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An Analysis and Response to President Obama's
Health Care Reform Address to the American Medical Association
The Only Structural Change Which Will Make a Difference -- Coordination of Care
Part II
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Part I of this analysis concluded with a discussion of the first two structural changes the President wants to make in healthcare. The third structural change is not a change at all but an emphasis upon one of the longstanding, cardinal aspects of modern health. That change is the support of research to find out "what works." The President stated, "…we are making a major investment in research to identify the best treatments for a variety of ailments and conditions." As already addressed, the President identifies two major issues which exist even after we identify "best practices":

1. That information must be provided to patients and doctors
2. Steps must be taken to motivate providers and patients to use the information

The President includes examples of those who have achieved excellence through the making of information available and the implementing of change in healthcare delivery based on that information. On this basis he identifies three goals which any legislation he signs will need:

1. A plan to "replicate best practices."
2. A method for "incentivizing excellence."
3. A strategy for "closing cost disparities."

To this point all doctors and patients can agree with this part of the President's address. It is here where he says things which it is unlikely he believes or intends to follow. The made the following statements:

1. "I need your help, doctors."
2. "…you are the health care system."
3. "…I will listen to you, and work with you to pursue reform that works for you."

It appears that the President knows what he wants to do and he intends to do it. It appears that the President's reform calculus is based on politics and therefore there is little concern for what physicians or other health care groups think, except to keep them in line until his plans are implemented.

The President's conclusion is that if the structural changes he recommends are implemented, "…we can bring spending down, bring quality up, and save hundreds of billions of dollars on health care costs while making our health care system work better

for patients and doctors alike." No one disagrees with these goals, but wishing it so, or saying it will be so does not make it so. The problem is that the costs and the quality of health care have many causative elements. Some of those elements are sociological; some are cultural; some are ethical; some are religious; some are philosophical.

All healthcare providers believe that the President is right that the structural changes of employing more information technology, changing how providers are compensated, encouraging more students to choose primary care, and developing and using evidence-based guidelines are some of the keys to the future of healthcare, but there are other issues as well. Even if we successfully deploy all of these, health care costs and quality may not go down. There are a variety of reasons why.

Americans are infatuated with technology and everyone, whether they need it or not, want the most expensive and the latest technological evaluations, and, of course, they want the government to pay for it. Look at the abuse and fraud in the power scooter industry. It's the senior citizen's bright red tricycle and according to multi-million dollar ad campaigns, "with the help of my scooter company Medicare paid for it all. I didn't have to pay anything." Unfortunately, when patients who do not need these devices get them, their health begins to deteriorate more rapidly than before. Tragically, Medicare regulations continue to expand the regulations which make more and more people eligible for these expensive toys. The scooter costs about what Medicare spends on the total healthcare for a Medicare beneficiary in a year. Thus every scooter that is paid for by Medicare doubles the cost of that patient's care for that year. There are some people who need them, but there are many, many more who want them.

Specialty societies continue to tell patients and providers that they need to use tests and procedures which are very expensive but marginal in benefit. None of the structural changes the President addresses is going to change any of this.

End-of- life issues involve cultural, religious and ethical values. Too often the goal of health care is unwittingly related to trying to prevent death rather than improved life. The fear of death makes it difficult for many to make a rational decision about healthcare choices. No one wants "rationed" care, i.e., if you are this age, you don't get this care; but we all need "rational" care. When the government assumes the responsibility for ALL health care, then those who are least able to make the difficult choices chose to make none and they want ALL health care possible whether it makes sense or not. When we do by-pass surgery on patients who are on kidney dialysis and they not surprisingly don't survive the surgery, we do, what is often the case, we raise the cost of care without improving the quality of care or the quality of life. Driven to the surgery by a number of circumstances, the patient's family is often angry with the one person who said, "Don't do the surgery."

I Do Not Want

I do not want a health care system where a Washington-based staff determines care but neither do I want a system where irrational choices are promoted and encouraged by the

Federal Government removing any economic responsibility from the patient. I do not want a health care system where the Federal government determines that it is its responsibility, which responsibility is then transferred to health care providers, to "make" everyone healthy. I do not want a health care system where there are insurmountable economic barriers to the obtaining of needed care but neither do I want a system which encourage irrational medical choices because there is no personal cost associated with those choices.

There is another sociological dilemma in the health care reform equation. When IBM was in trouble as a company, they hired "change agents." One of the lessons they learned was that "if you are going to make a change, it had better make a difference." For many people, the changes they need to make in their life style in order to achieve the results the President assures are possible, i.e. that we can eliminate "cancer, cardiovascular disease, diabetes, lung disease and strokes," are probably not going to happen. The President's unique and compelling personal life story is found on what he titles in his book as "the audacity of hope." Unfortunately, millions of Americans do not live with hope.

In order to "make a change," a person makes believe that it is "going to make a difference." In health care differences don't happen overnight. It takes months and even years of dietary discipline to achieve weight control. It takes months and even years of exercise to make a difference in one's health. The ability to make those long-term commitments is the idea, which is an idea of hope, that the making of a change will make a difference. It is the internalization of the "idea of progress," a relatively modern concept that things will change and that they will generally change for the better. The experiences of millions of people do not support the idea of hope and the idea of progress which is positive change. Health care reform will not address these issues and without them evidence-based measures will, for these patients, just be clever, valid and inept ideas.

The Only Structural Change Which Will Make a Difference -- Coordination of Care

Someone has to take charge of health care and there are only two legitimate choices: the patient and the primary care provider. And, the only change which will make a difference in health care is when these two form a strategic alliance and become a health-care-coordination team. Neither the Federal Government nor the healthcare provider can or should remove from the patient the ultimate responsibility for their own health. And, often, the only way to have the patient take personal responsibility is when there is an economic cost associated with not taking responsibility. But, the patient must have a team mate on whom they can count. (Many of these issues have been explored in a ten-part series entitled, "Patient-Centered Medical Home" which can be read at www.jameslhollymd.com under the heading Your Life Your Health)

Two things are novel and may be the energy behind Medical Home. First, the patient and the healthcare provider enter into a collaborative relationship where the more the patient knows and understands about his/her health, and the more the patient accepts and takes responsibility for his/her health, the closer they come to forming a healthcare team which

is defined by the concept of Medical Home. Second, Medical Home not only results from this team formation but also from the healthcare provider, who is identified by the patient as his/her principal healthcare provider, having information about the patient which is:

1. Comprehensive – this information goes beyond the routine medical, social, family and habits history and includes things such as the living condition, literacy, nutrition, etc., of the patient.
2. Accessible – this information must be readily accessible to the provider.
3. Considered in medical decision making for the patient – this information must be an active part of the patient's care and evaluation.

Historically, medical records and medical databases have looked more like a stick-figure than like a portrait of the patient. Electronic patient records have enabled that portrait to take on granularity and specificity so that the "picture" of the person is more personal. Now, Medical Home requires that that portrait take on the unique features of the patient which are personal, specific and unique. Creating the database for this information-set is the "first thing." Making that database interactive and dynamic is the "second thing." Using that database in an active and inter-active means in the care of patients is the "third thing."

Under the Medical Home model the provider has NOT done their job when they simply prescribe the care which meets national standards. Doing the job of Medical Home requires the prescribing of the best care which is available to the patient. For example, a year ago, the partners of SETMA formalized a 501-C3 not-for-profit foundation – The SETMA Foundation – which has as its purpose medical education and underwriting the care for patients who cannot afford care. Obviously, this fledgling foundation has limited assets but it is a beginning.

Recently, I saw a patient who has a very complex and fascinating healthcare situation. During his office-based hospital follow-up, I discovered the patient was only taking four of nine medications because of expense. I believe in this case, SETMA practiced Medical Home as the patient left the office:

1. Appointment to SETMA's American Diabetes Association-approve diabetes-education program. The fees for the education program were waived. However, while talking to the patient's family, I discovered that the patient could not afford the gas to come to education meetings. The patient also left with a gas card with which to pay for the fuel to get the education which is critical to the patient's care.
2. My staff negotiated a reduced cost with the patient's pharmacy and made it possible for the pharmacy to bill The SETMA Foundation.
3. Because the patient cannot work at his job, the patient's care also involved counseling that we will coordinate an application for Social Security disability.

Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not, but are they a part of Medical Home? Absolutely. This

patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with a smile and feeling that there is hope. It may be that the biggest result of Medical Home is hope.

Now, every healthcare provider doesn't have a foundation and even ours can't meet everyone's needs, but assisting patients in finding the resources to help our patients will be 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, for the ordering of tests, treatments, prescriptions which we know our patients cannot obtain is not healthcare even if the plan of care is up to national standards..

The provider must be intimately involved in the patient's life. A new data base will be required for this work which will include:

1. A living will on the basis of which to help the patient and family make rational choices about end-of-life issues BEFORE the time when they are required.
2. Special needs such as assistive devices which will be used to improve the patient's health and not to make then an invalid prematurely.
3. Barriers to their receiving care whether economic, social, religious or other.
4. Designations of medical power of attorney and response to emergencies such as evacuations.
5. Coordination of care reviews which will address preemptively preventive care issues and problems which could compound care needs such as fall risk, pain assessment, functional assessment, etc.

The patient must be empowered to assume responsibility for their appropriate and rational care by education, training and information. A "coordination-of-care-review" document need to be provided to the patient, which alerts them to needed and un-provided care. Patients must have life-style issues addressed at every encounter, particularly in regard to weight loss, exercise and tobacco avoidance. Medications being taken and allergy reviews must be completed and documented at each encounter. Every patient encounter for an acute or chronic health problem must be transformed into a preventive health and health maintenance opportunity.

However, there is a catch. This transformation does not come without a price. To do Medical Home "right," it is my estimate that it will take a full-time care coordinator – which will be a new employee to a medical practice -- for every 1500 active participants in Medical Home. In addition, a MSW (social worker) will be required for every three care coordinators. For SETMA, which essentially cares for 4,500 patients who would be initially "enrolled" in a Medical Home, it would require 4 new full-time, well-trained people along with active participation by healthcare providers and support staff to make it "work." It is expected that it will take 12 months to initially create the database. After that it can be maintained and new people added concurrent with initial care.

The above is calculated on the basis of a care coordinator giving ninety minutes of attention per year to facilitating, tracking and monitoring the care of each person in their unit. The MSW will be available for home assessments and counseling in more complex cases. It is expected that 20% of the Medical Home members will need this level of attention, giving the MSW 2.2 hours per year with each of this group.

Weekly care-coordination conferences will be held about active, unsolved coordination of care problems identified by healthcare providers, support staff, care coordinators or MSW. Those conferences can be held with lunch being provided so that it maximizes the time utilization of all members of the team.

Because SETMA has a hospice and a home health agency, resources from these agencies can be pulled in as needed by the coordinators. And, the physical therapy department can also be involved.

A THOUGHT: I don't believe for a minute that Medical Home is going to decrease the work of primary care providers and shorten their days Increased satisfaction? Yes. Improved outcomes? Yes. Cost improvement? No doubt. Less work? In the words of the Scotsman who was buying a used car from a man. When he asked the man how much he wanted for the car, his response to the answer was, "Silly boy!!!"

This is the structural change which must take place if all of the President's goals are going to be achieved.

And, now our second part of this review has concluded and we have only addressed the seventh page. A third part will have to be added next week and after that, my health-care-reform plan.