CAFP
BOLD CHAMPION FOR COLORADO FAMILY PHYSICIANS

The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

Volume 2, Issue 1 **January 2009**

Profiles of Change

Larry Kipe, M.D., FAAFP

Editor's Note: Profiles of physicians who are leading the movement toward Patient Centered Medical Homes are a regular feature of this newsletter. Larry Kipe, MD, FAAFP, practices at Moffat Family Clinic in Craig, Colo., with three other Family Physicians and a physician's assistant. Together they serve approximately 6,000 patients in three settings – the clinic, a hospital and a nursing home. Dr. Kipe has held several offices in the Colorado Academy of Family Physicians, including the presidency.

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

We've incorporated many of the features of a Patient Centered Medical Home all along in Craig, as most Family Physicians have. Now we're trying to incorporate preventive care into every visit. We try to implement the recommendations of the U.S. Preventative Services Task Force, grades A and B. When a patient comes in with a mild infection, we check to make sure they're up to date on their cancer screenings.

How did you learn about the PCMH approach to medicine?

The first professional group to use the term was the American Academy of Pediatrics. The pediatricians were the first to speak as a group about the topic. A few years ago, the American Academy of Family Physicians published a lot of articles about the Future of Family Medicine Project. The Patient Centered Medical Home was one aspect. Now the CAFP and the AAFP have signed off on the Patient Centered Medical Home and the concept has blossomed to become what it is now. ….. *Continued next page*

On page 2:

Team Med

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

Tips and ideas

"The secret to getting ahead is getting started".

Tip#3: Assess Your Practice

- Find out where you stand on the journey to becoming a Medical Home by measuring your practice against the TransforMED Medical Home IQ Assessment's 8 core sets of competencies or "modules".
- Log in at no charge http://www.transformed.com/MHIQ/welcome.cfm

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: Larry Kipe (cont)

Why did you decide to utilize the approach in your practice?
The whole concept meshes with Family Medicine. The idea of providing totality of care has been around a long time, but it's really hard to do. We need to treat people not as a bronchitis case, but as a person with bronchitis who happens to be in our office at the time and still has a lot of potential health issues to address.

What was the biggest challenge to getting started?
Changing the workflow of the clinic so we could get everything done was one challenge and establishing a process for checking on a patients' overall care each time they come in was another. You have to have something that reminds you what to do at each appointment and provides information at your fingertips. An electronic record helps a lot.

What has been the biggest impact on your practice?
Our staff takes more pride in the work we do. They take pride in the clinic as a whole for producing a product that's really what our patients deserve. It's a clinic-wide project, not just something the physicians are doing. For example, when diabetic patients come in, the nurses check to make sure they have their flu shots and give the shots if needed.

Could you provide a few details about how you implement just one of the seven principles of the PCMH?
We piloted and implemented changes in our scheduling system to provide enhanced access. We're losing doctors in our town so we were searching for ways to get more patients. We expanded our support staff to free up doctors' time and we now start most days with about 30 percent of our appointments vacant. Most are usually full by the end of the day. The doctors now spend more time providing care because they spend less doing paperwork. We now see about 30 percent more patients and provide the same amount of time with each as we did before the changes. We're providing a high quality of care to a larger number of patients and making more money while doing it. Financially, if you can see 30 percent more people, then hiring two to three additional people is inconsequential. But it is still scary to see those vacant appointments at the start of the day.

How have patients, insurers, staff and specialists responded to the PCMH?
I'm not sure our patients even know the concept. They just recognize they get more timely and better service. Insurers don't seem to care.
Do you have a favorite brief anecdote relating to the PCMH?
One patient in particular was glad to be able to have his annual physical on the same day he called for an appointment.

What do you like best about living in Colorado?
I like the people, especially in my town. They're very friendly and they're very open with the medical students and residents I have the privilege of teaching.

Team Med

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

> *Coming together is a beginning.*
> *Keeping together is progress.*
> *Working together is success*
> Henry Ford.

Over time, I understood the concepts of the PCMH and formed my vision on how it would look at my practice. I certainly felt the urgency, as most FPs, of being overwhelmed, overworked, undervalued, as well as, the distress over the waste, greed, inefficiencies and poor communications that harm our patients. The answers seemed clear and simple, but how to implement the plan, alone and isolated?
I studied the problems, developed a plan, created the tools, outlined the structure, built the process and with enthusiasm and fanfare launched the program. It was received with awe and admiration but sank quickly. Ouch! My staff and colleagues want to deliver the best medical care. The changes were clearly and logically written down. I was the respected leader of the group. What went wrong? I only made 8 major mistakes.

1. I plunged ahead without establishing the same sense of urgency in my staff and colleagues. Complacency driven by past success, lack of a visible crisis, lack of performance measures and standards maintained the status quo and created a powerful barrier to change.
2. I did not create a guiding committee to serve as role models, share the vision and represent the interests of the entire practice.
3. The working team I created was hierarchal and not collaborative; therefore, it did not change the practice culture and projects, eventually, stalled.
4. I did not clearly share the vision by reducing it to a simple message to give my staff a sense of direction on where we were heading and what we were doing..…*Continued on Page 3*

New Feature: Cool Tools

First sharpen the best tool in the shop- your brain. Check out FPM Resource Library on practice transformation:
http://www.aafp.org/online/en/home/publications/journals/fpm/collections/transformation.html#Parsys92039

New Feature: Spotlight on Standards

Before we start, you need to see the big picture.

Request and review the free PDF of NCQA's PCC-PCMH Standards and Guidelines
http://www.ncqa.org/tabid/631/Default.aspx

Muse News

CAFP members and friends of the PCMH: Send in your stories, news, tips, helpful tools and products, comments and humor to: shammond@evcohs.com

If you missed out on the Colorado PCMH Pilot, the Medicare Medical Home Demonstration project is taking application until March 2008.
Highlights:

- Eligibility – primary care practices with >150 Medicare patients (excluding Medicare Advantage)
- Has 2 tiers that follow NCQA PCC-PCMH criteria.
- Pays $27-$100 PMPM for patients with ≥ 1 eligible chronic disease depending on tier and HCC score.

For more info:
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1199247&intNumPerPage=10

(Team Med……….continued from page 2)

5. I did not engage other key personnel to communicate both the personal and patient benefits of change to all staff and providers.
6. I did not identify all the major obstacles and confront them. I did not have the buy-in or cooperation of all the top leadership which sent an inconsistent message to the staff and undermined the transformation.
7. I was impatient and delivered too much, too soon and bypassed the needed successes of small victories. I did not establish short term goals to achieve and celebrate. I did not build confidence in the staff that the vision was achievable.
8. I did not give enough feedback or reinforcement to make new changes a habit. I did not link improved performance measures to the new behaviors or process.

Along came IPIP, Improving Performance in Practice, (http://www.coloradoguidelines.org/ipip/) which aims to transform the way we deliver healthcare in Colorado by providing in-office assistance, tools, systems and support to primary care physicians. They are actively supporting over 60 practices in Colorado and provide:

- Quality Improvement (QI) Coach
- Disease registry
- Practice Redesign Team
- Consultation on work flow analysis, Chronic Care Model, Open Access Scheduling, Practice Culture Change, EMR conversion
- Focus on system redesign
- 1 or 2 Learning Sessions per year

This program is led by the Colorado Clinical Guidelines Collaborative (CCGC) which has gained a national reputation for leading PCMH change and is still recruiting new practices. It was a relief to finally have an ally and a portal to what other practices were accomplishing. I finally understood the true nature of teamwork and what it would take to implement changes. The national consensus is that Primary Care is the backbone of health care. It was time to show my practice that I had the spine to make the first changes. I abandoned my Walden utopian approach that everyone would spontaneously know their place and duty and started to build Team Med.

Next Month: Building Team Med