Empowering Future Physicians Conference
American Student Medical Association
UT School of Medicine, San Antonio
October 19-21, 2012

Primary Care: The Future of Medicine

Conflict of Interest Disclosure

Dr. James L. Holly, MD

- Salary: No
- Royalty: No
- Receipt of Intellectual Property Rights/Patent Holder: No
- Consulting Fees (e.g., advisory boards): No
- Fees for Non-CME Services Received Directly from a Commercial Interest or their Agents: No
- Contracted Research: No
- Ownership Interest (stocks, stock options or other ownership interest excluding diversified mutual funds): No
- Other: None
- Dr. Holly has no conflicts which need to be disclosed

James L. Holly, MD
CEO, SETMA, LLP
Adjunct Professor
Department of Family and Community Medicine
University of Texas Health Science Center
San Antonio School of Medicine

The Dimensions and Dynamic of Primary Care In The Future: Harnessing the Unique Skills of a Multi-Disciplinary and Interdepartmental Team in the Transformation of Healthcare

Primary Care Providers

1. Must know we are the “people specialists.”
2. May be only hope for real healthcare transformation.
3. Must distinguish professional and pecuniary interests.
4. Must re-define the primary care community and welcome the participation of those kept at arms length.
5. Must embrace the changes which are already taking place and lead healthcare transformation.
6. Must know change is coming with or without approval.
7. Must know this is the greatest time in history to be in primary care.

Transforming vs. Reforming

- The national healthcare policy debate has been fashioned in terms of reform.
- “**Reformation**" depends upon pressure from the outside; "**transformation**" comes from an essential change of motivation and dynamic from within.
- Anything can be reformed -- reshaped, made to conform to an external dimension -- if enough pressure is brought to bear. But, once the pressure is eliminated, redirected or lessened, the object returns to its previous shape, as nothing has fundamentally changed in its nature.

The Tools of Reformation

- **Reforming tools**: rules, regulations, and restrictions. Focused upon establishing limits and boundaries rather than realizing possibilities. There is nothing generative (creative) about reformation.
- The "lethal gene" of reform is the inclination of organizations to resist the tools of reformation.
- This requires more and newer tools, rules, regulations & restrictions with which to exert more pressure.

Transforming vs. Reforming

- Reform does nothing to change the healthcare model of a patient going to a provider, expecting something to be done to or for the patient. In this model, the patient was and is passive.
- There is little patient responsibility for their own care, as to content, cost, or appropriateness.
- This model offers no patient/provider leverage for improvement of care, health or cost.

Transformation

- Changes the nature of the organization.
- Is generative (creative) producing the energy and power for sustainable improvement.
- Is not dependent upon external pressure, but is energized by an internal drive which is the nature of a "learning organization. "
- Fueled by personal passion, it is self-sustaining, requiring no reward or recognition to continue.

The Tools of Transformation

- **Transformation creates mental images of what the future can be**.
- **These images are internalized** by the individual and by the organization.
- The images morph into **a personal and organizational vision**, which produces a passion for creating a remarkable future.
- These mental images then create new images, which propel further innovation and transformation.

Transformation Principle I: **Relationship**

- The healthcare provider is no longer a “constable” attempting to impose health upon a patient – the provider is a counselor, a consultant, a colleague, empowering the patient to achieve the health status he/she has determined to have.
- Provider and patient, with many others, are active team members, working together to preserve or improve the patient's health.
- All members of the team know and acknowledge that the “race of life is the patient's to run.”

Transformation Principle II: **Communication**

- Will require more communication between patient and provider, not only in face-to-face clinic encounters, but also by electronic or written means.
- The concept of *la maladie du petit papier* -- "the malady of the small piece of paper“ is no longer valid.
- Patients who came to the office with their symptoms written on a small piece of paper were thought to be neurotic.

Transformation Principle II: **Communication**

- Practices with electronic patient records are making it possible for a patient to record their chief complaint, history of present illness and review of systems, before they arrive for an office visit.

- And, when, as at SETMA, all care is documented in the same data base, by all members of the healthcare team, at all venues of care, the EMR creates a continuity of care record of excellence, increasing patient safety with seamless communication among members of the team.

Transformation Principle III: **Knowledge**

- Patients, becoming more knowledgeable about their condition than ever before, allows them to participate actively in their own care.
- Educational tools must be made available to the patient in order for them to do self-study.
- It will require a transformative change by providers who will welcome input by the patient to their care rather than seeing such input as obtrusive.

Transformation Principle IV: **Trust**

- The patient and the provider must rethink their common prejudice that technology - tests, procedures, and studies - are superior methods of maintaining health and avoiding illness than communication, vigilance and "watchful waiting."

- Both provider and patient must be committed to evidence-based, patient-centered medicine, which has a proven scientific basis for medical-decision making.

- This transformation will require a community of patients and providers who are committed to science and to personal relationships of mutual respect.

Transformation Principle IV: **Trust**

- Transformation will require the reestablishment of the trust which once existed between provider and patient. That cannot be done by fiat.
- Patients must be absolutely confident that they are the center of concern and of care.
- Patients must also know that they are principally responsible for their own health.
- These concepts are the genius behind Patient-Centered Medical Home and this trust cannot be achieved by regulations, restrictions and rules.

Transformation Principle V: **End of Life Planning**

- Patient and provider must lose their fear of death and surrender their unspoken idea that death is the ultimate failure of healthcare.
- Death is a part of life and it cannot forever be postponed.
- While the foundation of healthcare is that we will do no harm, recognizing the limitations of our capabilities and the inevitability of death can lead us to more compassionate and rational end-of-life choices.

Primary Care is the Future of Healthcare

- As primary care providers are the key to transformation of healthcare, primary care providers must be actively involved in the defining of public policy.

- To be successful, they must be able to put their personal and pecuniary interests aside and support and promote policies which will create a sustainable future for healthcare.

Public Policy Principle I

Piece Work Created the Healthcare Problem

- Governmental policy created the current conditions in which we find healthcare.
- Payment by "piece work" put the government's check book in providers' hands.
- A change in healthcare provider reimbursement is critical to the future of healthcare.

Public Policy Principle II
Must Reward What is Valued

Healthcare system must reward what the system promotes.

- Transformative activities in healthcare are **relational** rather than **technological**.
- The healthcare payment method must promote transformation by rewarding efforts to restore the patient/provider trust relationship.

Public Policy Principle III

Patient Centered

- The patient must be placed at the **center of concern** in the healthcare equation.
- The patient must also be at the **center of responsibility**.
- Patients cannot be allowed to be passive in their care and they cannot transfer responsibility for their own care to anyone else.

Public Policy Principle IV
Education Services

- Healthcare policy must pay for patient educational medical services but not in such a way as to create a new industry.
- Providers who create educational opportunities for their patients should be rewarded for doing so.
- A key part of this education is a personalized plan of care and treatment prepared for the patient at each patient encounter.

Public Policy Principle V
Accountability

- Patients, as well as providers, must be accountable for medical-decision making.
- Patients cannot be passive in the utilization of resources.
- If a patient continues an activity which adversely affects their health, there should be consequences and those could be partially financial.

Public Policy Principle VI

Preventive Care and Health Promotion

- The decrease in the national cost of healthcare produced by preventive care and screening care will be realized over a long period of time.
- The promoting of healthy lifestyles will also produce cost savings but over a long period of time.
- Public policy must address both as goals, recognizing that neither is a silver bullet without the other elements of transformation and public policy being addressed.

Public Policy Principle VII
Effective Change Will Be Local

- Physicians, nurse practitioners and physician assistants are working toward transforming their practices to fulfill the promise of the Triple Aim.
- To be lasting and to be effective, transformation will be done one practice at a time. Critical mass will be reached and we will see transformation of healthcare upon our country.
- Transformation will be sustained when all members of the primary care team embrace one another and create a cohesive roadmap to the future.

Information Explosion

Reality Facing Primary Care.

- The complexity of medical knowledge is created both by its volume and by the manner in which that information is packaged.
- Electronic medical records (EMR) provides the means for a shift in approach to healthcare information but does not dictate that such a shift will take place.
- Sometimes, EMR is only used as a glorified transcription tool whereby a patient encounter is documented electronically without providing significant advantages in processing of information and without the patient profiting from sound science.

Systems Thinking and Healthcare

- "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 (Peter Senge)

Medical Knowledge Overload

- In 2004, the *Journal of the Medical Library Association* published an article entitled, "How Much Effort is needed to keep up with the literature relevant to primary care?" Here are the authors' conclusions:
  - There are 341 currently active journals which are relevant to primary care.
  - These journals publish approximately 7,287 articles monthly.
  - It would take physicians trained in epidemiology an estimated 627.5 hours per month to read and evaluate these articles. That translates into 21 hours a day, seven days a week, every month.

Medical Knowledge Overload

- Without medical knowledge, quality-of-care initiatives will falter, but the volume of medical knowledge is so vast that it can overwhelm healthcare providers.
- Medical Informatics is the only way to bring the right information to the right place at the right time with the right outcome.
- If anyone harbors the delusion that your intellectual prowess is the exception, I remind you of the millions of data points of the human genome which in your professional careers will be a part of clinical medicine. No one can memorize that much information.

Primary Care is the Future of Healthcare

- Primary care physicians have been part of the major changes which have taken place in medicine. Now primary care physicians are resisting the changes being caused by nurse practitioners and by physician assistants.

- There are some things which NPs and PAs do better than physicians.

- **First Step: Can we all agree to stop using the condescending and patronizing terms "physician extenders" and "mid-level providers?"**

Primary Care Innovative Response

- The **Doctor of Nursing Practice (DNP)** is a revolution in nursing education that brings highly educated nurses to the healthcare team.
- The degree program was developed from 2000-2005 in response to the series of eight Institute of Medicine (IOM) reports (during Dr. Ken Shine's IOM Presidency) including *The Quality Chasm* and *To Err is Human*.

- The DNP programs have grown from 10 in 2005 to 200 in 2012.
- DNP curriculum emphasizes not only Advanced Practice Nursing, e.g., NP, skills and knowledge, but the application of engineering and business principles to healthcare, systems thinking, simulation, root cause analysis, human factors (theoretical underpinning for patient safety and quality), leadership development, cost value analysis, health policy, and information technology.

Primary Care is the Future of Healthcare

- Primary care providers will define new “models of care” and with experimentation and innovation will improve the healthcare system.
- This is illustrated by a primary-care-dominated, multi-specialty care group in Southeast Texas.
- **Created on a collaborative, team model, SETMA’s primary care team includes nurse practitioners, nurses, specialized (but not specialty) care delivery teams, administrative staff and physicians.**

Transforming of Healthcare

Four elements are essential to any sustainable, affordable and desirable healthcare transformation:

1. **The Substance** -- Evidenced-based medicine and comprehensive health promotion
2. **The Method** -- Electronic Patient Management
3. **The Organization** -- Patient-centered Medical Home
4. **The Funding** -- Capitation with payment for quality outcomes

SETMA Model of Care

1. The **tracking** by each provider on each patient of their 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.

SETMA Model of Care

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.

SETMA Model of Care

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."

SETMA Model of Care

5. The design of **Quality Assessment and Permanence Improvement** (QAPI) **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. We have completed Business Intelligence Reports which allow us to analyze our hospital care carefully.

Passing the Baton

- Perhaps the most radical change you are going to face in healthcare is the realization by the entire community that the all knowing and all powerful healthcare provider no longer exists.
- Modern medicine makes it clear that the patient is responsible for the overwhelming amount of their own care, which includes compliance with formal healthcare initiatives and with lifestyle choices which support their health.

Passing the Baton

Firmly in the providers hand
-- The baton -- the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The Baton

- The genius and the promise of the Patient-Centered Medical Home are symbolized by the “baton.”
- Its display will continually remind the provider and will inform the patient, that to be successful, the patient’s **care must be coordinated**, which must result in **coordinated care**.
- The new model of health care will require that all practices have a Department of Care Coordination, which will address transitions of care and which will embrace the healthcare-team which will evaluate, define, and execute all care.

The Healthcare Team

- Medical Home places major emphasis upon issues historically the concern of nurses such as “plans of care” and “treatment plans.”
- Physicians who use EMRs are discovering that the nursing staff can make the difference in the excellent and efficient use of this documentation and healthcare-delivery method.
- The nurse is a healthcare colleague essential to the patient’s healthcare experience.

The Healthcare Team Restructuring: Harmonics

- "Harmony" on the healthcare team is not the absence of discord; it is the presence of a common passion.
- In a room filled with tuning forks, all of a different frequency, when you strike one fork, all which are of the same frequency, or a multiple of the same frequency, will begin to sound.
- In this analogy, Nurse Practitioners, Physician Assistants and Primary Care Physicians have the same "frequency."

Harmonics

When the “sounding” is of **excellent in healthcare delivery, evidence-based medicine. containing the cost of healthcare while maintaining the quality**; **increasing access by removing barriers,**

each member of the healthcare team

– nurse, NP, PA, dentist, physician, scientist, physical therapist, laboratory technician --

will begin to resonate, with a common passion for the process of improvement in the delivery of healthcare.

Harmonics

- So the healthcare delivery team, becomes a symphonic orchestra made up of instruments which are different in sounding method but which harmonize to produce a positive result.
- Remember, the Greek word *symphonia* means "**sounding together**." So it is that the members of the healthcare-delivery team "resonate together" to produce the results we all desire.

The Primary Care Team

- The ideal setting in which to deliver and to receive healthcare is one in which all healthcare providers value the participation by all other members of the healthcare-delivery team. **In fact, that is the imperative of Medical Home.**
- Without t**eam-consciousness** and **team-collegiality**, Medical Home is just a name which is imposed upon the current means of caring for the needs of others.
- The lack of a team approach at every level and between every department of medicine creates inefficiency, increased cost, potential for errors and it actually eviscerates the potential strength of the healthcare system.

The Primary Care Team

More and more healthcare professionals
are discovering that
while their training isolates
them from other healthcare professionals,
the science of their disciplines
is crying for integration,
communication and collaboration.

Primary Care: Team Work and Collegiality

The 21st Century, Primary Care Healthcare Provider team is made up of:

- Nurse Practitioners both MSN and DNP
- Physician Assistants
- Physicians – including Internists, Pediatricians, Family Physicians, General Practitioners, Geriatricians, Gynecologists

The unique skills, interests, motivations and training of each of the units of the team work synergistically to produce an outcome superior to any that one discipline can produce by itself.

Primary Care: Team Work and Collegiality

- The uniqueness of primary care is partially seen by the fact that if a specialist wants to practice primary care, he/she cannot do that without participating in a program for training specialists in primary care.
- My and my wife's personal healthcare provider is a Nurse Practitioner. Seventeen years ago, I didn't know what a nurse practitioner was.
- Nurse practitioners' clinical judgment, diagnostic acumen, commitment to excellent care, knowledge of preventive care, screening care and coordination of care often exceeds that of some physicians.

Primary Care: Team Work and Collegiality

- Because SETMA public reports on over 250 quality metrics by provider name, we can compare the performance of NPs and physicians. This slide shows that comparison for the NCQA Diabetes Recognition program. The providers whose names are highlighted in red are NPs.

Primary Care: Team Work and Collegiality

NCQA Diabetes Measures

Encounter Date(s): January 1, 2012 to August 31, 2012

Provider	Encounters	A1c >9.0 <= 15%	A1c < 8.0 >= 60%	A1c < 7.0 >= 40%	BP > 140/90 <= 35%	BP < 130/80 >= 25%	Eye Exam >= 60%	Smoking Cessation >= 80%	LDL >= 130 <= 37 %	LDL < 100 >= 36%	Nephropathy >= 80%	Foot Exam >= 80%	Total Points
Ahmed	2,015	20.1%	58.6%	34.3%	7.8%	56.8%	61.4%	75.9%	12.8%	63.5%	74.6%	97.9%	60
Anthony	799	10.9%	78.5%	58.4%	18.0%	53.1%	77.2%	85.1%	12.1%	68.6%	96.1%	94.0%	100
Anwar	920	7.2%	78.2%	57.0%	6.5%	69.1%	67.7%	90.3%	13.3%	64.9%	89.3%	73.9%	95
Aziz	692	10.7%	75.7%	58.1%	19.7%	57.8%	51.9%	93.0%	11.1%	71.2%	90.2%	65.8%	85
Curry	141	8.5%	66.0%	54.6%	20.6%	56.7%	62.4%	100.0%	14.9%	60.3%	76.6%	70.2%	90
Darden	319	9.7%	73.0%	53.9%	11.9%	63.9%	54.9%	98.2%	13.5%	63.6%	72.4%	83.4%	85
Deiparine	663	13.9%	66.4%	48.1%	12.5%	58.4%	35.7%	90.2%	14.5%	58.8%	71.5%	63.2%	80
Duncan	570	9.6%	79.6%	60.9%	7.5%	70.4%	53.2%	91.9%	12.3%	69.5%	83.7%	70.9%	85
Halbert	913	7.1%	79.0%	60.8%	21.5%	53.1%	33.1%	86.8%	16.5%	62.4%	65.0%	60.2%	80
Henderson	614	10.1%	79.0%	59.8%	8.8%	67.6%	49.5%	96.7%	12.9%	66.4%	86.2%	83.9%	90
Holly	191	5.8%	84.8%	69.1%	7.3%	81.7%	84.8%	78.6%	9.9%	70.2%	95.8%	96.9%	90
Horn	607	8.7%	77.9%	59.3%	5.3%	53.9%	47.8%	95.3%	18.5%	57.2%	82.4%	86.8%	90
Leifeste	689	5.2%	84.5%	64.6%	13.2%	60.8%	73.7%	73.6%	8.3%	76.6%	91.3%	86.4%	90
Murphy	979	6.6%	85.2%	66.3%	18.8%	53.9%	44.3%	87.3%	10.9%	73.7%	89.9%	80.1%	90
Palang	764	9.3%	61.9%	46.2%	14.8%	62.3%	24.5%	93.3%	13.9%	54.6%	45.4%	26.8%	80
Qureshi	438	15.8%	64.8%	49.3%	12.1%	66.7%	41.1%	86.7%	16.9%	53.7%	67.6%	82.9%	73
Read	147	12.2%	80.3%	57.8%	18.4%	57.8%	60.5%	96.2%	15.0%	66.0%	92.5%	82.3%	100
Thomas	31	9.7%	67.7%	58.1%	9.7%	64.5%	48.4%	100.0%	22.6%	25.8%	58.1%	61.3%	70
Vardiman	190	8.9%	68.9%	51.1%	22.6%	53.2%	42.1%	92.9%	16.8%	58.4%	62.6%	77.9%	80
Wheeler	461	7.6%	83.1%	67.9%	18.2%	57.3%	64.9%	81.2%	12.6%	63.6%	93.5%	83.3%	100

Primary Care: Team Work and Collegiality

- The defining event of SETMA's collegial approach to relations with NPs and PAs occurred in the fall of 1996. The second day our first NP worked with us, I stepped into an examination room as she dropped a tube of blood on the floor and it broke.

- As she stooped down, I told her to stop and I asked her what she was doing. She said she was going to clean the blood up. I said, "No, I am going to clean it up. I want you to know that you are a healthcare provider with a license to diagnose illness and to prescribe treatment. You are not here as my scrub nurse, or to do what I don't want to do. We are colleagues and while we have different responsibilities, we have the same value. I will never ask you to do anything illegal, unethical or immoral. I will never ask you to do something that I would not do myself. Therefore, anything I ask you to do, I will expect you to do it. If I do and if you don't, I will do it and then I'll ask you why you didn't."

Primary Care: Team Work and Collegiality

- Our nurse practitioners take all after-hours outpatient calls with instant back-up by a physician. A different team of nurse practitioners take all inpatient calls with instant access to a physician. Our nurse practitioners are the first to see patients in the emergency department and they complete the initial evaluation of patents in the hospital with physician support and with treatment guidelines and electronic patient record algorithms to support their work.

- We have specialty teams for clinic, nursing home, hospital, and disease management. Nurse practitioners and physician, along with nurses, staff and other support team members including education, coordination and administration work together in a team setting.

Primary Care: Team Work and Collegiality

- SETMA judges that we cannot produce the results we do without the collaboration and collegiality of NPs and PAs. We support legislation to give independent practice privileges and licensure to NPs, particularly to those with doctoral level training and to PAs with exemplary training, and experience.

- With that said, we think that the healthcare model of the future will be that of SETMA with all members of the team – NPs, PAs, MDs -- working together to produce results which they could not achieve by themselves.

The Future is Primary Care

Welcome to the Future which is Primary Care – not medical primary care – interdisciplinary and interdepartmental primary care.