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## 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

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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  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.