



The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

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Profiles of Change

Laura Makaroff, DO

Editor's Note: Profiles of physicians who are leading the movement toward Patient Centered Medical Homes are a regular feature of this newsletter. Since 2007, Laura Makaroff, DO, has headed Mountaintop Family Health, www.mountaintopfamilyhealth.com, a solo practice in Parker, a suburb of Denver. Supported by a medical assistant and a patient care coordinator, she restricts the independent practice to outpatient care with no inpatient or obstetrical care. A participant in the Colorado Patient Centered Medical Home Pilot, Mountaintop is a Level 3 Medical Home as recognized by the National Committee for Quality Assurance.

When did you begin to provide your patients with a PCMH?

I believe that I have provided a patient-centered medical home since my practice first opened in 2007. Comprehensive, well-coordinated, accessible, patient-centered care has always been a top priority for my staff and me. The process of becoming a formally recognized PCMH began in 2009 when we enrolled with the Heath TeamWorks' PCMH pilot project.

How did you learn about the PCMH approach to medicine?

I first heard of the PCMH approach in 2004 when the Future of Family Medicine report was released. I was a resident at that time and that report served as a framework of what I hoped my future would be as a Family Physician. Once I completed my training and started my solo practice, I began hearing more and more about the PCMH at various meetings and through articles.

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

I believe the PCMH is fundamental to the future of our health care system and I also believe that the PCMH model helps me provide the right care at the right time to my patients. It is a structured avenue that guides us in providing comprehensive, patient-centered, quality care. The PCMH model also allows me to shift my focus from just the day-to-day acute problems and begin to look at my practice's entire population with extra attention toward chronic disease management. The team approach to care utilizing my medical assistant and patient care coordinator allows me to proactively care for patients instead of just reacting to what walks in the door each day.

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Community

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

Tips and ideas

"Everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances."

Victor Frankel MD, Holocaust survivor

Tip #14: Find Balance

Physicians have more heart disease, suicide and divorce than the average population.

Try focusing on the things that are good in your life - patients, family, work that you love.

Allow yourself at least an hour or 2 of non-work time each day.

Evaluate unmet expectations. Are they realistic in today's world?

Practice gratitude on a daily basis - before bed, write down 3 things you are grateful for.

Read [Finding Balance in a Medical Life](#). Lee Lipsenthal M.D., ABIHM on how to make changes to restructure your life to fit your values and life purpose.

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)**What was the biggest challenge to getting started?**

Time. Even though I believe that I have always provided a patient-centered medical home, I have had to invest a lot of time in understanding what truly makes a PCMH, understanding NCQA's requirements for PCMH recognition, and evaluating and redesigning my office processes and practices. The process of preparing the NCQA survey was challenging and burdensome at times, but I viewed it as an opportunity to ensure we had the right processes in place to be able to provide the kind of quality, coordinated care that we were aiming for. The other obvious challenge is financial. Providing well-coordinated, truly patient-centered care requires additional work outside of traditional office visits. Unfortunately, much of this work remains unpaid and there is a great need for payment reform.

What was the biggest impact on your practice?

As I have mentioned, we have been providing PCMH care since the beginning so there have not been huge changes in our office. However, we do spend more time measuring our quality and focus additional attention on our chronic disease population. As part of our attention on chronic disease management and prevention, we also started monthly patient education seminars emphasizing healthy lifestyles and disease prevention.

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

We have always used an electronic medical record, but we had to utilize it in some new ways in order to create useable reports and understand if we were actually providing the care that we think we are. We have spent countless hours learning how to put the right data into our system in order to get the right data out. It has been a worthwhile investment as we can now look at evidence-based, quality measures on a monthly basis. We use those reports to reach out to our patients and remind them when it is time for an office visit or labs.

How have your patients, their insurers, the staff and specialists responded to the PCMH?

I think our patients perceive very little change on the outside. However, they do comment that they like having one place and one doctor that form the center of their medical care. Likewise, the staff has not seen much change other than we do spend more time documenting and formally evaluating our processes to ensure that we are providing a true PCMH. I have a great team with my medical assistant and patient care coordinator and we enjoy working together to provide our patients with the best care possible. It has been encouraging to see the insurers' participation with the Health TeamWorks PCMH pilot and I hope that they will continue to embrace the model and payment models that value this model in the future. The specialists in our area do not seem very familiar with the formal PCMH concept, but they do appreciate the results of a PCMH including educated patients and coordinated care.

What do you love most about living in Colorado?

I love a lot of things about Colorado including the outdoors and our focus on healthy living. I also enjoy being a part of the community in Parker where I live and practice.

Community

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

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

Margaret Mead

Fall is here and the holidays are rapidly approaching. Families will soon gather and give thanks for what they are most grateful. Thanksgiving celebrates gratitude but is rooted in survival and hope. In the early winter of 1620, the Mayflower arrived with 102 Pilgrims from Plymouth, England. One-half would die from the rigors of a brutal winter before their first New England spring. Squanto (Tisquantum), kidnapped by Captain John Smith's lieutenant, found his way back to Patuxet from London and taught the Plymouth survivors how to cultivate corn and live off the land. Equally important, he forged a 50-year peaceful alliance with the Wampanoag Confederacy. A successful corn harvest in November 1621 led to the celebratory feast we enjoy today. Sugar supplies had been depleted and, alas, pumpkin pie was not on the menu. It was not until 1863, during the darkest and most horrific days of the Civil War that Abraham Lincoln, with great uncertainty whether the United States would remain united, proclaimed a national Thanksgiving Day every November. Despite the waste of war, he declared the Union prospered in harmony and bounty. He prayed to 'heal the wounds' and restore the "full enjoyment of peace, harmony, tranquility and Union". Last year, I spoke of thanksgivings for medical miracles and our obligation to continue the journey, begun in 1969, of the founders of Family Medicine who pledged to "rescue a fragmented health care system, put it together again, and return it to the people." (<http://www.coloradoafp.org/emhnews/11-15-09.pdf>). We are closer to that promise. Amidst economic uncertainty and threats to primary care survival, the PCMH gains momentum with landmark studies demonstrating reduction in health care costs and improvement in quality of care. Acceptance is certain as 7 PCMH recognition programs are in use or in development:

- **TJC** – (The Joint Commission formerly the Joint Commission on Accreditation of Healthcare Organizations - JCAHO),
- **URAC** - (formerly Utilization Review Accreditation Commission)
- **CARF International** - (formerly Commission on Accreditation of Rehabilitation Facilities)
- **AAAH** - (Accreditation Association for Ambulatory Health Care)
- **HFAP** – (Healthcare Facilities Accreditation Program)

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Spotlight on Standards

Standard 5:

This Standard uses electronic prescribing to order prescriptions in order to reduce medical errors and improve safety through drug alerts.

Standard 5A --This Element requires use of an electronic system to write and send prescriptions by fax or e-mail using either a stand-alone or EHR linked system.

- You can score more points if your system is linked to you EHR and provides safety alerts using patient-specific data.

For a comprehensive guide:

http://www.coloradoguidelines.org/pcmh/hidden/PPC%205/eHI_CIMM_Consumer_Guide_to_ePrescribing_Final.pdf

Muse News

Send in your stories, news, tips, helpful tools and products, comments and humor to:
[*shammond@evcohs.com*](mailto:shammond@evcohs.com)

- Through funding from the SOC-PCMH Initiative, CAFPP and Health TeamWorks joined forces to facilitate the rapid PCMH transformation of 13 practices from around Colorado.
- The Department of Health and Human Services has targeted PCMH research in minority and underserved populations by funding \$14 million in grants to universities and medical schools in five states.
- CIGNA Corp. has expanded their ACOs to four with the addition of Atlanta-based Piedmont Physicians Group. The others are in Connecticut, Texas and New Hampshire.
- Anthem, UnitedHealthcare and Humana will pay \$5 to \$6 per patient per month in "care management" funds to 11 Cincinnati PCMH Pilot practices.
- New Jersey unanimously passed S-665, which requires the state Medicaid program to establish a three-year medical home demonstration project to expand recipients' options to receive patient-centered, coordinated primary care.

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They have joined **NCQA** (National Committee for Quality Assurance) and **MHI** (Medical Home Index) to support, facilitate and/or implement patient-centered practice redesign. Collectively, these organizations accredit all medically related organizations from private practice to health plans, hospitals, long term care, ambulatory care, mental health, rehabilitation, residency training programs and more. The medical world has completely embraced the PCMH model as evidenced by the evolutionary step taken by the American College of Physicians (**ACP**). They recently published a policy paper on the specialist as a PCMH-Neighbor (PCMH-N) in a Medical Neighborhood. The Medical Neighborhood brings cohesion and enhanced coordination to the fragmented PCMH movement by defining the role of the specialist in this model.

The document recognizes the PCMH as the central hub of patient information and care coordination and underscores the need for specialists to support and collaborate with the model. ACP recognizes that the acceptance and participation of specialists with the PCMH is critical to the success of health care reform. This policy paper is the result of ACP's Council of Subspecialty Societies work to explore and define that relationship. The paper delineates the roles, definitions and function of this new relationship and offers recommendations on care coordination agreements, incentives for and recognition of the PCMH-N. They define the PCMH-N as a specialist who collaborates with a PCMH to facilitate the appropriate, timely and effective flow of patient information. The PCMH-N participates in the care team that effectively addresses issues of responsibility and accountability in transition of care and shared decision making.

Thanksgiving celebrates blessings, faith, courage and community. We have much for which to be thankful. The Medical Home is growing into neighborhoods and, through ACOs, into towns and cities. The American march to health care reform is unstoppable if we all work together and bring to fruition - the medical community.

Read ACP's *The Patient-Centered Medical Home-Neighbor: The Interface of the PCMH with Specialty/Subspecialty Practice*:
http://click.icptrack.com/icp/relay.php?r=1658126&msgid=258971&act=UM4N&c=542751&destination=http%3A%2F%2Fwww.acponline.org%2Fadvocacy%2Fwhere_we_stand%2Fpolicy%2Fpcmh_neighbors.pdf).

Cool Tools

Having trouble with Care Management or Patient Self-Management? Group Practice Forum (www.grouppracticeforum.com) leverages practical physician group dynamics and clinical guidelines to create a workflow solution designed to provide primary care groups with simple solutions that can be incorporated into their practices immediately to improve patient care. Elements of their PATIENT JOURNEY include:

- Practical solutions to incorporate into a chronic disease care model
- Methods to improve patients' health literacy
- Empowerment of motivated and informed patients
- Improved patient-physician dialogue quality
- Enhanced journey to physician-supervised patient self-management

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