



The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

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Profiles of Change



David Ehrenberger, MD

Editor's Note: Profiles of physicians who are leading the movement toward Patient Centered Medical Homes are a regular feature of this newsletter. David Ehrenberger, MD, is one of eight Family Physicians at Broomfield Family Practice, where the staff also includes seven mid-level practitioners. He divides his time between the clinic and Avista Adventist Hospital, where he is chief medical officer. Broomfield Family Practice 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?

The process has been incremental. We've been using technology to provide better care and we've focused on quality improvement for quite some time. In January, we joined the pilot sponsored by the Colorado Clinical Guidelines Collaborative and in April we submitted the paperwork for certification by the National Committee for Quality Assurance. That's a pretty complicated process involving an extensive application form that requires 80 to 100 supporting documents. We've applied for level III certification, which is the highest level, and we expect to hear back this summer.

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

It's been talked about in Family Medicine literature for four to five years and the concept has been developing during that time. About a year ago, CCGC announced the pilot project and it fit perfectly for our practice.

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

I believe the PCMH is foundational to health care reform. There's abundant evidence that primary care physicians will become extinct within 10 years if innovative programs like PCMH don't succeed. This isn't just going back to doing things the Marcus Welby, MD, way. Unfortunately, the word *home* conveys the idea of hominess.

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Just Do It!

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

Tips and ideas

*"Our lives begin to end the day we become silent about things that matter."
Martin Luther King, Jr.*

Tip #7: Set a Goal

Do not know where to start? Do a patient, staff or, even, physician survey and hone in on specific problems to address. You can select one aspect of care (diabetes, immunizations, lab reports) to focus on. Map out the flow, identify waste, set your goal or ideal end point, redesign the system and test your changes.

Read [Creating a Lean Practice](#).

<http://www.aafp.org/fpm/20060400/34creation.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)

The name doesn't convey the complexity and sophistication of this model. Actually, the practice becomes the functional hub and spokes of care. We view it as the lifeboat for survival of primary care.

In addition, incentives for becoming a medical home are provided through participation in the CCGC pilot and by the payment methodology reform. Through the pilot, several insurers have agreed to pay a on a per-member-per-month care management fee that's in addition to the fee for services. This is an exciting and concrete step forward.

What was the biggest challenge to getting started?

The biggest challenge has been finding resources. We estimate that for our practice it costs about \$100,000 per year and that's after we've already spent \$120,000 for our electronic health records. For our large practice, the EHR costs about \$100,000 a year to maintain but it's an essential element of the PCMH. Also, we needed two additional full-time staff. Leadership, project management and developing the necessary skill sets have also posed challenges. Learning how to become a PCMH is a big challenge and we are grateful for the expert support we've been getting from the CCGC. The pilot here, which is a multi-stakeholder project, is considered to be one of the most sophisticated and ambitious programs in the nation.

What has been the biggest impact on your practice?

The biggest impact is not anything that is perceptible now. We are still at the beginning of the journey. Instead, it's the way we have positioned ourselves to be sustainable in the future. Five years from now, we'll be successful instead of being run over. It's as if we've jumped off of the Titanic and onto a speed boat.

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

The payers, which are the major insurance companies, volunteered to support the medical home pilot and they're making a substantial investment. That reflects a significant willingness to cooperate. They see value in this design. The payers, particularly the ones that have good leadership, recognize that if they allow primary care to die, they will end up dying, too, or Kaiser will become the predominant model. Payers know they have to do something and this is definitely the most promising new thing for health care reform and the future.

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

Patients have been thrilled with the follow-up calls to check on self-management issues. It's more work, but it's more exciting work.

What do you love most about living in Colorado?

I worked in California for 10 years before moving here 12 years ago and I've found that health care leadership in Colorado is very sophisticated and exciting. As the CCGC and its PCMH pilot demonstrate, organizations in Colorado are on the cutting edge of health care reform in the U.S.

Just Do It!

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

"All truth passes through three stages. First, it is ridiculed, second it is violently opposed, and third, it is accepted as self-evident."

Schopenhauer

The Patient-Centered Medical Home must be getting close to the truth. It is being ridiculed on many fronts from Primary Care physicians to specialists to consumers. What is unusual is the lack of controversy or debate in corporate and government circles. They like the idea. They understand the statistics, recognize the urgency and are ready to test change. Perhaps they see the logic through a business lens. Physicians are currently the largest obstacle to the PCMH. Let's look at some of the problems that I have heard:

1. We are already worked to the max and have no breathing room to change.
2. We cannot make changes and invest capital in technology without increased reimbursement.
3. We already practice quality medicine. Why change?
4. There is no evidence that the PCMH will solve the problems.
5. Why should primary care carry this burden and not specialists?
6. The PCMH will lead to loss of autonomy and threatened the art of medicine.
7. I am not paid enough to suffer such brain damage.
8. Who says I will be paid more. I have heard these promises before.
9. This is a pseudo HMO managed care model that failed before.
10. I do not know how to begin.

These are all valid concerns that need to be answered (in more detail next issue). Primary care has toiled to provide quality care against considerable obstacles through hard work, vigilance and good intent but at a high cost of personal energy to control such chaos. The fact is we cannot sustain this energy and we are not doing a good job. A recent study from McGlynn (NEJM.2003;348:2635-2645) showed across 12 metropolitan areas and varied practice environments that we provide the right care only 55% of the time. There are many reasons for this bleak statistic but any way you slice it, we are part of the problem. Yes, we are paid by an antiquated system, but, what have we done to change how we practice. Of all industries, we

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Spotlight on Standards

Standard 1 is a good place to begin. Your patients will see immediate benefits with improved access.

1. Write a policy. Use the NCQA elements as a guide. Create your own or purchase a policy from MGMA. ACP will be releasing their Medical Home Builder soon that has policy and procedure templates at reasonable cost.
2. Review the policy with your staff and providers and listen very carefully to their input.
3. Test certain features of the policy to be sure it is doable.
4. Get control of your schedule by determining your physician capacity and patient demand.

Suggested reading: What Works, Effective Tools & Case Studies To Improve Clinical Office Practice by Sue Houck. HealthPress Publishing, 2004, chapters 3, 7

Muse News

Send in your stories, news, tips, helpful tools and products, comments and humor to:
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- The Commonwealth Fund, in collaboration with eight co-funders, is launching a national [Safety Net Medical Home Initiative](#), which will provide \$6 million to help 68 community health centers in five states transform into patient-centered medical homes. Health centers in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania will be given training and ongoing support to improve how they deliver care to patients.
- The Quantum Group announced its collaboration with IBM to facilitate IBM's Patient Centered Medical Home (PCMH) solution that provides physicians with a 21st Century process for electronic records integration, management, analysis and communication.

(Just Do It!.....continued from page 2)

have been slow to adopt new technologies. We are practicing with the same old systems that ultimately created the problems. Change is not easy. It challenges our integrity and taxes our minds; however, it is not all about us. Remember when you wrote your essay for medical school? My guess is it was centered on the desire to help others. The PCMH returns us to this ideal. We must learn to collaborate and cooperate and resist the independent nature that gave us the strength to complete our training. Medicine has become too complex. We cannot keep it all in our heads and we need the standardization of practice guidelines and infrastructure of the PCMH to provide the right care at the right time with the reliability and certainty that we all want to give our patients. 100 years ago, in 1910, 90% of physicians had no college education. They attended unregulated and proprietary 'medical schools' that were condemned by the Flexner Report as a "loose and lax apprenticeship system that lacked defined standards or goals beyond the generation of financial gain". Abraham Flexner said, "We have, indeed, in America, medical practitioners not inferior to the best elsewhere; but there is probably no other country in the world in which there is so great a distance and so fatal a difference between the best, the average, and the worst." He continued, "Such exploitation of medical education is strangely inconsistent with the social aspects of medical practice. The overwhelming importance of preventive medicine, sanitation, and public health indicates that in modern life the medical profession is an organ differentiated by society for its highest purposes, not a business to be exploited." Our medical education system was completely revamped and modern medical training was born. His changes were radical and 94 of 160 medical schools were closed. He dramatically changed the landscape of American Medicine for the next century. Can we take medical practice to the next level and sweep away as Flexner described, "a disgrace to the State whose laws permit its existence... indescribably foul... the plague spot of the nation." Yes, we can. Just do it.

Next month: Impossible Dream

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

Bonus corner

Read about the Flexner Report at: <http://jama.ama-assn.org/cgi/content/full/291/17/2139>

Cool Tools

Having trouble getting your diabetic patients to their eye exam? You can now bring the retinal exam to your office and be reimbursed (92250). Retasure, www.retasure.com, is a HEDIS-compliant, NCQA and FDA-approved non-invasive test that captures patients' retinal images during a 3-5 minute procedure without eye dilation. This allows primary care physicians to provide retinal risk assessments for their diabetic patients, increasing compliance with recommended protocols. Retasure transmits high-quality images to secure, HIPAA compliant eye care professionals for review and recommendations. Results are returned within 72 hours. "Single-field photography is not a substitute for a comprehensive ophthalmic examination. However, there is evidence from well-designed comparative studies that single-field fundus photography can serve as an initial evaluation tool for diabetic retinopathy by identifying patients with retinopathy for referral to ophthalmic evaluation and management"¹. Digital photography without mydriasis has sufficient sensitivity >80% with specificity of 95% to be used in a systematic national screening programme². This may have value to your practice depending on your patient population and access to specialty eye care.

¹ ADA Review - Diabetic Retinopathy, Donald S. Fong, MD, MPH. Jul 2004

² Health Technology Assessment of Organization of Services for Diabetic Retinopathy Screening, Cummings, E. Feb 2002

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