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**Medical Home Series Two Part XVII Introduction to SETMA's 2009, 2010 and 2011 Series of Articles on Medical Home**
**By James L. Holly, MD**

(**Note**: SETMA's three series on Medical Home are published on our website www.jameslhollymd.com under In-The-News. This is the introduction to the collection of those articles. It is reproduced here because it contains several key concepts about Medical Home which are not included elsewhere.)

In 2010, SETMA was recognized by the National Committee for Quality Assurance (NCQA) as a Tier 3, Patient-Centered Medical Home. In 2010, SETMA was also accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) and as a Medical Home. In 2011, SETMA was reaccredited by AAACH for both for a three-year term.

The contents of this notebook are the thoughts, ideas and analysis by SETMA about Medical Home since we first began to think about Medical Home in February, 2009. It is organized into three sections, each of which represents articles written in 2009, 2010 and 2011. The section on 2011 is in progress and although it represents eighteen articles, making it longer than the 2009 and 2010 series put together, there are still other issues with which we will deal.

## Healthcare Transformation

SETMA employs four elements in transforming healthcare and we believe these elements are the core to any sustainable, affordable and acceptable healthcare transformation (this is reviewed in more detail on page 94 of Section 3 of this notebook):

1. **The Substance** -- Evidence-based medicine and comprehensive health promotion
2. **The Method** -- Electronic Patient Management
3. **The Organization** -- Patient-centered Medical Home
4. **The Funding** -- Capitation with payment for quality outcomes

SETMA is confident that healthcare transformation, not reformation, will not be sustainable without these four elements being part of the solution. For more on SETMA's ideas of healthcare transformation see "Healthcare Policy Issues Part III: Reforming or Transforming Healthcare," August 20, 2009, under Your Life Your Health at www.jameslhollymd.com.

## Unique

Perhaps the most important revelation about this material is that while there is a structure, content and standard to guide a group in developing a medical home, each iteration of this important innovation in healthcare will be different. Medical Home, more than any other healthcare innovation, is an extension of the personality, passion and peculiar life story of each

person, or group of persons who organize and execute the Medical Home. And, remember that the primary definition of "peculiar" is "special, unique, one of a kind." Each successful deployment of a Patient-Centered Medical Home will be "special"; it will be "unique"; it will be "one of a kind." There will be similarities and there will be commonalities, but as a whole, the Medical-Home organism will be creatively unique.

## Stories

Anecdotal medicine is frowned upon as it is based on personal experience without the benefit of "random controlled" or "double-blind" studies. Anecdotal medicine does now allow for analysis to determine if the conclusions of the experience are valid or not.

However, 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 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 in Medical Home could be shared with everyone. Each story will flesh out, in three-dimensions "real life situations," our understanding of what otherwise are two-dimensional abstract ideals such as "coordination," "Care Transitions" and "patient-centric," among others.

## Our Stories

SETMA has a growing list of stories which in fact are the sign posts on our pilgrimage. We include only two here. One story is from the first day we started to think about Medical Home. The second occurred two days before this introduction was prepared.

## SETMA's Medical Home "Poster Child"

In February, 2009, I saw a patient in the hospital for the first time. He was angry, hostile, bitter and depressed. It was impossible to coax him out of his mood. Nurses did not want to go into his room. When he was ready to leave the hospital, I gave him an appointment to see me, even though he was not my patient. In his follow-up visit, his affect had not changed. In that visit, I discovered the patient was only taking four of nine medications because of expense. He could not afford gas to get the education he needed about his condition. He was genuinely disabled and could not work. He was losing his eyesight and could not afford to see an ophthalmologist. He did not know how to apply for disability. His diabetes had never been treated to goal.

When he left that visit, he had an appointment to SETMA's American Diabetes Association-approved diabetes self management education program. The fees for the education program were waived. The patient also left with a gas card with which to pay for the fuel to get the

education which is critical to his care. SETMA's staff negotiated a reduced cost with the patient's pharmacy and made it possible for the pharmacy to bill The SETMA Foundation. The patient's care included our assisting him in his application for Social Security disability. He had a visit that day with SETMA's ophthalmologist who arranged a referral to an experimental eye-preservation program in Houston, which was free.

Six weeks later, the patient returned for a follow-up visit. He had something which I could not prescribe for him; he had hope. He was smiling and happy. Without anti-depressants, or sedatives, he was no longer depressed as he now believed there was life after being diagnosed with diabetes for ten years. And, for the first time, his diabetes was treated to goal.

I continued to see him. Eighteen months later, he was in for a scheduled visit; he was sad. I asked him what the problem was and he said that he was afraid that we would get tired of helping him. He had applied for and had received disability but he would not be eligible for Medicare for two years. In two years, without care, he would be blind, in kidney failure, or dead. He asked if we would stop helping him. I said, "Yes, we will. Absolutely, the day after we go bankrupt." (page 87, Medical Home Series 2, 2011, Section 3 of this notebook)

## A Simpler Story but as powerful

Recently, CMS completed through a consulting firm, a study of 312 Medical Homes in contrast with matched benchmark practices which are not Medical Homes. The comparison was made on quality, coordination and cost. SETMA was a part of that study and our results are discussed in two articles beginning on pages 55 and 64 of the 2011 Section of this notebook. This second story illustrates SETMA addressing each of the elements of the CMS Study: quality, cost and coordination.

On the morning of October 10, 2011, I saw a patient at 3:00 AM in the emergency department. The emergency physician had seen the patient and admitted her to the hospital for chest pain. I saw the patient and reviewed her history thoroughly:

- Six months previously, she had had a normal cardiac catherization.
- Her pain was in the left upper back, not the chest.
- She had no angina equivalents, i.e., shortness of breath, exertional pain, diaphoresis, radiation, or nausea.

Her physical examination was normal, as were her EKG and laboratory work. I canceled the admission to the hospital and scheduled an appointment in my office for ten hours later. Her history and physical examination and her emergency department visit was documented in her personal electronic health record which is used in our office because we have connectivity with all hospitals, nursing homes, emergency departments and other points of patient care.

At 1:30 PM on the same day, I saw the patient again in the clinic. After reviewing the evaluation from the morning, another thorough evaluation by history and physical examination was done. Ultimately, the patient left the office with a diagnosis of rhomboid muscle strain. She had the following care completed before leaving the clinic:

1. *A stress Echo after being seen by our Cardiologist* – stress echo was normal (this was done because she has diabetes which is an independent cardiovascular risk factor and it was felt that the additional verification of my clinical judgment was appropriate. It probably could have been avoided)
2. **Having had physical therapy for her rhomboid strain** – **d**one with improvement after Physical Therapy will have a series of treatments.
3. **Flu immunization** – given, at every opportunity screening and preventive needs of a patient are assessed.
4. **Lab work for follow-up of her diabetes, lipids and hypertension** – HbA1c 6.5%, all other lab tests normal; again at every opportunity, a patient's health status is assessed. The patient's history had told me that she does not see her primary physician often thus this opportunity was taken to evaluate her progress to goals.
5. **SETMA's Foundation paying** for her statin which she cannot afford. SETMA's Department of Care Coordination arranged this while the other care was carried out.
6. **Referral for mammogram** – again screening care is addressed at every contact no matter what the chief complaint is.
7. **Medication reconciliation** -- it was at this point that the patient revealed that she had not filled the prescription for a statin given to her by the endocrinologist because she could not afford it. She left the office with the prescription paid for by the SETMA Foundation.
8. **Follow-up appointment with me in six weeks** – The was the key to the "Transition of Care" from this acute episode to the appropriate follow-up in a patient who had not been seeing her primary care provider regularly.

When the patient left the clinic she had a smile on her face. She felt that she had been well taken care of. She did not have to be unnecessarily hospitalized and virtually all of the above care is capitated, consequently cost effectiveness, quality, and coordination were all addressed. This is SETMA's Medical Home in operation with high quality, coordinated, cost effective care.

On October 11th, a review was made of the patient's chart. No point of care had been omitted. The patient was successfully and excellently treated without admission to the hospital. **This is a Medicare Advantage patient being treated in a Medical Home setting.**

## Welcome

Welcome to SETMA's "Medical Home Story Book." It is our hope that this material may stimulate you to start your own Medical-Home pilgrimage and that you will begin to collect your own Medical-Home stories. If so, then this notebook's purpose will have been fulfilled.