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Continuity, Creativity, Consistency Part V
Organizational Philosophical Foundation
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Sometimes the elements of organizational development are only discovered in retrospect, which means that the development happens and then the principles of that development are seen and understood. In 2014, when SETMA sought and achieved Joint Commission (formerly known as Joint Commission on the Accreditation of Healthcare Organizations, JACHO) accreditation for ambulatory care and for Patient-Centered Medical Home, they recognized the philosophical foundation to SEMTA.

Both the surveyors and one of the executives at The Joint Commission commented about the philosophical foundation of SETMA's work. Wednesday March 5, 2014, the executive said: "I was just talking to one of my colleagues and showing him SETMA's notebook which was prepared in response to The Joint Commission's 'Standards and Requirements Chapter Seven of leadership.'" The executive said, "Look at this; everything they do is founded upon a philosophical foundation. They know 'what they are doing,' but more importantly, they know why they are doing it.'"

SETMA is not the result of random efforts but of innovations and advances which are consistent with a structured set of ideals, principles and goals. This foundation is the puzzle into which the pieces of transformation fit, contributing to the healthcare portrait which is SETMA. It is helpful that The Joint Commission recognized this and commented upon it. It is one of the strengths of SETMA and it is one of the principle guides to SETMA's development history, i.e., what caused SETMA to become what it is.

Similarly, the Robert Wood Johnson Foundation (RWJF) in conjunction with their Learning Through the Learning from Exemplar Practices (LEAP) Study, conducted by the MacColl Institute addressed their perception of SETMA's uniqueness which addresses a foundational principle of SETMA's growth and development. In their report, the fifth area of uniqueness of SETMA identified by the RWJF team was a surprise to them; it was SETMA's IT Department. The RWJF team felt that SETMA approached healthcare transformation differently than anyone they have seen. They related that uniqueness to the decision SETMA made in 1999 to morph

from the pursuit of "electronic patient records" to the pursuit of "electronic patient management."

They were surprised to see how centrally and essentially electronics are positioned into SETMA and how all other things are driven by the power of electronics. They marveled at the wedding of the technology of IT with clinical excellence and knowledge. The communication and integration of the healthcare team through the power of IT is novel, they concluded.

Innovation, Diffusion of Ideas and the Medical Home

Another observer made the following comments about SETMA's growth and development. The original observation can be reviewed at Innovation, Diffusion of ideas and the Medical home: http://healthinnovators.blogspot.com/2014/01/innovation-diffusion-of-ideas-and.html.

"Early in my medical school education, I heard about the "science to service gap", i.e. " it takes 13 years for proven medical improvements to become mainstream." But after 20 years of clinical practice and 17 years of work with informatics, I consider it a truism.

"During my medical informatics work, it has become more than a curiosity as to why the 'science to service gap' exists. About 5 years ago, I discovered a series of books that explain the Diffusion of Innovations by Everett Rogers who was a professor of communications. It helped me to understand that there is a natural variation, a bell curve of sorts, for how any group adopts innovation. Since negative news travels fastest, physicians often get a bad rap when it comes to adopting health information technology (HIT) due to the vocal nature of what Rogers called 'laggards.' That is a complex topic for posts in the future. I would encourage anyone interested in innovation to read Rogers 2003 5th edition of Diffusion of Innovations as it includes many lessons learned during the 40 year period following his 1st edition in 1962.

"I recently re-visited a web site which comprehensively documents the 19-year journey of a medical home practice that was formed in 1995, called SETMA. The link to the SETMA site is a great example of how diffusion of innovation can happen within an organization with visionary leadership. I had the pleasure of meeting Larry Holly, MD, the founder of SETMA and I would encourage anyone interested in how to create a cultural framework for innovation to read his web site, which is beyond comprehensive in its depth and breadth of information shared. (emphasis added)"

Transformation

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.

At the core of these four principles is SETMA"s belief and practice that one or two quality metrics will have little impact upon the processes and outcomes of healthcare delivery and, they do little to reflect quality outcomes in healthcare delivery. In the Centers for Medicare and Medicaid Services (CMS) 2006 Physician Quality Reporting Initiative (PQRI), followed by the 2011 Physician Quality Reporting System (PQRS), and in 2017 replaced by the Merit-Based Incentive Payment System (MIPS), healthcare providers are required to report on at least three quality metrics and for MIPS twelve to be reduced to eight. SETMA's believes this is a minimalist approach to providers' quality reporting and is unlikely to change healthcare outcomes or quality. PQRI, PQRS and MIPS allows for the reporting of additional metrics and SETMA reports on 28 PQRS measures and reports on over 200 to our website by provider name. This has been done from 2009 through 2016 and continuing.

SETMA employs two definitions in our transformative approach to healthcare via quality metrics:

- A "cluster" is seven or more quality metrics for a single condition, i.e., diabetes, hypertension, etc.
- A "galaxy" is multiple clusters for the same patient, i.e., diabetes, hypertension, CHF, etc.

SETMA believes that fulfilling a single or a few quality metrics does not change outcomes, but fulfilling "clusters" and "galaxies" of metrics, which are measurable at the point-of-care, can and will change outcomes.

The SETMA Model of Care

1. The tracking by each provider on each patient of the provider's performance on preventive care, screening care and quality standards for acute and chronic care. SETMA"s design is such that tracking occurs simultaneously with the performing of these services by the entire healthcare team, including the personal provider, nurse, clerk, management, etc.
2. The auditing of performance on the same standards either of the entire practice, of each individual clinic, and of each provider on a population, or of a panel of patients. SETMA believes that this is the piece missing from most healthcare programs.
3. The statistical analyzing of the above audit-performance in order to measure improvement by practice, by clinic or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, payer class, socio-economic groupings, education, frequency of visit, frequency of testing, etc. This allows SETMA to look for leverage points through which SETMA can improve the care we provide.
4. The public reporting by provider of performance on hundreds of quality measures. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease management tool "plans of care" and the medical-home-coordination document summarizes a patient's state of care and encourages them to ask their provider for any preventive or screening care which has not been provided. Any such services which are

not completed are clearly identified for the patient. We believe this is the best way to overcome provider and patient "treatment inertia."

5. The design of Quality Assessment and Permanence Improvement (QAPI) Initiatives.

The principles and this philosophy have provided the structure and content for SETMA's practice transformation.