James L. Holly, M.D.

Pilgrimage to a Patient-Centered Medical Home
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For the past two years, Southeast Texas Medical Associates (SETMA) has been on a journey to be recognized as a patient-centered medical home (PCMH)—although, in truth, the journey began more than a decade ago.

The Beaumont, TX–based multispecialty practice began aggressively working with managed care in 1997, says CEO **James L. Holly, MD.** "This was an effective way to address many of the needs of our patients, especially the cost, quality, and access to care by our medically most vulnerable friends and neighbors." SETMA then became involved in Medicare Advantage, which enabled the practice to extend care to many patients who previously could not afford or obtain it.

In 1998, SETMA adopted electronic health records, but soon realized that they were too expensive and difficult to manage if the only benefit was an electronic method of documenting a patient encounter. So the following year, SETMA redirected its efforts to electronic-patient-management and began developing disease and data management tools.

In 2000, SETMA determined that to provide excellent care, it needed to track the quality of care, audit the care given to populations of patients, and statistically analyze its outcomes. "We began tracking and auditing various quality metrics, including diabetes, hypertension, care transitions, congestive heart failure [CHF], and chronic stable angina— most of which were published by Physician Consortium for Performance Improvement. In time, we expanded that to include other nation- ally recognized metrics," says Holly. Finally in 2009, SETMA embarked on its journey to be recognized as a PCMH.

Recently, Holly discussed with *HealthLeaders* his views on SETMA's care model, healthcare reform, and the lessons learned along the way:

HealthLeaders: What were driving forces behind your decision to adopt a PCMH model of care?

Holly: The features of medical home which intrigued, attracted, and challenged us were:

- The process of coordination of care and the outcome of coordinated care.
- The further development of our team approach to healthcare, including a truly collegial relationship between nurses, medical assistants, administration, information technology, nurse practitioners, and physicians.
- The realization that the "patient-centered"element of medical home was the ultimate reality of the principle we have stated to our patients for the past fifteen years.
- We have long given our patients report cards telling them what they should expect from their healthcare provider. Now, we have added outcomes transparency to those expectations with our decision to publicly report process and outcomes metrics.
- Our COGNOS Project (using business intelligence software to build a data mart and auditing tools) enables us to do real-time auditing on our care processes and outcomes.
- Believing the key to 21st century healthcare is thinking about our patients when they're not in our presence and using technology to fulfill the requirements of excellent care.

This process led us to seek medical home recognition from the National Committee for Quality Assurance [NCQA] and accreditation from the Accreditation Association for Ambulatory Healthcare [AAAHC], the two bodies offering evaluation of medical groups as medical homes.

HL: How does your model of care work?

Holly: At the core of SETMA's practice is that one or two quality metrics will have little impact upon the outcomes of healthcare delivery. SETMA employs two definitions: A "cluster" is seven or more quality metrics for a single condition (i.e., diabetes or hypertension), and a "galaxy" is multiple clusters for the same patient (i.e., diabetes, hypertension, lip- ids, and CHF). SETMA believes that fulfilling clusters and galaxies of metrics at the point of care will change outcomes.

The following are the key elements of our model of care:

- The **tracking** by each provider on each patient of their performance on preventive, screening, and quality standards for acute and chronic care. Tracking occurs simultaneously with the performing of these services by the entire health- care team, including the provider, nurse, and clerk.
- The **auditing** of performance on the same standards either of the entire practice, each individual clinic, and each provider on a population or panel of patients.
- The **statistical analyzing** of the above audit performance to measure improvement by practice, by clinic, or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, socioeconomic groupings, education, and frequency of visit.
- The **public reporting** of performance on hundreds of quality measures by provider. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease-management-tool plans and medical-home-coordination document summarizes a patient's state of care and encourages them to ask their provider for any preventive care that has not been provided. We believe this is the best way to

overcome provider and patient treatment inertia.

- The design of **Quality Assessment and Permanence Improvement initiatives**. This year, SETMA's initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension, and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital.

HL: How easy was it to transition to this model of care?
Holly: It is one of the most difficult things we have done. I use the word "is" because I believe that all of us who already have medical home recognition or accreditation or both are still in the process of transforming the practice of medicine by the principles, ideals, and goals of medical home. The formal process took SETMA from February 16, 2009, to the date we first submitted our NCQA application on April 12, 2010.

The transition is a true transformation rather than a reformation. 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 if enough pressure is brought to bear. Unfortunately, reshaping under pressure can permanently alter the structural integrity of that which is being reformed. Also, once the external pressure is eliminated, the object often returns to its previous shape as nothing has fundamentally changed in its nature. Transformation is not dependent upon external pressure, but is sustained by an internal drive, which is energized by the evolving nature of the organization.

The currently proposed reformation of the healthcare system does nothing to address the fact that the structure of our healthcare system is built upon a patient coming to a healthcare provider who is expected to do something for the patient. There is little personal responsibility on the part of the patient for their own healthcare, whether as to content, cost, or appropriateness.

Transformation of healthcare would result in a radical change in the patient-provider relationship. The patient would no longer be a passive recipient of care. The collaboration between the patient and the provider would be based on the rational accessing of care based on need, not desire.

HL: How is the patient experience different today under this model?
Holly: The patient experience has dramatically changed. For instance, the patient's care is evaluated on the basis of more than 200 quality metrics; the patient receives a summary of these quality metrics with a recommendation to contact his or her healthcare provider to request that any metrics not completed be done and care transition points are attended to; and a "plan of care" and "treatment plan" baton is handed off to the patient so that they can participate effectively as the head of their healthcare team.

Because of SETMA's department of care coordination, every patient who leaves the hospital receives a follow-up call the day after discharge. This is not a 15-second administrative call to

fulfill a metric, but it is a 12–30 minute call, which has substance. Selected patients seen in the clinic receive follow-up calls at any interval determined by the healthcare provider related to vulnerabilities or complexities of their care.

In addition, both during the visit and in the treatment plan, a section is included which is entitled, "What If?" This section shows the patient how his or her risk will change if a number of individual elements or a combination of multiple elements used to calculate the risk is changed.

HL: What steps did you take to ensure your providers and support staff were on board?

Holly: The first step we took in transforming our practice was an in-depth evaluation of our practice by the medical home standards published by CMS and NCQA. All of our executive management staff and providers were involved in this evaluation, which resulted in a 400-page review of our practice. The evaluation allowed all of our providers to see where we were, where we needed to go, and be part of the transformative process.

We looked at the requirements for medical home and designed tools that made it easier to fulfill the requirements than not to fulfill them. We were able to transform our disease management tool follow-up documents into plans of care and treatment plans.

We close the clinic one-half day each month and have a seminar to discuss the ideal of medical home and how we are performing or not performing. We have illustrations of where we are doing it well, and we share that by e-mail daily; and when we do not do it well, we share that as well.

We welcome and seek ideas from all members of our team to improve our processes and outcomes. We post on our website by provider name performance on more than 200 quality metrics.

HL: What advice do you have for practices seeking to undergo a similar transition?

Holly: Look into your own organization for the creativity and energy to change. There are many consultants and agencies who would like to charge you hundreds of thousands of dollars to transform you. At best that will be reformation. Transformation can only come from within, and it can only be sustained by your own passion, resolve, and relentless pursuit of excellence. Get counsel from those who have succeeded, evaluate their ideas, and modify them to your situation. Often the best help is free. Excellence and expensive are not synonyms.

HL: For practices seeking recognition as a medical home, what should they know about the application process?

Holly: It is tedious and complex, particularly NCQA. But that may just reflect my prejudice about forms; others may find them simple and straightforward. Currently, less than 1% of medical practices have any form of medical home recognition, so the process is in its infancy. It is SETMA's judgment that an ideal process would be a combination of AAAHC

and NCQA.

HL: What lessons have you learned along this journey? Holly: It is worth the process, the price, and the pain. This is the future of healthcare, and it is possible to be part of that future now. It is not easy, but it is not impossible. Measure your success by your own advancement and not by whether someone else is ahead or behind you. In the same way, share your success with others.

The following steps will help:

- Determine where you are and where you want to be.
- Select the template or model you will follow.
- Outline the steps you will take.
- Develop a timeline for completing each task.
- Be innovative. Emulate the best of others, but expand upon their work and make it yours
  Be patient but eager
  Enjoy what you are doing and celebrate where you are.