevertheless significant. It may be added at the discretion of the patient or prescribing health care professional by mutual consent.

Questions which will help with Medication Reconciliation

1. What medications do you take? Can you tell me the names of all your medications, including vitamins, OTC drugs, supplements and neutraceuticals.
2. What is it important to take your medications?
3. When do you take this medication? How long have you been taking this medication? Do you have a medical condition? What medical Condition?(s) do you have? What did you doctor say to you about this medication?
4. How do you take your medications (e.g., time of day, with food)?
5. Are you taking you medications the way the doctor told you to? When was the last time you took it? When was the time before that?
6. What do you do when you make a mistake? Do you every skip medication or take tow when you miss a dose?
7. Is your medication making you feel better or worse or no change?
8. What other medications, herbals, supplement, neutraceuticals, drops or sprays are you taking? Do you take other drugs that a physician has not prescribed?
9. From where do you get your medications? A local pharmacy? Mail order? The Internet? From another country? Other?

10. Who buys the medications in your family? Should we talk to him or her to make sue we have a complete list of all the medicines you take?

Giving Patients a List of Medications at Each Care Encounter

Reconciled Medication lists should be given to all patients at every point of transitioning of care and should include the following:

- A Reconciled List of Medications including Over the Counter, Herbal and Supplements
- Instructions in English (not Latin) for dosage, directions and timing of prescription
- A list of the patients allergies
- The date and time of the Reconciliation
- The person who did the reconciliation
- The contact information for the Reconciliation

Strategies to Assist Patient Understanding

1. Use plain, nonmedical language.
2. Slow down
3. Break information down, use short statements.
4. "Chunk and check" or organize information into tow or three key concepts, then check for understanding. Aim for a fifth to sixth grade reading level on all written information.
5. Use communication aids to assist in conversations, discussions or education sessions with patients, families and care givers.

    1) Offer to read materials aloud and explain
    2) Underline, highlight or circle key points.
    3) Provider a trained interpreter, when appropriate.
    4) Use visual aids to help patients navigate the health care system and understand health information.

6. Ask patients to teach-back what they were told\

    1) We have gone over a log of information. In your own words, can you review for me what we have discussed? How will you make it work at home?
    2) Sometimes I give a lot of information. Can you let me know what you heard me say? This helps me make sure I gave you the information you want and need/

Conclusion

Medication Reconciliation is hard and it is critical. The dynamic nature of medications being taken creates the complexity of maintaining and accurate lists as does the fact that most patients on multiple medications are being seen by two to seven providers annually. The probability for medication reconciliation to result in accuracy in medication administration is increased by the frequency of reconciliation being completed, particularly when each reconciliation is thorough. If a patient has ten to fifteen medication reconciliations or more per year, adverse medication

events will decline and hopefully disappear. Such reconciliations are time consuming and require perseverance, but the result will be increased safety and improved care with decreased cost.

Medical Home Series Two
Part XV The SETMA Foundation
By James L. Holly, MD
Your Life Your Health
The Examiner
October 27, 2011

While preparing this third series on Patient-Centered Medical Home, I reviewed the first two. SETMA's growing understanding of medical home and SETMA's expanding deployment of new capabilities in the practice of medical home are reflected in the progression of these series. .

In February, 2009, the first mention was made of The SETMA Foundation in relationship to Medical Home. SETMA began discussing the formation of a charitable foundation in 2003. The intent was to create a vehicle through which SETMA could help our patients obtain care when they could not otherwise afford it. In the February 26, 2009 article, it was stated:

> "(In) the Medical Home model, the provider has NOT done (his/her) job (by)… simply prescribing…care which meets national standards. Doing the job of Medical Home requires the prescribing of the best care which is ***available*** to the patient…" (Emphasis added)
>
> "…assisting patients in finding the resources to help (them get the care they need)… (is)…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; the ordering of tests, treatments, and/or prescriptions which we know our patients cannot obtain is not healthcare, even if (that)…plan of care is up to national standards."

In a Medical-Home article published June 3, 2010 article and which was quoted in series two on Medical Home, August 19, 2010, the Foundation was addressed again:

> "The genius of PC-MH is to discover the true implications of SETMA's motto which was adopted in August, 1995…: 'Healthcare Where Your Health is the Only Care.'" It is to put the patient and their needs first… SETMA…placed the patient…at the center of… (as) we developed The SETMA Foundation, through which we help provide funding for the care of our patients who cannot afford it."

Medical Home and Healthcare Resources

There have been many heroes in SETMA's Foundation experience. Other, non-SETMA healthcare providers have contributed their skills and time to the care of our patients. One of the

first patients the Foundation helped had very bad teeth. Beaumont dentist, Dr. Dave Carpenter, was consulted and he determined that repair of the patient's teeth would cost $10,400. The patient's health could not be helped without resolving her dental issues. It has long been known that dental care is a critical part of general health. In the case of patients with diabetes, dental care is so important; it has become one of the quality measures for SETMA's care.

SETMA proposed to Dr. Carpenter that he make a $4,000 contribution to the Foundation and the Foundation would pay him $10,400 to do the dental work. Without hesitation, he agreed. The result is remarkable. First of all the patient's gratitude made the effort worth it, if there were no other benefit, but the real benefit is that the patient is off all medications and all health problems have resolved. The patient's life has been permanently changed and the patient's future has been made bright. That's Medical Home and in that a non-SETMA healthcare provider was key to its success, it really is Medical Neighborhood.

Another patient, who had no insurance, was virtually crippled due to degenerative disease in the hip. Surgery was not possible because there were no funds. The Foundation negotiated a payment to a local hospital for the patient's care. That same day, I approached Dr. Carl Beaudry and said, "We have a patient that needs a hip replacement and we'd like for you to do the surgery." I then said, "There's only one problem; we would like for you to do the surgery free." In the same breath, without asking any questions, Dr. Beaudry said, "OK!' The surgery has changed this patient's life.

Concerns about the Foundation

There have been concerns about the Foundation. One of them is about "setting precedents." This really is a question about if you help one person and can't help another, how will you deal with that. In a recent discussion about this, I said:

> "The fear of setting precedents is only valid if we become victims of our own beneficence. The ability to say, 'Yes,' when appropriate must be balanced by the willingness to say, 'No.' when appropriate. I enjoy saying, 'Yes,' but find it easy to say, 'No,' even when it is not welcomed. If we become shackled by those fears, we will do…nothing."

What about those we can't help? After we have done all that we can do, we'll still try to help others. When at last we can do no more; we can confidently say, "We did all we could."

The Debt of Gratitude

Seven years ago, my School of Medicine asked me to write an article for the Alumni News; the following is part of that article:

> "Tremulously, Private James Ryan, now in his seventies, approached the headstone of

Captain John Miller who gave his life that Ryan might live. In perhaps the most poignant moment in a great film, tears stream down his face, as Ryan plaintively said to his wife, 'Tell me that I have lived a good life; tell me that I have been a good man.' The sacrifice of others, imposed upon Private Ryan a debt only a noble and honorable life could repay.

"Everyone owes such a debt to someone. The circumstances of that debt may not be as dramatic, but it is just as real. Years ago, a man asked me, 'Aren't you proud of what you have accomplished?'…'Proud? Yes, but more grateful and humble than proud.' And, ultimately, I am responsible for the gift and honor of being a physician.

"…there are few gifts as great as that of the opportunity to be a physician. The trust of caring for others has always been a sacred trust. It is a trust which should cause each person so honored to tremble with fear that he/she will not have lived worthily of that honor. It should cause us to examine our lives for evidence that we have been good stewards of the treasure of knowledge, skill, experience, and judgment which has been bequeathed to us by our university, by our professors and by the public which funded our education.

"What nobler calling could one have than the opportunity to collaborate with others in their quest for health and hope? The honor of trust and respect given by strangers, who share their deepest secrets, knowing they will be held sacrosanct, is a gift which exceeds any pecuniary advantage. The pursuit of excellence in the care of others is a passion which is self-motivating.

"Passion is the fuel which energizes any noble endeavor. It is what makes a person get up early in the morning, work hard all day, and go to bed late at night looking forward to the next day. It is a cause of great sadness that today's society is so devoid of true purpose-driven passion. Many only vicariously experience passion through the eyes and lives of athletes, movie stars, or musicians. Ultimately, passion and purpose are what make life worth living. Those of us, who have been allowed the privilege of being physicians, can and should know the passion of a noble purpose every day of our lives."

The Nature of the Foundation

The SETMA Foundation is an extension of gratitude, honor and passion felt by each partner, provider and participant at SETMA. In the same time period as these Medical Home series have been written – 2009, 2010, 2011 – the partners of SETMA have given $1,500,000 to the Foundation. This was not done by coercion but by "cheerful giving." Universal American, the parent company for Texan Plus Medicare Advantage gave a $150,000 gift to the Foundation in honor of SETMA's becoming a Joslin Diabetes Affiliate in 2010. .

There are restrictions on how the funds of The Foundation can be spent. One of them is that none of the money can profit or benefit SETMA. None of the funds can benefit any provider or partner of SETMA. The Foundation's resources are relatively meager. SETMAs partners will continue to fund the Foundation as long as we can. There are no guarantees that it will last forever, but it is our hope that it will last for the length of all of our careers at least.

SETMA's Medical Home and Foundation are great collaborators

Recently, one of SETMA's nurse practitioner colleagues came to my office. She was beaming and exclaimed, "I have never enjoyed practicing medicine more than I do now. I just had a patient who I can help but she couldn't afford her medication. I sent a referral to the Care Coordination Department and the lady now has her medications. This is really fun." That story can be repeated by every member of SETMA's team multiple times.

The *Associated Press* published an article about one of SETMA's patients and our Medical Home. This patient has benefited extensively from personalized, compassion care through both the PC-MH and the Foundation. Another patient who was seen initially in February, 2009, has been called SETMA's Medical Home Poster Child as the patent's needs and care perfectly illustrate the genius and dynamic of patient-centered medical home with support from The Foundation.

Medical Home Poster Child and the SETMA Foundation

In February, 2009, I saw a patient in the hospital for the first time. He was angry, hostile, bitter and depressed. It was impossible to coax him out of his mood. Nurses did not want to go into his room. When he was ready to leave the hospital, I gave him an appointment to see me, even though he was not my patient. In his follow-up visit, his affect had not changed. In that visit, I discovered the patient was only taking four of nine medications because of expense. He could not afford gas to get the education he needed about his condition. He was genuinely disabled and could not work. He was losing his eyesight and could not afford to see an ophthalmologist. He did not know how to apply for disability. His diabetes had never been treated to goal.

When he left that visit, he had an appointment to SETMA's American Diabetes Association-approved diabetes self management education program. The fees for the education program were waived. The patient also left with a gas card with which to pay for the fuel to get the education which is critical to his care. SETMA's staff negotiated a reduced cost with the patient's pharmacy and made it possible for the pharmacy to bill The SETMA Foundation. The patient's care included our assisting him in his application for Social Security disability. He had a visit that day with SETMA's ophthalmologist who arranged a referral to an experimental eye-preservation program in Houston, which was free.

Six weeks later, the patient returned for a follow-up visit. He had something which I could not prescribe for him; he had hope. He was smiling and happy. Without anti-depressants, or sedatives, he was no longer depressed as he now believed there was life after being diagnosed with diabetes for ten years. And, for the first time, his diabetes was treated to goal.

I continued to see him. Eighteen months later, he was in for a scheduled visit; he was sad. I asked him what the problem was and he said that he was afraid that we would get tired of helping him. He had applied for and had received disability but he would not be eligible for Medicare for two years. In two years. without care, he would be blind, in kidney failure, or dead. He asked if we would stop helping him. I said, "Yes, we will. Absolutely, the day after we go bankrupt."

Melodramatic, yes, but true. He smiled and relaxed. He now has Medicare; his diabetes is still controlled, and he is doing well.

Healthcare providers have always been warmed about "transference," which essentially is an emotional bond which a patient develops with a provider and which a provider can also develop with a patient. While there is a caution to be heeded here, in patient-centered medical home there is an appropriate bond which develops between patients and providers. This bond is a caring compassion which has appropriate boundaries but is essential for trust and hope to power the medical home partially funded by a Foundation.

Medical Home Series Two
Part XVI Quality Metrics in the Medical Home
By James L. Holly, MD
Your Life Your Health
The Examiner
November 3, 2011

One of the greatest inventions in western civilization was the front porch. The porch so defined American culture that in the first decades of the "technological 21st Century," the most popular magazine, *The Ladies Home Journal*, had an annual "Porch Edition," in which illustrations, diagrams and building plans for various kinds of "front porches" were described. The front porch was the community center, family gathering place, neighborhood visiting center and the communication hub for much of what was great about America.

The porch was the coolest place in the house. It provided the opportunity for families to connect with their friends. It was the place where people who did not have the time to visit, greeted one another with a wave, or a loud "howdy." I remember as a child sitting on the porch, or returning home to find my parents sitting on the porch. Whether singing 'Swanee River" or reviewing the family album which is in my mind, the porch and my parents will always be cherished parts of my memory.

The Encroachment of Technology

The porch tied families and communities together. I remember sitting on the porch and wishing that there was not so much dust when someone passed on the dirt road in front of our house. Then one day, the road was paved. However, this technological advance of a "black top" road actually increased our isolation, as less and less time was spent on the porch and more and more time was spent on the smooth road. Then the ultimate advance came. I was a teenager when our family physician replaced the air conditioners in his home in town. He gave the old air conditioners to his dear friend, my father. I can feel the coolness today. It was a great day to have "conditioned air." You could be warm in the winter – we had heat – and cool in the summer, but what you could not have was the community connection of the front porch because it was not air conditioned. We didn't sit on the porch very often after that.

Healthcare Technology

Like the loss of the community created by the loss of the front porch, technology has improved what we can expect of healthcare but it has not necessarily ultimately improved the quality of our lives. There was a time, because there wasn't much that we could do about it, that we did not spend all of our time thinking about extending the length of our life; we spent all of our time living.

The New York Times Magazine of May 2, 2010, carried an article entitled, "The Data-Driven Life,." which asks the question, "Technology has made it feasible not only to measure our most basic habits but also to evaluate them. Does measuring what we eat or how much we sleep or how often we do the dishes change how we think about ourselves?" The article asks, "What happens when technology can calculate and analyze every quotidian thing that happened to you today?" I admit I had to look up the word "quotidian." It means "daily; occurring or recurring every day; common, ordinary, trivial." Does this remind you of Einstein's admonition, "Not everything that can be counted counts, and not everything that counts can be counted?"

Technology must never blind us to the human. Bioethicist, Onora O'Neill, commented on our technological obsession with measuring things. In doing so she echoes the reality that that not everything that is counted counts. She said:

> "In theory again the new culture of accountability and audit makes professionals and institutions more accountable for good performance. This is manifest in the rhetoric of improvement and rising standards, of efficiency gains and best practice, of respect for patients and pupils and employees. But beneath this admirable rhetoric the real focus is on performance indicators chosen for ease of measurement and control rather than because they measure accurately what the quality of performance is."

Technology Can Deal with Disease but Cannot Produce Health

In our quest for excellence, we must not be seduced by technology with its numbers and tables. This is particularly the case in healthcare. In the future of medicine, the tension – not a conflict but a dynamic balance – must be properly maintained between humanity and technology. Technology can contribute to the solving of many of our disease problems but ultimately cannot solve the "health problem" we face. It is my judgment that the major issue facing healthcare delivery today is that men and women, boys and girls have replaced the trust they once had in their physician with a trust in technology. It is as if the "front porches" of healthcare have disappeared and the air-conditioning has forced us inside the building so that we can't say "howdy" to one another any longer.

The entire focus and energy of "health home" is to rediscover that trusting bond between patient and provider. In the "health home," technology becomes a tool to be used and not an end to be pursued. The outcomes of pure technology alone are not as satisfying as those where trust and

technology are properly balanced in healthcare delivery.

The challenge for our new generation of healthcare providers and for those of us who are finishing our careers is that we must be technologically competent while at the same time being personally compassionate and engaged with our patients. This is not easy because of the efficiency (excellence x time) of applied technology. A referral or a procedure is often faster and more quantifiable than is a conversation or counseling.

Quality Metrics

No one would argue that quality metrics are the only solution to healthcare improvement. Those who grapple with the design of quality metrics do not sit around thinking up new ways to aggravate healthcare providers. Using scientific methodology and a growing body of medical literature on quality metrics, these pioneers look for leverage points in identifying potential for real change in healthcare-delivery processes, which will reflect real change in the quality of patient health. Unfortunately, quality metrics are not static such that once you identify one metric that it will have permanent relevance to quality improvement. Once processes are in place, such that the outcomes are virtually totally dependent upon the process, rather than healthcare provider performance, new metrics must be found to move the system further toward excellence.

A single quality metric for a complex disease process will have little if any impact upon patient safety and health. And, all quality metrics of value should point to treatment change which will improve patient health. Though a single metric is of extremely limited value, a "cluster," or a "galaxy" of quality metrics can effect real change in healthcare quality and in patient health. A "cluster" is defined as a group of quality metrics (seven or more) which define quality treatment standards in both process and outcomes for a single disease process. "Comprehensive quality measures" for diabetes are a good illustration. Unfortunately, PCPI, NQA, NCQA Diabetes Recognition, AQA, PQRI, HEDIS and Joslin Diabetes Center, all have comprehensive quality measures for diabetes; and, they are all different.

A "galaxy" of quality measures is a group of "clusters" which relate to the health of a single patient. When "comprehensive quality measures" for diabetes, hypertension, dyslipidemia, CHF, Chronic Stable Angina, Cardiometabolic Risk Syndrome, Chronic Renal Disease Stage 1-III and then Stages IV-ESRD are identified and measured for a single patient, the successful meeting of those metrics, which may exceed 50 in number, WILL reflect quality treatment and WILL result in improved health.. Quickly, physicians will say, "But, that will take a two-hour visit for each patient." That would be the case if we were using paper records; in fact, two hours by paper may not be enough time to accomplish all of this. However, with electronic patient management via a well-designed electronic patient record, and with a well-trained and highly functioning healthcare team, this "galaxy" of metrics can be met within in the time and economic constraints currently existent in healthcare in the United States.

How Can Quality Metrics Effect Quality Care?

While quality metrics will always reflect quality, they will not always effect quality unless they are transparent to the healthcare provider at the time and point of a patient encounter. A "report card" delivered retrospectively, six months to two years after the care event which was measured, will have absolutely no impact on provider behavior. But, if the provider is able to "see" his/her performance at the time of the patient encounter, behavior will begin to change.

And, if the panel or population a single provider manages, or participates in managing, has data aggregated daily, monthly, quarterly and annually, treatment inertia can be overcome. And, finally, when that provider's performance is publicly published by provider name, treatment inertia will disappear.

As the pressure increases for healthcare organizations and for healthcare providers to produce quality outcomes in healthcare delivery, to prove that they are delivering quality and to report the results of their performance, there are an increasing number of agencies who are publishing standards of measurement of quality. The simplest way to measure quality is via data analysis, but this restricts measurement to processes or outcomes which can be expressed numerically or with simply "yes" or "no" answers. The problem with identifying and measuring quality is that quality in healthcare is often the result of complex processes which are not subject to simple measurement.

Diabetes is a target of quality measures for several reasons:

1. Process Quality Measures, i.e., was a hemoglobin $A1_c$ ($HgbA1_c$) done, and Outcomes Quality Measures, i.e., what was the $HgbA1_c$ value, are easy to determine and to report.
2. Standardization of the treatment goals for the elements of diabetes are generally known and accepted.
3. Standardization of methods for laboratory testing is generally accepted.
4. These three make diabetes a model for the idea of "precision medicine" presented in The *Innovator's Prescription: A Disruptive Solution for Health Care. "Pre*cision medicine," exists *"*Only when diseases are diagnosed precisely…can therapy that is predictably effective ...be developed and standardized. We term this domain *precision medicine*." The care of diabetes calls for little intuitive judgment or guess work. Anyone willing to learn the principles can do excellent care of diabetes.
5. Diabetes is a devastating disease but evidence-based medicine demonstrates that aggressive and successful treatment dramatically changes the outcome of the disease.
6. Diabetes is a major public health problem in that the increasing prevalence of diabetes is almost on the scale of a pandemic.
7. The cost of caring for diabetes and its complications is enormous making the potential benefit of treating the illness both for the individual and for the society large.

Each of these makes diabetes an ideal condition for the development of quality metrics. Yet, one of the problems with quality measures is demonstrated here. There are seven "comprehensive

diabetes quality measures sets" and all of them are different. They are not contradictory; they are just not the same. This complicates tracking and auditing of provider performance. SETMA and others are encouraging that one standardized quality measures set for diabetes be adopted by all. Eventually this will happen, but even as we argue that the treatment of diabetes is an example of "precision medicine," some of the elements of that process are imprecise.

Limitations of Quality Metrics

Even as we want to talk about 'precision medicine' and even as we want to measure quality using quantifiable processes and outcomes, we still have to admit that there are limitations to quality metrics. Because healthcare does not deal with machines but with people, there will always be subjective, poorly quantifiable elements to quality in healthcare.

There are several critical steps which can help bridge the gap between quality metrics and true quality in healthcare. At the foundation of quality healthcare, there is an emotional bond – a trust bond –between the healthcare provider and the patient. It is possible to fulfill all quality metrics without this bond; it is not possible to provide quality healthcare without it. That is why the patient-centered medical home (PC-MH), coupled with the fulfilling of quality metrics is the solution to the need for quality healthcare.

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

The good news is that the right questions are being asked and historically in that setting .the right answers have been found. We will continue to pursue quality healthcare and we will continue to use quality metrics. We will also realize that the one does not necessarily produce the other and viewed incorrectly the two can become incompatible.

Medical Home Series Two Part XVII
SETMA's Model of Care & Patient-Centered Medical Home
By James L. Holly
Your Life Your Health
The Examiner
November 10, 2011

SETMA employs four elements in transforming healthcare and we believe these elements are the core to any sustainable, affordable and acceptable healthcare transformation:

1. **The Substance** -- Evidenced-based medicine and comprehensive health promotion
2. **The Method** -- Electronic Patient Management
3. **The Organization** -- Patient-centered Medical Home
4. **The Funding** -- Capitation with payment for quality outcomes

Evidence-based medicine must be the substance of healthcare. All care must be tied to proved therapeutics, treatment guidelines and pharmaceuticals. Anything, such as Chiropractic care must only be paid for if there is scientific evidence of its effectiveness. The reality is that if a therapy is legal, even if it is not evidence-based, it can be received by a patient. However, insurance and particularly publicly-supported insurance payments must not be used for such treatments. Patients can pay for anything legal and ethical, but the government must pay only for what is evidenced-based, no matter who the provider.

Electronic patient management (EPM) is different from electronic patient records (EHR). EHR is a method for documenting a patient encounter; EPM is a method for leveraging the power of electronics to produce better outcomes and better health. EPM includes integrating quality metrics, data analytics, clinical decision support and clinical process support into the healthcare process. An extension of EPM is the transparency of public reporting of quality performance by provider name. And, it involves fulfilling the contract with patients which states, "If you make a change; it will make a difference."

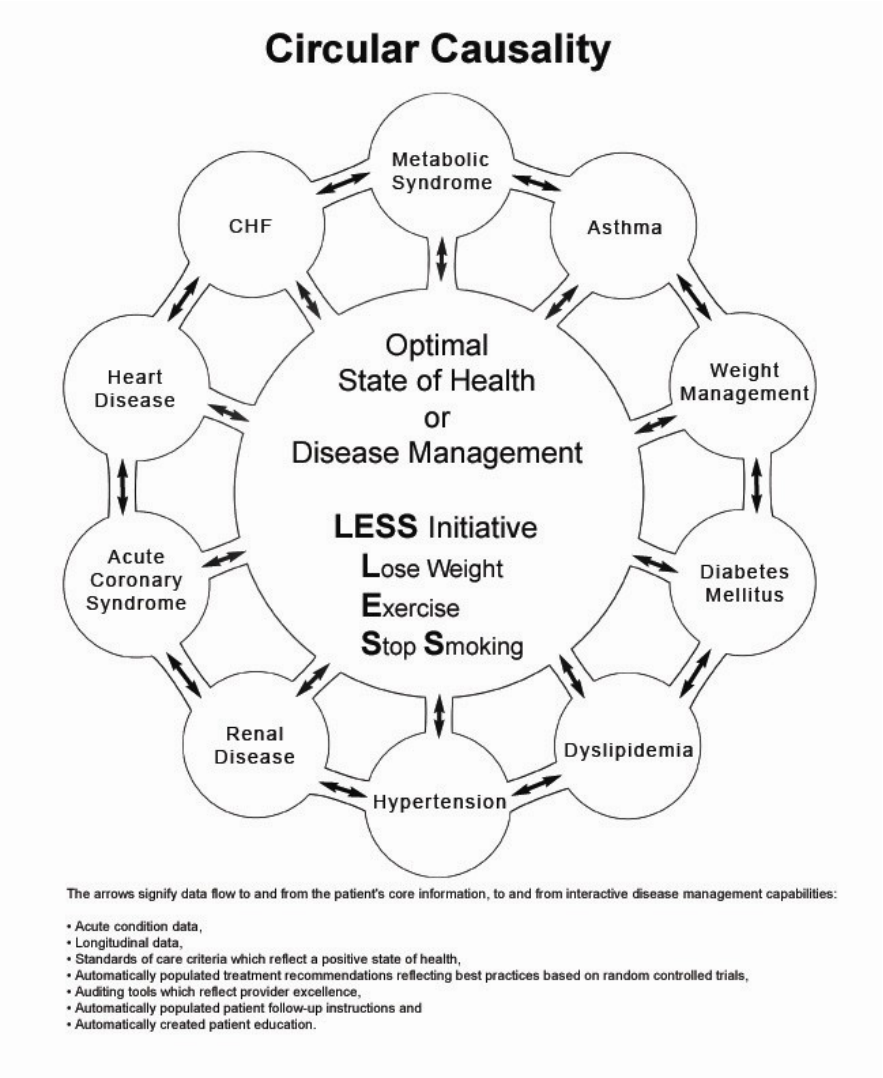
These parts of the equation for successfully transforming healthcare will not happen automatically. The principles which SETMA enunciated in 2000 for the development of our EHR are:

The principles which have guided Southeast Texas Medical Associates' development of a data base which supports these requirements are:

1. Pursue Electronic Patient Management rather than Electronic Patient Records
2. Bring to bear upon every patient encounter what is known rather than what a particular provider knows.
3. Make it easier to do it right than not to do it at all.
4. Continually challenge providers to improve their performance.
5. Infuse new knowledge and decision-making tools throughout an organization instantly.

6. Establish and promote continuity of care with patient education, information and plans of care.
7. Enlist patients as partners and collaborators in their own health improvement.
8. Evaluate the care of patients and populations of patients longitudinally.
9. Audit provider performance based on the Consortium for Physician Performance Improvement Data Sets.
10. Create multiple disease-management tools which are integrated in an intuitive and interchangeable fashion giving patients the benefit of expert knowledge about specific conditions while they get the benefit of a global approach to their total health.

The data display of an EHR which is equipped to perform EPM is illustrated by the following graphic and legend:



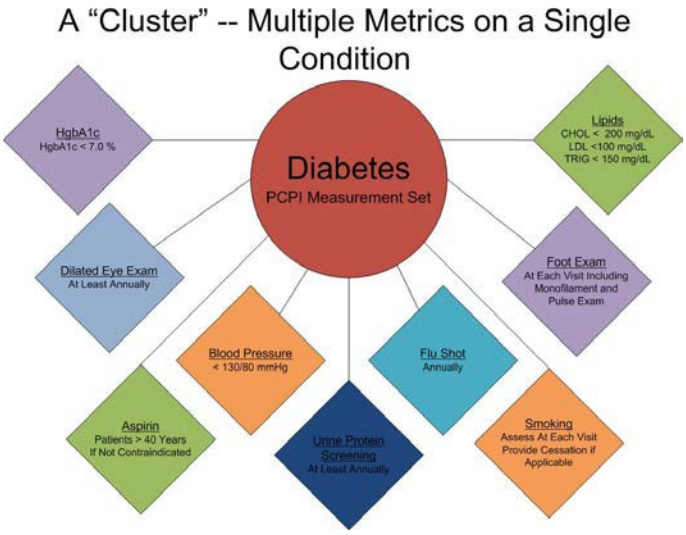
The funding of healthcare to be transformative must abandon the “piece” payment method which was instituted in 1965 with the advent of Medicare. Capitation, with payment for quality

outcomes, coordination of care and care management incentivize healthcare providers to be efficient and excellent in their care rather than just being expensive.

Finally, all three elements logically merge into a patient-centered medical-home setting. The coordination of care with a primary focus on health and secondarily on disease treatment rounds out the transformative process, which SETMA believes is the future of healthcare in America. It addresses cost, quality and coordination of care.

Quality Metrics

At the core of these principles is SETMA's belief and practice that one or two quality metrics will have little impact upon the processes and outcomes of healthcare delivery. SETMA believes that fulfilling a single or a few quality metrics does not change outcomes, but fulfilling "clusters" and "galaxies" of metrics at the point-of-care *can* and *will* change outcomes. The following illustrates the principle of a "cluster" of quality metrics. A single patient, at a single visit, for a single condition, will have eight or more quality metrics fulfilled, which *WILL* change the outcome of that patient's treatment.



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

SETMA's model of care is based on these four principles and these concepts of "clusters" and "galaxies" of quality metrics.

The SETMA Model of Care

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

preventable readmissions to the hospital. We have completed a COGNOS Report which allows us to analyze our hospital care carefully.

Passing the Baton

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

If responsibility for a patient's healthcare is symbolized by a baton, the healthcare provider carries the baton for .68% of the time. That is less than 1% of the time. The patient carries the baton 99.32% of the time. The coordination of the patient's care between healthcare providers is important but the coordination of the patient's care between healthcare providers and the patient is imperative.

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

Firmly in the providers hand
--The baton – the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.

5. That the imperative for the plan – the "baton" – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

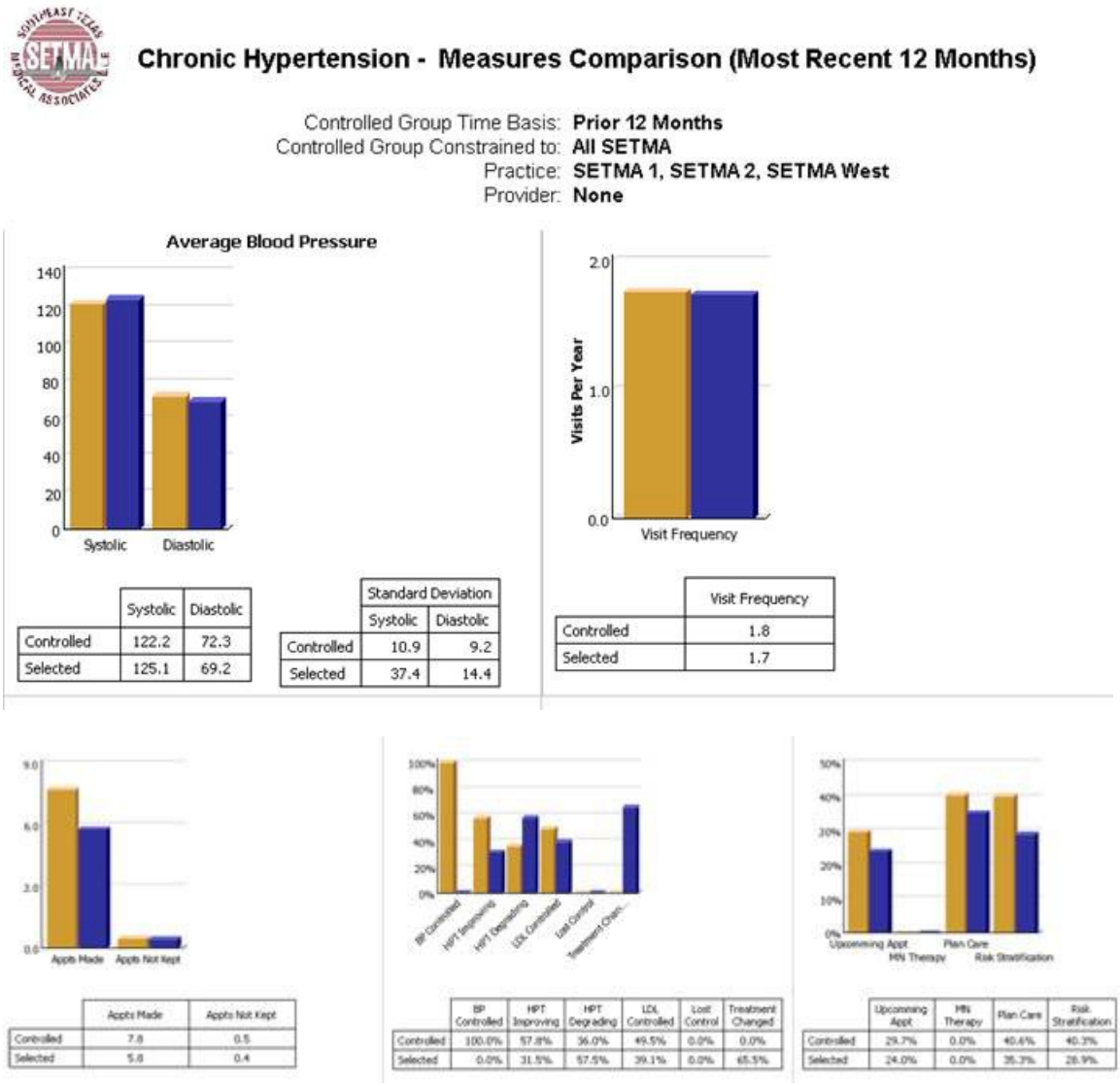
The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display will continually remind the provider and will inform the patient, that to be successful, the patient's care must be coordinated, which must result in coordinated care. In 2011, as we expand the scope of SETMA's Department of Care Coordination, we know that coordination begins at the points of "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute that care.

Auditing

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

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

The following are a few examples of the auditing SETMA does of provider performance.



Analytics

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

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

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

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

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

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

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

From 2000 to 2010, SETMA has shown annual improvement in the mean (the average) and the median results for the treatment of diabetes. There has never been a year when we did not improve. Yet, our standard deviations revealed that there were still significant numbers of our patients who are not being treated successfully. Even here, however, we have improved. From 2008 to 2009, SETMA experience a 9.3% improvement in standard deviation. Some individual SETMA providers had an improvement of over 16% in their standard deviations. Our goal for 2011 is to have another annualized improvement in mean and in median, and also to improve our standard deviation. When our standard deviations are below 1 and as they approach .5, we can be increasingly confident that all of our patients with diabetes are being treated well.

Conclusion

SETMA's Model of Care is unique among over 300 published models of care. SETMA believes that it is uniquely designed and deployed to support Patient-Centered Medical Home at its best.

Medical Home Series Two
Part XVIII
Introduction to SETMA's 2009, 2010 and 2011
Series of Articles on Medical Home
By James L. Holly, MD

(**Note**: SETMA's three series on Medical Home are published on our website www.jameslhollymd.com under In-The-News. This is the introduction to the collection of those articles. It is reproduced here because it contains several key concepts about Medical Home which are not included elsewhere.)

In 2010, SETMA was recognized by the National Committee for Quality Assurance (NCQA) as a Tier 3, Patient-Centered Medical Home. In 2010, SETMA was also accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) and as a Medical Home. In 2011, SETMA was reaccredited by AAACH for both for a three-year term.

The contents of this notebook are the thoughts, ideas and analysis by SETMA about Medical Home since we first began to think about Medical Home in February, 2009. It is organized into three sections, each of which represents articles written in 2009, 2010 and 2011. The section on 2011 is in progress and although it represents eighteen articles, making it longer than the 2009 and 2010 series put together, there are still other issues with which we will deal.

Healthcare Transformation

SETMA employs four elements in transforming healthcare and we believe these elements are the core to any sustainable, affordable and acceptable healthcare transformation (this is reviewed in more detail on page 94 of Section 3 of this notebook):

5. **The Substance** -- Evidence-based medicine and comprehensive health promotion
6. **The Method** -- Electronic Patient Management
7. **The Organization** -- Patient-centered Medical Home
8. **The Funding** -- Capitation with payment for quality outcomes

SETMA is confident that healthcare transformation, not reformation, will not be sustainable without these four elements being part of the solution. For more on SETMA's ideas of healthcare transformation see "Healthcare Policy Issues Part III: Reforming or Transforming Healthcare," August 20, 2009, under Your Life Your Health at www.jameslhollymd.com.

Unique

Perhaps the most important revelation about this material is that while there is a structure, content and standard to guide a group in developing a medical home, each iteration of this important innovation in healthcare will be different. Medical Home, more than any other healthcare innovation, is an extension of the personality, passion and peculiar life story of each

person, or group of persons who organize and execute the Medical Home. And, remember that the primary definition of "peculiar" is "special, unique, one of a kind." Each successful deployment of a Patient-Centered Medical Home will be "special"; it will be "unique"; it will be "one of a kind." There will be similarities and there will be commonalities, but as a whole, the Medical-Home organism will be creatively unique.

Stories

Anecdotal medicine is frowned upon as it is based on personal experience without the benefit of "random controlled" or "double-blind" studies. Anecdotal medicine does now allow for analysis to determine if the conclusions of the experience are valid or not.

However, in the case of Medical Home, while there is an objective standard against which to measure the essential functions of a Medical Home, it is the "stories" which are powerful. It is the "stories" which give breath (in this case we refer to respiration and life) and depth (in this case we refer to significance and validity) to the experience. In fact, SETMA would recommend that NCQA, AAAHC, the Joint Commission and URAC – currently, the four agencies reviewing Medical Home applications -- establish a "stories exchange." This would be a place where illustrates of successes in Medical Home could be shared with everyone. Each story will flesh out, in three-dimensions "real life situations," our understanding of what otherwise are two-dimensional abstract ideals such as "coordination," "Care Transitions" and "patient-centric," among others.

Our Stories

SETMA has a growing list of stories which in fact are the sign posts on our pilgrimage. We include only two here. One story is from the first day we started to think about Medical Home. The second occurred two days before this introduction was prepared.

SETMA's Medical Home "Poster Child"

In February, 2009, I saw a patient in the hospital for the first time. He was angry, hostile, bitter and depressed. It was impossible to coax him out of his mood. Nurses did not want to go into his room. When he was ready to leave the hospital, I gave him an appointment to see me, even though he was not my patient. In his follow-up visit, his affect had not changed. In that visit, I discovered the patient was only taking four of nine medications because of expense. He could not afford gas to get the education he needed about his condition. He was genuinely disabled and could not work. He was losing his eyesight and could not afford to see an ophthalmologist. He did not know how to apply for disability. His diabetes had never been treated to goal.

When he left that visit, he had an appointment to SETMA's American Diabetes Association-approved diabetes self management education program. The fees for the education program were waived. The patient also left with a gas card with which to pay for the fuel to get the

education which is critical to his care. SETMA's staff negotiated a reduced cost with the patient's pharmacy and made it possible for the pharmacy to bill The SETMA Foundation. The patient's care included our assisting him in his application for Social Security disability. He had a visit that day with SETMA's ophthalmologist who arranged a referral to an experimental eye-preservation program in Houston, which was free.

Six weeks later, the patient returned for a follow-up visit. He had something which I could not prescribe for him; he had hope. He was smiling and happy. Without anti-depressants, or sedatives, he was no longer depressed as he now believed there was life after being diagnosed with diabetes for ten years. And, for the first time, his diabetes was treated to goal.

I continued to see him. Eighteen months later, he was in for a scheduled visit; he was sad. I asked him what the problem was and he said that he was afraid that we would get tired of helping him. He had applied for and had received disability but he would not be eligible for Medicare for two years. In two years, without care, he would be blind, in kidney failure, or dead. He asked if we would stop helping him. I said, "Yes, we will. Absolutely, the day after we go bankrupt." (page 87, Medical Home Series 2, 2011, Section 3 of this notebook)

A Simpler Story but as powerful

Recently, CMS completed through a consulting firm, a study of 312 Medical Homes in contrast with matched benchmark practices which are not Medical Homes. The comparison was made on quality, coordination and cost. SETMA was a part of that study and our results are discussed in two articles beginning on pages 55 and 64 of the 2011 Section of this notebook. This second story illustrates SETMA addressing each of the elements of the CMS Study: quality, cost and coordination.

On the morning of October 10, 2011, I saw a patient at 3:00 AM in the emergency department. The emergency physician had seen the patient and admitted her to the hospital for chest pain. I saw the patient and reviewed her history thoroughly:

- Six months previously, she had had a normal cardiac catherization.
- Her pain was in the left upper back, not the chest.
- She had no angina equivalents, i.e., shortness of breath, exertional pain, diaphoresis, radiation, or nausea.

Her physical examination was normal, as were her EKG and laboratory work. I canceled the admission to the hospital and scheduled an appointment in my office for ten hours later. Her history and physical examination and her emergency department visit was documented in her personal electronic health record which is used in our office because we have connectivity with all hospitals, nursing homes, emergency departments and other points of patient care.

At 1:30 PM on the same day, I saw the patient again in the clinic. After reviewing the evaluation from the morning, another thorough evaluation by history and physical examination was done. Ultimately, the patient left the office with a diagnosis of rhomboid muscle strain. She had the following care completed before leaving the clinic:

1. *A stress Echo after being seen by our Cardiologist* – stress echo was normal (this was done because she has diabetes which is an independent cardiovascular risk factor and it was felt that the additional verification of my clinical judgment was appropriate. It probably could have been avoided)
2. **Having had physical therapy for her rhomboid strain** – **d**one with improvement after Physical Therapy will have a series of treatments.
3. **Flu immunization** – given, at every opportunity screening and preventive needs of a patient are assessed.
4. **Lab work for follow-up of her diabetes, lipids and hypertension** – HbA1c 6.5%, all other lab tests normal; again at every opportunity, a patient's health status is assessed. The patient's history had told me that she does not see her primary physician often thus this opportunity was taken to evaluate her progress to goals.
5. **SETMA's Foundation paying** for her statin which she cannot afford. SETMA's Department of Care Coordination arranged this while the other care was carried out.
6. **Referral for mammogram** – again screening care is addressed at every contact no matter what the chief complaint is.
7. **Medication reconciliation** -- it was at this point that the patient revealed that she had not filled the prescription for a statin given to her by the endocrinologist because she could not afford it. She left the office with the prescription paid for by the SETMA Foundation.
8. **Follow-up appointment with me in six weeks** – The was the key to the "Transition of Care" from this acute episode to the appropriate follow-up in a patient who had not been seeing her primary care provider regularly.

When the patient left the clinic she had a smile on her face. She felt that she had been well taken care of. She did not have to be unnecessarily hospitalized and virtually all of the above care is capitated, consequently cost effectiveness, quality, and coordination were all addressed. This is SETMA's Medical Home in operation with high quality, coordinated, cost effective care.

On October 11th, a review was made of the patient's chart. No point of care had been omitted. The patient was successfully and excellently treated without admission to the hospital. **This is a Medicare Advantage patient being treated in a Medical Home setting.**

Welcome

Welcome to SETMA's "Medical Home Story Book." It is our hope that this material may stimulate you to start your own Medical-Home pilgrimage and that you will begin to collect your own Medical-Home stories. If so, then this notebook's purpose will have been fulfilled.

Medical Home – Series Two
Letter of Introduction
SETMA's Patient-Centered Medical Home
By James L. Holly, MD

"What did you welcome me to? " A Medical Home! What's that? Actually, 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. Your medical home at SETMA has been recognized by the National Committee for Quality Assurance (NCQA), from which SEMTA has received the highest award which is a Tier Three. It is also accredited by the Accreditation Association for Ambulatory Health Care. Very few organizations have more than one accreditation. Two other agencies accredit medical home: URAC and the Joint Commission. In 2012, SETMA will seek accreditation by both.

The goal of medical home 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 SETMA 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 new dimensions have been added which are the Care Coordination Team (CCT) and the Department of Care Coordination (DCC).

The CCT is a team of people who focus on your needs, whether they are ordinary, like every one else's, or whether they are special, extraordinary needs which are unique to you. Your 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 a hurricane 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 multiple quality metric sets published by the National Quality Forum, the Physician Consortium for Performance Improvement, National Committee for Quality Assurance, or other agency 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.

The Department of Care Coordination will be involved in your care in many special ways. If you are in the hospital, they will call you the day after you leave the hospital to make sure you have your medications and that you are clear on your treatment plan and plan of care which you received when you left the hospital. They will also help you find the resources you need in order to achieve the maxim health possible, including helping where possible with the financial resources to meet those needs.

In your medical home, over two hundred quality standards of care will be tracked. How your personal healthcare provider performs on these standards will be publicly reported on SETMA's website at www.jameslhollymd.com under Public Reporting. One of the most common quality metric sets is published by the NCQA and is called HEDIS. More than ninety percent of America's health plans measure provider performance by HEDIS measures. 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.

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 and other quality metric sets 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 you 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.

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.