We talked to Dr. Martha Twaddle, HCCI's Senior Vice President of Education and Quality, just as she was leaving on a family trip to France. The conversation was edited for clarity and length.

At HCCI, you're a high-level subject matter and education expert. You're also a practicing physician, and teach resident physicians at the Feinberg School of Medicine at Northwestern University. Tell us about the different parts of your career.

For me, my career and life are very focused on a triumvirate of combined passions.

1. I love to teach! In addition to caring for patients, I see a physicians' role as being an educator; we teach patients, families, colleagues, and the public. Being a doctor is about imparting knowledge.
2. I feel a calling and a great purpose to care for seriously ill people and their families. I enjoy engaging with people and helping them to achieve wellness.
3. I want to create better models and approaches to caring for those with chronic illnesses.

These three points all complement each other, and each one makes me better at the other, so it's important that I stay involved in all three areas.

Did you always want to be a doctor?

NO! During my senior year of high school a close friend, Andy, was diagnosed with testicular cancer. He was the first one of my friends to face a serious illness, and it was scary. I went to college to find a cure for cancer, so I became a biology major. My biology teacher, who became one of my mentors, asked if I wanted to be pre-med and I said I'd rather die. I didn't know any pre-med students or doctors with whom I identified.

My junior year I did a research practicum within the medical school and found a tribe of people with similar thoughts and goals. It was then that I decided, with trepidation, to enroll in medical school. Interestingly, I went to Indiana University and was a student of the two researchers who found a cure for testicular cancer. I like the serendipity of that, and Andy is now in his early 50s and healthy, with children.

How did you become involved in Home-based Primary Care (HBPC) and find the other parts of your triangle?

People and relationships continued to guide me to my true vocation. During my sophomore year of medical school, my aunt died in hospice care. The way my family described her death, as being beautiful, positive, and spiritual, moved me. It was such a juxtaposition from my experiences in the hospital setting, where death is often not as patient-centered nor dignified.

Later, when I was the chief resident at Northwestern, my friend and boss said: "I have a job for you." I was his house and dog sitter, so I thought he was leaving town for a while. Instead, he said, "I want you to be a hospice medical director" and then walked away.

That was 1989, and I started volunteering at a small hospice in the Evanston/Wilmette area outside of Chicago. As it turns out, for their program to be Medicare certified, they needed to have a medical director. So, I volunteered there a few hours a week and enjoyed it. After my first year, I went on as a contractor doing hospice work that took me into the home.

What is your overarching vision for the HCCI curriculum?
The first thing I wanted to facilitate was a framework, or skeleton, on which HCCI can continue to build a living and dynamic curriculum.

First, we created buckets:

- Foundation Principles
- Economic Principles
- Operational Principles
- Clinical Principles

Now, we're building out each of these buckets using adult education theory, engaging the learner rather than talking at them. In late April, we began working with a dynamic instructional designer. She's making it a three-dimensional, engaging experience, one that will facilitate self-discovered knowledge. Our goal is to facilitate self-discovered knowledge. We want to help the learner find his or her own "A-Ha Moment."

What might prevent physicians or a mid-level medical professional from choosing to provide care in a home setting? How can HCCI's curriculum help them?

One barrier to expanding this type of primary care is economics. In most places, the current payment model still fee-for-service based, and there's a mismatch for reimbursement and activities. Moving to a value-based system would help make HBPC a more viable practice model

Another barrier is the unknown. I believe our curriculum will give providers greater confidence to explore this type of primary care. Many doctors today don't feel confident going into someone's home, they don't know the first thing about it, and most

physicians don't want to go where they aren't comfortable. So, that is a barrier the curriculum can help them overcome.

You're on your way to France, but what do you love about Chicago?
I've been in Chicago since 1985, and I have to admit, I like the weather! I like seasons, and I appreciate a place like Chicago where you can have three seasons all in one week. I also love the city itself. It's one of the most beautiful and accessible cities. With the lake and what my kids used to call the "Serious Tower," you can always get your bearings.

I also love Midwesterners and the friendliness of the Midwest; there's more collegiality here, even in medicine. In Chicago, we have fellowships in the field of medicine at several different universities. About eight years ago, we decided that rather than each of us having a lecture series for our one or two fellows, we would bring it together and have one series. The fellows have community with each other, and we as faculty share responsibility. That level of collaboration is unique and wonderful and makes Chicago a great place for innovation.

You're creating a curriculum that focuses on excellence in care. What is your definition of excellence?
To excel is to extend yourself beyond where you thought you could go. For me, again, it's about relationships. Relationships are where excellence is truly defined. In home-based primary care, you can know the best course of treatment, but because your patient also has other medical and family issues, excellence in regards to the guideline and in regards to how she would define it might not align. Ultimately, excellence is about how the patient would define it. Excellence is the achievement of what the ultimate stakeholder, the patient, determines is good or excellent. Excellence is negotiated between people.