James L. Holly, M.D.

What is SETMA's Medical Home? Part II
By James L. Holly, MD
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The Goal of SETMA's and of Your Medical Home

The Goal of SETMA's medical home – of YOUR medical home – is to fulfill both the Triple Aim as defined by the Institute for Healthcare Improvement (IHI) and the Moral Test of Healthcare delivery as defined by Vice-President Hubert Humphrey in September, 1977. The "Moral Test" of government is: "How that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped." While this was defined as the "moral test of a government," SETMA has adopted this as the test by which we measure our standards of care and of conduct.

In 2007, the IHI launched the Triple Aim Initiative which includes the "simultaneous pursuit of three aims":

1. Improving the experience of care
2. Improving the health of populations
3. Reducing per capita costs of health care"

IHI defined a set of components of a system that would fulfill the Triple Aim. Five of the components are:

1. Focus on individuals and families
2. Redesign of primary care services and structures
3. Population health management
4. Cost control platform
5. System integration and execution"

It is in pursuit of the Triple Aim before and after we learned of it, that SETMA has been redesigning primary care's service and structures. In reviewing the ten principles of EHR design and of practice design in 1999, it can be seen by while we did not know the principles of the Triple Aim, we intuitively were pursuing those goals since our origins.

What Does the Medical Home Mean to You?

Essentially, the medical home model means that you are no longer a passive recipient of healthcare instructions from a healthcare provider, but you are now an active participant in your own care. Viewed as a "race," your health-care is yours to run. Viewed as a "baton" in a relay race, you will carry your baton for the majority of your life. With 8760 hours in a year, and with your formal healthcare received from a healthcare provider occupying fewer than twenty hours a week, you are in charge of your care for over 8740 hours a year.

SETMA being a medical home means that your care will be "coordinated", i.e., you will know where, when and how to obtain the care you and your provider have determined that you require. It means that you will receive a plan of care which is more than a prescription and a follow-up visit. It means that in a process called "shared-decision making," you and your SETMA provider agree upon comprehensive steps to retain or regain your health. It means that because active learning is the only effective way for you to participate in your own healthcare decision making, your "activation" occurs when you gain the knowledge and skills needed. This is called "activation," after which you become "engaged" in your care.

The foundation of this new dynamic is the patient-centric conversation in which you and your provider discuss your healthcare concerns and needs in a dialogue which is an active process rather than the traditional monologue where you passively received information and instructions. Under the old model of care, which might be referred to as a "paternalistic" healthcare system, you were very often told what to do and it was expected that you would follow the healthcare providers' instructions without modification.

"Paternalism" meant "treating you in a fatherly manner, especially by providing for your needs without giving you rights or responsibilities." The medical home redefines your relationship with your provider and changes how you relate! Rather than healthcare encounters being didactic (to lecture or teach, as one with knowledge instructions or informs), where the healthcare provider tells you what to do, how to do it and when to do it, the patient-centric encounter becomes a dialogue (an exchange of ideas or opinions) - where you and your provider discuss mutual concerns and together come to a conclusion with a mutually agreed upon plan. This new relationship is somewhat like a partnership.

The concept of a patient encounter being a dialogue where your interests and desires are respected is alien to the old paternalistic model of care. The only way in which the patient-centric conversation in a healthcare encounter can be a dialogue is where you and your provider become collegial and where you both enter into a collaborative relationship.

As we transformed our ambulatory practice into a PC-MH, we began to understand that your convenience and satisfaction were important aspects of healthcare transformation. In August of 2010, SETMA struggled with whether "patient convenience" was a worthy goal. As we formed our Department of Care Coordination, we began to realize that "coordination" meant 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 (adherence) 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.”

It is your right to have your care coordinated for your convenience and as a result, it is your responsibility to be engaged in your care. That not only means that you adhere to the plan you have developed in collaboration with your healthcare provider but that you are involved in developing your healthcare plan of care and treatment plan.

Part of that plan is seeking the counsel and collaboration with other healthcare provider when needed through a “referral process.” The “referral process” does not just mean choosing a provider from who a referral will be obtained, but also it means you keeping the appointment for the consultation requested by the referral and it means that your medical home will track that process to make sure that:

1. The referral request is completed according to standards of excellence
2. The consultant receives your healthcare information which supports his/her ability to give you the maximum benefit from the consultation.
3. The consultants notes and conclusions are included in your primary care providers’ electronic health record.
4. The recommendations of the consultant are incorporated into your plan of care and treatment plan after discussion with you.

Welcome to your medical home. This is what you can and should expect. It is new and it is hard work for you and for us. We believe that in the medical home your care will improve, your satisfaction with your care will improve and the effectiveness and safety of your care will improve. We still have a great deal to learn, but together we will learn and we will transform healthcare.