



The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

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Profiles of Change

James J. Meyer, MD

Editor's Note: Profiles of physicians who are leading the movement toward Patient Centered Medical Homes are a regular feature of this newsletter. Previously in a solo practice in Littleton, James J. Meyer, MD, is one of four Family Physicians at Clinix Healing Center in Centennial, which is described on its [Web site](#) as "a unique health care center where traditional Family Practice providers and alternative health care providers work together to provide the patient the best health care in one facility." The other Family Physicians include one who is an osteopath, one who is a bariatrician and another who is certified by the American Board of Holistic Medicine. Providers also include five chiropractors, three exercise therapists, two massage therapists, a licensed acupuncturist and a naturopathic doctor who has been formally trained in the Pacific Northwest. Clinix is a participant in the Colorado Patient Centered Medical Home Pilot.

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

In the first quarter of 2006, when I was in my solo practice, I became involved in the TransforMed National Demonstration Project, which was basically a nationwide learning lab for testing the principles of the medical home. In March 2008, I left my solo practice mainly because of the financial problems involved with starting up a new business and joined Clinix, bringing with me the medical home concept. The clinic was already following a team approach and providing care in a very medical home-consistent manner, but it wasn't defined as such. The Patient Centered Medical Home pilot provided the road map for Clinix and the leadership was eager to become a part of the Colorado PCMH pilot.

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

I was a resident at the University of Colorado Family Medicine Residency where I had the privilege of learning from Larry Green, MD. A former chairman of the Department of Family Medicine at the university, Dr. Green is a national leader in the Future of Family Medicine Project. I heard him and other instructors with similar ideas speak often and their message inspired me. I obviously learned most from my participation in the TransforMed National Demonstration Project. In addition, my residency program has become involved in P4, which is the Family Medicine residency "arm" of the TransforMed project.

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Humble Pie

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

Tips and ideas

"Nothing is more dangerous than an idea when it is the only one you have"
Emile Auguste Chartier

Tip #6: Build a Team.

The best team building conference is coming to Denver on August 28-29. The Practice Enhancement Forum (PEF) is supported by a grant from the AAFP Foundation and provides family medicine teams with practical tools, skills and knowledge to begin implementing the Chronic Care Model into their practice.

<http://www.aafp.org/online/en/home/practicing/quality/cme/pef.html>

Until then, read Creating a High-Performing Clinical Team, L. Gordon Moore.

<http://www.aafp.org/fpm/20060300/38creating.html>

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

The primary reason is that, in my opinion, this is the only way that Family Medicine will be practiced in the future. As a young Family Doctor, I know I'll be practicing a certain way and this is the way I want to practice. I try to be among the early adopters or, at least, the early majorities in new technologies and methods. I like to take a new approach before it becomes ubiquitous I don't want to spend my career following a reactive medicine model, running in the hamster wheel. I knew I didn't want to be seeing a different patient every seven minutes. I don't think anybody wants to practice that way; they just feel like they have to.

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

The physician directed medical team practice – the team approach – is where Clinix really shines. They were shining before I joined to the extent that members of the staff were fully empowered to implement certain protocols on behalf of the physician. With the Patient Centered Medical Home, we've created two new positions. One is a care coordinator who handles predominantly referrals and monitors communication among patients and offices and coordinates patient care both in and beyond the clinic. She makes sure loops are closed. The other position is a medical coordinator who can do all the things a medical assistant does, and go beyond that. The medical assistant focuses on each patient during the office visit and afterward, providing patient education and making sure that patients follow through with their post-visit treatment plan.

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

The response from patients has been overwhelmingly favorable. In keeping with the medical home philosophy, we systematically gather patient feedback by conducting a brief survey during certain weeks. Every tenth patient is asked to respond so that we don't concentrate on a specific type of respondent. We also have a plan to implement change when we get negative feedback. Honestly, I'm not quite sure the specialists really know what we're doing or how much it will affect them. In the future, we want to enter into memoranda of understanding with the specialists to whom we refer. These agreements would address issues like communication, prompt feedback and prompt reporting.

What do you love most about living in Colorado?

It's probably cliché, but my answer is the people. I believe the biggest contributor to a person's happiness is the kind of people that surround him or her. The kind of people who live in Colorado are the kind of people I like around me. I can't imagine better people than those in Colorado, including a lot of my patients. If the medical home had a theme song, it should probably be the one from the "Cheers" television series. It is an upbeat place where everyone knows your name and they're glad you came.

Humble Pie

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

If knowledge hangs around your neck like pearls instead of chains, you are a lucky man.

Alan Price, The Animals

Last month I discussed the threat to our profession unless we take action and prove our value. A recent article in the Boston Globe, March 12, 2009 clearly identifies who is knocking at the door:

"Six months after the first CVS MinuteClinics opened in Massachusetts, thousands of residents have visited the in-store clinics for treatment. With MinuteClinics opening at a rate of more than two a month in Massachusetts, company executives said they have taken off there faster than in the 24 other states where the company owns clinics. Nurse practitioners at the 16 Massachusetts clinics open so far have treated more than 10,000 patients with acute problems and given about 10,000 flu shots, the executives said. One major factor in the clinics' success is that the state's three largest insurers cover the visits without a physician's referral, they added."

I echo the lament of Annie Skaggs, a Lexington FP, who said, "I never really wanted to do anything but fabulous primary care, but my patients, even the ones I love like family, don't believe they have any obligation to help me make a living". On second thought, does anyone have an obligation to ensure that I thrive and prosper in the business of medicine? I, too, am well-trained and even graduated with honors. I consistently score high in the FP boards. I collect excessive CME hours and study relentlessly. I work long hours, half of which are essentially unreimbursed. I put the care of my patients as my priority and advocate for them behind the scenes. I try my hardest to be my best, BUT is that an entitlement to make a living? I do these things because I choose to. It is who I am. Society determines the value of services, sometimes, only realized after their loss. It is up to me to provide value, to make a living and to determine when I step over those nebulous ethical boundaries of quality, practicality, balance and compromise.

S. Leonard Syme, Professor Emeritus of Epidemiology University of California, Berkeley and eminent researcher in Public Health, wrote and executed a brilliant 5-year, \$2 million National Cancer Institute grant to study community-based smoking cessation intervention in Richmond, California. NCI later used the design in 20 other communities in their COMMIT study. **It failed**. Dr Syme, in a later commentary said, "It was only later, after I finished brooding, that I understood the challenges of that community-partnership model.....But, of course, I had never asked them about their priorities, and even if I had, I probably would have persisted with my plan anyway; I was, after all, the expert."
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Spotlight on Standards

The Strategy

Define your goals and what you plan to accomplish. Review the 10 Must Pass Elements of NCQA and pick at least 5 that you believe your practice can achieve. Assign tasks to your team. Collect your resources. Estimate how long it will take to complete each task and agree on a realistic timeline. Initially, pick one standard that is meaningful to your practice and determine what elements you want to work on. If possible, in order to engage the support and willingness of your staff, include the entire practice in regular meetings to spread your vision, and develop your needs assessment, action plan, policies, procedures, measures, and feedback. Be sure to plan to achieve small and immediate successes to feed practice enthusiasm and cooperation. Next month, the 1st inning starts.

Muse News

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

- One of Washington State's largest insurers is supporting a PCMH project with \$20 million.
- AAFP continues to dialog with key White House health advisors last week . Congressional support also grows with House Energy & Commerce Committee Chair Henry Waxman (D-CA) suggesting an overhaul of the health care system that ensures there are enough primary care physicians to provide care and at a Senate Health, Education, Labor and Pensions committee hearing, Senator Tom Coburn, M.D. (R-OK) spoke emphatically in favor of increasing the value of and payment for primary care services.
- The AMA voted to support the Joint Principles of the PCMH with the notable exception of ACOG and Congress of Neurological Surgeons.

(Humble Pie.....continued from page 2)

It took me a lot longer, about 20 years, but a lot less money to figure out that what I thought was the right care may not be the right practice. Six years ago, I implemented the Chronic Care Model into my practice. I really enjoyed giving value to my patients with an organized patient-centric model following Diabetes guidelines to the tee. I thought my care must be great and my patients must be happy. Then I implemented a Registry and when I measured my performance, I had the same dismal results as the national average. How was that possible? I was practicing evidence-based medicine. After a year of redirected activities, listening to the priorities of my patients and learning new skills, my performance measures improved 2-3 times better than national average. I, subsequently, achieved NCQA certification for Diabetes and Heart/Stroke. Certainly, I should now easily pass the Patient-Centered Medical Home criteria. However, when I really looked at the Standards, I was not delivering care in a consistent and comprehensive way. Patient access was only fair. Communication was lacking and even self-management, my strongpoint, was frequently undocumented and spotty. There was a long list of deficiencies to correct before I could say that I was delivering the right care, at the right time, at the right place. It does not matter how smart you are or how much you care or how hard you work if you do not improve your patients' outcomes. 6 months later, and a tremendous amount of work and revelations, we submitted our application for the PCMH, but only, after swallowing a large serving of Humble Pie.

Next Month: Just do it!

I have not heard from anyone? Not even hate mail. Should I be more controversial? More inflammatory? [Medical Home Forum for physicians](#) is waiting for YOU.

Bonus corner

For those of you fascinated with etymology, check out the origins of the term Humble Pie at:
http://en.wikipedia.org/wiki/Humble_pie

Cool Tools

Your one-stop shopping and ultimate Swiss Army knife for help on how to slice through the Standards is available in the 'Coach in a Box' from the Colorado Clinical Guideline Collaborative (CCGC). The web-based document provides a systematic approach to divide and conquer with abundant tools, policies, templates and other resources to understand and complete the NCQA requirements. You can obtain this outstanding resource at no charge from CCGC on their Website at www.coloradoguidelines.org on the Medical HomeTab. For Practice Transformation Support call Allyson Gottsman at 720-297-1681 to learn more about Improving Performance in Practice (IPIP).

A similar comprehensive resource, 'Road to Recognition', is available from the AAFP and is free to members. This document translates the NCQA Standards into a readable document and supplies many resources that will help choose the right level of recognition for practice and help in practice redesign. You can get your copy at:
<http://www.aafp.org/online/en/home/membership/initiatives/pcmh/ncqaquide.html>.

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