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Can America's Healthcare Problems be Solved?
Part I – How?
By James L. Holly, MD
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Your Life Your Health's February 2, 2012 column concluded with the following: ""'….the imperative for Care Transitions and Care Coordination became real and personal again."

"…. It is impossible to maintain…objectivity in policy making decisions when you are faced with good people with difficult problems…(the uninsured) had little screening and preventive care. They had no resources through which to get future care. They needed dental care, routine care, nutrition help, financial support, family support and the list goes on and on. They need mental health support, smoking cessation assistance, some needed drug rehab and all needed a place where they could receive compassionate, affordable care. They all need a medical home.

"SETMA does not have the answers to all of these problems but we do have a commitment to make sure that everyone for who(se)….(care) we assume (responsibility)…is given excellent care. The social, political, economic, and sociological challenges for the uninsured are enormous. In fact, they are bigger than the government, or any one person…Ultimately, these problems are only solvable when we, acting like our "brother's keeper," assume responsibility for the needs of those who approach us and when we respond to those needs, not as an act of charity, but as acts of brotherhood."

Affirm

With a week to continue thinking about the issue of indigent and uninsured care, the above comments continue to echo as true. And, SETMA is not the only medical group and SETMA healthcare providers are not the only providers who are concerned with the healthcare of the indigent. Furthermore, more than a policy issue, the care of the indigent is a healthcare-systems problem. If objections are raised against the Affordable Care Act, it can only be done in the context of a better solution. And, an embracing of the status quo is not a solution; it is an acquiescence which leaves only the government's solution as an alternative.

Systemic Solutions

In his seminal work, *The Fifth Discipline*, Peter Senge argued that "the more complex a problem, the more systemic the solution must be." No problem is so complex as the human problem of health, healthcare, cost, safety and a myriad other issues related to our healthcare system. Ignored long enough by the foundational unit of society, an increasingly higher unit will assume the responsibility abrogated by the lower.

If for whatever reason, legitimate or not, a lower unit such as the family, fails to fulfill its responsibility to each member of society, a higher unit will devise a less satisfactory and possibly

a less effective solution. No matter how well intentioned, these higher units create as many problems as they solve and their solutions are never as equitably applied as the ideal of the lower unit. Whether it is municipal health departments, county health clinics, state indigent care plans, or Federal health laws, each creates it own problems. The largest problem is the inability of these units to integrate care and to leverage the power of the integration of units of care.

Yet, those who object to the care plan of higher units, cannot simply reject those plans. To earn the right to be heard, those who object must design and execute their own plan to fill the void created by the abrogation of individual, family, or community responsibility for the neighbors in that community who for good or bad, legitimate or not, reasons cannot make provision for themselves.

One person, supportive of all that SETMA is doing, asked, “How does what you are proposing differ from socialism?” The answer, “Because it is driven, organized and supported by private citizens and with private funding. It is not a mandate of the government; it is not administered by the government and it is not funded by the government.” The reality is that any sustainable solution must be a collaborative between public and private means and initiatives.

We have met the enemy

In 1952, the carton character Pogo forever identified who is responsible for our problems. Pogo announce, “We have met the enemy and he is us.” Our healthcare problems were not caused by the government, and no matter how much we might object to their solutions to those problems, they do have a plan, which is more than most others have.

If we could set politics aside and if those who think and opine about such things could sit down with most of those who are charged by the government with solving the nation’s healthcare problems, both groups would, I think, be surprised how much their goals are alike, even as their methods may be different. It has been my personal experience that federal employees who are working on healthcare solutions bright, committed, thought people. I have come to admire, respect and appreciate those who are thinking about healthcare solutions, even while I might want to propose modifications in their methods.

Nothing illustrates this more than the differences between the preliminary rule and the final rule published for Accountable Care Organizations (ACO). When the healthcare reform legislation was passed in March, 2010, it created a Medicare Shared Savings Program. That program was to be launched no later than 2012 and the act proposed ACOs. In this instance, the proposed rule. would have made it impossible for the new organizations to succeed. The final rule, was changed after Federal agency staff listened to healthcare policy specialists and practicing healthcare providers.

Furthermore, when we focus our energy upon opposing the efforts of others to solve the healthcare problems we face, everyone loses as the real focus should be the inability of many to get healthcare, the patient safety issues due to the complexity of care and the escalating and unsustainable cost of our healthcare system. The reality is, as seen clearly by Pogo, that we are all part of the problem. What is the solution?

A Beginning

I would propose that we begin with first principles. The first principle is that while it is true of a problem, is also true of a solution and that is that a geometric progression can define the future. In the Chicago Museum of Natural History, I am told, there is a shadow box which shows a checker board with a kernel of corn on one square. The question is then asked, "If you double the amount of corn on each succeeding square, how much corn will you have when you reach the 64th square?": The answer: enough corn to cover the subcontinent of India eight feet deep.

No one would be very impressed with the person who placed the first kernel of corn on the board, but in reality that person laid the foundation for the amount of corn on the 64th square. So no one will be very impressed with what I am suggesting as a beginning for the solving of our healthcare problem, but if pursued and sustained, it can have the same result as the corn illustration.

How can a patient become a "geometric kernel?"

The place where I would begin is with uninsured patients who present themselves to an emergency department for care of an acute illness or accident. The potential for the care given to those individuals becoming like a "geometric kernel" is when their care is seen in the total context of their lives and not as an incident which must be addressed as quickly, as efficiently and as inexpensively as possible. It becomes a "geometric kernel" when those patients are taken into the system and when solutions for their life-long care are designed.

The sad reality is that the lack of access to care, or the lack of access to integrated, continuity of care, has created health problems that are irremediable for many. And, while, we must still do our best for those in that circumstance, our ultimate goal is to make sure that others do not have the same experience by the time we get to the 64th square of healthcare delivery.

The crux of our problem is how do we integrate the uninsured and the indigent seamlessly into a healthcare delivery system to where they are not sequestered into a "special category" where they are seen as "without resources" but to where their care is the same as those who have health insurance and they have access like that of congressmen?

Honest Exchanges

As SETMA has assumed responsibility for caring for almost 25% of the indigent patients admitted to one of our local hospitals, the question of continuity of care has been a central focus of our concern. Because Care Transitions and follow-up care are critical to patient safety, health and care quality, most of our discussions have not focused on inpatient care. Everyone is committed to giving the same care to all patients while in the hospital. The question is how do we provide care for these patients in the outpatient setting?

Addressing this issue, one SETMA provider commented:

- I have serious reservations about making all self-pay individuals SETMA patients.
- The contract with__________is very specific that once the uninsured patient is established a provider, the patient will be admitted to that provider, i.e., SETMA, regardless of who will be on call.
- Based on our current desire to make everyone a SETMA patient, in my opinion, we will be looking at a hospital census between 60 and 70 within a year, of which at least 40 % will be uninsured.
- In my opinion that would be a huge stress on our work force, finances and frankly speaking our sanity.
- So I would propose we come up with a simple qualification process of the patients that we intend to follow in our clinic and the ones we send to county / city clinic

These candid remarks are real, not imaginary, concerns. They do not come from a desire not to help others but from a reality that if in helping others we lose our ability due to physical exhaustion or exhaustion of resources, then everyone loses. They do not represent selfish, uncaring feelings.

One response to the above stated: "First, those of us who have and who are eating from the fat of this great country can insure our decline by closing our hearts to those who are desperate for help. This country is great because of the generosity of its people…As we decide how we will proceed, we must not let our self-interest defeat what has made us great."

The dialogue continued with the following:

"As we discuss the issue of indigent care, we need to put it into perspective In the past three years, the partners have put their money where their mouth is, i.. e., they have given $1,500,000 to the SETMA Foundation. This money is used to care for our patients who cannot afford their care. The key: none of that money can profit SETMA

"With the indigent and uninsured, we are only extending that vision and commitment. It would be consistent with the mission of SETMA if we hired a nurse practitioner who would, with the collaboration of other SETMA health care providers and staff who would like to participate, design a clinic available at low cost or no cost to the neediest of our community.

"Because we cannot do it all, does not excuse us from doing what we can. We have the tools to track and deliver exceptional care to here-to-fore un-served neighbors. With our HIE, we can lay the foundation for a „real' solution To quality healthcare in this region. (Note: a solution which SETMA defined in an address to the Beaumont Chamber of Commerce in August, 2000. This solution is posted at www.jameslhollymd.com under Your Life Your Health for January 6 and 13, 2011)

"I believe that if we do this, the hospitals, the County Commissioners and others will want to support the effort. More than big houses and fast cars, this effort can build a legacy which will make your grandchildren proud of you. Let's talk more about this. This is the beginning of something which is worth your life's blood. Can you dream about the possibility of pharmacists, dentists, physicians, nurses, administrators, and many others caring for their neighbors. Wow!!"

In addressing one uninsured patient's‟ circumstance who us barely out of her teens and who has been abounded by her family and who has life threatening and life limiting acute and chronic conditions, SETMA said:

"Heart breaking and we have the **power** and **ability** and **tools** and **resources** to make a difference in her life. We are not all of the same faith but all of faiths would affirm the following truths which come from the sixth chapter of the first book of Timothy in the Christian New Testament. It states:

> „…Set your hearts not on riches, but on goodness…Tell those who are rich in this present world not to be contemptuous of others, and not to rest the weight of their confidence on the transitory poorer of wealth but on the Living God, Who generously gives us everything for our enjoyment. **Tell them to do good, to be rich in kindly actions, to be ready to give to others and to sympathize with those in distress**. Their security should be invested in the life to come, so that they may be sure of holding a share in the Life which is permanent.‟ (Phillips *Letters to Young Churches*, a paraphrase of the New Testament, emphasis added)

"…As we discuss how we shall proceed with caring for uninsured and indigent patients, let's keep SETMA‟s private motto in mind which states: „We want to do good while we do well,‟ in mind as well.

"None of us have taken a vow of poverty, and I neither intend to, nor wish to ask anyone else to take such a vow, but I do believe that our blessings, the gift of the education we received from the people of our State and our success all impose upon us a debt of gratitude which can only be paid by kindness and beneficence to others. And, beside, just as all of our partners have been proud of the SETMA Foundation and the „good‟ that it has been doing, the expressions of gratitude, the well-being and the improved health of those who have for so long been neglected will bring satisfaction far greater than the dollars invested in those lives. If we spend a relative small amount of our time, energy and resources the benefit in the lives of others will be geometrically greater than the size of our investment."

Next week, we shall continue this discussion about Care Transitions for indigents and how critical that is to their continuity of care.