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Questions About SETMA
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The following questions were put to SETMA by a national organization trying to help others replica our experience.

1. **How did you become interested in the technology side of healthcare?**

My interest came because it is possible for healthcare providers to be overwhelmed by the volume of medical decision making information. And that information is not easily accessed at the point of care. In the early 1990s we began to see that electronic patient records had the potential for making information available for improving the quality and safety of treatment

In 1995, I read *The Fifth Disciple*, in which Peter Senge stated: "System thinking is needed more than ever because for the first time in history, humankind has the capacity:

- To create far more information than anyone can absorb,
- To foster far greater interdependency than anyone can manage
- To accelerate change far faster than anyone's ability to keep pace.

Senge concluded that healthcare provider confidence is undermined when the vastness of available, valuable and applicable information is such that it appears futile to try and "keep up." In healthcare, once confidence is undermined, responsibility is surrendered as providers tacitly ignore best practices, substituting experience as a decision-making guide. While experience is not without merit, in medical decision making, it is not the best guide.

Senge added, "Systems thinking is the antidote to helplessness that many feel in his “age of interdependence.'" It because apparent the informatics, electronic patient records and ultimately electronic patient management would allow us to "see" how the treatment of one disease processes is required in order to augment and/or to facilitate the treatment of another. An integrated, intuitively organized EMR was the solution.

2. **In 1998, electronic medical records were barely on any physician group's radar. How did SETMA know how to implement them and determine that it would make sense to adopt the then very new technology?**

   Thirty-seven years ago, when I started practice, I bought a Dictaphone which I couldn't make work. A few months after I had returned the Dictaphone to the supplier, my records were subpoenaed by a patient suing a fast-food chain. Not being terribly busy, I took my medical record and showed up in court. When I was sworn in, the judge asked if I had my records. I passed them to him. Looking over his glasses the judge turned to me and asked, "Can you read this?" I looked and said, "No, sir." To which he responded, "Son, I recommend that you get a Dictaphone." I did; I repurchased the same instrument I had returned three months before.

   But even a Dictaphone and transcription only improved the legibility of paper records without solving the p[portability, the availability and the interoperability of paper records. Paper-based records only created an accurate and complete account of a healthcare encounter, but the information was still:

   - Static - there was no data in the record which could be correlated or analyzed;
   - Geographic - the record stayed in one place;
   - Non-integrated - the record couldn't interact with other systems in the medical office.

   When SETMA was founded in 1995, we realized that pencil and paper (19th century medical record technology) and dictation and transcription (20th Century medical records technology) would not support 21st Century health care advances. In 1997, SETMA partners attended the annual MGMA conference and looked at EMRs. March 30, 1998, we bought our EMR. It took until January, 1999, to build the EHR system to where we could use it and we were off and running.

3. **How difficult was the learning curve for adopting technology in your medical group? ? Has it paid off?**

   Four months after SETMA deployed our EHR, January 26, 1999, we experienced four seminal events. First, we realized that EHR was too hard and too expensive if all we gained was the ability to document a patient encounter electronically. If we could not leverage the power of electronics to improve the care of each and of all patients, it was not worth it. We immediately morphed into pursuing electronic patient management (EPM) with disease management, clinical decision support with a focus on care quality and safety.

   Simultaneously, my co-founding partner expressed frustration saying, "We're not even crawling yet." I responded "You're right, but we have begun and I am going to celebrate that. If in a year, we have not advanced, I will join your lamentation, but today I am going to celebrate our beginning." That celebratory spirit empowered and sustained the core of SETMA's culture. The third event was we wrote, published and distributed a paper 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.

This allowed our community and our patient colleagues to share our vision, passion and expectations.

The fourth seminal moment was the publication of ten principles of our model of care, which foreshadowed our adoption of PC-MH. They are:

1. Pursue EPM rather than EHR..
2. Bring to bear upon every patient encounter what is known rather than what a 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. Establish and 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 the Consortium for Physician Performance Improvement Data Sets.
10. Create multiple disease-management tools which are integrated in an intuitive and interchangeable fashion giving patients the benefit of expert knowledge about specific conditions while they get the benefit of a global approach to their total health.

These principles have guided and sustained us for the ensuing fifteen years.

4. Why did you decide to develop a medical home? How has that model contributed to the health of your patients?

Technology Can Deal with Disease but Cannot Produce Health

Medical Home became a logical and essential progression for SETMA because we must not be seduced by technology. Healthcare demands a dynamic tension between humanity and technology. Technology can contribute to the solving “disease problems” but ultimately cannot solve "health problems." With "health home" we can rediscover the trusting bond between patient and provider. In the "health home," technology becomes a tool to be used and not an end to be pursued. The outcomes of technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

Future generations will experience healthcare methods and possibilities which seem like science fiction to us today. Yet, that technology risks decreasing the value of our lives, if we do not in the midst of technology retain our humanity. As we celebrate science, we must not fail to embrace the minister, the ethicist, the humanist, the theologian, indeed the ones who remind us that being the bionic man or women will not make us more human, but it seriously risks causing us to being dehumanized. And in doing so, we may just find the right balance between technology and trust and thereby find the solution to the cost of healthcare.

The science of quality metrics have made us better healthcare providers. The public reporting of our performance of those metrics has made us better clinician/scientist. But what makes us better

healthcare providers is our caring for people. This is Patient-Centered Medical Home. In reality, SETMA did not so much "decide" to become a PC-MH, as we arrived at a point in our development where it was the only logical next step. As EHR had transformed our approach to healthcare and to patient encounters, PC-MH provided a method for achieving the results we wanted.

5. **SETMA takes quality metrics seriously. How do you as a leader of the organization instill in your group the importance of achieving a variety of clinical measures?**

After surveying SETMA, The Joint Commission commented: "Everything at SETMA 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, all of which are driven and sustain by an internalized passion for excellence.

Optimal health at optimal cost is the goal of quality care. Metrics are like a healthcare "Global Positioning Service": they tell you where you want to be; where you are, and how to get from here to there. It is as Abraham Lincoln said, April 16, 1856: ***'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,' "***

This is the imperative for data analytics and performance auditing by healthcare providers. Auditing gives providers a coordinate of where they are in the care of a patient or a population of patients. Ultimately, success will be measured by the well-being of patients, but the guide posts to that destination are given by the analysis of patient-population data.

No metric alone provides a granular portrait of the quality of care a patient receives, but multiple metrics and multiple sets of metrics can give an indication of whether the patient's care is going in the right direction or not. However, the collection of metrics must be incidental to excellent care and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible.

This philosophy and our intuitively designed tools which automatically aggregate the data, makes it easier for providers to do what is right than not to do it at all, which makes the effort sustainable.