James L. Holly, M.D.

Summation of All SETMA TCPI Materials

Index

Transforming Your Practice TCPI

- **Overview and the Philosophical Underpinnings to SETMA's Website (www.jameslhollymd.com) which is SETMA's "Offer" to the Center for Medicare and Medicaid Services' (CMS) Transforming Clinic Practice Initiative (TCPI) By James L. Holly, MD**

Summation of SETMA's TCPI Website

- **Complete copy, with Index composed of hyperlinks, of all sections of SETMA's TCPI website**

CMS Quality 12.2015 TCPI

SETMA's Description of the TCPI Program

- Transforming Clinical Practices Initiative

  The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation. The initiative is designed to support more than 140,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely. It aligns with the criteria for innovative models set forth in the Affordable Care Act:

  - Promoting broad payment and practice reform in primary care and specialty care,
  - Promoting care coordination between providers of services and suppliers,
  - Establishing community-based health teams to support chronic care management, and
  - Promoting improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.

- The CMS Transforming Clinic Practice Initiative

  December 3, 2015 Your Life Your Health Examiner Column -- The initiative is designed to support clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely. It aligns with the criteria for innovative models set forth in the Affordable Care Act:

Prepared prior to the 2015 CMS Quality Conference and the TCPI Meetings

- CMS's Transforming Clinical Practice Initiative

  October 1, 2015 - Summary of Preparation for First Telephone Conversation with Christy Guillory, M.S., J.D., Senior Consultant for The Lewin Group concerning the

TCPI Program - the content was a follow-up to the discussion in our telephone conversation.

- November 13, 2015 Acceptance of Invitation to Address the Transforming Clinical Practice Initiative at CMS December 1-3 Healthcare Quality conference

  November 13, 2015 - Acceptance of Invitation to attend the TCPI Meeting December 1-3, 2015

December 1-3, 2015 TCPI and CMS Quality Meeting

- CMS' Transforming Clinical Practice Initiative, Response to December 1, 2015 Session in Baltimore, Maryland at the CMS Quality Conference

  After the first meeting of the TCPI Potential Faculty, December 1, 2015, this note was sent. It includes ideas about "story books," an example of clinical practice transformation, the end of the beginning (four seminal events), and others.

- Contributing to the library required for the success of TCPI, December 2, 2015

  Contributing to the library which will be necessary for the success of TCPI - Automated Team, SETMA's Model of Care, Summary of April, 2015 CMS/ONC meeting, Analytics, Process Analysis, Transforming Teamwork.

- TCPI information which may be helpful to PTNs and SANs

  Care Coordination, From Quantity to Quality, Activating and Engaging Patients through Trust and Hope, The power of Story Telling

- Disparities and Hope

  Response to a brief conversation about resolving disparities of care through the process of developing hope.

- What I Offer to TCPI - SETMA's website

  SETMA's "Offer" to CMS for the TCPI Program - SETMA's website

- TCPI, Director, Center for Clinical Standards and Quality, CMS

  Note to the TCPI, Director, Center for Clinical Standards and Quality, CMS, about SETMA

SETMA's Prior Contacts with CMS

- SETMA has experienced three overall functionalities required to meet the goals identified by CMS/ONC in this conference

  April 23, 2015 -- Team dynamic and Being a Learning Organization; Solid Philosophical Foundation, knowing both what we are doing and why we are doing it; Communication and integration of the healthcare team through the power of IT **--** "Most of us at one time or another have been part of a great 'team,' a group of people who functioned together in an extraordinary way - who trusted one another, who complemented each other others' strengths and compensated for each others' limitations, who had common goals that were larger than individual goals, and who produced extraordinary results. I have met many people who have experienced this sort of profound teamwork - in sports, or in the performing arts or in business. Many say that they have spent much of their life looking for that experience again. What they experienced was a learning organization. The team that became great didn't start off great - it learned how to produce extraordinary results."

- SETMA's Solution for CMS and ONC Meeting on Health IT to support ACO

  SETMA's Notebook Prepared for: CMS and ONC Co-hosting a Meeting on "Health IT to Support ACO and Group Reporting" -- A Note Book which was prepared for the April 23rd CMS/ONC meeting about ACO's and Analytics

- Letter to CMS Staff of April 23, 2015 ONC/CMS Joint Meeting Requesting Introduction to Person or Department to Discuss CMS Compliance with Physician Hospital Team Membership

  October, 2015 Letter seeking direction to CMS's Definition of team members working in hospitals; what RNs can and cannot do.

- The Value and the Power of the Healthcare Team: Answering Dr. Amy Townsend's Imperative

  Description of a Healthcare Team and the value of the members of the team -- The following is your charge to Dr. Anwar and to me. You stated that, ""I feel it is imperative for SETMA to give specific examples of how the RN taking call is able increase efficiency but yet remain compliant with the rules in the Nurse Practice Act." This is my response. In the midst of a months-long effort on the part of the Medical Executive Committees (MEC) of two Southeast Texas hospitals to limit the activities of registered nurses (RN), this is Dr. Townsend's question to SETMA; I shall attempt to answer it. The foundation of my answer began with SETMA's beginning and a significant aspect of the MECs' actions can be found in the history of physicians responses to nurses.

- Medical Home Magno CMS Question Medical Home Servicers Delivered by James L Holly, MD

  Letter to Ms. Linda M. Magno, Medicare Demonstrations Program Group, Centers for Medicare and Medicaid Services, Office of Research, Development and Information, for clarification of her comment in a March 3, 2010 as to CMS's definition of "Medical Home Services."

- CMMI Care Innovation Summit, Washington, D.C. January 26, 2012: Observations of an Attendee

  During the CMMI Summit, Dr. Holly responded to some of the presentations. In the introduction to the conference, reference was made to the participants. Repeatedly, the names of companies who make products were mentioned. Dr. Holly's comment was: "....(he) discussed "companies," "companies," "companies!!!" Companies **WILL NOT**, companies **CANNOT**, transform healthcare. Providers and Patients **WILL** make this transformation happen!!! "Healthcare reform can be top down and with enough pressure and regulation, reform can bring temporary change, but sustainable, permanent, self-perpetuating change requires transformation. Transformation comes from internalized values and personal passion, which operates independent of reform and which will in fact find reform slow, ponderous and inadequate. "Real change will require a dynamic partnership between government, private companies, academics and practicing healthcare providers. To imagine success while functionally ignoring the last group will result in either failure or at best partial success. "Top down will not work. Collaboration, dynamic partnership, between all four groups will get us where we want to be and it will keep us there. The best which reform demands cannot match what transformation will produce."

- CMS Medical Home Feedback Report Qualify & Cost

  With funding from the Centers for Medicare & Medicaid Services (CMS), RTI International, a nonprofit research organization, conducted a research study to analyze 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, they were 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.

  In January 2011, SETMA was invited to participate 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. To thank SETMA for

participating, RIT prepared the attached report summarizing information for SETMA's three clinics (SETMA I - Calder; SETMA II - College; Mark A. Wilson Clinic - Dowlew; providing comparative information with two groups: a bench mark group of non-Medical Home practices and the NCQA recognized Medical Home group.

RTI used Medicare fee-for-service (FFS) billing data as the information source. For practices with multiple practice sites, a report was produced for each practice site.

Payment Model Discussion with Texas Insurance Commissioner - November 1998

- Description of November 28, 1998 Testimony to Texas Insurance Commissioner

  November 1998 Testimony to the Texas Insurance Commissioner's Public Hearing. The unfolding of events in Austin at Public Hearing. This link is to the testimony I delivered to the Texas Department of Insurance Commissioner, 17 years ago. I am personally amazed at how this is as valid today as it was 17 years ago. There are a few factual differences but essentially SETMA has fulfilled the promise which this presentation made to the Commissioner.

- Responses to my September 25, 1998 Testimony to the Texas Department of Insurance Commissioner's Public Hearing -

  2015 responses to 1998 testimony - "Larry, you really are a prophet. Your observations in 1998 are spot on. You could update your 1998 remarks with a couple of value-based catch phrases, and it would be as good a description of cost-effective care as I have heard since joining Health Leaders last year. Always a pleasure hearing from you, Chris." - "Dear Larry, I am so pleased to be included in this circulation. Your paper was inspired then and is inspirational today. Especially for Australians grappling with a similar system to the one you worked in 17 years or so ago. It isn't surprising that robust principals survive the decades. My regards, Michael." - "Impressive---good medicine has not changed much---good ethics have become more inconsistent with the secular logic that is being applied--- good people practicing quality care remain the same." - "What a powerful message! Those very issues are about to become far more significant than many providers are prepared for." - "Larry. We had a cascade of meetings in the past 2 weeks and your name and thoughts were mentioned and highly praised from us all here." -- "Truly prescient!! Congratulations! Ken."

- Testimony before Texas Department of Insurance Proposed Financial Incentive Guidelines Austin, Texas, September 24, 1998 -

  Text of 1998 testimony to Texas Insurance Commissioner's Public Hearing. Mr. Commissioner, every physician who makes his or her services available to the public takes risk that no one will respond. And, society, whether as an agency of the government or as an agency of a private business, assumes the risk of paying for healthcare services for a defined population. The only way to eliminate risk - and indeed the only way to significantly reduce risk - is with a concomitant reduction in freedom. As physicians who have embraced the managed-care model of healthcare, we

want to be able to accept risk. And, we would ask you and your Department not to limit our ability to choose to take that risk. In the old healthcare system, where physicians were rewarded on the basis of how many units of work they produced, rather than how much health they created, and in a system where others had the responsibility for paying for that care, there were no checks or balances on utilization. In the old system...

Prepared in the Past Relevant to Practice Transformation

- The Joy of Medicine - The Imperative of Celebration:: The History of SETMA's Preparation for and Journey to ICD-10

  An illustration of celebration of an accomplishment which promotes success in the future. "The fourth seminal event was that we determined to adopt a celebratory attitude toward our progress in EMR. In May, 1999, my cofounding partner was lamenting that we were not crawling yet with our use of the EMR. I agreed and asked him, 'When your son first turned over in bed, did you lament that he could not walk, or did you celebrate this first milestone of muscular coordination of turning over in bed?' He smiled and I said, 'We may not be crawling yet, but we have begun. If in a year, we are doing only what we are currently doing, I will join your lamentation, but today I am celebrating that we have begun.' SETMA's celebratory spirit has allowed us to focus on the future through many lamentable circumstances and has allowed us to press forward through many disappointments. Focusing on our successes kept us moving forward and the cumulative effect was always success."

- CMS's Transforming Clinical Practice Initiative Michael Kinne Star Medicaid Introduction to SETMA

  SETMA and Care Coordination, Medical Home and Behavioral Health - The following statement which has no relevance for SETMA, """Providers, in the old days, used to discharge people into the community and had no idea what happened in the form of follow-up. With managed care companies, physical health was the focus, but there was nothing regarding behavioral or mental health**."**

Transformation Introductory Concepts

- Leadership: Character Traits Needed for Healthcare Transformation - The need for change by The Joint Commission

  Transformation of an Organization Requires Changes of and by Leadership -- The type of leadership needed from The Joint Commission and needed at the local organizational level is transformative because it is self-sustaining. With a reform/pressure philosophy, SETMA will only pay attention to the standards of The Joint Commission after the 18-month widow of no surprise visits passes, at the end of which we'll have to think about these things again, lest you "catch us" relaxing because the "pressure is off." Can you imagine the impact The Joint Commission could have

if rather than being an “overseer,” (as stated on your certificate), you embraced the organizations with which you work as the sustainers of “quality and safety” where both see each other as collaborators, colleagues and consultants rather than one as the sustainers of excellent (The Joint Commission) and the other (the practice, hospital or other organization) as the one who only pursued quality and safety as they were forced to by the oversight of The Joint Commission.

- Transforming 21st Century Healthcare Through The Power of Electronic Patient Management

  Transformation Through the Power of Electronic Patient Management -- The foundation of modern healthcare began before the 19th Century, but patient medical records really began in the 1800s. That history can be briefly summarized in three steps: 19th Century records, such as they were, were produced by pencil and paper. 20th Century records were produced at their best by dictation and transcription. With the advent of extensive technologically-based care and with expanded access to care, these methods became obsolete. **Even in the last quarter of the 20th Century, it became obvious that old methods of documenting, storing, sharing and using of healthcare information and of medical records were inadequate. In the 21st Century, excellence in medical records was going to be electronic.**

- The Place and Spirit of Accreditation Activities for Improving Healthcare which is Sustainable

  Accreditation and Transformation - Sustainability -- The Question: 2. You note that "The provider must be an extension of the family. This is the ultimate genius behind the concept of Medical Home, and it cannot be achieved by regulations, restrictions and rules." Are you implying by this statement that there is no role for "regs, rules, and restrictions", or simply that they are insufficient to sustain long-term change?

  The Answer: No doubt, as our accreditation efforts suggest, we believe that there is a key place for standards and guidelines. My point is directed at the government’s preoccupation with creating “change” with demands and dictates. I have said to the ONC often, “if you demand that everyone must do the same thing, the same way, every time, you will eliminate creativity, generative thinking and transformation. Tell us what you want done and let us demonstrate our unique way of doing it. Then evaluate it and find the ‘best practice or best solution’ and promote that.”

Value-Based Payment Model

- Value-Based Payment Models, Questions for the Industry, Health Leader Media, Answers By James L. Holly, MD April 2, 2015

What are the key factors for physician practices to consider when weighing involvement in value-based payment models?

1. Do they have the infrastructure to measure value?
2. Have they begun a cultural change to focus on value measurement?
3. Have they achieved or are they working toward achieving PC-MH recognition or accreditation and preferably are they committed to gaining both NCQA Tier III recognition and accreditation by one or more of the following: AAAHC, URAC, The Joint Commission and/or Planetree.
4. Do they recognize and accept the inevitability of value-based payment models as the future of healthcare. At the TEPR Conference, May 11, 2000, in San Francisco, California, addressed the reality, responsibilities and rights of healthcare providers. The following link is to the entire address: Managed Care and Electronic Patient Records.

- Value-Based Payment Models, Questions for the Industry, Health Leader Media, Answers by James L. Holly, MD April 15, 2015

Value-Based Payment Models, Questions for the Industry, Health Leader Media, Answers by James L. Holly, MD April 15, 2015. SETMA believes that the key to the future of healthcare is an internalized ideal and a personal passion for excellence rather than reform which comes from external pressure. Transformation is self-sustaining, generative and creative. In this context, SETMA believes that efforts to transform healthcare may fail unless four strategies are employed, upon which SETMA depends in its transformative efforts:

1. The methodology of healthcare must be electronic patient management.
2. The content and standards of healthcare delivery must be evidenced-based medicine.
3. The structure and organization of healthcare delivery must be patient-centered medical home.
4. The payment methodology of healthcare delivery must be that of capitation with additional reimbursement for proved quality performance and cost savings.

Leadership and Governance

Governance Board - the keys to a successful practice transformation are clear chains of command, identification of leadership, leadership responsibilities and leadership training:

- Administrative Organization Chart

- Governance Board Members

- Governance Board Responsibilities

- Governance Board Leadership Training
  Institute for Healthcare Improvement. High-Impact Leadership to fulfill the Triple Aim: Improve Care, Improve the Health of Populations and Reduce Cost.

Governance Board defines the corporate team, culture, mission, vision and goals

- The SETMA Team and The SETMA Culture

- SETMA's Mission, Vision and Goals: Patient Safety and Quality Care

- Harassment, Neglect, Abuse, Exploitation - Role of HCAHPS & CAHPS

Governance Board establishes Healthcare Provider Standards

- Provider's Responsibility
- Medication Refills, Reconciliation and Maintenance
- Provider and Leadership Use of Data and Analytics
- Commitment To All Patients -- Ethnic Disparities
- *Kaizen - Board Creates Culture of Safety and Quality*
- SETMA's Policy and Practice for Advanced Directives
- SETMA's Policy on Completion of Medical Records

Governance Board establishes duties of Executive Management

- Chief Executive Officer
- Chief Operations Officer
- Chief Information Officer

- Managing Partner

- Chief Medical Officer

- Chief Clinical Systems Engineer

- Chief Financial Officer

- Director of Operations

Governance Board established organization-wide Planning to Maintain Focus on Safety and Quality

- CMS Medical Home Feedback Report Qualify & Cost

- SETMA Awarded by HIMSS for Quality and Safety

- 2011 John M Eisenberg Patient Safety and Quality Awards - this award was not won by SETMA but the application explains SETMA's quality and safety programs.

- Healthcare Quality Award 2012

- Principles of Quality and Metrics

- Principles Contacting SETMA & Secure Texting

- PC-MH Mission, Vision, Goal, Access, End-of-Life

- Communications and Public Reporting

- Change Existing Processes to Improve Performance

- Team Members Focused on Safety and Quality

Governing Board establishes care guidelines, responds to sentinel events, manages all sites, and provides patients information about PC-MH

- Care Guidelines : Improve processes to evaluate and treat

- Integrated patient safety program (Sentinel Events)

- Effectively Manages all programs, services or sites

- Provides Patients with information about Primary-care Medical Home

Care Coordination

Generic information given to the patient, which is not personalized and/or which does not contain the patient's personal health information will usually be ignored. But, when the patient is given educational materials or instructions with their name on it and with their data in it, they will pour over it. This is why the structure of "care coordination" requires that the information given to a patient have the patient's name on it and that it includes the patient's personal information. One of the most teachable moments in medicine occurs when the patient returns to a follow-up visit, and with the previously given "plan of care' and "treatment plan" in hand, declares, "This information is wrong!" At this point, the patient is engaged and ready to learn. This statement does not glorify error, if error exists, but it does focus on the value of patient realization that their “reality” appears to them to be unreal.

The more important information is, the more probable it is that a person will forget that information, remember it incompletely, or be confused by it. This is particularly the case when the information is complex, containing unfamiliar terms and spoken to the patient only once and briefly.

It is at this "transitions of care" - when the patient leaves the point of care, which most often is the healthcare provider's office-- where "care coordination" is most critical. As a result, a poster now appears in all of SETMA's examination rooms and in strategic points around the clinic. It is called "The Baton," and it illustrates the necessity for the healthcare provider to "hand off" "the baton" to the next member of the team - the patient -- who is to carry the team's plans and purposes to the goal - improved or sustained health.

The following appears on the "Baton" poster:

"The baton" is a metaphor for the "plan of care' and a "treatment plan" which informs and empowers the patient to assume responsibility for his/her own care. In this context, the term "grasp" is apt, as the word refers both to physical and mental acts. The patient must not only receive "the baton' in the hand physically (grasp it), but must also comprehend the content of the "baton" mentally - "lay hold of it with the mind." If the patient "grasps" - understands, comprehends -- the "plan of care" and the "treatment plan," i.e., "the baton," and if the patient accepts - agrees to it and determines to carry it out -- the "patient/provider complex" is formed, completing the team and maximizing the opportunity for the team's success.

The patient/provider complex" is the essential element of success for effective healthcare action to be taken; particularly in the ambulatory setting. Without the formation of this element, at best the process will be incomplete and the outcome will only be partially successful. The "baton" is the key "care coordination" document which is the core of "care transitions."

Medical Home Transitions of Care: One Form of Care Coordination

- Transition of Care - One form of Care Coordination
    - Care Transitions - the Heart of PC-MH
    - Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan
    - Changing the name to clarify the function
    - Medical Home Plan of Care and Treatment Plan
    - Passing the Baton
    - Summary of Care Transitions
    - Care Transitions Data Set from PCPI
    - Transitions of Care Management Codling
    - Transitions of Care To Reduce Preventable Readmissions
    - Improving SETMA Care Transitions and Care Coordination

Coordination is the process of continuity of care. In the case of all documents created in the care of a patient, whether:

- Ambulatory disease management plan of care or treatment plan: Medical Home Plan of Care and Treatment Plan

- Automated Team Patient Engagement and Activation Document: Patient Engagement and Activation -- Patient Engagement and Activation Document

- Ambulatory care summary of care document

- Hospital Admission Plan of Care and Treatment Plan, what was once called the "discharge summary": Hospital Admission Plan of Care

- Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan: An Example of SETMA's Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. (De-identified)

Transforming Your Practice - Care Coordination

- A Care System for Effecting Reductions in Preventable Readmission Rates

  April, 2012 - Includes 15 links to other, related materials; 13 methods for reducing readmissions; The Baton; Lesions to Date.

- SETMA's Care Coordination Department's Functions

  At its founding in 2010, the Department had five functions. The following are a list of 12 "duties" performed by the Care Coordination Department at the beginning of 2013. Keep in mind that the Department's staff encounters many patient needs which are dealt with as they arise. These needs do not always fall into one of the following categories.

- SETMA's Care Coordination and Transitions of Care: Part I

  SETMA's work in coordinating care between inpatient hospital care, outpatient ambulatory, clinic care, long-term residential care, and SETMA's care coordination department activities.

- Patient-Centered Medical Home - Care Coordination and Coordinated Care

  January, 2011 - Traditional Care Coordination and its Seven Deficients.

- Medical Home Series Two: Part VII Care Coordination

  August, 2011 - Collaboration, Convenience, Comprehensiveness, Connection, Communication, Continuity, Integration of Care

- Medical Home Series Two: Part XII - National Quality Forum and Care Coordination

  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."

- Medical Home Series Two: Part XIII - National Quality Forum and Care Coordination Part II

  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.

- SETMA's Inpatient Team Based Process Analysis: The Interaction of SETMA's Hospital Care Team - Collegiality and "Electronic Huddles"

  January, 2013 -- It is for this reason that SETMA has come to believe that while a personal relationship with a healthcare provider is valuable, ultimately the ideal of continuity-of-care is maintained by the EHR being available at every point-of-care and that the care at all points of care is documented in the same data base. The personal relationship is important to provider and patient, but patient safety and the goals of the Triple Aim (improved processes, improved outcomes and sustainability or lower cost) are supported more by the common data base than by the personality of the provider.

- Medical Home Part IV: Help and Hope in Healthcare

  March 12, 2009 -- The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and highly-functioning medical organization is the concept of Coordination of Care. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current

NCQA, CMS, national standards and HEDIS requirements for demonstration of excellence in the providing of care.

- From Homicidal Threat to Reciprocal Caring: A Patient-Centered Journey

  October 6, 2012 -- It was October 13, 2009. The morning was cold and raining - well, not really, but isn't that the way every story should start? When I arrived at the hospital early in the morning, I had a number of patients to see. On the South Tower, I was met by several nurses, who said, "You can't go into room_____." I asked why and they added because the patient said that he will kill the next doctor who comes into the room. I asked, "Does he have a gun?" They did not think so. I said, "Then let's go see him."

- Medical Home Part III: Requirement Number 1 of 28

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

HIPPA and Security

- Medical Records: Is it Secure?

  January, 2001 -- Once you are confident that your medical records contain all of the information needed (see Your Life, Your Health, Examiner, January 12th and 17th) , you want to be sure that only those who have the "right or responsibility" to know your medical history have access to it. In the past, the security of your medical record consisted of the lock on your doctor's office door and the receptionist who sat at the front desk in the doctor's office. No one thought much about how many people had uncontrolled access to the medical records because in reality most people are honest and wouldn't read someone else's record. With the advent of electronically stored data, i.e., electronic medical records (EMR), this has changed. All of the functions and capacities which our previous articles identified as essential for 21st Century medical records can only be achieved with EMR. This means that now the issues of security of your medical record and the confidentially of that record requires new levels of access control.

  While electronic medical records are more secure than the old paper charts, new initiatives are being undertaken to insure the continued improvement in that security and the guarantee of the confidentiality of those records.

  A humorous anecdote illustrates these points. When making the decision to migrate to EMR, SETMA's founding partners attended the Medical Group Management Associates annual meeting in Washington, D.C. During one of the sessions at this 1997 conferences, a representative of an EMR company related her experience while making a presentation to a group of hospital administrators in a large mid-western city. Close to the end of her discussion, the elder statesmen of the administrators confronted her and said, "Young lady, you can't make your electronic stored medical records more secure than our paper records!" He was aggressive, adamant and loud. Realizing that her success potential was waning rapidly, she assured this gentleman that the electronic records were more secure than his paper records. He persisted, repeatedly making the same point: your electronic records can't be as secure as our paper records. She attempted to convince him without success. Finally, with an instantaneous change in his facial expression -- a smile now broke out on his face -- he said, "Young lady, we can't

find our medical records, you can't make them more secure than that!" The entire audience broke out into laughter, and the speaker breathed a sigh of relief.

- Health Insurance Portability and Accountability Act (HIPAA) Privacy Tutorial

  If the Federal HIPAA requirements were not difficult to interpret and to comply with, the Texas Legislature in 2011 passed Texas HB300 which increased that complexity geometrically. Effective September 2014, all Texas Healthcare practitioners were required to renew their employee HB300 certification. That certification has to be renew every two years after that. The details of the requirements of Federal HIPAA Primacy and Texas HB300 are given below. The major problem faced by a large medical practice is the number of patient charts which are requested daily by insurance companies and other covered entities. If a practice receives 200 requests a day compliance with Privacy Regulations means we must examine every chart for information which requires special handling. That special handling may involve getting a more inclusive permission from the patient or patient's power-of-attorney before the information can be released even for the most common and simple reason. Because a chart can contain hundreds of pages and because the privacy issues apply even to Chronic Problem Lists, we needed an automated means of examining charts. Those which require special handling can be set aside while others can be sent out immediately. Because the Texas Privacy requirements are much more restrictive than the Federal Law, if you comply with Texas, you automatically comply with the Federal regulations.

- Is Your SETMA Medical Record Secure?: Part I

  September, 2012 -- This two-part series explains SETMA's active program for securing the medical information entrusted to us by our patients. It is critical that the safety, security and the confidentiality of that information be kept safe and available. This is both a professional and a legal obligation. This review lets all of patients know how seriously we take this responsibility.

- Is Your SETMA Medical Record Secure?: Part II

  The complexity of SETMA's systems requires that we depend on software produced by many different companies, like Microsoft Windows, Microsoft SQL, Microsoft Exchange, Adobe Reader, Adober Flash, Java, Cisco IOS, etc. Each of these products is used heavily in the IT industry. Keeping systems updated with the latest patches and firmware is critical but challenging. However, not doing it also increases the opportunity for data breeches, or for inappropriate access. It would take numerous employees to keep checking our system to make sure there are no security risks or updates we have overlooked. But, the problem created by technology, i.e., security can also be solved by technology.

  SETMA has incorporated a device in our system which at regular intervals scans our system. This product is named Nexpose by Rapid7 and is considered the enterprise

leader in vulnerability management and penetration testing. It continually looks at all software in our system. It regularly sends a report to SETMA's CIO about new versions or upgrades of the software that we use. It tells the CIO that SETMA is on one version and another is available. Included in that report, is an assessment of the value of the upgrade and the security risk of not upgrading to the new version. The risk is graded as moderate, severe and critical.

Since deploying this tool, SETMA has found almost 9,000 such security risks which were vulnerable to attack. Most of these were because outside entities we interact with do not keep their systems updated. In order to allow our systems to work together, we had to leave our systems on older software. SETMA's CIO was instructed by the SETMA Partners to secure our systems regardless of whether or not it broke our ability to interact with others. The others would either be forced to upgrade their systems, or we would find other vendors to replace them, i.e., vendors that properly secured their systems. Within one 27-hour weekend period, SETMA's IT department reduced the almost 9000 vulnerabilities to just under 2000. Within the next week, the vulnerabilities were down to 1100. That accounts for 87% of the vulnerabilities being eliminated in only one week. SETMA IT Department is actively addressing the remaining issues and expects to have them to zero within the next four weeks. Going forward, the scanning system will alert us to new issues which will be able to be remedied immediately.

- SETMA's Provider Training for September, 2013

  September, 2013 -- A presentation by **SETMA's Chief Information Officer** on SETMA's extensive and continuing HIPPA Compliance Program and our IT information and data security program.

- Notice of Privacy Practices

  Southeast Texas Medical Associates, **Notice of Privacy Practices, Effective Date: February 1, 2015, Privacy Officer: Margaret Ross, RN, MSN, 2929 Calder Ave, Suite 100, Beaumont Texas, 77702, 409-833-9797,hipaaprivacy@jameslhollymd.com.** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Your Rights -- You have the right to:

  - Get a copy of your paper or electronic medical record
  - Correct your paper or electronic medical record
  - Request confidential communication
  - Ask us to limit the information we share
  - Get a list of those with whom we've shared your information
  - Get a copy of this privacy notice
  - Choose someone to act for you
  - File a complaint if you believe your privacy rights have been violated...

- Principles Contacting SETMA & Secure Texting

  iMessage traffic is encrypted, only readable for the two end users and therefore HIPAA compliant. You can tell when a message is being sent using iMessage because it will show in **blue** and not **green**...

- SETMA September Provider training HIPAA and Security

  The Security Rule: Establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. Requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information. Requires Policies and Procedures Requires Annual Risk Analysis Requires Implementation of certain technologies.

Data Analytics

- The Importance of Data Analytics in Physician Practice

  March, 2012 Presentation to Massachusetts Medical Society on the "Important of Data Analytics in Physician Practice," Analytics transform knowledge into an agent for change. In reality, without analytics, we will neither know where we are, where we are going or how to sustain the effort to get there. For transformation to take place through knowledge, we must be prepared to ask the right questions, courageously accept the answers and to require ourselves to change.

- Abraham Lincoln and Modern Healthcare

  Contained within Abraham Lincoln's famous "House Divided Speech," delivered to the Republican Convention on April, 16, 1856, is the imperative for data analytics and performance auditing by healthcare providers today. Lincoln said, "If we could first know where we are, and whither we are tending, we could better judge what to do, and how to do it,". (Quoted by David Eisenhower in the Foreword to *Churchill: The Prophetic Statesman*, by James C. Humes, Regnery, New York, 2012) In any human enterprise, if the participants are unwilling to objectively and honestly face where they are, it is improbable that they will ever get to where they want to be, let alone to where they should be.

- Patient-Centered Medical Home: The Power of Data in Designing the future of healthcare

  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.

- Patient-Centered Medical Home and Care Transitions: Part I

  As the nation grapples with the theory of the future of healthcare, some of us are experimenting not only with ideals but with practical solutions. At SETMA, we believe that the future of healthcare has four domains, which must be addressed in any solution which will be sustainable. They are: The Substance -- Evidenced-based medicine and comprehensive health promotion; The Method -- Electronic Patient Management; The Organization -- Patient-centered Medical Home; The Funding -- Capitation with payment for quality outcomes.

- Business Analytics and Your AQ

  April, 2011 -- During the drive from Austin to College Station on Friday, Dr. Holly conducted a one-hour conference call with seven IBM executives to discuss a new initiative which IBM is working on called, "What is your AQ, or Analytics Quotient." Of this, IBM said, "We are promoting how our best customers use business analytics to extend the value of their information, gain new insights, increase collaboration and in some cases understand risks. These are companies where senior and executive management are engaged in utilizing this information to improve their operations, extend visibility and drive profitability. Following is a maturity model to give you a bit more information on the Analytics Quotient journey to improved performance."

- Transforming Healthcare: Public Reporting of Provider Performance on Quality Measures

  December, 2009 -- We have already stated that accountability and transparency are the principal reasons for public reporting of our performance, but there is more to accountability and transparency in healthcare than that. We b believe that public reporting of quality performance will change provider and patient behavior. Typically healthcare providers only receive delayed, retrospective reviews of their performance, which does not change behavior significantly, in our judgment. In the Old Testament, a verse declares that "because punishment against an evil deed is delayed, the hearts of men are set upon doing evil." The principle is that without immediacy between the consequences and/or evaluation of an action and the action itself, the potential for the consequence to effect positive change is diminished or eliminated. While auditing provider performance is never for punitive reasons, the principle is the same. If the reporting of the results is significantly removed in time from the events being audited, it will have little impact upon provider behavior.

- 2010 - SETMA and the Future

  Since 1998, Southeast Texas Medical Associates, LLP (SETMA) has been involved in the transformation of healthcare delivery through the deployment of an electronic health record (EHR). In 1999, we realized that EHR was too expensive and too difficult if all we were to achieve in the process was an electronic methodology for documenting a patient encounter. As a result, we adopted the goal of "electronic patient management"

(EPM), which we define as the ability to leverage the power of EHR to improve healthcare processes and outcomes.

- Patient-centered Medical Home SETMA's COGNOS Project

  October, 2009 -- Perhaps the most important aspect of being recognized as a Patient-Centered Medical Home is the ability to examine patient-care data in order: to change provider and patient behavior; to change procedures and processes in the practice; and, to provide patients with information about, and strategies for improving or preserving their health. The organization and analysis of raw data obtained in the care of patients can produce information on the basis of which decisions, treatment plans, and plans of care can be provided to patients. These materials can help patients take charge of their own care and become actively involved in the management of their own health.

- COGNOS and SETMA - Why and What is our goal?

  What is the purpose of the COGNOS project? Why are we doing this? The cost of COGNOS, the licenses and the customization of the data mart and audits is not inconsequential. Why would SETMA's partners do such a thing? First, we want to know what we are doing. Without auditing our performance, we will never know how we are performing. The COGNOS Project will allow us to objectify our performance. We will no longer "think" we are doing well; we will know if we are doing well. Second, we want to improve what we are doing. Evidenced-based medicine with the treatment targets established by science can tells us where we want to be. If we know where we are and if we know where we want to go, we can design and way to get there. Third, when we know that a patient is not treated to target or to goal, we want to know why. COGNOS will allow us to know if evidenced-based standards of care are being employed. If they are, and if the patient is still not to goal, it will allow us to address hindrances and/or obstacles to the patient getting to goal...

- AHRQ - Ethnic Disparities in Care

  June, 2010 -- One of our major quality initiatives this year is to totally remove ethnic disparities in the care of diabetes, hypertension and dyslipidemia. Our experience is that several issues contribute to the disparities. These include: Access to care which is a healthcare structure problem. This includes the lack of insurance and/or inadequate insurance. Also, it includes the lack of healthcare providers who are willing to take on complex patients. And, as is illustrated below, it sometimes is the result of Health and Human Services rules through CMS which creates gaps in care. Co-morbidities particularly obesity, tobacco, inactivity and sometimes alcohol. Personal resources which limit access to gymnasiums, healthy nutrition, education, medications, etc. Cultural predilection for foods and habits which contribute to many of the above. Limited access to dental care. Fragile social, economic and health infrastructures.

- SETMA -- HIMSS Stories of Success: Part I -- Improving Population Healthcare and Safety Through Real-time Data access, Auditing and Reporting

  (Editor's Note: The Health Information and Medical Management Society (HIMSS) is the largest medical-information-technology organization in the world. Their annual meeting which ended today attracts over 15,000 people. Dr. Holly serves on several key committees with HIMSS. In 2006, SETMA was award the HIMSS Davies Award (see www.jameslhollymd.com -- *In-the-News*) which is the most prestigious award for innovation and development in electronic medical records. HIMSS Stories of Success is in its second year. It is a highly prized program with Tier 1 (the highest) and Tier II designations. For 2011, SETMA has been awarded Tier I HIMSS Stories of Success, and is only one of two organizations so designated. This two-part series is a summary of the content which resulted in this award.)

- SETMA HIMSS Stories of Success: Part II -- Improving Population Healthcare and Safety Through Real-time Data access, Auditing and Reporting

  Through its EHR and BI data management tools, SETMA has eliminated any uncertainty about whether it is meeting national quality standards - and its providers no longer need to wait months to receive quality reports from payers. COGNOS software allows every provider to examine performance at the point-of- service on over 200 quality metrics, including age-appropriate screening and preventive care needs. The discrete data capture capabilities of SETMA‘s EHR are used to measure, on a daily basis, each individual physician‘s performance of -best practice- standards against every applicable healthcare quality measure available. Before a patient is seen, for example, his or her chart is searched to determine if all HEDIS, NQF, PQRI, PCPI, AQA or NCQA standards have been met. Nurses independently initiate the completion of preventive and screening services according to age requirements.

Care Transitions

Generic information given to the patient, which is not personalized and/or which does not contain the patient's personal health information will usually be ignored. But, when the patient is given educational materials or instructions with their name on it and with their data in it, they will pour over it. This is why the structure of "care coordination" requires that the information given to a patient have the patient's name on it and that it includes the patient's personal information. One of the most teachable moments in medicine occurs when the patient returns to a follow-up visit, and with the previously given "plan of care' and "treatment plan" in hand, declares, "This information is wrong!" At this point, the patient is engaged and ready to learn. This statement does not glorify error, if error exists, but it does focus on the value of patient realization that their “reality” appears to them to be unreal.

The more important information is, the more probable it is that a person will forget that information, remember it incompletely, or be confused by it. This is particularly the case when the information is complex, containing unfamiliar terms and spoken to the patient only once and briefly.

It is at this "transitions of care" - when the patient leaves the point of care, which most often is the healthcare provider's office-- where "care coordination" is most critical. As a result, a poster now appears in all of SETMA's examination rooms and in strategic points around the clinic. It is called "The Baton," and it illustrates the necessity for the healthcare provider to "hand off" "the baton" to the next member of the team - the patient -- who is to carry the team's plans and purposes to the goal - improved or sustained health.

The following appears on the "Baton" poster:

"The baton" is a metaphor for the "plan of care' and a "treatment plan" which informs and empowers the patient to assume responsibility for his/her own care. In this context, the term "grasp" is apt, as the word refers both to physical and mental acts. The patient must not only receive "the baton' in the hand physically (grasp it), but must also comprehend the content of the "baton" mentally - "lay hold of it with the mind." If the patient "grasps" - understands, comprehends -- the "plan of care" and the "treatment plan," i.e., "the baton," and if the patient accepts - agrees to it and determines to carry it out -- the "patient/provider complex" is formed, completing the team and maximizing the opportunity for the team's success.

The patient/provider complex" is the essential element of success for effective healthcare action to be taken; particularly in the ambulatory setting. Without the formation of this element, at

best the process will be incomplete and the outcome will only be partially successful. The "baton" is the key "care coordination" document which is the core of "care transitions."

Medical Home Transitions of Care: One Form of Care Coordination

- Transition of Care - One form of Care Coordination

1. Care Transitions - the Heart of PC-MH

2. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan

3. Changing the name to clarify the function

4. Medical Home Plan of Care and Treatment Plan

5. Passing the Baton

6. Summary of Care Transitions

7. Care Transitions Data Set from PCPI

8. Transitions of Care Management Codling

9. Transitions of Care To Reduce Preventable Readmissions

10. Improving SETMA Care Transitions and Care Coordination

- HiMSS-2012 Care Transitions: The Heart of Patient-Center Medical Home

  Analyze the process of a desired outcome by designing and deploying an IT solution to support Care Transitions from inpatient hospital to ambulatory care; Demonstrate how IT solutions can aide in dealing with barriers to care in the transition from hospital to ambulatory care; Demonstrate the place of care coordination in Care Transitions; Demonstrate the place of auditing of performance in sustaining effective care transitions; Demonstrate the place of a healthcare delivery team in an IT solution to care transitions.

- HIMSS 2012: Leaders and Innovators Breakfast Meeting

  Innovators Breakfast -- Convenience is the New Word for Quality

- SETMA's video submitted to the Robert Wood Johnson Foundation's Video Contest

  November, 2012 -- The Institute for Healthcare Improvement's Triple Aim is to improve care, improve health and decrease cost. A difficult problem in healthcare is the frequency of 30-day readmission to the hospital. Often the cause for readmission are related to medication problems and to poor care transitions. SETMA has designed a care transition program which combines the forces of a hospital care team with informatics and care coordination to: -- A two minute video presentation of SETMA's Transition of Care is accessible through this link.

- A Care System for Effecting Reductions in Preventable Readmission Rates

  April, 2012 - News Letter from Readmissions News features SETMA Transition of Care program.

- SETMA and the National Quality Forum

  NQF responded with the following invitation: "Thank you as well for sending along this useful and encouraging information on care coordination. I see you have registered as part of our audience, which is an open invitation extended to all NQF members. Allow me to offer you a formal initiation to attend the workshop as an invited content expert in this field and to participate in the round table discussions we will be having. Assuming this is agreeable we will send you along additional logistics." During that conference, it became apparent that one fundamental flaw in healthcare is the name used for the hospital summary of care It is currently called a "discharge summary," and is essentially an administrative document required to complete the patient's record. However, when seen in its "real" purpose, this document would better be entitled, "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." SETMA has made that name change and is benefiting from the new and clearer understanding of the rationale for this document.

- Patient-Centered Medical Home and Care Transitions: Part I

  April, 2011 -- We immediately changed the name of that document 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. From June, 2009 to April, 2011, SETMA has a 99.1% rate of completing this document at the time the patient leaves the hospital. During this time we have discharged 6,147 patients from the hospital.

- Patient-Centered Medical Home and Care Transitions: Part II

  "The Baton" is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race. It is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares: 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.

- Passing the Baton: Effective Transitions in Healthcare Delivery

  In healthcare there are transition points-of-care, where the "baton", which now represents the transfer-of-care responsibility from one person to another, must be smoothly, efficiently and timely accomplished, or the value of the care provided by each care giver will be diminished to the point that the overall quality of care may be less than the sum of the contributions of each care giver. This diminishing of the value of care occurs when only a small part of the value of each participant's contribution is successfully transferred to the next point-of-care. This occurs when the "baton" is dropped.

- SETMA's Inpatient Team Based Process Analysis: The Interaction of SETMA's Hospital Care Team - Collegiality and "Electronic Huddles"

  January, 2013 --- SETMA's team approach to inpatient care is a success as demonstrated by the facts that our lengths of stay, quality metrics, cost of care and patient satisfaction are excellent. And, it is one of the reasons why the indigent, uninsured and unassigned patients for whom we care receive the same quality of care as our private patients. I would offer the following observations about SETMA's team. SETMA has licensed and credentialed healthcare professionals who work to the top of, but not beyond their legal scope of practice as defined by each of their accreditation agencies.. As a policy issue, the prestigious and influential *Health Affairs* publication of January 14, 2013, published an extensive article entitled, *Primary Care Physician Shortages Could Be Eliminated Through Use Of Teams, Non-physicians, And Electronic Communication*" The goal of this transformation is the

integrate the teams to increase their efficiency, excellence and economy This is what SETMA started eighteen years ago.

- Reducing Preventable Readmissions to the Hospital

  July, 2012 Study on Readmissions and their Prevention

- Medical Home Series Two: Part VI Care Transitions

  One of the principle elements of continuity of care is 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: Hospital inpatient to Ambulatory Outpatient; Ambulatory outpatient clinic to ambulatory outpatient home; Hospital inpatient to long-term, residential care (Nursing Home); One provider to another.

- CMMI Care Innovation Summit, Washington, D.C. January 26, 2012: Observations of an Attendee

  During the CMMI Summit, Dr. Holly responded to some of the presentations. In the introduction to the conference, reference was made to the participants. Repeatedly, the names of companies who make products were mentioned. Dr. Holly's comment was: "....(he) discussed "companies," "companies," "companies!!!" Companies **WILL NOT**, companies **CANNOT**, transform healthcare. Providers and Patients **WILL** make this transformation happen!!! "Healthcare reform can be top down and with enough pressure and regulation, reform can bring temporary change, but sustainable, permanent, self-perpetuating change requires transformation. Transformation comes from internalized values and personal passion, which operates independent of reform and which will in fact find reform slow, ponderous and inadequate. "Real change will require a dynamic partnership between government, private companies, academics and practicing healthcare providers. To imagine success while functionally ignoring the last group will result in either failure or at best partial success. "Top down will not work. Collaboration, dynamic partnership, between all four groups will get us where we want to be and it will keep us there. The best which reform demands cannot match what transformation will produce."

- The Future of Healthcare - SETMA's View

  In 1949, George Orwell wrote a book entitled *1984*, which year came and went. In the year 1984, the movie *2010* was released and now we approach that year. More of the science fiction of the latter movie has become reality in the intervening 25 years than have the dire predictions of Orwell in his 60-year-old prophesy. As we approach the beginning of the second decade of what only recently was a new century, I pause to think about the past and the future. In 2010, SETMA will celebrate fifteen years since its founding. Only one of the founding partners' remains and sadly in March of the New

Year, we will experience the one-year anniversary since the death of our dear friend and colleague, Mark A. Wilson.

LESS Initiative

- Less Initiative: SETMA

  Lose Weight, Exercise, Stop Smoking: Shared Responsibilities -- The LESS Initiative is dependent upon the sharing of responsibility by the various members of SETMA's healthcare team:

  - The IT team (Information technology) has to make it possible to easily and conveniently produce the documents and to audit the performance.
  - The Nursing and support staff have to collect the data - weight, height, waist size, abdominal girth, hip measurements, neck size, chest size, body fat, etc. - which allows the computation of the information used in determining the patient's health risk.
  - The Nursing Staff have to create, print and distribute the documents, as well as initiate the discussion with the patient of the information in each.
  - The Healthcare Providers - physicians and nurse practitioners - have to interact with the patient about the imperatives for change which are indicated by the information in the document, discussing with the health risks of doing nothing and the health benefits of changing the lifestyles...
  - The Nurse Management Staff must audit the charts at the end of the day to make certain that this has been done. It has been established that a 95% effectiveness is the standard for determining success.

- http://www.jameslhollymd.com/epm-tools/Tutorial-LESS

  The first event led to the LESS. We concluded that EHR was too hard and too expensive if all we gained was the ability to document an encounter electronically. EHR was only "worth it," if we leveraged electronics to improve care for each patient; to eliminate errors which were dangerous to the health of our patients; and, if we could develop electronic functionalities for improving the health and the care of our patients. We also recognized that healthcare costs were out of control and that EHR could help decrease that cost while improving care. Therefore, we began designing disease-management and population-health tools, which included "follow-up

documents," allowing SETMA providers to summarize patients' healthcare goals with personalized steps of action through which to meet those goals. We transformed our vision from how many x-rays and lab tests were done and how many patients were seen, to measurable standards of excellence of care and to actions for the reducing of the cost of care. We learned that excellence and expensive are not synonyms.

After developing, several disease management tools, we realized that in the plan of care for each, we identified three life-style changes which we wanted everyone to make. One of them was to stop smoking. Whether it was for diabetes, cholesterol, hypertension or others, it was critical that our patients decrease the inflammatory burden on their cardiovascular systems by avoiding primary, secondary and now tertiary tobacco products. We want patients to decrease their risk by losing weight and to increase their cardiovascular health with routine, regular aerobic exercise, strengthening and stretching exercise.

To address these issues with one patient is not problem, but how to do it with 400+ patients a day and how to know that you are doing it, is a different matter. As a result we designed the LESS Initiative (Lose weight, exercise, stop smoking). The program included a diabetes risk assessment, a diabetes screening assessment and a hypertension prevention program.

This tutorial explains the LESS and other tutorials explain the Diabetes and Hypertension Prevention programs. Those can be found on the web site under Prevention Tools, also.

- SETMA's LESS Initiative and AHRQ Health Care Innovations Exchange

  The **Agency for Healthcare Research and Quality** (AHRQ) has created the AHRQ Health Care Innovations Exchange. AHRQ explains the goal of the exchange: **The Innovations Exchange helps you solve problems, improve health care quality, and reduce disparities**.

  - **Find** evidence-based innovations and Quality Tools.
  - **View** new innovations and tools published biweekly.
  - **Learn** from experts through events and articles.

  There are presently over 500 innovation s and quality tools published by AHRQ. There is a rigorous application process to have an innovation accepted and then professional writers prepare the description of the innovation for publication on the Exchange. AHRQ has accepted and has posted SETMA's LESS Initiative for publication on the Innovation Exchange. SETMA's LESS Initiative is completed on all patients who come to SETMA.

- LESS Initiative: Response to Beaumont Enterprise Article on the Less Initiative

The healthcare providers and staff of Southeast Texas Medical Associates (SETMA) wish to thank Enterprise Health Affairs writer Ms. Becky Bowman for her piece on SETMA's LESS Initiative. The positive benefits of this program far outweigh the "threat" of firing a patient who refuses to quit smoking. One patient, seen a month ago, called to say, "After receiving the weight management assessment, exercise prescription and smoking cessation materials at SETMA, I have been watching what I eat, walking and making more health-conscience decisions. I feel better that I have ever felt and have really enjoyed reading all the information that was given to me at my/her visit. In only a month, I have noticed a change and I am excited about the future."

- Less Initiative: Response to Letter to the Editor about **Less Initiative** Article

  SETMA's LESS Initiative with the potential of dismissing a patient was characterized as absurd by Shane Martinez. The question raised by Martinez is reminiscent of the following comment on the nature of warning: "Is admonition in a time of peril as authentic an expression of love as assurance in a time of uncertainty? Absolutely! The difficult thing about admonition is that it is rarely recognized as an expression of love. But love must sometimes admonish. The tone of it does not sound like love." (J. W. MacGorman, 1981)

  If a bridge is out and a 200-foot fall to certain death awaits the traveler, is it kind to wave and shout, "Have a nice day?" Or, should caring dictate that you stand in the way and shout, "Stop"?

  No business wants to offend or lose customers, but as healthcare providers, we must put the health and well-being of our patients above our business interests, even to the point of refusing to continue to enable them to be comfortable in self-destructive habits whether smoking, overeating, alcoholism, neglect of exercise or other. None of us is perfect and at SETMA we do not require perfection, but we do require a good faith effort to improve your health. If you do not make that effort, we will stand in your way and shout, "Stop!" That is "love in its urgency." That is good medicine and that is effective caring for others.

  The Less Initiative is critical to the care of patients with diabetes, hypertension and Cardiometabolic risk syndrome. The following materials address details of Cardiometabolic Risk:

  1. Cardiometabolic Risk Syndrome Part I: Introduction

     One of the most interesting "syndromes" in medicine and one which affects more people than are aware of it has been known by several different names. You may already be suffering from this syndrome which is often overlooked. It's not a deadly new virus, cancer, or heart disease. It's a disease, surprisingly enough, caused by your body's inability to make the most of the food you eat. It is estimated that over 43,000,000 Americans have this condition.

Because this syndrome is so common and because it is so complex, this week's article will begin a serious of articles which will address each element of the syndrome. If you will bear with us, I believe by the end of this series you will understand a great deal more about how to improve your health and about how to ask your healthcare provider for special attention to this syndrome and its impact upon your health.

This syndrome was first called "Syndrome X"; then it was called "Insulin Resistance Syndrome," because it is thought that the an abnormal response to insulin is the principle causative factor in the condition. However, because it is associated with a number of metabolic abnormalities, it became known as the "Metabolic Syndrome". It has also been called "The Deadly Quartet" in recognition of the four underlying elements of the condition.

However, because of this syndrome's contribution to the rise of heart disease, the American Diabetes Association (ADA) has embarked upon a campaign to change the name again to "Cardiometabolic Risk Syndrome". The ADA's Cardiometabolic Risk Initiative (CMRI) is a national effort that stresses the association between diabetes, heart disease, and stroke. CMRI encourages physicians and the public to adopt cardiometabolic risk (CMR) as an umbrella term that will help them better understand and manage all cardiovascular and diabetes risk factors.

2. Cardiometabolic Risk Syndrome Part II: Insulin Resistance

3. Cardiovascular Disease Risk Factors - Part III - Obesity

4. Cardiometabolic Risk Syndrome Part IV: Endothelium Dysfunction

5. Cardiometabolic Risk Syndrome Part V: Fibrinolytic Dysfunction

6. Cardiometabolic Risk Syndrome: Part VI: Plasminogen Activator Inhibitor I

7. Cardiometabolic Risk Syndrome Part VII: Inflammation - chronic, low-grade

8. Cardiometabolic Risk Syndrome Part VIII: C - Reactive Protein

9. Cardiometabolic Risk Syndrome Part IX: Pro-inflammatory and Anti-inflammatory Diet

10. Cardiometabolic Risk Syndrome Part X: Inflammation Altered by Diet

11. Cardiometabolic Risk Syndrome Part XI - Healthy Eating: The Age of Nutrionism

The following articles carry the Cardiometabolic risk syndrome and the Less Initiative into specific cardiovascular risk factors.

1. Cardiovascular Disease Risk Factors - Part I - Introduction

2. Cardiovascular Disease Risk Factors - Part II - Sedentary Life Style

3. Cardiovascular Disease Risk Factors - Part III - Obesity

4. Cardiovascular Disease Risk Factors - Part IV - Smoking

5. Cardiovascular Disease Risk Factors Part V - Cholesterol

6. Cardiovascular Disease Risk Factors - Part VI - Hypertension

7. Cardiovascular Disease Risk Factors - Part VII - Combined Factors which Begin in Childhood

8. Cardiovascular Disease Risk Factors - Part VIII - C-Reactive Protein

9. Cardiovascular Disease Risk Factors - Part IX - Family History

10. Cardiovascular Disease Risk Factors - Part X - Psychosocial Stress

11. Cardiovascular Disease Risk Factors - Part XI - Age

12. Cardiovascular Disease Risk Factors - Part XII - Insulin Resistance

13. Cardiovascular Disease Risk Factors - Part XIII - Gender - Part 1

14. Cardiovascular Disease Risk Factors - Part XIV - Gender - Part 2

15. Cardiovascular Disease Risk Factors - Part XV - Addendum: Questions and Answers About Estrogen Replacement and Heart Disease

Medical Records

- More Than a Transcription Service: Revolutionizing the Practice of Medicine: And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) which Evolves into Electronic Patient Management

  May, 1999 -- When I was a child, medical records were kept on a 3x5-file card. The information essentially reflected the date and a one-word statement of what transpired in the visit to the doctor, often related merely to a shot or medicine, which was given. Patients paid a dollar for the visit, a dollar for the shot and a couple of dollars for the medication. Expectations were low and expenses were, also. The physician kept most of the important patient information in his/her head. Therefore, when the physician wasn't available, data on the patient wasn't available. This system was extremely personal and was often very satisfying for the patient and the physician. When I was born, Dr. Culpepper was my family doctor. In 1949, my family moved and did not use Dr. Culpepper as a physician again. In 1973, when I graduated from medical school, I called Dr. Culpepper and said, "Dr. Culpepper, I wanted to say hello and tell you I have graduated from medical school." Dr. Culpepper was in his early eighties and said spontaneously, "How are Bill and Irene," calling my parents by their first names, after not having seen them in 24 years. Dr. Culpepper had a wonderful mind, but it could only be in one place at a time. For a PDF copy of this article, see: Revolutionizing the Practice of Medicine And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) which Evolves into Electronic Patient Management .

- May, 1999 -- Four Seminal Events in SETMA's History

  Formed August 1, 1995, Southeast Texas Medical Associates, LLP (SETMA) recognized that excellence in 21st-Century healthcare was not possible with 19th-Century medical-record methods, i.e., pencil and paper, or with 20th-Century methods, i.e., dictation and transcription. Therefore, eighteen years ago, SETMA began the process of adopting an electronic medical record (EMR). In October, 1997, SETMA examined over fifty EMRs. On March 30, 1998, writing a $650,000 check, SETMA purchased the EMR which we currently use. Eighteen years ago many thought that was a mistake, as in those early days healthcare providers had to develop the content of the EMR themselves. We had bought an empty box. Therefore, it was Tuesday, January

26, 1999 before we began using the EMR to document patient encounters, but by Friday, January 29, 1999, all patient visits were documented in the EMR. In 1996, SETMA also believed that 21st Century healthcare was going to be driven by quality performance and SETMA rejected the old model of care where the healthcare provider was the constable imposing health upon a passive recipient, the patient. Therefore, SETMA developed a model of care where the patient is an active member of his/her healthcare team and where the healthcare provider is like a consultant, a colleague, a collaborator to facilitate healthy living, with safe, individualized and personalized care for each patient. SETMA's model is driven by the fact that we serve a population which had received disjointed, unorganized, episodic care, focused upon things done to, or for patients who have limited resources with which to support their health care goals. **Four Seminal Events - May, 1999 will always be critical**

- Designing an EMR Guided by The Fifth Discipline by Peter Senge, PhD

  January, 2007 -- It is possible for healthcare providers to be overwhelmed by the volume of valuable information available for medical decision making. The organization and storage of that information is particularly ill suited for easy access and application in clinical settings. Electronic patient records have the potential for making current and future information available for use in improving the quality of treatment out comings. Success in applying medical science and random-controlled-trials date to healthcare will be dictated by the design of EMR products and particularly by the display of data and treatment decision-making tools. In his book, The Fifth Discipline, Dr. Peter Senge identifies "systems thinking" as the solution to the management of complex data issues in business. These principles are equally applicable in medicine and particularly in the design of EMR tools for the support of healthcare decision making. Utilizing Senge's concepts of *metanoia* and "circular causality", this paper examines the implications of systems thinking for the design of EMRs and for the display of data. In addition, the issues of data sharing between specialties, disciplines and disease management is addressed.

- Healthcare: EMR only distantly related to 'real' electronic patient management

  If all we generally talk about is Electronic Patient Records or Computerized Patient Records or Electronic Medical Records, or ...then everyone is going to get the idea that when they create the ability to produce an electronically generated document of a patient encounter, they have arrived. The problem with this is that many health care providers, who are very interested in joining the 21st-Century methodology of health care (EPM), are going to buy a product which they suddenly find is wholly inadequate for the tasks at hand. To accomplish *metanoia* in medical informatics, I would immediately hold up the standard of Electronic Patient Management (EPM). I would describe it at least, if not define it. I would detail and illustrate its every aspect. I would model it where it exists, and I would dream about it where it does not. And I would herald the truth that the ability to document a patient encounter only "gets you on to the playing field" in EPM. That ability is not the end point; and, the vendor who can only do that is not holding the winning hand.

- Don't Load Both Barrels - The Story of SETMA's Implementation of NextGen EMR and EPM

  But, it was not always so. When SETMA was formed there was no uniformity in how medical records were created, filed or stored. Some dictated records, others hand wrote records. Some organized records alphabetically, others used a numeric system. On August 1, 1995, SETMA's medical-record-keeping illustrated all of the problems facing the future of healthcare in America. With the new millennium approaching, with all of the potential of 21st-Century technological care, SETMA was hamstrung by the use of mixture of a 19th Century documentation system, i.e., pencil and paper, and a 20th-Century system, i.e., dictation and transcription. Neither system was capable of supporting innovation in healthcare delivery.

  By the spring of 1997, the frustrations of dictation and filing led SETMA to discuss electronic medical records (EMR). Usually, when modern men and women name an object, their mind envisions a picture of that object. With the mention of EMR, our minds were blank. We had no idea what it looked like, or how to do it.

  This led the partners of SETMA to attend the 1997 MGMA meeting in Washington DC. The MGMA program was dissected and tracks were laid out; each partner had a different focus. In the evening, the partners met to discuss the day's program and what might apply to SETMA and how. One of those tracks was EMR. There were hundreds of vendors at the conference. Each one told us they had the best solution. The partners returned determined to purchase an EMR, but uncertain as to which one.

- March 30, 1998 - March 30, 2012: SETMA's Journey Toward Electronic Health Records

  With the use of an EMR, SETMA has become a recognized and accredited Patient-Centered Medical Home. SETMA has built a website which represents the cutting edge of EMR use. Thought leaders in healthcare transformation from across the nation, use SETMA's website as a source for creative and innovative ideas about the future of healthcare. From a personal standard point, in the 36 years I have maintained a private clinic before and including SETMA, 39% of the time I have used EMR as a means of documenting a patient encounter and as a means of improving the quality of care delivered in those clinics. If I practice for eight more years (a total of 44 clinic years), I will have practiced 22 years or 50% of my career with an EMR. To the next generation of healthcare providers, this observation will seen quaint but to those of us who form the bridge between the before EMR and after EMR, it is significant.

- Pursuing Excellence in Healthcare Delivery: Personal Mastery and Electronic Medical Records as Tools of Excellence

  SETMA's "target" for 2009 is EXCELLENCE. The problem with this goal is that it requires persistency which will look like relentlessness. It will require, in Churchill's words that we, "never ever surrender." We will be tempted to "surrender" to fatigue, or

to convenience, or to expediency, but when surrender is rejected, excellence can be the result. And, why would we choose excellence? We choose it because anything less is compromise and is unworthy of the "calling" which we all have as participants in the delivery of healthcare to our friends, families and patients. Lest the choosing of the goal of excellence be considered arrogant, after all, how can you judge excellence, in the words of Dr. Mark Wilson it must be stated, "Excellence is not a stop sign which you pull up to having - arrived.' Excellence is a direction in which you are going."

Essentially, excellence is the determination to be better than you were before, with the constant goal of continuing to improve. Excellence does not happen by accident. It is intentional and its achievement requires the establishment of goals, objects, measures, reviews and critiques.

However, excellence will never be achieved by design or by resolution; it will only be achieved by character. It is only as excellence is compelled from our heart and soul that we will have the resolve and the strength to daily and hourly pursue excellence. The drive to excellence which comes from within us has many faces. Some of those are found in a competitive spirit, but the good news about excellence is that I is not a zero-sum game, i.e., if you are excellent, it does not prevent others from being excellent as well. Excellence is objective but it is not comparative. It is not like an examination in school where a bell-shaped curve determined who could receive an "A" for "excellence" and who would receive a "C" for "mediocrity." In fact, in life and particularly in the delivery of healthcare, in the short run those who are excellence may not have the best results because they accept the challenge of meeting the health care needs of the neediest.

Today, I invite you to join the journey which will not end at a destination, but a journey which is defined by our commitment to a standard which is excellence. Only you can sustain that standard. Only you can relentlessly pursue that goal every day, every way, every time. No amount of scrutiny or auditing can achieve excellence which is not driven by your heart and soul. Excellence as the standard for your 2009 story will be the inevitable result of caring for every person you see, every day this year. Caring is first the result of you seeing everyone as someone of import. For Christmas, I gave my wife a porcelain box which has the following hand-painted message on its top: "To the world you are one person, but to one person you are the world." So it is with each person we see each day, they must for the moment we "see" them become, "our world," receiving from us our full attention and caring.

But excellence will also be seen as we apply the highest standards to that caring; standards which are defined by "best practices" and "national standards." Whether it is the care of a patient with diabetes, hypertension, heart disease, depression, anxiety, uncontrolled pain, etc., excellence requires the application of the best knowledge in existence and our best effort - every time. This may be the greatest promise of electronic patient records (EMR). Designed and executed best, the EMR is a tool for

excellence. The EMR provides a benchmark of excellence against which you can measure your performance every day with every patient. The EMR provides an objective standard for determining that you have applied "best practices" and "national standards" to every patient. And, when coupled with genuine caring for others; when coupled with that person being the world to you receiving your full attention as if they are the most important person to you, the EMR will fulfill its greatest potential.

The commitment to excellence is an individual passion but it becomes a collective, organizational passion as two, then three, then ALL embrace from their heart and soul the same standard. Sustaining excellence is much easier when it is the product of a group's effort. Like the "three-fold cord which is not soon broken," the group sustains the one's commitment to excellence at times of fatigue and discouragement. The physics of the three-fold cord is that at the point of one cord's weakness another is strong and the reciprocal is also true. A cord which can only support 200 pounds, when intertwined with two equally strong cords, the three can sustain 2,000 pounds. So it is with our effort and commitment of excellence. What we cannot do alone, we can do together.

- Principles of Change Agents: If you are going to make a change, it had better make a difference

August, 2012 -- SETMA has used the following phrase for years: “If you are going to make a change, it had better make a difference.” The only way people are going to follow a leader is if that leader helps them define and fulfill their own vision. I have always associated this phrase with an article which I read in a Continental flight magazine. It turns out, my wife read it. The article was about “change agents” and IBM’s transforming itself in the early 1990s. I looked and looked for the reference to the quote and could not find it. I even asked IBM executives about the article. On August 8, 2011, I found it! Early in SETMA, I wrote the *SETMA Sentinel* which was an in-office publication. It was a way of communicating with all of the practice and of getting everyone to know each other. It was our first step in team building. I would write it early in the morning and walk around and put a copy on everyone’s desk before they got to work. Fourteen years and four months ago, the March 30, 1998 Volume IV Number III, the following *Sentinel* appeared. *SETMA Sentinel (An In-house Publication Designed for Team Building)* Volume IV Number III March 30, 1998 **Responses to SETMA.**

- Healthcare: Metanoia -- A Shift of Mind

(Editor's Note: On February 5, 2003, Dr. Holly addressed the Massachusetts Medical Society's Medical Informatics meeting in Boston Massachusetts. Today's article and the next two weeks installments of Your Life Your Health are excerpts from his address which was entitled: "Beyond Electronic Medical Records: The Hope and Promise of Electronic Patient Management." Several years ago, I was browsing in a book store, and saw a book with a black fly leaf. I picked it up and it fell open to page thirteen. An interlinear jumped out at me, which stated: "*Metanoia*: -- A Shift of Mind." The

paragraph went on to say, "(*Metanoia*is) the most accurate word in Western Culture to describe what happens in a learning organization&"

I knew the word *metanoia* and I knew that it had nothing to do with business. As a Christian and a Bible teacher, I have studied, written and taught that word for years. It is the Greek word for "repentance," and means to "have a change of mind or to change one's direction." I was absolutely confident that it had nothing to do with American business. In order to "debunk" what the author said, I read Peter Senge's *The Fifth Discipline*. Needless to say, "I had a change of mind." I found in Dr. Senge's book a structural and philosophical foundation for what we were already doing at Southeast Texas Medical Associates in Beaumont, Texas. I also found another illustration of a principle a friend had taught me years before: the person who helps you the most is not one who teaches you something new, it is the person who teaches you how to say that which you already know or suspect.

- The Titanic: Technology, Temerity and Tradition - What Healthcare Can Learn From the Titanic

  April, 2013 -- 100 years ago today, the Titanic sank. Since that time, almost a dozen movies have been made about that tragedy and over 100 books have been written, the most recent in the past few months. As we mark the centennial of this disaster, it is possible that more and more attention will be given to the Titanic. The story illustrates at least two lessons. One was not known in 1912, but should have been learned by the loss of the Titanic, and one is not known in 2012, but should be learned by our reflecting upon the fate of the Titanic.

  Trust in Technology – Misplaced

  The first lesson is that trust in technology is misplaced. For centuries, the seas have been the highways of the world, but were fraught with danger. Probably no greater fear faced sailors as they left their homeports than that of their ship sinking at sea. The thought of one's ship sinking below the cold, dark waters of the North Atlantic and the image of those same deep waters leaching the warmth of life out of one's body in only a few minutes was enough to send dread into the heart of the bravest of men.

  But, in 1912, technology had overcome man's fears: the Titanic could not sink! But, it did. The unsinkable was sunk; the impossible happened. And, now, 100 years later, evidence is mounting that the Titanic's sinking may have not been from an "act of God" - a killer iceberg loose upon the sea - but defective rivets put in place by men. How ironic it will be if the temerity of the men in charge of the Titanic - their "foolhardy contempt of danger" -- demonstrated by their rushing headlong into the dark night, encouraged by man's "faith" in technology, resulted in the old seafarers' worst fears being lived out again, because men used defective rivets in constructing the Titanic.

- Abraham Lincoln and Modern Healthcare

  Contained within Abraham Lincoln's famous "House Divided Speech," delivered to the Republican Convention on April, 16, 1856, is the imperative for data analytics and performance auditing by healthcare providers today. Lincoln said, “If we could first know where we are, and whither we are tending, we could better judge what to do, and how to do it,”. (Quoted by David Eisenhower in the Foreword to *Churchill: The Prophetic Statesman*, by James C. Humes, Regnery, New York, 2012) In any human enterprise, if the participants are unwilling to objectively and honestly face where they are, it is improbable that they will ever get to where they want to be, let alone to where they should be.

Clinical Decision Support

The following are examples of Clinical Decision Support materials which have been developed by SETMA and which are used every day in our clinical, EMR workflow. There are many others we use, also. In February, 2011, ETMA was named one of Thirty Exemplary Practices for Clinical Decision Support by the U. S. Office of the ONC for HIT -- "Advancing Clinical Decision Support" is an intensive, multi-part project funded by the U.S. Office of the National Coordinator for Health Information Technology (ONC) to address the major barriers to achieving widespread use of clinical decision support. The project is being led by the RAND Corporation and Partners Health Care / Harvard Medical School. Rand Case Summary.

- Texas State Reportable Infectious Diseases Tutorial

  May, 2011 -- How can healthcare providers design a solution to a complex healthcare problem, particularly when the problem is not generated by a patient's request but by a public-health need. In the former case, the provider simply determines if the request is appropriate or not. In the latter case, no one is in the provider's office requesting a service; a requirement has been established and it is up to the provider, in the midst of many other demands, to remember and to fulfill the requirement. In the case of infectious diseases, requirements have been published for providers to report the occurrence of dozens of conditions. The problem is that the medical literature is filled with studies showing very low compliance of physicians with reporting infectious diseases to State Health Departments. In Texas, there are 78 infectious diseases which require reporting. The window for reporting compliantly varies from immediately, to one working day, to one week, to ten days, to one month. It is improbable that many healthcare providers know the entire list or the requirement for reporting. The Department of Health wants the report to be triggered by a suspicion and not by a confirmed diagnosis. If the provider waits until the confirmation is made, the opportunity for a public health intervention is lost. A systems solution would be best. The ideal solution would be an electronic medication record (EMR) system in which the reporting action is triggered by the documentation of the diagnoses in the assessment in the EMR.

- Electronic Tickler File Tutorial

  One of the most difficult management issues in outpatient care is the making certain that patients follow through on recommended, or scheduled studies, or evaluations. Also, it is the following up with a patient to whom you have given a target for smoking cessation, or other behavior modification to see if they are have succeeded. Many efforts have been made to create a tool for managing these complex problems over a large population. In 1998, SETMA adopted an EMR, particularly one that has Microsoft Outlook embedded, it occurred to us that we could use the EMR and Outlook to create an **Electronic Tickler File**. Because Microsoft Outlook allows delay of the delivery of an e-mail and actually to specify the time and date for that delay, it because obvious that we could use this function as an **Electronic Tickler File**. SETMA uses the Electronic Tickler File in many applications...

- Problem List Reconciliation: The Tools Required to Facilitate the Maintenance of a Current, Valid and Complete Chronic Problem List in an EMR

  The two most difficult, chronic problems in medical recording keeping are valid, complete medication records and valid, complete problem list. Unfortunately, they just happen to be the two most important parts of the record. Both issues are foundational to the fulfillment of the Triple Aim and to patient safety. Because the chronic problem list is also critical for reimbursement, the sustainability of excellence in care, which is fundamentally an economic issue, the list is critical to quality outcomes. This is particularly related to HCC and RxHCC values which are not important not only in Medicare Advantage, but also in ACO work with Fee-for-Service Medicare and for Patient-Centered Medical Home. (for the full tutorial see: Problem List Reconciliation: The Tools Required to Facilitate the Maintenance of a Current, Valid and Complete Chronic Problem List in an EMR).

- Transitions of Care Management Coding (TCM Code) Tutorial

  In January, 2013, CMS published two new Evaluation and Management Codes (E&M Codes) which were adopted in order to recognize the value of the processes of transitioning patients from multiple inpatient sites to multiple outpatient venues of care. The value of this work is now being recognized by enhanced reimbursement. CMS has also published three codes for Complex Chronic Care Coordination, which is considered bundled payments in 2013 but in 2014 are scheduled for additional payment to primary care providers. Those will be discussed later. SETMA has been tracking and auditing the Physician Performance for Performance Improvement Transitions of Care Quality Metrics since they were published in 2009. By provider name, those metrics are published at www.jameslhollymd.com under Public Reporting for 2009, 2010, 2011, 2012. In the past 36 months, SETMA has discharged over 14, 000 patients from the hospital. 98.7% of the time patients have received their Hospital Care Summary and Post Hospital Plan of

Care and Treatment Plan (previously called "Discharge Summary "when they left the hospital. Since 2010, SETMA's Care Coordination Department has also been involved in the transitions process. It is only logical that SETMA would be prepared to utilize the new Transitions of Care Codes. At this time, there is only one unresolved issue related to using these codes. Neither CMS nor the Medicare State Contractors are willing to clarify that issue. In order to determine which of the Transitions of Care Management Codes to use, the healthcare provider must distinguish between a Moderately Complexity visit and a High Complexity visit. This tutorial assumes that the complexity discriminator refers to the E&M codes for 99214 and 99215, in which case it would generally be possible for a provider only to use the lower of the TCM codes, i.e., 99495.

- Nutrition Assessment Tutorial

  One of the most neglected areas of acute and critical care is nutrition. Also, one of the most litigated areas in long-term residential and/or nursing home care is malnutrition. SETMA's Nutrition Assessment Template makes it possible to objectively document a patient's nutritional status in regard to: Risk Factors for Malnutrition; Physical Signs and Symptoms of Malnutrition; Chemical and Metabolic Indications of Malnutrition.

- Skin Care Tutorial

  The next template which is unique to the Nursing Home Suite of Templates is Skin Lesions. The full name of the template is "**Clinically Unavoidable Skin Lesions**." Skin lesions are common in long-term care facilities, and often are unavoidable. This template helps identify the patients who are at risk of unavoidable skin lesions. **Risk Factors** - 22 conditions are listed which contribute to the patient's being at risk for "Clinically Unavoidable Skin Lesions." These should be reviewed and any risk factors which apply to the patient should be documented by checking the box next to it. These are in demographic fields, which means that once they are checked, they remain checked in subsequent visits until they are unchecked...

- Hydration Assessment Tutorial

  It is often relatively easy to demonstrate that a patient is currently dehydrated or hydrated. However, it is often difficult to declare with objective evidence that while the patient is dehydrated today, he/she was not dehydrated at their last healthcare encounter. The **Hydration Assessment** tool is designed to enable you to objectively establish the patient's state of hydration and to document that in an objective, supportable way. This tool is particularly important to use in the Nursing Home setting as the patient's state of hydration is an important aspect of long-term residential care and is often the focus of malpractice actions.

- Fall Risk Tutorial

  This is one of the greatest health threats to all elderly patients but particularly to those who are in long-term residential care. Through the review of seven categories, a score is developed which indicates whether the patient is at high risk or low risk of falls.

- Depression Tutorial

  Depression is a serious and often life-threatening problem in the elderly and particularly in the elderly in long-term residential care facilities. In addition, the complexity of mediation treatment of the elderly is greater because they are often on multiple drugs which have serious interactions. While this template is mostly educational, it is key to the successful treatment of residents of long-term care facilities

- Future Labs Tutorial

  The following is a common event in a patient's visit to a physician. The doctor says, "I would like for you to return on Friday for lab work." The patient complies but when he/she arrives at the laboratory, they have no idea what the doctor wanted. The lab calls the doctor, but he is not in. The nurse says, "I'll page him and find out what he wanted to order." The nurse reaches the doctor and he says, "I don't remember, look it up in the chart." The nurse looks and there is nothing there. Meanwhile the patient has been waiting for 45 minutes in the lab. To avoid this, SETMA has designed a **Future Labs** function which the healthcare provider can complete at the time of his/her discussion with the patient. When the Future Lab template is completed, the patient arrives at the lab, the orders are already there and the tests are done efficiently and the patient is on his/her way.

- Stratifying End-of-Life Risk for Hospice Services: Tutorial for SETMA's Deployment of Four Risk Calculators for Hospice Care

  As end-of-life planning becomes increasingly an important part of patient care, it is important to find ways of quantifying patient's qualification for hospice care and where possible, a means of quantifying a reliable estimate of survival time for patients. While there will never be an absolute, four scores are being used to aid in this process. The first, the Karnofsky Scale, was first described in 1949; the second, the Palliative Performance Scale has been used in cancer patients since 1996; the third the Braden Clinically Unavoidable Skin lesions and the fourth Functional Assessment Testing Alzheimer's and Related Conditions (FAST). SETMA has deployed all four of these scores, along with a fifth which is the Lansky Scare. The Lansky is like the Karnosky Scale but is used with patient under 16. These tools can be found by going to GP Master Template. In the second column you will find these four scales. They are also deployed on the Master Template in the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan Suite of templates.

- HCC/RxHCC Risk Tutorial

  In 2007, Medicare Advantage programs (HMO) were funded by CMS (Center for Medicare and Medicaid Services) using both demographics and the Hierarchical Conditional Codes, known as the HCC Diagnoses. 2007 also was the year that RX HCC codes were added to complement the reimbursement for managing patients with illnesses, which while they did not rise to the level of complexity and cost-for-care, as the HCC diagnoses, they did qualify for a lower additional payment due to increased medication costs. In the interim, the use of HCC and RxHCC designation has been expanded to include not only Medicare Advantage beneficiaries, but also Medicare Fee-for-service beneficiaries through Accountable Care Organizations (ACO) and patients treated in a Medical Home. In the case of the ACO, the savings for the calculations of shared savings will be determined by actual cost of care measured against the benchmark costs including the HCC and RxHCC factor for the patients in the benchmark. In the case of Medical Home, the payment of the per member per month (PMPM) payment will be calculated with the level of Medical Home recognition and the HCC/RxHCC coefficient aggregate value, i.e., if a patient is being treated by a Tier III Medical Home and the aggregate HCC/RxHCC score is 2.0 or above, the provider would be eligible for the maximum PMPM as determined by contract.

- Pain Management Tutorial

  This represents SETMA's refill policy. This policy will print on the pain management document that will be given to the patient at the end of the visit. This policy states: Under no circumstances will the medication be refilled:

  a. Prior to the renewal date at the prescribed dosage and frequency of use.
  b. Without the patient being seen in the office
  c. Without evidence of continuing need for medication
  d. On the weekend, evenings after hours, holidays or other times when your regular doctor is not available.

  The following reasons will not be accepted by any SETMA provider for an early refill of pain medication and/or medication with a significant potential for habituation:

  e. My medications were stolen.
  f. I only got half of the prescription filled.
  g. I dropped my medications into the sink, the sewer, the swimming pool or other watery body.
  h. I left my medication in my hotel on my trip.
  i. I missed my appointment.
  j. The neurosurgeon and/or the surgeon cancelled my appointment.

Hospital Care Tools

Through SETMA's deployment of our ambulatory care EMR, and with the collaboration of SETMA's Hospital Care Team, we have been completing hospital history and physical examinations, discharged summaries (renamed "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan in September, 2010) in the EMR for over twelve years. We have the capacity to complete daily progress notes in the EMR, also. The tools for excellent performance in the hospital are described below.

- Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan Tutorial

Nomenclature Can Confuse Function

While the traditional "discharge summary" should have been the most important document created during a patient's hospital stay, it historically came to be nothing but a document created for an administrative and billing function for the hospital and attending physician. It has long cease to being a dynamic document for the improvement of patient management. The "discharge summary" rarely provided continuity of care value, or transitions of care information, such as diagnoses, reconciled medication list, or follow-up instructions. In reality, the "discharge summary" was often completed days or weeks after the discharge and was a perfunctory task which was only completed when hospital staff privileges were threatened or payment was delayed. The "discharge summary" should have always been a transition-of-care document which not only summarized the patient's care during the hospitalization but guided the patient's post-hospital care with a plan of care and treatment plan. In this way, the document would have been a vehicle for patient engagement and activation.

Changing the Name to Clarify Function

In September, 2010, SETMA representatives as an invited participate attended a National Quality Forum conference on Transitions of Care. (NQF - Summary of Dr. Holly's Comments - September 2nd, 2010) During that conference, SETMA realized that the name "discharge summary" needed to be changed. It was thought that a name

change would clarify and focus the intent of this critical document. The name was changed to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." The purpose and content of the new document was defined as:

- Physician Consortium for Performance Improvement Care Transition Data Set Tutorial

  In June, 2009,the Physician Consortium for Performance Improvement, which in part includes the American Board of Internal Medicine Foundation, American College of Physicians, Society of Hospital Medicine and the AMA Physician Consortium, published Care Transitions: Performance Measurement Set entitled Phase I: Inpatient Discharges and Emergency Department Discharges. Since 2003, SETMA has utilized NextGen EMR in the in-patient setting in order to complete Admission History and Physician examinations and Discharge Summaries (renamed Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan in 2010) for the patients whose care we manage. SETMA has also designed and used a Daily Progress Note in our EMR. That project was suspended until we get an interface built between the hospital and NextGen so that daily vital signs and patient-condition data, laboratory values and medications can be automatically posted to our EM. We hope that will be accomplished with the deployment of our Health Information Exchange (HIE). After reviewing the content of the Care Transitions Measurement Set, it was apparent that with a few modifications which have been made, SETMA performs all of the elements of this set. We believe that the auditing of this performance measure by the provider at the point of service will improve that quality of care given to patients transitioning from inpatient or ER to another place of care. The following links are discussions posted on SETMA's website about the complexities of care transitions.

- Transitions of Care Management Coding (TCM Code) Tutorial

  In January, 2013, CMS published two new Evaluation and Management Codes (E&M Codes) which were adopted in order to recognize the value of the processes of transitioning patients from multiple inpatient sites to multiple outpatient venues of care. The value of this work is now being recognized by enhanced reimbursement. CMS has also published three codes for Complex Chronic Care Coordination, which is considered bundled payments in 2013 but in 2014 are scheduled for additional payment to primary care providers. Those will be discussed later.

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It is only logical that SETMA would be prepared to utilize the new Transitions of Care Codes. At this time, there is only one unresolved issue related to using these codes. Neither CMS nor the Medicare State Contractors are willing to clarify that issue. In order to determine which of the Transitions of Care Management Codes to use, the healthcare provider must distinguish between a Moderately Complexity visit and a High Complexity visit. This tutorial assumes that the complexity discriminator refers to the E&M codes for 99214 and 99215, in which case it would generally be possible for a provider only to use the lower of the TCM codes, i.e., 99495. Others argue that the terms "moderate" and "high" complexity are not defined by the E&M code descriptions and if they are, the correct reference would be 99213 and 99214. That seems unreasonable as in that case, the higher TCM Code, i.e., 99496 would be the most commonly used TCM Code. Until this is officially clarified, SETMA is going to assume that the terminology refers to 99214 and 99215. This will cause us to use a lower code than may be valid, but at least it will not result in fraud and abuse charges.

SETMA's Tools for the Transitions of Care Management Codes (TCM Codes)

When a patient is seen at SETMA who has been discharged from the hospital or another in-patient setting, a note automatically appears on the AAA Home Template, indicating that the patient is eligible for a Transitions of Care Management evaluation. If the patient is not eligible, then that space will be blank. This alert is illustrated below outlined in green.

- Using The Clinic and Hospital Follow-up Call Templates

  As part of patient-centric care, SETMA's Care Coordination Department staff places care coaching calls to selected patients seen in the clinic and to all patients who have been discharged from the hospital or from the emergency department.

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Tutorial for SETMA's Internal HCAHPS Survey

  Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a structured set of standards by which to measure healthcare provider and hospital performance. SETMA has long had the philosophy that if healthcare providers are going to be held accountable for certain actions, they ought to: Know what they are going to be held accountable for; Measure their performance before an external organization reports this performance at some distant time in the future; Have a plan and a method for improving their performance. In August, 2014, SETMA designed a system by which SETMA's Care Coordination department in the Care Coaching Call the day following discharge from the hospital, SETMA could assess our own HCAHPS performance. While this will not be accepted as THE official score, it does involve SETMA providers in the fulfillment of these standards. Below this tutorial is a lengthy discussion of SETMA's 8-day pilgrimage to excellence in HCAHPS performance as a

function of patient-centeredness in inpatient care. This is the beginning of our becoming patient-centered in our inpatient care...

- Admission Orders Tutorial

  The transition from the outpatient to the inpatient setting is important. It is critical to initiate care in the inpatient setting as quickly as possible. With predetermined order sets, it is possible for any provider regardless of personal experience or knowledge to generate a disease-specific order set designed by a specialist. Using SETMA's Admission Order sets, it is possible for excellent care to be started without delay.

- Hospital Daily Progress Note Tutorial

  The **Hospital Daily Progress Note** templates enable an inpatient-hospital note to be completed efficiently and excellently with data being accumulated over the course of an inpatient stay. This data is then automatically aggregated for the Discharge Summary to be completed quickly and completely. The complexity of this task will become obvious as you review this tutorial. However, the use of the Hospital Daily Progress Note is very much easier than it may seem from the length of this tutorial. Of necessity, the variety of documentation needs for inpatient, daily progress notes is such that the suite of templates will be large, but applied to individual patients, they are manageable and valuable. In addition, the Hospital Daily Progress Note is the "last piece" in making a patient's care seamless regardless of where the patient is being treated. The inpatient record is not isolated in a patient's hospital chart but through the hospital daily progress note has become a dynamic part of the patient's medical record and contributes to the continuity of care and to the continued building of a detailed, accurate and complete portrait of the patient's health history, condition, care and needs.

- Care Transitions Data Set from Physician Consortium for Performance Improvement

  In June, 2009,the Physician Consortium for Performance Improvement, which in part includes the American Board of Internal Medicine Foundation, American College of Physicians, Society of Hospital Medicine and the AMA Physician Consortium, published Care Transitions: Performance Measurement Set entitled Phase I: Inpatient Discharges and Emergency Department Discharges. Since 2003, SETMA has utilized NextGen EMR in the in-patient setting in order to complete Admission History and Physician examinations and Discharge Summaries (renamed Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan in 2010) for the patients whose care we manage. SETMA has also designed and used a Daily Progress Note in our EMR. That project was suspended until we get an interface built between the hospital and NextGen so that daily vital signs and patient-condition data, laboratory values and medications can be automatically posted to our EM. We hope that will be accomplished with the deployment of our Health Information Exchange (HIE). After reviewing the content of the Care Transitions Measurement Set, it was apparent that with a few modifications which have been made, SETMA performs all of the elements of this set. We believe that the auditing of this performance measure by the provider at

the point of service will improve that quality of care given to patients transitioning from inpatient or ER to another place of care. The following links are discussions posted on SETMA's website about the complexities of care transitions.

Disease Management Tools

Early in our EMR pilgrimage, SETMA transitioned to EPM - Electronic Patient Management. This transition resulted in our development of multiple disease management tools. To maximize their use, we developed tutorials for teaching all providers how to use these tools. These tutorials are more than "computer - how to" directions and are actually mini-courses on best practices and evidenced-based medicine for each of the conditions addressed. The following is a link to the start of that story: May, 1999 -- Four Seminal Events in SETMA's History.

Formed August 1, 1995, Southeast Texas Medical Associates, LLP (SETMA) recognized that excellence in 21st-Century healthcare was not possible with 19th-Century medical-record methods, i.e., pencil and paper, or with 20th-Century methods, i.e., dictation and transcription. Therefore, eighteen years ago, SETMA began the process of adopting an electronic medical record (EMR). In October, 1997, SETMA examined over fifty EMRs. On March 30, 1998, writing a $650,000 check, SETMA purchased the EMR which we currently use. Eighteen years ago many thought that was a mistake, as in those early days healthcare providers had to develop the content of the EMR themselves. We had bought an empty box. Therefore, it was Tuesday, January 26, 1999 before we began using the EMR to document patient encounters, but by Friday, January 29, 1999, all patient visits were documented in the EMR.

In 1996, SETMA also believed that 21st Century healthcare was going to be driven by quality performance and SETMA rejected the old model of care where the healthcare provider was the constable imposing health upon a passive recipient, the patient. Therefore, SETMA developed a model of care where the patient is an active member of his/her healthcare team and where the healthcare provider is like a consultant, a colleague, a collaborator to facilitate healthy living, with safe, individualized and personalized care for each patient. SETMA's model is driven by the fact that we serve a population which had received disjointed, unorganized, episodic care, focused upon things done to, or for patients who have limited resources with which to support their health care goals.

Four Seminal Events - May, 1999 will always be critical

Without doubt, in 1995, the first step in forming what is now SETMA was the adoption of a team approach to patient care. (see The SETMA Team and The SETMA Culture) That team focus will be the central part of the story when the history of SETMA is written. The second critical decision was the EMR. But, in SETMA's history May, 1999 will always be central. In the first week of May, 1999, only 100 days after SETMA first used the EMR, four seminal events took place. These events defined and directed SETMA's future.

The first event took place the first week of May, 1999, when SETMA's CEO announced that the EHR was too hard and too expensive if all we gained was the ability to document a patient encounter electronically. When we began, it took a provider five minutes to create a chart note. Our CEO concluded EHR was only "worth it," if we leveraged electronics to improve care for each patient; to eliminate errors which were dangerous to the health of our patients; and, if we could develop electronic functionalities for improving the health and the care of our patients and of population groups. This was our transition from EMR to electronic patient management (EPM).

We also recognized that healthcare costs were out of control and that EPM could help decrease that cost while improving care. Therefore, we began designing disease-management and population-health tools, which included "follow-up documents," allowing SETMA providers to summarize patients' healthcare goals with personalized steps of action through which to meet those goals. We transformed our vision from how many x-rays and lab tests were done and how many patients were seen, to measurable standards of excellence of care and to actions for the reducing of the cost of care. We learned that excellence and expensive are not synonyms. In ten years, these steps would lead us to begin public reporting by provider name on over three hundred quality metrics (Public Reporting - Reporting by Type).

The second event was that from Peter Senge's *The Fifth Discipline*, we defined the principles which guided our development of an EHR and which defined the steps of SETMA's transformation from an EMR to EPM (Designing an EMR on the Basis of Peter Senge's The Fifth Disciple). These principles would also be the foundation of SETMA's morphing into a patient-centered medical home (PC-MH). The principles were to:

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

The following are the Disease Management Tools which are the result of these seminal moments. As these are links to tutorials which should be studied, no explanatory material will be attached:

- Acute Coronary Syndrome Tutorial
- Adult Weight Management Tutorial
- Angina Tutorial
- Cardiometabolic Risk Syndrome Tutorial
- Chronic Renal Disease Tutorial
- Congestive Heart Failure Tutorial
- Diabetes Tutorial
- Hypertension Tutorial
- Lipids Tutorial
- Lipid Quality Audit Tutorial
- Primary Pulmonary Hypertension Tutorial

Preventive Health Tools

The future of healthcare is going to be focused upon health and not simply upon excellent care of disease processes. Yet, the ideal of preserving and/or regaining of a healthy state of being is not as easy as it sounds. Often, patients do not see any immediate benefit in making a change which may or may not make a difference in their sense of well-being. Also, making a change in one's life style requires the hope that such change will make a difference. Many patients do not have hope. Many do not have the resources or mental or emotional capacity to make those changes. All of this complicates our realizing the promise of preventive care.

Typically, when we talk about "preventive health" we are talking about immunizations, screening and disease avoidance strategies. Another element of preventive health has to include risk stratification. Evidenced-based medicine not only helps us understand what treatment methodologies work but also who needs the most aggressive treatment either in prevention or therapeutics. "Preventive health" also must include life-style changes by individuals.

Preventive health initiatives can be measured and they should be. But, if those measurements are going to make a difference, the results must be disclosed. In a recent conversation with the staff of the American Medical Association's Physician Consortium for Performance Improvement (PCPI) Department, SETMA addressed the "missing element" in quality measures. That missing element is a systematic and consistent auditing of a practice's and/or of a provider's performance on those quality measures.

The foundation of effective preventive care is “hope.” The following link gives a more detailed explanation of this last statement: Value, Virtue, Trust and Hope - The Foundation of Health Improvement. Without a sense of person value and personal virtue from which comes the capacity to trust, the result of the coexistence of these three, hope, will not exist. And without “hope” individuals will not take the steps and make the changes for the power and potential of preventive medicine to improve health.

- Introduction to Preventive Health Tools

    1. If You Make A Change Will it Make a Difference.

    2. Dynamic Complexity

    3. Cardiovascular Risk Assessment

    4. Annual Questionnaires

    5. Accountable for Good Preventive Care

    6. Less Initiative

    7. Smoking Cessation

    8. Exercise

- Adult Weight Management Tutorial

    SETMA's Weight Management Program is built on the AMA's Adult Weight Management Program which was published in February, 2004. It is premised on the proposition that excess weight and/or frank obesity is not simply coincidental with virtually every disease which we treat but is either contributory and/or directly causative of those conditions including hypertension, congestive heart failure, diabetes, metabolic syndrome, hyperlipidemia, coronary artery disease, and a number of types of cancer, among many others. SETMA's weight management program is designed to make it simple for health care providers to determine and to document whether or not patients are qualified for treatment with medication or surgery, based on sound scientific evidence. This tutorial will help all providers learn to utilize this suite of

templates either for intensive weight management of a patient, or for giving the patient a weight-management assessment, and/or to help a patient understand why they do, or do not qualify for pharmaceutical and/or surgical treatment of their weight. The weight management assessment is a part of SETMA's LESS Initiative which is utilized with every patient we see.

- LESS Initiative Tutorial

  The premiere primary preventive health initiative of SETMA is the LESS Initiative. LESS is an acronym for: lose weight, exercise, and stop smoking. Included in the LESS Initiative are diabetes prevention, hypertension prevention and insulin resistance risk analyses. The following procedure is the proper way to complete the LESS Initiative. The LESS Initiative is explained in the TCPI section of this website under its own drop down.

- Diabetes Prevention Tutorial

  The best way to treat diabetes is "don't get it". It is in diabetes and in hypertension where "screening" and "prevention" are best seen as two parts of the same process. SETMA's Diabetes Prevention Tool enables SETMA providers to systematical screen patients for diabetes, activate the patient with the knowledge of the process of developing diabetes and engage the patient in a program which will prevent or delay the onset of diabetes in patients who are at high risk and to work with the patient in a "shared-decision" making process. If patient has "pre-diabetes" their record is note so that efforts can be sustain to prevent the disease.

- Hypertension Prevention Tutorial

  If a person is 55 years of age and does not have hypertension, their life-time risk of developing hypertension is 90%. That is not a misprint. Without taking affirmative steps to avoid hypertension almost everyone will develop it. SETMA's prevention program teaches the patient how to avoid the development of hypertension.

- Intensive Behavioral Therapy (IBT) Obesity and Cardiovascular Disease Medicare Preventive

  Health and Human Services through CMS is becoming increasingly more involved with preventive care and more payments are being made for screening and preventive care which will ultimately make a difference in the care, the health and the cost of care for Medicare beneficiaries. Two new services are: Intensive Behavioral Therapy (IBT) for Obesity (G0477) and Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (G0446).

- Initial Preventive Physical Exam & Annual Wellness Visit Tutorial

  CMS is getting serious about Preventive Health Services which have the potential for moving us toward the fulfillment of the Triple Aim: improved care (processes), improve health (outcomes) and decreased costs (sustainability). The new Intensive Behavioral Therapy codes for obesity and cardiovascular disease along with the Initial Preventive Physical Exam (IPPE), the Annual Wellness Visit Initial and Annual Wellness Visit Subsequent are significant advances in recognizing the value of preventive care and in recognizing the expertise of those who have the tools to provide those services. Along with the Transitions of Care Management Codes which have been published this year, these preventive codes encourage the "right stuff" in primary healthcare delivery. SETMA is determined to support and to promote these efforts by utilizing them in our practice. The following is a link to our published deployment on our website of the Transitions of Care Management Codes which we are currently using in our almost 5,000 hospital discharges a year. The following references provide content information for Preventive Services authorized by Centers for Medicare and Medicaid (CMS). SETMA's Clinical Decision Support (CDS) tools for these Preventive Services were developed on the basis of these and other official AMA and CMS publications.

The last four preventive tools are elements of the LESS Initiative; they are:

- Exercise Prescription Tutorial

  Exercise Assessment

  The foundation to health is physical activity regardless of age and/or state of one's health. Research has shown that when a healthcare provider discusses physical activity with a patient at every visit, that there is a significantly increased level of physical activity in the patient's life style. SETMA's Exercise Prescription, along with the disease specific exercise prescriptions for CHF and Diabetes, aid healthcare providers in the fulfillment of this element of quality healthcare.

  Current Exercise Activity

  This allows for the documentation of the patient's current structured activity in:

  - Running/Walking/Jogging,
  - Outdoor Cycling,
  - Swimming,
  - Tennis (Singles and Doubles),
  - Rowing, and
  - Golf

This is not to imply that these are the only valuable forms of exercise or that activities such as golf give effective aerobic benefit. In fact, it is possible to achieve health with the level of activity in one's routine work, gardening, house work, or other activities. However, the above six categories are the most common forms of activities which are done with health in mind. When completing the exercise prescription, once the distance, when it applies, the duration of exercise and frequency are documented, the Calculate button displays the Aerobic Units per Session and the Aggregate Units per week. These aerobic units are based on the Cooper Clinic data which is published elsewhere...

- CHF Exercise Tutorial

  This is an exercise prescription specifically for patients with CHF or other exercise limiting conditions. Congestive heart failure (CHF) has been steadily increasing over the past 10 years. Lack of physical activity is considered an independent risk factor for the development of CHF. In addition, other primary risk factors include: obesity, hypertension, and diabetes. Patients diagnosed with CHF benefit greatly from participating in exercise-training programs. For example, exercise training of patients with moderate to severe CHF: lowered all-cause mortality by 63% and reduced hospital readmission for heart failure by 71%. The Agency for Health Care Policy and Research Guidelines on Cardiac Rehabilitation recommended exercise training for patients with chronic stable HF.

- Diabetic Exercise Tutorial

  There are three groups of cautions for exercise with patients who have diabetes. None of these are absolute contraindications but represent cautionary guides to help patients with diabetes improve their glycemic levels with safe physical training or activities. The cautions are indicated by: Risk Factors for CVD, Age >35 and Type 2 Diabetes >10 years or Type 1 Diabetes >15 years. Patients with longstanding diabetes are at higher risk for cardiovascular disease, as the very presence of diabetes is a cardiovascular risk equivalent, which means that a patient with diabetes is at the same risk for a future cardiac event as a person who has already had a heart attack or other cardiac event. Therefore, exercise programs in patients with diabetes ought to be started but they ought to be started with caution.

- Smoking Cessation Tutorial

  Only about half of smokers are ever advised to quit smoking by their physicians. The Agency for Health Care and Policy and Research recommends that physicians should discuss the dangers of smoking with their patients and should continue to encourage them to quit at every office visit. Physicians are in an ideal position to advise against smoking because 70 % of smokers see their primary care physician about three to four times a year. Research indicates that success rates for unaided smoking cessation doubles from 5% to 10% of attempts when instigated by simple advise to quit from the clinician. Yet, the literature continues to document the failure of physicians and other

healthcare professionals to intervene with all of their patients who smoke, with only half of current smokers reporting having been encouraged to quit and even fewer receiving specific counseling. Healthcare settings provide an important teachable moment for smoking cessation intervention. Seventy-five percent of the adult population visits a physician at least once a year, with the average adult making five visits per year. In the physician's office, patients are often conscious of their health and most receptive to risk factor intervention, providing an important opportunity for change.

Behavioral Health

- Behavioral Health in SETMA's Patient-Centered Medical Home Model of Care

Behavioral health is a term that covers the full range of mental and emotional well-being - from the basics of how we cope with day-to-day challenges of life, to the treatment of mental illnesses, such as depression or personality disorder, as well as substance use disorders and other addictive behaviors. While they are not precisely synonyms, behavioral health and mental health are functionally the same. The following is a published description of mental health. It is a level of psychological well-being, or an absence of a mental disorder; it is the "psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment." From the perspective of positive psychology, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience.

According to the World Health Organization (WHO) mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others.: WHO further states that the well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community. However, cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. A person struggling with his or her behavioral health may face stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities,mood disorders, or other psychological concerns. Counselors, therapists, life coaches, psychologists, nurse practitioners or physicians can help manage behavioral health concerns with treatments such as therapy, counseling, or medication. The new field of global mental health is "the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide."

- Medical Home Transtheoretical Model Assessment Stages of Change Tutorial

  In the Medical Home Model of healthcare, it is imperative that the patient participates in their own care. Terms like "activated," "engaged," and "shared decision making" are important descriptions of the dynamic of the patient participating in and actually "taking charge" of their own care. As part of this process, it is important that the patient's preparation to change be sustained. In other tools, SETMA discusses the power of "What if Scenario," which addresses the providers ability to quantify for the patient that fact that "if they make a change, that that change will make a difference in their health." This is principally done through the Framingham Risk Scores and the ability to display the difference a change in behavior will make. That tool can be reviewed in either:

  1. "SETMA's Disease management tools for Diabetes, Hypertension and Lipids used for patient activation and engagement via written plans of care and treatment plans."

  2. Framingham Heart Study Risk Calculators Tutorial

  The assessment of a patient's preparation to make a change can most effectively be done through the Transtheoretical Model Assessment of the Stages of Change which can measure the patient's preparation of making the changes recommended in SETMA's "What if Scenario." The following steps explain how to use SETMA's deployment of the Transtheoretical Model.

- Intensive Behavioral Therapy (IBT) Obesity and Cardiovascular Disease Medicare Preventive

  Health and Human Services through CMS is becoming increasingly more involved with preventive care and more payments are being made for screening and preventive care which will ultimately make a difference in the care, the health and the cost of care for Medicare beneficiaries. Two new services are: Intensive Behavioral Therapy (IBT) for Obesity (G0477) and Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (G0446).

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times a year. Research indicates that success rates for unaided smoking cessation doubles from 5% to 10% of attempts when instigated by simple advise to quit from the clinician. Yet, the literature continues to document the failure of physicians and other healthcare professionals to intervene with all of their patients who smoke, with only half of current smokers reporting having been encouraged to quit and even fewer receiving specific counseling. Healthcare settings provide an important teachable moment for smoking cessation intervention. Seventy-five percent of the adult population visits a physician at least once a year, with the average adult making five visits per year. In the physician's office, patients are often conscious of their health and most receptive to risk factor intervention, providing an important opportunity for change.

- Fall Risk Tutorial

  This is one of the greatest health threats to all elderly patients but particularly to those who are in long-term residential care. Through the review of seven categories, a score is developed which indicates whether the patient is at high risk or low risk of falls.

- Depression Tutorial

  Depression is a serious and often life-threatening problem in the elderly and particularly in the elderly in long-term residential care facilities. In addition, the complexity of mediation treatment of the elderly is greater because they are often on multiple drugs which have serious interactions. While this template is mostly educational, it is key to the successful treatment of residents of long-term care facilities.

- Annual Questionnaires: Fall, Functional, Pain, Stress, Wellness

  As part of SETMA's Patient-Centered Medical Home, we annually complete five questionnaires for each patient to assess each of the following: Fall Risk, Pain Assessment, Functional Assessment, Wellness, Stress. The standard is that each should be completed on all patients at least once a year and more frequently if a change in conditions dictates. The Fall Risk should be completed on all patients over 50 and on younger patients who as a result of chronic condition are at risk of falling.

- Adult Weight Management Tutorial

  SETMA's Weight Management Program is built on the AMA's Adult Weight Management Program which was published in February, 2004. It is premised on the proposition that excess weight and/or frank obesity is not simply coincidental with virtually every disease which we treat but is either contributory and/or directly causative of those conditions including hypertension, congestive heart failure, diabetes, metabolic syndrome, hyperlipidemia, coronary artery disease, and a number of types of cancer, among many others. SETMA's weight management program is designed to make it simple for health care providers to determine and to document whether or not patients are qualified for treatment with medication or surgery, based on sound

scientific evidence. This tutorial will help all providers learn to utilize this suite of templates either for intensive weight management of a patient, or for giving the patient a weight-management assessment, and/or to help a patient understand why they do, or do not qualify for pharmaceutical and/or surgical treatment of their weight. The weight management assessment is a part of SETMA's LESS Initiative which is utilized with every patient we see.

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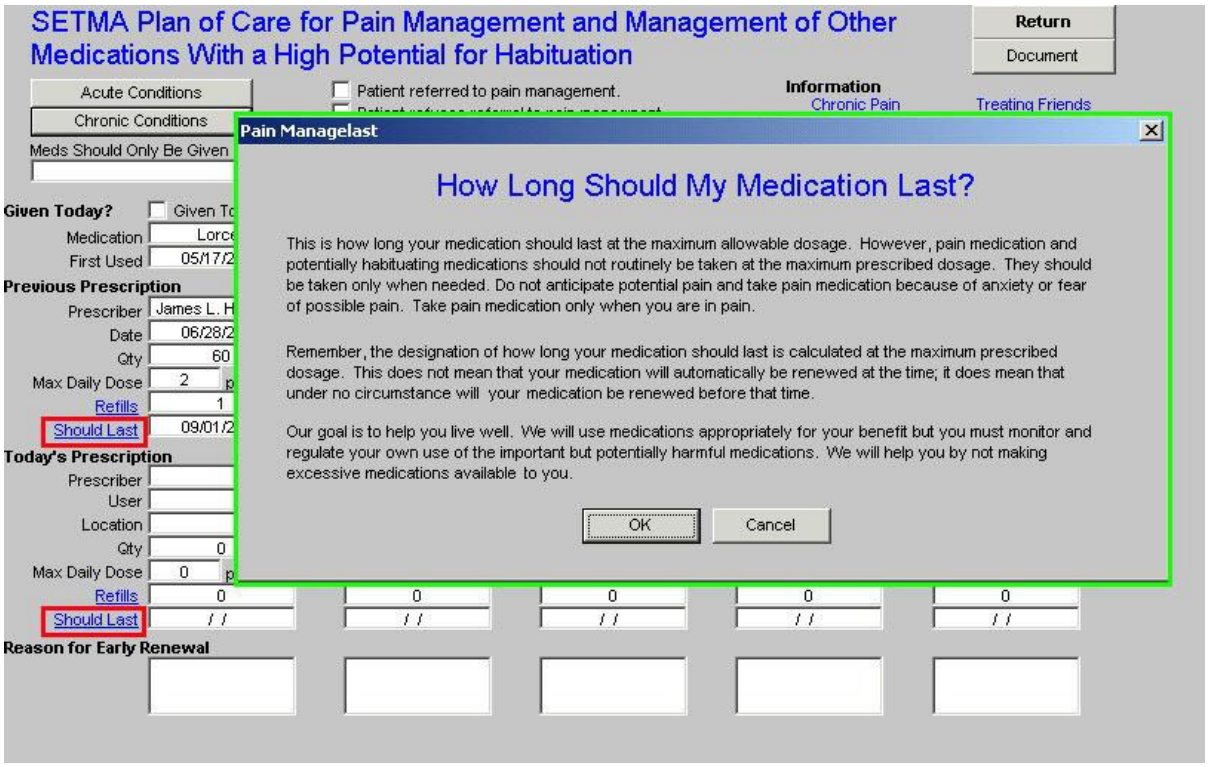
- Stratifying End-of-Life Risk for Hospice Services Tutorial

  As end-of-life planning becomes increasingly an important part of patient care, it is important to find ways of quantifying patient's qualification for hospice care and where possible, a means of quantifying a reliable estimate of survival time for patients. While there will never be an absolute, four scores are being used to aid in this process. The first, the Karnofsky Scale, was first described in 1949; the second, the Palliative Performance Scale has been used in cancer patients since 1996; the third the Braden Clinically Unavoidable Skin lesions and the fourth Functional Assessment Testing Alzheimer's and Related Conditions (FAST). SETMA has deployed all four of these scores, along with a fifth which is the Lansky Scare. The Lansky is like the Karnosky Scale but is used with patient under 16. These tools can be found by going to GP Master Template. In the second column you will find these four scales. They are also deployed on the Master Template in the Hospital Care Summary and Post-Hospital Plan of Care and Treatment Plan Suite of templates.

- [Pain Management Tutorial]



- [Reduction of Antipsychotic Medications Toolkit]

In an effort to decrease the inappropriate use of antipsychotic medications in Texas Nursing Homes, The Texas Medical Foundation and the Texas Department of Aging and Disability provided this toolkit. Because SETMA provides care to over 90% of the long-term care residents in Southeast Texas, which comprises a five county area, and because SETMA documents the care of those patients in our electronic patient record (EMR), we have taken this tool kit and created a Clinical Decision Support tool to improve the care of the patients for whom we have responsibility.

Transformation Tools

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

On the other hand, "transformation" is defined as, "a marked change in appearance or character, especially for the better." "Metamorphosis," a synonym for "transformation," is the transliteration of a Greek word which is formed by the combination of the word "*morphe*" which means "form," and "*meta*" which means "change." "Metamorphosis" conveys the idea of a "noticeable change in character, appearance, function or condition." Metamorphosis is what happens when a caterpillar morphs into a butterfly.

In function, the distinction between these two concepts as applied to healthcare is that "reformation" comes from pressure from the outside, while "transformation" comes from an essential change of motivation and dynamic from the inside." Anything can be reformed - reshaped, made to conform to an external dimension - if enough pressure is brought to bear. Unfortunately, reshaping under pressure can fracture the object being confined to a new space. And, it can do so in such a way as to permanently alter the structural integrity of that which is being reformed. Also, once the external pressure is eliminated, redirected or lessened, the object often returns to its previous shape as nothing has fundamentally changed in its nature.

Being from within, transformation results in change which is not simply reflected in shape, structure, dimension or appearance, but transformation results in a change which is part of the nature of the organization being transformed. The process itself creates a dynamic which is generative, i.e., it not only changes that which is being transformed but it creates within the object of transformation the energy, the will and the necessity of continued and constant change and improvement. Transformation is not dependent upon external pressure but is sustained by an internal drive which is energized by the evolving nature of the organization.

Reform is sustained by rules, regulations, and requirements. As long as there is pressure which comes from external demands reform has an effect. Transformation comes from an internalized ideal, from a personal passion, and it is self-sustaining.

The Ultimate Hope of the Future of Healthcare is Transformation

To be successful, the implementation of new polices and initiatives which will produce the future TCPI imagines, must be transformative which comes from within. Transformation results in change which is not simply reflected in shape, structure, dimension or appearance, but transformation results in change which is part of the nature of the organization being transformed. The process itself creates a dynamic which is generative, i.e., it not only changes that which is being transformed but it creates within the object of transformation the energy, the will and the necessity to sustain and expand that change and improvement. Transformation is not dependent upon external pressure (rules, regulations, requirements) but is sustained by an internal drive which is energized by the evolving nature of the organization.

While this may initially appear to be excessively abstract, it really begins to address the methods or tools needed for reformation, or for transformation. They are significantly different. The tools of reformation, particularly in healthcare administration are rules, regulations, and restrictions. Reformation is focused upon establishing limits and boundaries rather than realizing possibilities. There is nothing generative - creative - about reformation. In fact, reformation has a "lethal gene" within its structure. That gene is the natural order of an organization, industry or system's ability and will to resist, circumvent and overcome the tools of reformation, requiring new tools, new rules, new regulations and new restrictions. This becomes a vicious cycle. While the nature of the system actually does change, where the goal was reformation, it is most often a dysfunctional change which does not produce the desired results and often makes things worse.

The tools of transformation may actually begin with the same ideals and goals as reformation, but now, rather than attempting to impose the changes necessary to achieve those ideals and goals, a transformative process initiates behavioral changes which become self-sustaining, not because of rules, regulations and restrictions but because the images of the desired changes are internalized by the organization which then finds creative and novel ways of achieving those changes.

It is possible for an organization to meet rules, regulations and restrictions perfunctorily without ever experiencing the transformative power which was hoped for by those who fashioned the external pressure for change. In terms of healthcare administration, policy makers can begin reforms by restricting reimbursement for units of work, i.e., they can pay less for office visits or for procedures. While this would hopefully decrease the total cost of care, it would only do so per unit. As more people are added to the public guaranteed healthcare system, the increase in units of care will quickly outstrip any savings from the reduction of the cost of each unit.

Transformation of healthcare would result in a radical change in relationship between patient and provider. The patient would no longer be a passive recipient of care given by the healthcare system. The patient and provider would become an active team where the provider would cease to be a constable attempting to impose health upon an unwilling or unwitting patient. The collaboration between the patient and the provider would be based on the rational accessing of care. There would no longer be a CAT scan done every time the patient has a headache. There would be a history and physical examination and an appropriate accessing of imaging studies based on need and not desire.

This transformation will require a great deal more communication between patient and provider which would not only take place face-to-face, but by electronic or written means. There was a time when healthcare providers looked askance at patients who wrote down their symptoms. The medical literature called this *la maladie du petit papier* or "the malady of the small piece of paper." Patients who came to the office with their symptoms written on a small piece of paper where thought to be neurotic.

No longer is that the case. Providers can read faster than a patient can talk and a well thought out description of symptoms and history is an extremely valuable starting point for accurately recording a patient's history. Many practices with electronic patient records are making it possible for a patient to record their chief complaint, history of present illness and review of systems, before they arrive for an office visit. This increases both the efficiency and the excellence of the medical record and it part of a transformation process in healthcare delivery.

It will require educational tools being made available to the patient in order for patients to do self-study. Patients are already undertaking this responsibility as the most common use of the internet is the looking up of health information. It will require a transformative change by providers who will welcome input by the patient to their care rather seeing such input as obstructive.

This transformation will require the patient and the provider to rethink their common prejudice that technology - tests, procedures, and studies - are superior methods of maintaining health and avoiding illness than self-discipline, communication, vigilance and "watchful waiting." In this setting, both provider and patient must be committed to evidence-based medicine which has a proven scientific basis for medical-decision making. This transformation will require a community of patients and providers who are committed to science. This will eliminate "provider shopping" by patients who did not get what they want from one provider so they go to another.

This transformation will require the reestablishment of the trust which once existed between provider and patient to be regained. The restoration of trust between the provider and patient cannot be created by fiat. It can only be done by the transformation of healthcare in to system which we had fifty to seventy-five years ago. With that trust relationship coupled with modern science, healthcare can produce a new dynamic which we call patient-centered medical home. In this setting the patient must be absolutely confident that they are the center of care

but also they must know that they are principally responsible for their own health. The provider must be an extension of the family. This is the ultimate genius behind the concept of Medical Home and it cannot be achieved by regulations, restrictions and rules.

- Process Analysis and How Many Tasks Can You Get A Provider to Perform at Each Encounter?

  How can healthcare providers design a solution to a complex healthcare problem, particularly when the problem is not generated by a patient's request but by a public-health need? In the former case, the provider simply determines if the request is appropriate or not. In the latter case, no one is in the provider's office requesting a service; a requirement has been established and it is up to the provider, in the midst of many other demands, to remember and to fulfill the requirement. In the case of infectious diseases, requirements have been published for providers to report the occurrence of dozens of conditions.

- Teaching Tool for PC-MH Course â€“ Patient Care Activation, Engagement, Shared-Decision Making

  This document began as a summary to a specific patient as is explained in the Introduction below. In addition, it is being prepared as an example to the two Senior Medical Students from the University of Texas Health Science Center at San Antonio School of Medicine (UTHSCSA) who were participating in a Senior Medical Student Selective in Patient-Centered Medical Home. In addition, because of this patient's personal sophistication in information technology and because his care illustrates many elements of PC-MH, this document morphed into an excellent example of how electronic health records (EHR), used in the practice of electronic patient management (EPM), can produce an analysis of a patient's health status and how EHR and EPM can design a plan of care and a treatment plan for a complex patient. The EPM tools which SETMA uses (all of which are displayed at www.jameslhollymd.com under EPM Tools) allows us to break the patient's healthcare needs down into pieces, but then compile those pieces into a cohesive and integrated, global plan for the patient's care.

  This document would not be appropriate for every patient but the process of its development is appropriate for all patients. And, because this document is going to be used as an example to future medical students and residents who spend time at SETMA, it has been prepared anonymously so as to be HIPAA compliant. The specific instructions to our patients can be found in red on pages: 10, 15, 18, 19.

- Tutorial for the EMR Automated Team Function

  In 1993, John Patrick set IBM on another course and changed the company's future. Reading his story made me wonder, is it possible for SETMA to set medicine on another course and to change the future. John did not want people to work "collaterally," side by side, maybe going in the same direction, maybe even having the same goal, but working independently and at best in a cooperative manner; he wanted

people to work “collaboratively,” synergistically, leveraging the generative power of a team in creating a new future which they partially envision but which even they could not control.

What can we do today in healthcare which would mirror the changes IBM experienced? How can we change “collaterallists” into “collaborativists”? How can we use the power of electronics, analytics, and informatics principles to energize radical change to create a new future in healthcare? Testing and measurement is a science. In most industries, quality is determined by testing performance. But, in healthcare we are involved in a new kind of “testing.” The tests used to measure the performance of healthcare providers are unique. Therefore, if you are going to measure the quality of care given by healthcare providers:

- SETMA's Model of Care Patient-Centered Medical Home: The Future of Healthcare Innovation and Change

  There are at least three hundred models of care described in the medical literature. Each one was defined to improve care of patients while focusing on a particular aspect or method of care. As healthcare policy and plans have defined new goals for our healthcare system, they have suggested even newer models of care. The Institute for Healthcare Improvement (IHI) defined the Triple Aim in 2007. The goals of improving patients’ experience of care, improving community health and decreasing healthcare cost have led to and provided increased incentive for new structures of healthcare delivery, chief among those has been patient-centered medical home.

  As SETMA has worked both to qualify and to function as a patient-centered medical home (PC-MH), we defined a model of care which is different from previously published ones. With this October, 2013, update of *The Future of Healthcare, Innovation and Change, SETMA’s Model of Care, patient-Centered Medical Home*, SETMA has qualified as an NCQA Tier III PC-MH (2010-3016) and as an AAAHC medical home (2010-2014). In October we will submit application to URAC and in February, 2014 to Joint Commission for accreditation as a PC-MH.

  As this iteration of our Model of Care description is prepared in October, 2013, we believe that in the last three to six months, we have begun to understand and to function as a “real” medical home. Terms like “shared decision making”, “patient activation”, “patient engagement”, “patient-centered conversation”, “care coordination”, “coordinated care”, and “care transitions” are more than vocabulary with definitions. They are real to us, in experience, and form the dynamic of what was initially a structure of PC-MH.

- NCQA Interview February 14, 2014: Written Answers to Questions Submitted by Ashley Carter NCQA, Communications Specialist

  When I started practicing medicine in 1975, primary care was high volume - which referred more to the number of patients seen, than to the number of tests and procedures ordered. At that time healthcare was paternalistic. Under the old model of care, which we might refer to as a paternalistic healthcare system, patients were very often told what to do and it was expected that they would follow the healthcare providers' instructions without modification. The definition of "paternalism" helps understand the old model of care; it is: "A policy or practice of treating or governing people in a fatherly manner, especially by providing for their needs without giving them rights or responsibilities."

  The dynamic of the medical home redefines the relationship of healthcare provider and patient, and changes how they relate! Rather than the patient encounter being **didactic** (to lecture or teach, as one with knowledge instructions or informs those who do not) - where the healthcare provider tells the patient what to do, how to do it and when to do it - the patient/provider encounter becomes a **dialogue (**An exchange of ideas or opinions) - where the healthcare provider and the patient discuss a mutual concern and then together come to a mutual conclusion with a mutually agreed upon plan. This new relationship is somewhat like a partnership. (see more at Paternalism or Partnership: The Dynamic of the Patient-Centered Transformation)

- Health IT to Support ACO and Group Reporting

  SETMA has experienced three overall functionalities required to meet the goals identified by CMS/ONC in this conference: Team dynamic and Being a Learning Organization - The concept of "team" and of being a "Learning Organization" from Peter Senge's *The Fifth Discipline*; Solid Philosophical Foundation, knowing both what we are doing and why we are doing it; Communication and integration of the healthcare team through the power of IT.

- The Primary Care Team: Learning from Effective Ambulatory Practices (PCT-LEAP): Performance Measures Worksheet - Robert Wood Johnson Foundation

  In 2000, we began auditing and analyzing data including using statistical analysis to look beyond individual patients to assess the quality of our population wise. For diabetes, our mean HbA1c has improved from 7.54 in 2000 to 6.64 in 2011, and our standard deviation has improved from 1.98 in 2000 to 1.2 in 2011. Gradually, we realized that we wanted to do "real time" auditing and analysis of our care. In 2009, we adapted IBM's Business Intelligence software, COGNOS, to healthcare. In that year, we began Public Reporting on over 200 quality metrics on our website.

SETMA's Model of Care Evolved To

1. Tracking metrics one patient at a time
2. Auditing metrics over panels and populations of patients
3. Analyzing the audited data to find leverage points for improvement
4. Public Reporting provider performance and transparently sharing with our patients that performance.
5. Designing quality improvement initiatives based on these four steps.

A complete description and explanation of this Model of Care can be found here: Primary Care: The Future - Primary Care Progress (PCP)
In this process, SETMA, SETMA came to believe that the future of healthcare will be founded on four domains:

1. Method -- The methodology of healthcare must be electronic patient management.
2. Content -- The content and standards of healthcare delivery must be evidenced-based medicine.
3. Structure -- The structure and organization of healthcare delivery must be patient-centered medical home.
4. Compensation - The payment must be capitation with rewards for quality in both process and outcomes.

New Transformation Tools

This section will display new transformation tools. This is consistent with the pursuit of excellence, as excellence is not a stop sign at which you arrive but it is a direction in which you are continually moving; so, transformation is never finished. Peter Senge talks about the gap between your "reality" - where you are - and your "vision," where you want to be. When you can hold both in your mind at the same time, you develop "creative tension" which drives you forward, as tension always seeks a resolution. The reality is, that when the tension has driven you to where your vision becomes your new reality, your vision will have changed and it will drive you forward more than you originally envisioned. The following are recent developments in SETMA and are thus display here.

- Chronic Care Management Code (CCM) Tutorial

  Current format of The Chronic Care Management (CCM) Code was instituted by CMS in January 2015. It was first proposed in 2013 with a projection of beginning in 2014, but the requirements were such that it would have been virtually impossible for a primary care provider to successfully use it.

  When the final version was released, changes had been made such that it could be used. Because the compliance requirements were specific and significant, SETMA decided not to deploy it until we had built a tool so that we could efficiently fulfill the billing demands and so that we could internally audit those requirements to prove that we were meeting all of the demands. The tool would also allow us easily to respond to a CMS audit if one were initiated.

  SETMA's deployment of Chronic Care Management can be found on the AAA Home template, as shown below outlined in green

- **e-Prescribing of Controlled Substances (ePCS)**

  - ePCS and High Intensity Drug Trafficking Areas (HIDTA) Program

    All Southeast Texas Medical Associates, LLP physicians can now prescribe controlled substances electronically (ePCS). A smaller group of SETMA physicians has been experimenting with this function for the past six months and now all physicians are authorized to use it,. This is another major step in the

safe and effective use of controlled substances and places SETMA in the company of only 4% of physicians nationally who are currently using this function.

In the August 20, 2015 *Examiner*, this column discussed SETMA's addressing of the "conundrum for patient and provider use of pain medications": see http://www.jameslhollymd.com/your-life-your-health/prescribing- pain-medications-a-conundrum-for-patient-and-provider. The "conundrum" is created by the tension which exists between

- patients who need pain medications and other medications which are subject to abuse,
- providers who want to properly treat patients with these medications,
- an increasing abuse of pain medications and
- increasing demands by the Texas Medical Board upon physicians who prescribe these medications.

- Prescribing Pain Medications: A Conundrum for Patient and Provider
- SETMA's letter with Inclusions sent to 105 Pharmacies About e-Prescribing

Patient-Centric Care

Welcome to SETMA's Medical Home "Story Book." The contents are the thoughts, ideas and analysis of SETMA about Medical Home and particularly about our medical home.. Formally, our story began February 17, 2009 when we attend a lecture about Patient-Centered Medical Home (PC-MH). In reality, our medical-home pilgrimage began decades ago. The initial part of our story is organized into three sections, each of which represents articles written in the years 2009, 2010 and 2011. A primer to SETMA's medical home is at: *The SETMA Model of Care: Patient Centered Medical Home; Healthcare Innovation, the Future of Healthcare*.

The following are links to some of our "stories:"

- Paternalism or Partnership - the Dynamic of the PC-MH
- Learning From One's Mistakes
- Medical Home Poster Child
- Patient Centered Medical Home Poster Child: An Update after Five Years of Treatment in a Medical Home
- Evolution of Health Care
- Homicidal Threat to Reciprocal Caring

- Medical Home Pilgrimage - Stories

Never sell your “stories” short; they are the lessons and “learning” of your life. Through them, you will learn and grow.

Perhaps the most creative initiative in the transformation of health care is the concept of PC-MH. At a time when there is great pressure for "reforming of the healthcare system," few understand that it is only transformation which will ultimately make a permanent difference. Reform is brought about by external pressure from without to force conformity to someone else’s idea of what healthcare ought to be. Reform only works for as long as pressure is applied and it is often resisted. Transformation is driven by an internalized passion which is generated by principles, convictions and personal vision.

In 2010, SETMA was recognized by the National Committee for Quality Assurance (NCQA) as a Tier 3, Patient-Centered Medical Home and 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. In 2013 SETMA renewed NCQA’s Tier III Medical Home for 2013-2016. In 2014, SETMA was recognized by URAC and the Joint Commission for ambulatory care and for PC-MH.

It is our hope that this material may stimulate others to start their own Medical-Home pilgrimage and that others will begin to collect their own Medical-Home stories. If so, then this notebook's purpose will have been fulfilled. These articles chronicle our development of a medical home. The developmental history of SETMA will show that as early as 1999, we began defining the principles of what would become SEMTA’s Patient-Centered Medical Home. After becoming a Medical Home, SETMA realized that without knowing it, we had spent over ten years developing the functionalities which enabled us to be a medical home.

Our caution to others comes from our own failure which was that initially we focused almost totally on the structures of medical home without understanding the dynamic and spirit of patient-centeredness. Our story will repeatedly illustrate and example the tension between the structure and dynamic of PC-MH.

- Medical Home Series Two: Part I The Movie -- *People Will Talk* (1951)

  People Will Talk 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 any time, 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."

- Medical Home Series Two: Part II The Caution Lights

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.

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.

- Citadel - A 1937 Introduction to the Spirit of Patient-Centered Medical Home

There is nothing new under the sun, we are told; and, new models of healthcare reinforce the truth of that statement. As we discussed in 2011, the concept of medical home was demonstrated in the 1951 movie, *People Will Talk (see* http://www.jameslhollymd.com/your-life-your-health/medical-home-series-two-part-i- the-movie). And now, we come to an older movie which addresses the issue of professionalism and entrepreneurism. In the 1937 movie, *Citadel*, we see concierge and subscription models of care illustrated as a doctor abandons his passion for medicine for a commitment to wealth. One summary describes the doctor as being "seduced by the thought of easy money from wealthy clients, rather than the principles he started out with. (He) becomes involved with pampered private patients and fashionable surgeons."

The doctor's pilgrimage has three stages. The first occurs when he miraculously saves the life of a new-born baby. Leaving the family home with a live and healthy mother and baby, he exclaims to himself, "Thank God that I am a doctor." He labors to help the poor and to do clinical research to improve the care of those he treats. His wife is content and happy even though his wages are meager. They live and prosper on their passion not upon their possessions.

After moving to the city, the young doctor is influence by affluent physicians who refer him patients who pay handsomely for unneeded attention from a medical doctor. At first he is shocked at the amount of money which can be made in this turnstile referral system which maximizes reimbursement. Then he enjoys the clothes, the home, the cars and all the other things he can buy. But, his wife laments his loss of passion for medicine even though she has many "things."

Rich, our young doctor is now insensitive to innovative efforts to improve healthcare, brought to him by his friend, many of which innovative opportunities would require him to contribute his own funds to the new efforts. His friend's vision was rejected. Ultimately, the friend was injured in an accident caused by our young doctor's callousness. His friend dies because, while the elegantly dressed specialist has made him wealthy, he incompetently causes the death of the friend at surgery. It is then that our doctor looks around him and sees the suffering and the need and his heart is soften and he returns to his roots.

The Moral Test

At the heart of patient-centered medical home is The Moral Test of a government; Hubert H. Humphrey said: "The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped." This same test can be applied to healthcare organizations and to health care providers.

In SETMA's September, 2013 Provider training, we watched small parts of *Citadel* and each SETMA provider was given a copy of the DVD. The snippet from the first stage of the doctor's career shows him thanking God that he a physician; the second shows his declaration that he has the right to make money; the last shows recovery of his professional soul as he begins to see the suffering around him. As they played in our meeting, there was a hush over the room. The gripping heartache, as our young physician sees the suffering around him and as he realizes that he in part was responsible for the death of his friend, caused us all to be silent.

Patient-centered medical home does have a structure and the final steps to being a medical home includes effective structure, the heart and soul of PC-MH is a dynamic born of a passion and a commitment to caring for others and particularly for those who cannot afford the care they need.

- Paternalism or Partnership: The Dynamic of the Patient-Centered Transformation

  The dynamic of the medical home redefines the relationship of healthcare provider and patient, and changes how they relate! Rather than the patient encounter being **didactic** (to lecture or teach, as one with knowledge instructions or informs those

who do not) - where the healthcare provider tells the patient what to do, how to do it and when to do it - the patient/provider encounter becomes a **dialogue (**An exchange of ideas or opinions) - where the healthcare provider and the patient discuss a mutual concern and then together come to a mutual conclusion with a mutually agreed upon plan. This new relationship is somewhat like a partnership.

Healthcare Providers No Longer Constables

The concept of a patient encounter being a dialogue where the interests and desires of both parties are respected and engaged is alien to the old paternalistic model of care. The only way in which the patient-centric conversation in a healthcare encounter can be a dialogue is where patient and provider become collegial and where they entered into a collaborative relationship.

On October 1, 1999, five months after SETMA had defined the structure of the medical home, SETMA published a booklet about EMR entitled, *More Than a Transcription Service: Revolutionizing the Practice of Medicine And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) which Evolves into Electronic Patient Management* (the booklet can be read athttp://www.jameslhollymd.com/your-life-your- health/transcription-more-than-a-transcription-service). In that booklet, SETMA said:

> "Doctors need to learn new technological ways of organizing and conducting the business of medicine. They need to allow the power of information systems to change the way they approach healthcare. They need to maintain personal contact; patients are people first and last, but doctors need to see EMR as a powerful tool and not simply as a new and expensive toy. If they do, they will begin the 21st Century with an ability to impact the delivery of healthcare in America.
>
> "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."

In 1999, we did not know that we were defining the most critical half of patient-centered medical home, i.e., patient-provider collaboration. It would take thirteen more years before terms like "shared decision making," "activated patients," "patient engagement," "patient-centered conversations," and programs like "Conversation

Ready" would guide us to the fulfillment of the vision of patient-centered medical home. In coming weeks, we will look at illustrations of the fulfillment of the dynamic of patient-centered care and at illustrates of how we failed to practice that dynamic.

- What is patient-centered communication? Have you really addressed your patient's concerns?

  This link is to a power point presentation which was prepared for one of SETMA's monthly training meetings. This study is based upon a paper entitled, "What is Patient Centric Conversation," (*FAMILY PRACTICE MANAGEMENT(*www.aafp.org/fpm), March 2008, Ronald M. Epstein, MD, Larry Mauksch, MEd, Jennifer Carroll, MD, MPH, and Carlos Roberto JaÃ©n, MD, PhD." The paper includes concepts such as: "A physician-dominated medical encounter, with little opportunity for patient input," "A patient-centered medical encounter, without explicit agenda setting," "Two important elements of patient-centered communication: drawing out a patient's true concerns and identifying which ones to address first." "Physicians often assume that: first concern a patient mentions is the most important one; that patients will spontaneously report all of their fears and concerns." Neither of these assumptions is true. Think of the patients who wait until the end of the visit to report substernal chest pain.

  It was only after reading, studying and teaching the concepts in this paper that I truly understood what a patient-centered conversation was.

- SETMA 8.20.13 Provider Training -- Health Affairs 2.14.13 -- Patient Engagement

  This power point was created from the *Health Affairs*, February 14, 2013, and was taught in SETMA's Provider Training, August 20, 2013. It contain concepts of patient engagement such as: "A growing body of evidence demonstrates that patients who are more actively involved in their health care experience better health outcomes and incur lower costs"; "'Patient activation' refers to a patient's knowledge, skills, ability, and willingness to manage his or her own health and care"; "'Patient engagement' is a broader concept that combines patient activation with interventions designed to increase activation and promote positive patient behavior, such as obtaining preventive care or exercising regularly"; "'Patient engagement' is one strategy to achieve the 'triple aim' of improved health outcomes, better patient care, and lower costs."

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Tutorial for SETMA's Internal HCAHPS Survey

  Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a structured set of standards by which to measure healthcare provider and hospital performance. SETMA has long had the philosophy that if healthcare providers are going to be held accountable for certain actions, they ought to: Know what they are going to be held accountable for; Measure their performance before an external organization reports this performance at some distant time in the future; Have a plan

and a method for improving their performance. In August, 2014, SETMA designed a system by which SETMA's Care Coordination department in the Care Coaching Call the day following discharge from the hospital, SETMA could assess our own HCAHPS performance. While this will not be accepted as THE official score, it does involve SETMA providers in the fulfillment of these standards. Below this tutorial is a lengthy discussion of SETMA's 8-day pilgrimage to excellence in HCAHPS performance as a function of patient-centeredness in inpatient care. This is the beginning of our becoming patient-centered in our inpatient care...

- The Conversation Project

  For patients, traditionally, healthcare has been a spectator sport. Almost like a passive bystander, patients were told what, when, where and how to receive "healthcare." That system worked fairly well when there was little which could be done for illness; but, in the 21st century when many things can be done, new questions arise such as:

  1. Even when something can be done, should it be done?
  2. When there are several different things which can be done, which one does the patient want done?

  Maureen Bisognano, CEO of the Institute for Healthcare Improvement (IHJI) and a recognized international expert on improving healthcare systems, has taught us to ask a much more profound question and that is, "What do you want?" The elimination of the word "done," changes the healthcare conversation from one of procedures, tests, services, etc., to one of outcomes, goals and desires. It changes the conversation from science to humanity.

  One of Maureen's most significant contributions to healthcare improvement -- The Conversation Project -- resulted from her personal experience. The Project; is IHI's program to make certain that healthcare providers, healthcare recipients and the healthcare system know how to talk about end-of-life issues. The key is to ask the question, "What do you want?"

  Maureen's personal and poignant story was about her brother who died when he was 21 and Maureen was 23. She shared their story:

  "When my brother Johnny was 17 years old, he was diagnosed with Hodgkin's disease. It progressed quickly, and he was in and out of hospitals regularly over the next several years. When Johnny was 20, he came to my apartment and told me, 'I'm not gonna make it.' He was ready to face death, but I wasn't. I didn't know what to say or do. All I could think of was to offer encouragement and try to give him hope. But Johnny stopped me and asked me, 'Can I tell you what I want?' 'What do you want? I asked him. 'I want to turn 21,' he said.

"Johnny did turn 21 and died just a few days after that birthday. Throughout that last year of his life, I still didn't grasp the power of that simple question that Johnny was asking me to ask: "'What do you want?' Looking back, I wonder what might have come from asking that question. I wonder about the people Johnny would've wanted to meet and see. I wonder about the conversations they might have had. And I wonder about the functionality he could have had, to the extent he could, out of the hospital. But instead of Johnny realizing his wishes for his last year, he spent it mostly in the hospital. I finally learned the power of the question from a radiation oncologist. While Johnny was in the hospital during that last year of his life, doctors would come and go from his room. They'd speak over him, and about him, but almost never to him. Finally, this radiation oncologist went into my brother's room and asked him, 'Johnny, what do you want?' 'I want to go home,' Johnny answered.

"The doctor then took off my jacket, put it on Johnny, picked him up from his hospital bed, and carried him to my car. Johnny came home, and spent his final days surrounded by the friends and family that loved him. That one interaction between Johnny and the radiation oncologist taught me not to rely on just providing encouragement and hope. These things are important, but more important, almost always, is having the conversation with a loved one about what they want. Find out what they want, then act on it, and carry it through. Trust me, you'll be forever grateful you asked, 'What do you want?'" I wept as I read this story for the first time.

Patient-Centered Medical Home (PC-MH)

As Southeast Texas Medical Associates has spent the last five years becoming a PC-MH, we have developed technologies to do "things" and to perform "actions" and to fulfill "metrics," but we have only recently begun to understand the power of "patient centric conversations," "patient activation," patient engagement," and "shared decision making." We have begun to understand that each of these categories is more than a once-and-for-all act. They are a dynamic which are more accurately addressed in the continuing tense of the verb. We have begun to understand that patient-centric requires continuous re-engagement more than just engagement, continuous re-activation more than just activation, and patient-centric conversions are not a single conversation but is an on-going dialogue which takes place at many venues, at many times and with many different contents. We have begun to understand that patient-centric is more completely defined by the profound question, "What do you want?" than it is by the powerful electronic capabilities we have created.

IHI's 'the Conversation Project"

SETMA's end-of-life conversation, which we perform with every patient and which we document as part of the structure of our medical home, is always begun by "What do you want us to do?" What we should be asking is, "What do you want?" My life stories reinforce what Maureen has taught us.

As a sophomore in high school, I learned a lesson which has enabled me to carry out the most difficult personal and professional tasks. One day, my friend's father died suddenly. That evening, I went his home. I remember feeling very awkward. I knew that I should be there, but at fifteen, I didn't have the foggiest idea what to do, or what to say.

Only one other friend came. We made small talk and tried to forget the great loss. At one point, we were talking about our families. I said, "If my father ever did that, I'd kill him." If spoken words have a life beyond the hearing and memory of those present, these words seemed to have; eternal life. They hung in the air like a Damocles sword waiting to fall on my head. If I did not know what to say, I surely knew what not to say and I had just said it. Kindly, my friend glossed over my blunder. The evening ended with goodbyes and expressions of sorrow.

The next day, after his father's memorial service, my friend was sitting in the family car. I walked over and said, "Louis, I don't know what to say." Wiser than I at fifteen, he said, "You don't have to say anything, you were there." To that point in my life, I had never heard kinder words. They echoed in my mind louder than what I had blurted out the night before. I turned them over and over in my mind, again and again. My friend and I never spoke about this, but fifty-five years later, I have never forgotten those words.

Twenty years ago, I had a 24-year-old patient who declared that she had a dread disease but no diagnosis could be made. A year later, during a pregnancy, we found the malignancy which was incurable. She was from the Pacific Northwest and returned there. Three months later, she called me and said, "Can I come home?" As she was with her parents, I thought she was. She added, "No one will talk to me; they pretend that everything is OK," They had the same problem I had when I was fifteen. She concluded, "I want to come home so that I can talk about what is happening to me."

She returned to Southeast Texas and for the next six months, we visited and talked often. We prayed and planned for her son's life. My wife and family were involved with her. Never once did we talk about medicine, surgery, pills or treatment. She did not want that; she wanted to come home. She wanted to talk about the future and her life, not her death. We never talked about healthcare; we talked about what she wanted.

- Patient and Family Engagement: Part I

  Addressing the importance of patient engagement the authors quoted other sources: "'Patient engagement has been called a critical part of a continuously learning health system', 'a necessary condition for the redesign of the health care system', the 'holy grail' of health care, and the next 'blockbuster drug of the century'." The concept of a "continuously learning health system" is not developed in this article, but it is illustrated. As stated by Peter Senge in The Fifth Discipline, "continuously learning" is

not so much defined by the "taking in of more information," but it is the "changing of one's mind" about the structures and systems which leverage change in the processes and outcomes of healthcare delivery. It is this kind of learning we are pursuing in understanding "patient engagement." While giving the healthcare community theories about healthcare delivery redesign, the authors also have given us practical descriptions and guidelines for how to implement patient engagement.

Definitions

Definitions and understanding of the concepts of this redesign are inextricably related. The authors stated: "Adding to the confusion, the term patient engagement is also used synonymously with patient activation and patient- and family-centered care. Although the concepts are related, they are not identical" If healthcare providers are going to be able to make the transition from expecting "compliance" on their clients part, to the experience of patients "adhering" to a mutually agreed upon healthcare plans of care, it is imperative that we understand the vocabulary.

- "Patient activation-an individual's knowledge, skill, and confidence for managing his/her own health and health care -- is one aspect of an individual's capacity to engage in that care. But this term does not address the individual's external context, nor does it focus on behavior.
- "Patient- and family-centered care is a broader term that conveys a vision for what health care should be: a partnership among practitioners, patients, and their families (when appropriate)' to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.
- "...Patient and family engagement as patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system-direct care, organizational design and governance, and policy making-to improve health and health care. Although we use the term patient engagement for simplicity's sake, we recognize that those who engage and are engaged include patients, families, caregivers, and other consumers and citizens."

With these definitions, we can begin to design activities which support the processes they identify. The authors then identify circumstances which are driving patient engagement:

- "First, work related to patient- and family-centered care and shared decision making both reflects and accelerates the shifting roles of patients and families in health care as they become more active, informed, and influential.
- "Second, a growing body of evidence suggests that patient engagement can lead to better health outcomes, contribute to improvements in quality and patient safety, and help control health care costs.
- "Third, virtually every discussion about the US health care system begins by noting that spending is spiraling upward while quality lags behind. In the search

for solutions, gaining ground is the belief that patients are at the core of our system and, as such, are part of the solution."

Similarities to Healthcare Reform and Healthcare Transformation

In many ways, patient engagement, patient activation, and patient centeredness, which all lead to patient adherence as contrasted with the coercive nature of the concept of compliance, are not unlike the dialectic between healthcare reform and healthcare transformation. Healthcare reform, similar to patient compliance, comes from the external pressure of rules, regulations and requirements. Healthcare transformation, similar to patient adherence comes from internalized ideals which become a personal passion. Ideals voluntarily adopted create a tension between the current state of affairs and the goals of the ideal. That tension creates a transformative energy which is therefore self-sustaining and generative.

Exhaustion in healthcare delivery results from providers trying to "drive" the patient to good health. This is the "old system" where the provider was the "constable" attempting to impose health upon the patient. When the patient is engaged and activated by patient-centric care, the patient joins the provider in driving the healthcare process to excellence. This is the "new system" where the patient and provider are colleagues, working together for common goals and outcomes.

Nursing Home

- EPM Tools - Nursing Home

  The Nursing Home is a unique place to practice medicine. The special needs of patients in the nursing home provide an opportunity for electron patient management to raise the standard and the level of that care. SETMA's nursing home service team provides an excellent level of care in that all patient management is done through the EMR. SETMA has design a special suite of templates for the nursing home. These templates address the five most difficult problems faced in long-term residential patient care. SETMA has designed special templates for each of these concerns and these templates are used in many other places in SETMA's electronic patient management.

  This is one of the great strengths of EPM - a solution to a problem in one setting, can be used in all other settings where that same problem occurs. With the use of the EMR and with the continuity of care provided with EPM, SETMA has reduced nursing home patients' admission from a national standard of 7-10% to below 3.5%. This shows the power of EPM not only for quality of care but also for reducing the cost of that care.

- Nursing Home Suite of Templates Tutorial

  For many reasons, the long-term residential-care setting presents serious and unique challenges to excellence of care for patients who require such placement. SETMA's commitment to dignified, personal and excellent care for all who require long-term-residential care, whether due to advanced age and infirmity, disability and infirmity, or other reasons, has resulted in the forming of a team of healthcare professionals to coordinate and deliver that care. This team is supported by a reference laboratory, mobile x-ray service and hospital-care team which provide a continuity of care between the outpatient, inpatient, and residential-care settings. With this commitment SETMA has expanded the use of electronic patient records, and, electronic patient management, into the long-term residential-care setting. The Nursing Home Suite of Templates is the foundation of that expansion.

- Nursing Home Guidelines for Care Tutorial

  The full name of this template is **Guidelines for Care of Nursing Home Patients**. It consists of 28 sets of guides for treatment of specific problems which are common in many clinical settings particularly in long-term residential care.

- Tutorial for SETMA's Deployment of the Texas Department of Aging and Disability Services' Reduction of Antipsychotic Medications Toolkit

  Tutorial for SETMA's Deployment of the Texas Department of Aging and Disability Services' Reduction of Antipsychotic Medications Toolkit. In an effort to decrease the inappropriate use of antipsychotic medications in Texas Nursing Homes, The Texas Medical Foundation and the Texas Department of Aging and Disability provided this toolkit. Because SETMA provides care to over 90% of the long-term care residents in Southeast Texas, which comprises a five county area, and because SETMA documents the care of those patients in our electronic patient record (EMR), we have taken this tool kit and created a Clinical Decision Support tool to improve the care of the patients for whom we have responsibility.

- Nutrition Assessment Tutorial

  One of the most neglected areas of acute and critical care is nutrition. Also, one of the most litigated areas in long-term residential and/or nursing home care is malnutrition. SETMA's Nutrition Assessment Template makes it possible to objectively document a patient's nutritional status in regard to: Risk Factors for Malnutrition; Physical Signs and Symptoms of Malnutrition; Chemical and Metabolic Indications of Malnutrition.

- Skin Care Tutorial

  The next template which is unique to the Nursing Home Suite of Templates is Skin Lesions. The full name of the template is "**Clinically Unavoidable Skin Lesions**." Skin lesions are common in long-term care facilities, and often are unavoidable. This template helps identify the patients who are at risk of unavoidable skin lesions. **Risk Factors** - 22 conditions are listed which contribute to the patient's being at risk for "Clinically Unavoidable Skin Lesions." These should be reviewed and any risk factors which apply to the patient should be documented by checking the box next to it. These are in demographic fields, which means that once they are checked, they remain checked in subsequent visits until they are unchecked…

- Hydration Assessment Tutorial

  It is often relatively easy to demonstrate that a patient is currently dehydrated or hydrated. However, it is often difficult to declare with objective evidence that while the

patient is dehydrated today, he/she was not dehydrated at their last healthcare encounter. The **Hydration Assessment** tool is designed to enable you to objectively establish the patient's state of hydration and to document that in an objective, supportable way. This tool is particularly important to use in the Nursing Home setting as the patient's state of hydration is an important aspect of long-term residential care and is often the focus of malpractice actions.

- Fall Risk Tutorial

  This is one of the greatest health threats to all elderly patients but particularly to those who are in long-term residential care. Through the review of seven categories, a score is developed which indicates whether the patient is at high risk or low risk of falls.

- Depression Tutorial

  Depression is a serious and often life-threatening problem in the elderly and particularly in the elderly in long-term residential care facilities. In addition, the complexity of mediation treatment of the elderly is greater because they are often on multiple drugs which have serious interactions. While this template is mostly educational, it is key to the successful treatment of residents of long-term care facilities

Medical Home SETMA, LLP The Story and the Ideals

- Medical Home

Medical Home - Display and Explanation of SETMA's Patient-Centered Medical Home Tools

- Display and Explanation of SETMA's Patient-Centered Medical Home Tools