



The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

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Profiles of Change

David Nuhfer, 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 Nuhfer, MD, practices at Family Practice Associates, which was established in Louisville four decades ago and is a participant in the Colorado Patient Centered Medical Home Pilot. The practice includes three physicians, five medical assistants, a practice manager, a biller and five additional full-time-equivalent support staff. There are no mid-level professionals. Though the practice is independent, it is affiliated with Avista Adventist Hospital and clinically connected with approximately 160 additional physicians through the Integrated Physician Network.

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

When the pilot project began May 1, 2009, we were already incorporating some PCMH practices as part of the Integrated Physician Network, which might be said to extend the PCMH concept to the medical neighborhood. We already had an electronic medical record that is shared throughout the network. Around the start of the project, we received level-three certification as a PCMH through the National Committee for Quality Assurance.

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

We're able to work as a team to deliver high quality patient care in an efficient and cost-effective manner. In keeping with PCMH principles, we're moving from physician care to team care. All members of the team are important and equal. People feel like they are making a difference and providing good care, which results in staff satisfaction. The payment reform of the PCMH replaces the unsustainable traditional model, where expenses go up every year as reimbursement stays flat, eventually leading to a situation where costs outweigh reimbursement. In the fee-for-service model, the only way to get more money is to work more. This helps explain why two prominent Boulder County primary care offices closed in the past year and why less than 2 percent of medical school graduates went into primary internal medicine last year. On the other hand, with the medical home project, we are paid an additional per-patient per-month charge. We get reimbursed for what we want to do, which is take good care of patients, keeping them out of emergency rooms and hospitals. The model is win-win-win for patients, insurance companies and primary care providers.

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Victim or Victor

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

Tips and ideas

"The important thing is to not stop questioning"

Albert Einstein

Tip #10: Ask the right questions

- Do you have questions about the Patient Centered Medical Home? Do you find yourself asking questions regarding the evidence that supports elements of the PCMH or that supports staffing changes or practice transformation? The CAFP is collecting questions from practicing physicians in order to create a "question data bank" that will be used to guide evidence collection around what works and what doesn't in the PCMH. Please submit any and all questions about the PCMH to the CAFP, angel@coloradoafp.org.

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?

The cost in time and money has been challenging. I spent about 300 hours or more preparing the application for NCQA certification. And, we had a head start in terms of the things we were doing with the physician network and having an electronic medical record already in place. There were several times along the way when I questioned whether we could become a medical home. It was a painful process, but I saw light at the end of the tunnel. I felt the effort would prove worthwhile in the end.

What has been the biggest impact on your practice?

A shift has occurred in how we view what we're doing. We've always focused on quality, but in the past we saw that as a separate concern from getting the job done. Now we see quality care as the ultimate goal and getting the job done as part of what we do in support of the goal. We are tracking our outcomes so we can be sure to provide the best evidence-based care to our diabetic patients and those with high blood pressure, as well as our other patients.

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

Probably one of the most exciting changes is the shift from treating individual patients to population management. The shift has occurred most robustly with diabetic patients. We used widely accepted evidence-based guidelines and protocols to develop a registry that includes all of our diabetic patients and a flow sheet to guide care. We update the data monthly and can pull reports to see when patients were last seen and what special tests they may need. We call patients to make sure they are coming in as needed and they've been very receptive to the approach.

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

The PCMH improves the patients' perception of the office, but we still need to work on marketing and education for patients. The insurance companies have embraced the idea for the most part. The bottom line is that it's saving them money. They had approached the Colorado Clinical Guidelines Collaborative with support for the pilot project. In the end, we're on the same team. We all want to improve quality of care and reduce the expenses of care. Staff members find more purpose and meaning in their jobs, but the PCMH takes more staff than traditional offices. To be a quality medical home takes resources. It's a big challenge. As for specialists, I think the concept of the medical home is still pretty foreign to them. It's our responsibility as primary care physicians to recruit the specialists to be supportive. With our group, the support is there. But with the community as a whole, we need to reach out.

What do you love most about living in Colorado?

I like the overall quality of life, which very much complements the PCMH idea. We're all about healthy living here in Colorado. It's neat to expand the idea of healthy living to the way we provide patient care.

Victim or Victor

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

*"Strong people are formed by opposition, like kites that rise against the wind."
Nelson Mandela*

We recently concluded the Systems of Care--PCMH Poll in Colorado. About 700 primary care and specialty physicians responded in a 60:40 split. The responses supported some of our suspicions but also revealed unexpected findings.

	PCP	Specialist
Aware of PCMH-- Very familiar/somewhat	80%	38%
Concept of PCMH – Extremely/Very important	72%	76%
Definitely/probably will become PCMH after reading description	56%	
Willing to meet and work with PCP		79%
Communication satisfaction with facilities – Total/very satisfied	15%	21%
Staff finds other office cooperative - Always/regularly	40%	54%
Receives necessary clinical information -- Always/regularly	51%	36%
PCP included in care by specialist	36%	
Specialist care plan supported/followed by PCP		70%

The results show that most PCPs and many specialists in Colorado are aware of the PCMH model and the vast majority support the concept. Communication and informational continuity is lacking; yet, there is a strong willingness on both sides to improve health care. Quality of care was the primary goal and principle value of both PCPs and specialists. Colorado physicians are clearly patient-centered and ready to take action to change.

On the negative side, primary care physicians feel battered and consistently focus on problems rather than solutions. They bemoan that there is not enough time nor adequate reimbursement to change. They exclaim that they are tired of repeated broken promises, over-regulation and rules that are heavily weighted to powerful self-interest groups. They ask, "What will be different now?". Working harder to line the pockets of the greedy health complex monopsony has become the norm. There is some truth to these sentiments and following the old ways will produce the same results. However, we are on the verge of 'disruptive innovations' that may well lead to a new model of practice and payment reform. Can we forgive the legacy of broken promises and second-class status and muster the energy to engage and promote change?

People are a curious lot. T.S. Eliot said that, "human kind can not bear very much reality" but the realities that patients endure have inspired me to find the strength and resolve to change my practice in the midst of chaos and calamity.[Continued on Page 3](#)

Spotlight on Standards

Standard 3: Care Management

This Standard involves how the practice systematically manages care for patients according to their important clinical conditions and needs, and how the practice coordinates patients' care

Standard 3C

This Element demonstrates the team approach to care management by sharing responsibilities with non-physician staff through job descriptions, protocols, and standing orders. This brings significant efficiencies to your practice, builds teams and improves morale.

Go to AAFP Road to Recognition and CCGC Coach in a Box. Also:

http://www.ncqa.org/Portals/0/Programs/Recognition/Companion_Guide/Standard%203.pdf

Muse News

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

- COPIC has recognized the value of the PCMH and awards 2 ERS points for Level 1, four ERS points for Level 2 and six ERS points for Level 3 (**thanks go to CAFP and Raquel Alexander**).
- More than 500 practices and 4600 physicians have gone through NCQA PCMH recognition. An expert panel has been convened to review and update criteria to be released in early 2011.
- Nebraska lawmakers recently passed legislation calling for a two-year medical home pilot and Access HealthColumbus is leading an effort in Ohio to create medical homes for 30,000 patients.
- Robert Kocher, M.D., from the National Economic Council and special assistant for health care to President Obama, said mounting evidence is "unequivocal" in showing that if done right, medical homes are more cost-effective than traditional models of care and improve patient outcomes.

(Victim or Victor.....continued from page 2)

Sally (not her real name) was a young, vibrant, attractive woman with a career on the move. A relatively minor rear-end collision triggered her hardly recognizable congenital torticollis and her life slowly unraveled over the next 15 years. Her pain became unbearable and her cervical dystonia became progressive and intractable. She found little relief and suffered significant side effects with conventional therapies until Botox became available. This gave her temporary respite; however, she developed antibodies and eventually the treatment lost its efficacy. She was rudely treated and depersonalized as she progressed through the maze of specialists and tertiary care. She could no longer drive, then lost her job. Her husband eventually left her and she was estranged from the rest of her family and children. Due to the severe neck contracture, she struggled to eat and take her medications. Her chronic pain generalized and she developed a peripheral neuropathy. She became wheel-chair bound living off meager and inadequate disability payments. Through steadfast determination and grit she managed to walk again. A non-profit foundation agreed to pay her travel expenses to Mayo Clinic for specialized neurosurgery. One week prior to her trip, she fell and fractured her ankle requiring an open reduction and fixation. Undaunted, she struggled through her rehabilitation only to slip on ice and fracture her knee. She can not afford many of the recommended medications that might ease her pain yet she never complained, never uttered, "why me". She has lost everything except her life of pain and her indomitable spirit. She refuses to surrender to her disease; and, every day, she fights for recovery and to regain control of her life. She is the victor, not victim. In comparison, my complaints seem so trivial, my excuses so shallow.

In the *Power of Now*, Eckhart Tolle would query, what is wrong with this moment? The answer demands you make a choice and reveal either the presence or lack of your inner conflicts. Sure I could dwell on the litany of social, financial, physical and intellectual insults over my 25 years of practice and fall prey to the learned helplessness that travail and repeated losses bring. On the other hand, I could focus on what is right about this moment. Personally, I am warm, fed, housed and loved. Intellectually, despite the daily, mundane, administrative drivel, I am stimulated and challenged by my patient's needs. Professionally, despite the daily struggle to stay in the black, I am working at what I like to do. Patients come to us for health, function and comfort needs and, despite the barriers we all face, I have purpose. What is wrong with this moment? Nothing.

No doubt that Primary Care has been victimized and undervalued since our creation as a specialty. We now have an opportunity to lead positive change in health care. Success will rest with your answer—are you a victim or victor?

Cool Tools

Frustrated with the lack of time, lack of effective treatment and lack of reimbursement to counsel your overweight/obese patients? Numerous studies point to the benefits of physician involvement in patient weight management, yet today fewer than 40% of physicians advise obese patient to lose weight. **Microlife Medical Home Solutions, Inc.** (www.mimhs.com) addresses these concerns and provides an effective weight management system for your clinic. WatchWT provides your practice with a highly efficient and reimbursable model for obesity assessment and management. WatchWT Practice Solutions developed an individualized obesity assessment and systematic energy-balance educational program utilizing the patient's unique Resting Metabolic Rate (RMR). This data is coupled with a patient-centered nutrition and activity plan that promotes patient self-management. This evidence-based practice solution is designed to fulfill some of the requirements for the PCMH as required by the National Committee for Quality Assurance (NCQA) without placing burden on staff or on the operational resources of the physician practice.

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