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A New Day in Healthcare for You and for Us
Part III – Medical Home
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"You're 'one in a million,''" Few things qualify for this statement and most often it is an exaggeration. So it would be if anyone claimed that in being a patient-centered medical home, they are "one in a million." Nevertheless, they are in a special group. Currently, there are two organizations who offer a medical practice the opportunity to be examined for whether or not they qualify as a "medical home": National Committee for Quality Assurance (NCQA) which was founded in 1990 and the Accreditation Association for Ambulatory Healthcare (AAAHC) which was founded in 1979.

There are approximately 230,000 medical groups in the United States. As of March, 2010, fewer than 500, have achieved the status of "medical home." No figures exist for how many practices have received medical home designation in the past four months, but assuming that it is 50 a month, there are now 700 recognized medical homes in the United States. This means that .3 of 1% of physician groups have achieved patient-centered medical home status. That is far from being one in a million but it is the exception rather than the rule at present to be a "medical home". As of March, 2010, there was only one medical home group in Texas.

NCQA and AAAHC

This is the context of Southeast Texas Medical Associates, LLP (SETMA) achieving of medical home status by both NCQA and AAAHC. To our knowledge no other medical practice has sought review by both organizations. The two processes are different and the outcomes differ also. NCQA awards "recognition" as a patient-centered medical home after the review of an extensive application which can be hundreds of pages long. NCQA identifies 9 Standards, 30 Elements and 183 data points as the standard for medical home. AAAHC awards "accreditation" as a medical home after the review of a briefer application and an on-site survey of the practice by a team of physicians and administrators. AAAHC's definition of medical home is found in seventeen "core chapters," which address concerns common to all ambulatory health care organizations, and a comprehensive chapter on medical home. Further analysis of the similarities and differences between these two processes will be addressed in a subsequent article.

In AAAHC's recent exit conference at SETMA, the following statements were made about SETMA:

1. "SETMA is an exquisite organization."

2. “Clearly your passion has achieved a level of clinical care based on evidenced-based medicine which is inspirational and is found in very few practices. Your results approach those of the best practices in the country.”
3. “You are one of few practices in this rare atmosphere.”
4. “I haven’t seen an electronic patient record which facilitates chronic and preventive care like yours anywhere. This is the best I have every seen.”

AAAHC pointed out areas where SETMA needs to create written polices and procedures for what we are doing. Over the next year, we have plans to write down the policies and procedures which will document what we are already doing. We learned many things in this survey about how important it is to “write down” what we do in provider education, risk management, peer review and an area which we have never thought about, which is that in addition to responding to hospital credentialing and privileging requirements, the need for us doing our own practice credentialing of our providers and of delineating their privileges. We are confident that after responding to AAAHC’s survey results, we will be a stronger and better organization.

SETMA’s response to the AAAHC survey, both their affirmation of the quality of SETMA’s work and their challenging of us to complete and to document the administrative processes which we have neglected, is for SETMA to move farther down the road toward excellence. We have established a one-year plan for to achieve this.

What is unique about a medical home?

Coordinated Care

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

“Coordination” has come to mean to SETMA, scheduling which translates into:

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

As with the structure of quality metrics in tracking, auditing, analyzing and public reporting process and outcomes measures, coordination requires intentional efforts to identify opportunities to:

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

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

Director of Coordinated Care (DCC)

The Director of Coordinated Care is responsible for building a department of Care Coordination. In many ways this could be called the "Marcus Welby Department," as it recognizes the value of each patient as an individual and has as its fundamental mission the meeting of their healthcare needs and helping them achieving the degree of health which each person has determined to have. The driving force is to make each patient feel as if they are SETMA's ONLY patient, just like Dr. Welby.

Initially, the DCC will work as a department of one but will have others assigned to the department as the demands of the mission expand. The DCC will establish protocols and methods for facilitating the care of patients with: special needs, complex-care needs, disease management and case management needs.

An illustration of this new function will be that of a patient who is seen at SETMA's Wilson clinic on the West End of Beaumont. The provider determines that the patient needs an

echocardiogram. The nurse will call the Care Coordination Department, which will determine if the patient can be sent to the Ultrasound Department immediately to have the test done that day. We believe that this will increase patient satisfaction as well as compliance which will improve the quality of care the patient will receive.

Integration of Care

The medical home sees the patient as a whole and not as a collection of isolated and disconnect disease processes. While this is not new and has always been the ideal of health care, it becomes a significant focus of the patient-centered medical home. Not only is the patient the major focus of the attention given, but all elements of the patient's needs are attended to and future needs are anticipated and addressed. No longer is a patient encounter simply used to address current needs but potential future needs are identified and addressed. For instance, the young person who is seen for an upper respiratory condition but who is moderately obese, and who has a family history of diabetes, has his disease-risk addressed. In addition, recommendations are made for diabetes prevention and wellness including exercise, weight reduction, avoiding tobacco and others. Future contacts are scheduled, with our without a clinic visit, for assessing whether the patient has made the changes necessary to maintain their health.

Furthermore, through NextMD, SETMA's secure web portal, the patient is referred to education material for achieving the desired results and a follow-up contact via e-mail is scheduled to remind the patient, without a clinic visit and without cost, to pay attention to their health.

Quality of Care and Patient Safety

A medical home measures the quality of care which patients are receiving both through process analysis and outcomes measurement through quality metrics. Quality Improvement Initiatives are planned for the improvement of care across an entire population of patients. For instance, while it is anticipated that the new Director of Coordination of Care will result in improved care, that must be measured and analyzed before it will become obvious that the anticipated improvement has occurred.

As the Director of Coordinated Care works with SETMA's Call-Center staff to address preventive health needs of our patients, it will be important to see if more people are getting their mammograms, bone densities, immunizations, etc. If they are, then the position will have proved value. If they aren't then new ways will have to be used to improve those outcomes.

If the Director of Coordinated Care is responsible for scheduling multiple visits or studies on the same day, it will be necessary to measure whether or not that has improved compliance and consequently quality of care.

If the Director of Coordinated Care is responsible for evaluating whether the post-hospital follow-up call program and the post-clinic-visit follow-up call program is having the desired

result, it will be necessary to measure those outcomes. If the desired result does not occur new or additional initiatives will have to be designed.

Continuity of Care

To be a medical home, a practice must provide communication with a personal physician who accepts primary responsibility for the patient's care. This is more than a friendly affect when the patient is seen in the clinic. It means answering inquires about health from the patient at times other than when they are seen in the clinic. It means providing telephone access with same-day response; e-mail contact through a secure web portal with same day access; it mean eliminating a patient's anxiety about whether or not their healthcare provider cares about them by the provider being available to the patient. It may mean in some cases that the patient has the provider's home telephone number or cell phone number. It means doing whatever is necessary for making sure the patient knows how to access care when it is needed. The reality is that the more confident a patient is that they can reach their provider when needed; the less likely the patient is to pester the provider over trivial or unimportant matters.

Continuity of care in the modern electronic age means not only personal contact but it means the availability of the patient's record at every point-of-care. One of the AAAHC surveyors said that his standard for judging medical records is, "Could I pick up this chart and provider excellent care for a patient whom I had never seen?" His answer after reviewing dozens of SETMA charts is, "I could easily treat any of these patients as the records are legible, complete and well organized." Because all of the patient's health needs are clearly documented; because all preventive and screening health needs are constantly and automatically audited; because every patient's laboratory results, medications and diagnoses are interactive; every patent can be confident that all of their health needs are being addressed, can be addressed and will be addressed, no matter who the provider is that they see..

Another issue of continuity of care is communication among all providers and institutions that are providing care for each patient. The Health Information Exchange which SETMA is launching will provide the confidence that care given by hospitals, emergency rooms, specialists, other primary care providers, etc., will be accessible to all providers and will be integrated into the patient's health record. In addition the secure web portal, NextMD, will allow the patient to maintain and periodically review their own personal health record. This places the patient at the center of their healthcare decision-making process, which is the ideal of patient-centered medical home.

Conclusion:

NextMD, HIE (Health Information Exchange) and now medical home are elements of the "new day" in health care for patient and provide alike. Other elements will be discussed in coming days.