James L. Holly, M.D.

LEAP Fish Bowl, April 18, 2017 Response to
Comment "Taking Advantage of People's Illnesses"

April 19, 2017

LEAP Fishbowl Webinar – April 18, 2017

Due to not being able to connect to the LEAP webinar on April 18th, I was only able to listen. I found the discussion stimulating. One comment I wish to address was the lament by one discussant that she "is not comfortable taking advantage of people in their need." I applaud her compassion and sensitivity to the needs of others but I wish to give a different perspective about the economics of healthcare. SETMA's private motto is that "we want to do good while we do well." A local healthcare institution which is religious based is fond of saying, "Where there is no money, there is no mission."

Rather than feeling that we are taking financial advantage of people in their need, I think that healthcare is providing a ministry and a benefit to those in need. Southeast Texas Medical Associates, LLP (SETMA, LLP, www.jameslhollymd.com) takes care of the most vulnerable patients in our community. Over half of our patients participate in an HMO where we are capitated and many other are either uninsured, underinsured or cannot benefit from their insurance company benefits because of structural barriers such as high deductibles and unaffordable co-pays.

Unless, a practice is fully funded by Federal subsidies, like SETMA, fees must be collected in order to continue to provide the services which we do. Here are some facts:

1. SETMA, like most practices, is for-profit which means that everyone's needs are met before the providers' needs are met. More about that later.
2. In the Medicare Advantage program, which represents over half of our patients, there has been an annual 4% fee reduction for 7 years for an aggregate reduction of 28%. In a business which has less than a 10% profit margin, it is obvious that long ago, the providers of SETMA began to subsidize the practice out of their income. In the past 18 months all employees have received their full salaries and benefits but the fourteen partners of SETMA have seen significant salary reductions and have not receive regular salaries even at the reduced rate.
3. While SETMA has participated in the ACA exchange healthcare plans, the reimbursements have been less than what it takes to fund patient care. In addition the $1,700,000 annual ACA tax on our IPA which is 90% run by SETMA, has further stressed our ability to provide the high quality of care we have provided in the past. In fact, financial pressures have caused

us to only renew our NCQA Tier 3 PC-MH recognition (2010-2019) and our Joint Commission PC-MH and Ambulatory Care accreditation (2014-2020). We have not renewed our AAAHC PC-MH and Ambulatory accreditation (2010-2017) and our URAC PC-MH accreditation (2014-2017) due to financial constraints.

4. Seven years ago, SETMA founded the SETMA Foundation to which the partners of SETMA have given $500,000 annually, but which we have been unable to continue in the past two years. None of this money could profit SETMA. The beneficiaries of the Foundation are treated free by SETMA but many specialists will not see patients unless their co-pays are met and we pay those, buy medications, extend extensive dental care and other benefits to our patients. The dental care has cost us over $500,000 but has yield incredible health benefits to our patients.
5. The financial vulnerability of our patients is such that we went to our principal HMO twelve years ago and told them that we want to have zero co-pay for primary care. They argued that in that case we would be inundated with inappropriate visits. We persisted, they relented and changed the co-pays to zero (which has forced other HMOs in our market to do the same thing) and we have had zero patients abuse the privilege of seeing us at no cost. Through analytics and statistical methods, we have been able to demonstrate that our patients who have zero co-pay have better outcomes than our fee-for-service patients of similar make up. We infer from this that the absence of a financial barrier to the obtaining of care, improves care outcomes.

I will not belabor this point any longer except to say that in May, 2017, I will make a presentation at a Region PC-MH conference. My subject is "story telling." You may remember that one of the 30 LEAP practices had a "story teller" on the staff whose job was to collect, publish and distribute the organization's stories. In my May, 2017 presentation, I will distribute the following document: Your Life Your Health - PC-MH: SETMA's First Nine Years - Continuity, Creativity, Consistency. This is a collection of eleven articles recently prepared by SETMA. Article VIII on page 32 is about "story telling." In part it states:

"In ancient times, the power of story telling was well known. History was communicated by story telling. Values and beliefs were transmitted from generation to generation by story telling. Families sat around fires and tables and told stories. Young people sat at the feet of old people and listened to stories which helped them understand who they were and what was required of them. Sacred texts began as stories told for generations, and they were told precisely and accurately.

"First print and then electronic media adopted the pattern of story telling; they called it 'news' and 'reporting.' Radio, television, computers and cell phones began to take up the story telling time. Often, rather than enhancing our lives, these media diminished that value particularly by incidentally devaluing personal and family stories with dramatic cinema graphic and Technicolor story telling.

"However, to realize how well and how alive 'story telling' still is, one only has to ride a bus, a train or fly on plane to discover how readily people want to tell their story and how eager they are to do so even to do so to perfect strangers.

“Anecdotal medicine – story telling medicine -- is frowned upon as it is based on personal experience without the benefit of ‘random controlled’ or ‘double-blind’ studies. Anecdotal medicine does not allow for analysis to determine if the conclusions of the personal experience are valid or not. Nevertheless, story telling is still an essential part of being human.

In the case of Medical Home, while there is an objective standard against which to measure the essential functions of a Medical Home, it is the "stories" which are powerful. It is the "stories" which give breath (in this case we refer to respiration and life) and depth (in this case we refer to significance and validity) to the healthcare experience.

“In fact, SETMA would recommend that NCQA, AAAHC, the Joint Commission and URAC - currently, the four agencies reviewing Medical Home applications -- establish a ‘stories exchange.’ This would be a place where illustrates of successes or learning in Medical Home could be shared with everyone. Each story will flesh out, in three-dimension ‘real life situations,’ our understanding of what otherwise are two-dimensional abstract ideals such as ‘coordination,’ ‘Care Transitions’ and ‘patient-centric conversations,’ among others.

“While we often don’t think of it in terms of ‘story telling,’ every patient encounter is an exercise in a form of story telling. Often that story is guided by medically related questions but in the context of the Patient-Centered Medical Home the more effective patient interview is found in allowing the patient to ‘tell their own story, in their own words, in their own way.’ Not only does that method give a more granular picture of a patient’s needs but it increases patient satisfaction greatly. The patient-centered conversation, which is the structure of that story telling was discussed in part seven of this series.

“Perhaps no other single activity is more helpful to the PC-MH transformation of a medical practice than is the intentional telling of the practice’s own stories. The following are benefits of stories:

1. “They give us insight into the progress we are making in our transformation efforts.
2. “They capture ‘lessons learned,’ mistakes corrected, and processes changed.
3. “They give a human face to an often otherwise impersonal activity.
4. “They help us remember ‘from whence we have come and ‘whither we are going’ (see Abraham Lincoln and Modern Healthcare for the original of that last phrase)
5. “They give us an effective and charming way of relating our pilgrimage to others in an interesting and memorable way.
6. “They provide a map for others and they teach others how to tell their stories for themselves.
7. “They allow us to memorialize and acknowledge the contribution of others and particularly of our collaborators who formerly were called ‘patients.’”

I hope you will distribute this to all the LEAP Practices and to the participants in the webinar yesterday.

Sincerely yours,

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