James L. Holly, M.D.

Follow-up to Drs. Maxwell and Bourgoin telephone conversations on August 16th

August 17, 2017

Drs. Maxwell and Bourgoin:

This is a follow-up to our telephone conversations on August 16th.

Project REV -- Reduce Readmissions From the Primary Care Perspective -- This link is to our recent correspondence which is now preserved on our website. After our conversation yesterday, I realized that are several important matters to address:

The ideas of PC-MH apply equally to patients in the transition of care from the inpatient to the ambulatory settings as well as to patients from visit to visit and other points of transition. In addition to the principle points of prevention of readmissions which are a follow-up care coaching call the day after discharge and the follow-up visit within 72 hours of discharge, the patients activation (knowledge and preparation for self-care), engagement (actually participating in their own care) and share-decision making (understanding, embracing and agreeing to the care plan) are critical. One of the principal means of executing these three critical steps in the process of fulfilling the HCAPHS measures. The following is the tutorial for **Jameslhollymd.com | EPM Tools | Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Tutorial for SETMA's Internal HCAHPS Survey** which can be found at the following link: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Tutorial for SETMA's Internal HCAHPS Survey. This detail, annotated index guides to the understanding of the value of this tool in patient care. Couple with the fulfillment of the Hospital Core Measures, HCAPHS is a good start to preventing readmissions.

The other key issues to preventing readmissions are:

1. Care coaching and rapid follow-up visits
2. Dealing with issues which address the need for admission in the first place such as dental care. Story below is about a patient who had been hospitalized seven times in three years, was on nine medications and her health was deteriorating. After the below events transpired, in the past eight years she has not been back in the hospital; is on one medication and her health is excellent.

a. In February 2009, the first mention was made of The SETMA Foundation in relationship to Medical Home. SETMA began discussing the formation of a charitable foundation in 2003. The intent was to create a vehicle through which SETMA could help our patients obtain care when they could not otherwise afford it. In the February 26, 2009 article, it was stated: "(In) the Medical Home model, the provider has NOT done (his/her) job (by)… simply prescribing…care which meets national standards. Doing the job of Medical Home requires the prescribing of the best care which is available to the patient…" (Emphasis added)
b. "…assisting patients in finding the resources to help (them get the care they need)… (is)…a part of medical home. And, when those resources cannot be found, Medical Home will be 'done' by modifying the treatment plan so that what is prescribed can be obtained; the ordering of tests, treatments, and/or prescriptions which we know our patients cannot obtain is not healthcare, even if (that)…plan of care is up to national standards."
c. In a Medical-Home article published June 3, 2010 article and which was quoted in series two on Medical Home, August 19, 2010, the Foundation was addressed again: "The genius of PC-MH is to discover the true implications of SETMA's motto which was adopted in August, 1995…: 'Healthcare Where Your Health is the Only Care.'" It is to put the patient and their needs first… SETMA…placed the patient…at the center of… (as) we developed The SETMA Foundation, through which we help provide funding for the care of our patients who cannot afford it."
d. Medical Home and Healthcare Resources: There have been many heroes in SETMA's Foundation experience. Other, non-SETMA healthcare providers have contributed their skills and time to the care of our patients. One of the first patients the Foundation helped had very bad teeth. Beaumont dentist, Dr. Dave Carpenter, was consulted and he determined that repair of the patient's teeth would cost $10,400. The patient's health could not be helped without resolving her dental issues. It has long been known that dental care is a critical part of general health. In the case of patients with diabetes, dental care is so important; it has become one of the quality measures for SETMA's care. SETMA proposed to Dr. Carpenter that he make a $4,000 contribution to the Foundation and the Foundation would pay him $10,400 to do the dental work. Without hesitation, he agreed. The result is remarkable. First of all the patient's gratitude made the effort worth it, if there were no other benefit, but the real benefit is that the patient is off all medications and all health problems have resolved. The patient's life has been permanently changed and the patient's future has been made bright. That's Medical Home and in that a non-SETMA healthcare provider was key to its success, it really is Medical Neighborhood.
e. Another patient, who had no insurance, was virtually crippled due to degenerative disease in the hip. Surgery was not possible because there were no funds. The Foundation negotiated a payment to a local hospital for the patient's care. That same day, I approached Dr. Carl Beaudry and said, "We have a patient that needs a hip replacement and we'd like for you to do the surgery." I then said, "There's only one problem; we would like for you to do the surgery free." In the same breath, without asking any questions, Dr. Beaudry said, "OK!' The surgery has changed this patient's life.

f. Concerns about the Foundation: There have been concerns about the Foundation. One of them is about "setting precedents." This really is a question about if you help one person and can't help another, how will you deal with that. In a recent discussion about this, I said: "The fear of setting precedents is only valid if we become victims of our own beneficence. The ability to say, 'Yes,' when appropriate must be balanced by the willingness to say, 'No.' when appropriate. I enjoy saying, 'Yes,' but find it easy to say, 'No,' even when it is not welcomed. If we become shackled by those fears, we will do…nothing." What about those we can't help? After we have done all that we can do, we'll still try to help others. When at last we can do no more; we can confidently say, "We did all we could."

3. Frequently hospital admissions and increased healthcare cost are due to stress. An elderly patient's blood pressure and diabetes could not be controlled not matter how much medication was used. When I discovered that her grandson was living with her and causing great stress, it was in helping the grandson, relieving the stress that the patient's care was treated to goal and her quality of life improved. Often, the solution to admissions and readmissions has little to do with the patient's diagnoses but with their sense of worth, security and hope. For more about this see: Value, Virtue, Trust and Hope - The Foundation of Health Improvement. The relationship between, value, virtue, trust and hope are critical in this whole process.
4. Medications are critical. Medication reconciliation is pivotal to admissions and readmissions. Our patients receive a medication reconciliation on admission, on discharge, during their care coaching call and at their post hospital follow-up visit. Coupled with electronic prescribing of routine medications and controlled substances, the management of medications has become much more accurate and easier than it once was.
5. One of the important pieces to preventable readmissions is "access." This is both by the care coaching call, the quick follow-up visit and the ability of the patient to see the healthcare provider as the safety value and not the emergency room. Wittingly or not, the ER Physician has a principal goal of finding a reason to admit or to readmit patients. That is the safest thing for them. Being the governor of continuity of care and of access to care the primary care provider can make sure the patient gets timely, even immediate, care often making reemission not necessary. When the patient is confident that his/her provider will answer the phone or answer their questions or "be there," many unnecessary and preventable admission will be avoided. This is the responsibility of the provider and of the patient.
6. The power of stories must be understood. Two stories which illustrate this can be read at the following links: From Homicidal Threat to Reciprocal Caring: A Patient-Centered Journey, Medical Home Series Two: Part XVIII - Introduction to SETMA's 2009, 2010 and 2011 Series of Articles on Medical Home, Patient Centered Medical Home Poster Child: An Update after Five Years of Treatment in a Medical Home. (Note these two patients have been readmitted to the hospital only once each in the past eight years.) The power of coordination of care is illustrated in both of these cases.
7. Connectivity and contact with patients outside of traditional patient/provider venues, i.e., appointments and other formal visits, is important. The following link is to the tutorial for SETMA's telephone follow-up for the hospital and clinic: Using The Clinic and

Hospital Follow-up Call Templates. It would be interesting to measure the reduction in readmissions in patients enrolled in he Chronic Care Management program: see Chronic Care Management Code (CCM) Tutorial. Weekly or monthly calls to chronically ill patients addresses almost all of the above principles.

This is enough for the moment. If other issues of importance arise, I will send you a note. Many of the above are not intuitive, particularly dental care and family counseling, but they are all important for success, not just a function of healthcare cost but as a function of quality of life. For your free time reading,

I note the following which is not related to your research: UT Health Historical Summary in Response to Drs. Henrich and Berggren.

James (Larry) Holly, M.D.
C.E.O. SETMA
www.jameslhollymd.com

Adjunct Professor
Family & Community Medicine
University of Texas Health San Antonio
The Joe R. and Teresa Lozano Long School of Medicine

Clinical Associate Professor
Department of Internal Medicine
School of Medicine
Texas A&M Health Science Center