



The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

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Profiles of Change

Helen Story, MD, FAAFP

Editor's Note: Profiles of physicians who are leading the movement toward Patient Centered Medical Homes are a regular feature of this newsletter. Helen Story, MD, FAAFP, was a founding partner 23 years ago of Family Care Southwest, P.C., a private practice with two full-time physicians and 2.5 full-time-equivalent physician's assistants. A participant in the Colorado Patient Centered Medical Home Pilot, the practice, located in Littleton, offers outpatient care only with no obstetrics. The Web site is <http://www.familycaresw.com/>.

When did you begin to provide your patients with a Patient Centered Medical Home?

We became involved with Cindy King at the Colorado Foundation for Medical Care when we started using electronic medical records about five and a half years ago. Personnel visited our office and performed an efficiency and flow analysis. That led to our involvement with the Colorado Clinical Guidelines Collaborative. We worked for several years with Zula Solomon, BA, who helped us in meeting recommendations from the National Committee for Quality Assurance for diabetes care. When the pilot was started, we applied to participate. As we learned more about the program, we realized we were already following the basic principles of the PCMH and joining the pilot would not involve a huge transition for our practice.

How did you learn about the Patient Centered Medical Home approach to medicine?

We learned about it through our involvement with CCGC. There have also been quite a few articles about the PCMH in Family Practice journals and the American Academy of Family Physicians has been heavily promoting the concept.

Why did you decide to utilize this approach in your practice?

By implementing the PCMH model, we can be sure we're providing continuity of care. We were able to hire a full-time clinical coordinator, which improves tracking of all of our patients' tests and referrals. We applied to participate in the pilot because we wanted to help to develop the future of Family Medicine. We believe that the PCMH model is going to be the standard of care, and we wanted to become involved with it early in the process. We were confident in joining the program because of our existing relationship with CCGC, and the positive interactions that we have had with that organization.

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A New Neighborhood

R. Scott Hammond, M.D.,
Chair, CAFP PCMH Task Force

Tips and ideas

"You must either modify your dreams or magnify your skill"

Jim Rohn

Tip #9: Make a Change

- Start small
- Make it easy
- Succeed and celebrate

Test a PDSA with an easy change. One that you know will succeed and then celebrate to energize your staff e.g.,

Task: Create/adopt a Diabetes template.

Test: Use the template on the next 5 DM patients.

How do you identify patients? Who puts templates in the chart? Who collects the data? What did you learn? Retest.

LINKS

- 1** [Medical Home Forum for physicians](#)
- 2** [Conferences and Events](#)
- 3** [CAFP Medical Home](#)

Follow the tips and links starting with the first newsletter and become a PCMH in a kind and gentle way

Profile in Change: (cont)

grace and it has made a lot of the transition and data gathering much easier. Other challenges included getting the staff up to speed and delegating tasks and responsibilities that had previously been done by the physicians.

What has been the biggest impact on your practice?

The first change that we implemented was creating teams for the providers, medical assistants and front office personnel. We clearly designated the duties of each position and we all work as a team. The PAs and medical assistants have more responsibilities than they did in the past, which helps the doctors be more productive. Follow-up on medical issues and callbacks to patients are now done within the team. This improves communication with our patients and within our infrastructure.

Could you provide a few details about how you implement just one of the seven aspects of the Patient Centered Medical Home?

Our medical assistants now help take care of the patients by performing tasks that were previously performed by providers. They now do the foot and eye exams and take the micro albumin levels. With electronic records, it's easy for the assistants to follow checklists, which helps to make sure that every important aspect of each patient's care receives attention.

How have your patients, their insurers, the staff and specialists responded to the Patient Centered Medical Home?

So far, only some patients are aware we're following a PCMH model, but many more know they're getting better service. They're happy that when they have questions they can talk to many members of their care team. The insurance companies are excited about the PCMH model and have agreed to help offset our costs. They are also trying to develop a plan to implement pay-for-performance for good patient care. Our staff is still trying to learn about what the PCMH model can mean to our practice. So far, the feedback has been positive from our staff. Specialists are not highly aware of the PCMH, but they do get consult notes to us.

Do you have a favorite anecdote relating to the Patient Centered Medical Home?

We've had some patients who were astonished when they could call in the morning and be seen later in the same day because of our open-access scheduling.

What do you love most about living in Colorado?

I'm from Montana and I like living in the West. I like my commute, which takes me through an open space area between Morrison and Kittredge.

A New Neighborhood

R. Scott Hammond, M.D., Chair, CAFP PCMH Task Force

"We must indeed all hang together or, most assuredly, we shall all hang separately."

Benjamin Franklin

Wow, we did it! Our small practice received PCMH Level 3 recognition in July but not so fast. Paul Nutting, M.D. whose group is the independent evaluator for the TransformMed National Demonstration Project recently published an admonition (Ann Fam Med 2009;7:254-260). His preliminary and cautionary conclusions regarding the PCMH transformation process are:

- Continuous, unrelenting change is required
- 2+ years are needed to make changes
- Change fatigue is a risk
- Technology is difficult and not 'plug and play'
- The identity of the physician is challenged
- A shift from physician workflow to patient experience is required
- Financial support is needed
- A flexible, learning culture is needed
- Change skills need to be learned

Fortunately, we had been involved in change process for years and already had a registry (without EHR), as well as, the foundations of team care. Once we seriously committed to NCQA recognition, it took 6 months and 80 documents to submit our application. However, Dr. Nutting is right. It took unrelenting effort to make these changes. They were only possible because of a genuine commitment to the principles of the PCMH and passion for Family Medicine. At times, it took a heroic effort to stay the course and maintain enthusiasm when the effort of yet another change loomed. We had to face the unpleasant reality that we must doctor in a new way. We silently grieved over the loss of our well entrenched attitudes of entitlement and station in order to put the patient at center. We had to learn how to actually collaborate with staff and not dictate. We had to be open to others' ideas and admit that ours were sometimes not on-course. We had to put in extra, unreimbursed time to create the endless templates, protocols and policies to modernize our clinic operations and infrastructure. We had to study and apply change models to a practice entrenched in 50 years of habit. We had to do all this without an extra dime of reimbursement.

Achieving Level 3 recognition in this time frame was difficult and not recommended except for those human mutants with 3 adrenal glands. Level 1 recognition, however, is doable and does not require the overwhelming commitment possessed by the Colorado PCMH Pilot practices.[Continued on Page 3](#)

Spotlight on Standards

Standard 2: Patient Tracking & Registry Functions

This Standard involves basic systems to manage patient data that includes searchable demographic and clinical data with the ability to generate lists. Elements A,B,C,F require an EHR but 2 'Must Pass' elements can be completed with paper charts. Standards 2D and 2E requires auditing 36 charts.

Standard 2D demonstrates lists and templates for problem lists, med lists, progress notes, growth charts.

Standard 2E demonstrates that you can show your most frequently seen diagnoses and risk factors and link these to the 3 most important medical conditions for which you provide care management. Go to AAFP Road to Recognition and CCGC Coach in a Box. Also:

http://www.ncqa.org/portals/0/programs/Recognition/Companion_Guide/Standard%202.pdf and for risk factors: <http://apps.nccd.cdc.gov/BRFSS/page.asp?cat=AS&yr=2008&state=CO#AS>

Muse News

Send in your stories, news, tips, helpful tools and products, comments and humor to:
shammond@evcohs.com

- Many primary care physicians practicing under contract with Blue Cross Blue Shield of Massachusetts received a total of \$27 million as a reward for meeting certain cost and quality goals in an annual incentive program that was among the first of its kind in the country when it began in 2000.
- President Obama called for increased reimbursement for primary care during a Town Hall Meeting in North Carolina (Wednesday, July 29).
- Grants will help transform 14 community health centers in Massachusetts into patient centered medical homes through a Safety Net Medical Home Initiative led by the Commonwealth Fund
- Arlington Free Clinic (VA), received a \$100,000 grant from CareFirst BlueCross BlueShield to implement a PCMH to facilitate optimum patient outcomes through an improved method of health care delivery.

(A New Neighborhood.....continued from page 2)

Our medical life is not perfect, but it is certainly a lot better. We are proud that we provide cutting edge, up-to-date high quality medical care with better outcomes than most in the nation and comparable to the best. We are proud to contribute to the future of Family Medicine by showing that this model is real and achievable. We are proud that our staff has grown personally and professionally. We are, especially, relieved that we have turned chaos into efficiency. We have unburdened our shoulders and now share responsibility with our staff and patients. We are delighted to feel the joy of medicine again.

But wait! Is this enough? Will this solve our health care problem and bring us to Family Medicine nirvana? Elliott Fisher, M.D. (NEJM. 2008;359(12):1202-1205) warns us that there is even more to do. The true success of the PCMH depends on the cooperation and collaboration with specialists and hospitals. It requires that patients accept the new concept of a gateway and not dwell on the old gatekeeper disaster. Fortunately, all the elements for a "perfect forecast" are present in Colorado as we lead the nation in innovative health care reform with the PCMH Pilot, the Medical Home Initiative and the SOC-PCMH grant (be sure to fill out the upcoming poll).

Now we have the necessary resources to enable family physicians to become a PCMH and the collaborative forum for all physicians, primary care and specialist, to join together to make a difference. It is time to turn from architect/builder to developer. We have met with our local hospital and they are anxious to help. We have set up meetings with our major cardiology and oncology groups to develop a mutual compact of expectations and responsibilities. We are educating our patients on the PCMH and the advantages to them to choose and use us as their Home. We do not know where this journey ends but do know that the best way to predict the future is to make it. Our next step is to build and welcome all to *a new neighborhood*.

Next issue: Thanksgivings

Start a dialog! [Medical Home Forum for physicians](#) is waiting for YOU.

Cool Tools

The American College of Physicians just released their PCMH workbook, **The Medical Home Builder**. The product is organized into modules and contains a cornucopia of resources and tips to facilitate your transformation. The *Practice Biopsy* will help you identify areas for improvement. You can get this great resource at a discount of \$85 through CAFP.

Physician practices interested in earning medical home recognition from NCQA now have a new tool to help them understand the recognition requirements. NCQA recently released a companion guide that seeks to aid practices in their goal of achieving Recognition through NCQA's Physician Practice Connections® – Patient Centered Medical Home™ (PPC-PCMH) program. The guide, created with support from Pfizer Inc, provides summaries of the PCMH standards and examples from physician practices. To download the companion guide, visit www.ncqa.org/ppcpcmh_guide.

Erratum: please note the correct website for Microlife Medical Home Solutions is : www.mimhs.com

This is a product review and does not represent an endorsement from CAFP