



2014 NO. 01



Frank deGruy, MD, MSFM, Woodward Chisholm Professor and Chair
Department of Family Medicine | University of Colorado School of Medicine

THE PRECIPICE

AND AN INVITATION TO A SALON

Welcome to *Precipice*, from the University of Colorado Department of Family Medicine. This is not an annual report, though it might appear annually. This is written for those interested in the changing healthcare landscape, particularly those working in family medicine departments. It's something new, and a little dangerous, or at least a little scary.

This is also an invitation. What you read here will form the basis of a running conversation about the most important issues facing family medicine departments today. We will host a *salon*, a conversation about these issues, at our national meetings (and elsewhere), and you are invited to join the circle of conversants. We are encouraging lively, passionate, uncensored, challenging, convention-breaking discussion, and problem-solving around our hardest and most important problems.

In the next few pages, we describe three tough problems our department has recently attacked. We did this for the best of reasons, but we have been pushed to the precipice—to the edge of our own comfort and capacities. On some points we are succeeding, on some we are failing, and on many we don't know what we are doing or what to do next. By sharing these stories, we are inviting you to discuss these projects and the ideas behind them. We hope that your participation will make these programs “public property” and that our collective discussion will equip you and us with experience, precedents, principles, prerequisites, advice and warnings that might improve all our chances for success.

We feel a particular responsibility to imagine the best ideas for health, and then to wrestle them into existence, refine them in the crucible of discussion and study and testing, and put them in place for the better health of the people and patients we serve. What should family medicine become? What are our core attributes? What do people most need from us? What roles should we assume in a new health care system? What are the permissible limits of variation that still allow us to call ourselves family physicians (FP) or primary care clinicians? What is a primary care practice, and what is not? Who are we responsible to train? What do we need to know to be effective, and how do we acquire that knowledge?

Think of the three ideas presented in this document as practical efforts to get at what we might become. Think of them as crystals we are dropping into the supersaturated solution of our collective restless searching for a better way. These ideas are presented as unfinished business—efforts that contain mistakes, hide assumptions, take longer and are much harder than expected and showcase some success. Let these ideas precipitate a discussion about the shape of our professional futures. Help us get this right—we are willing to fail, and show you our failures; as long as we fail fast and fail smart, and then get up and try again. Your attention and reaction to these small efforts will catalyze a discussion that helps all of us. Think of the pages that follow as the seed of our salon—the start of the intense conversations I described above.

“WE FEEL A RESPONSIBILITY TO IMAGINE THE BEST IDEAS FOR HEALTH, AND THEN TO WRESTLE THEM INTO EXISTENCE.”

First a word about the values, priorities, resources and other contextual elements that gave our efforts their particular shape. Your values and context will be different from that described here—similar, but different. Both the similarities and the differences are interesting and important, and we hope you share both.

We are an unusual family medicine department by most criteria. For starters, we're large: we have about 300 regular faculty members and almost 700 clinical faculty members. We have faculty members in this department who are physician assistants (PAs), nurse practitioners (NPs), psychologists, general internists, pediatricians, psychiatrists, public health people, preventive and occupational medicine physicians, educators, anthropologists, statisticians, qualitative methodologists, and an

assortment of others; our faculty work in federally qualified health centers (FQHCs), health foundations, competing hospital systems, and state health offices. Six residency programs (four of which are family medicine) live inside this department, with another one or two in the offing. We sponsor a health psychology internship, a marriage and family therapy (MFT) program, and six or eight fellowships. So we are accustomed to professional diversity, and work to accommodate it.

Our practice plan and hospitals are traditional in their structure and are financially healthy. We operate four community-based family practices and a few other miscellaneous clinics. All clinical departments in our university practice plan, including our own, operate in the black. We generally have the capacity to reward our faculty members for their

productivity, and have accumulated reserves sufficient to support a modest innovation fund. Thus, we have a little breathing room, and prize risk-taking. We celebrate failure as evidence of pushing the limits of excellence, and strive to learn what we can from our failures.

We favor partnership over ownership. We seek controlled, principled conflict as a means to surface the best ideas. Ideas are our investments. We believe that we should not undertake a project unless it is manifestly important and nearly impossible. We believe in heavy front-end planning. Lao-Tzu said “Put things in order before they exist,” and we try to live by that principle. These are a few organizational realities and operating principles that shape our particular efforts. What follows are three specific instances of those efforts.

TABLE OF CONTENTS

2

The Little Clinic
Q&A featuring
Colleen Conry



6

Training the
Primary Care
Workforce



10

Research Solutions: A
Network of Networks
featuring Wilson Pace

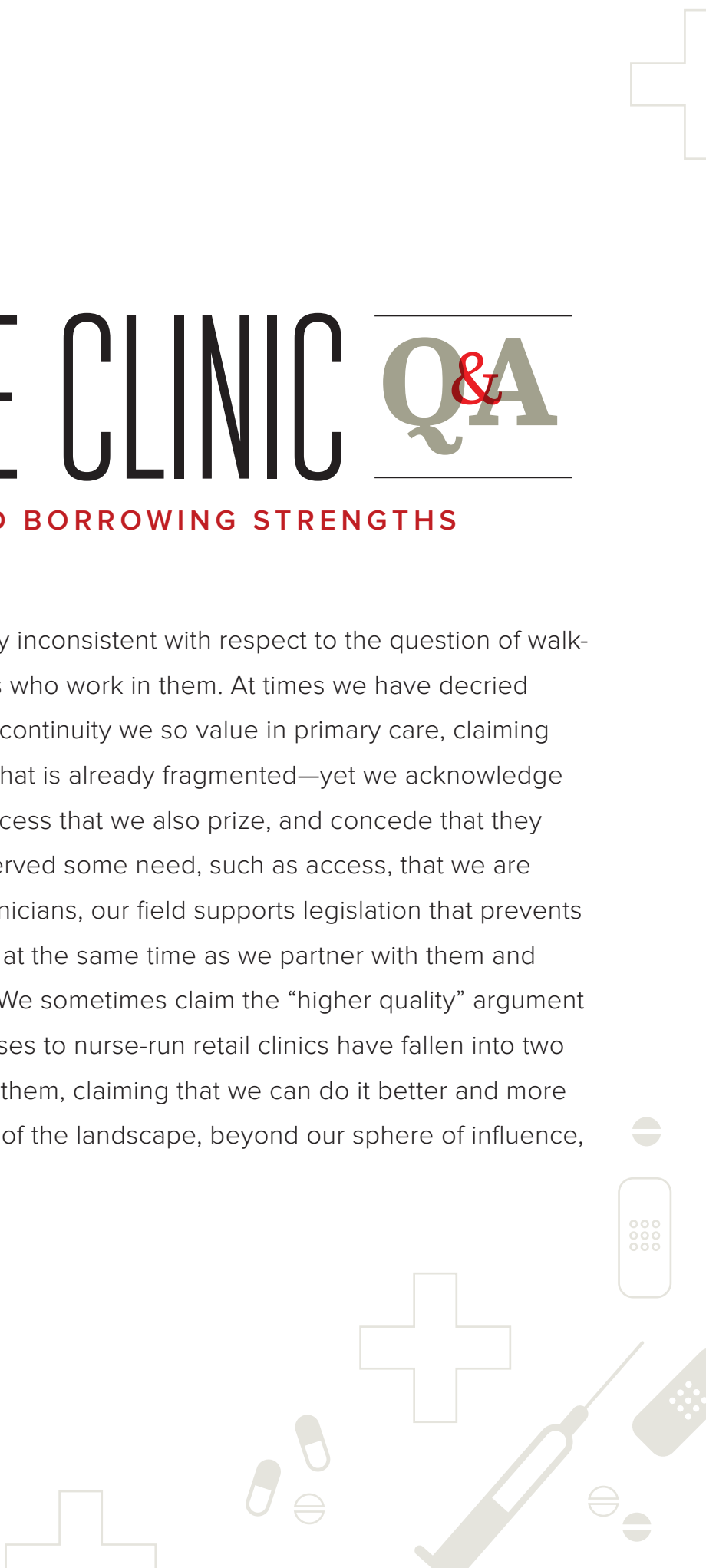




THE LITTLE CLINIC

LINKING ARMS AND BORROWING STRENGTHS

Our field has been embarrassingly inconsistent with respect to the question of walk-in retail clinics and the clinicians who work in them. At times we have decried retail clinics as an affront to the continuity we so value in primary care, claiming that they further fragment care that is already fragmented—yet we acknowledge that they provide convenient access that we also prize, and concede that they could not survive unless they served some need, such as access, that we are failing to serve. With respect to nurse clinicians, our field supports legislation that prevents them from freely practicing primary care at the same time as we partner with them and hire them and train them and use them. We sometimes claim the “higher quality” argument for FPs over NPs. In general, our responses to nurse-run retail clinics have fallen into two categories: either we oppose and resist them, claiming that we can do it better and more safely; or we concede that they are part of the landscape, beyond our sphere of influence, and we learn to coexist.



Q Is there a third way to think about these clinics and these clinicians?

A Rather than extrude these nurse-run clinics because of their failures of comprehensiveness and continuity, what would happen if we included them inside our circle of primary care? Is it possible to link arms and borrow strengths from one another? Is it possible to take advantage of their exceptional convenience and access and somehow connect that to our more comprehensive, coordinated, continuous practices; and work together to assure that the quality of care rendered there is of the highest order?

Q Can we make a partnership that creates the best of both systems—that creates a better primary care than either of us alone is capable of creating?

A We want to try. A few years ago The Little Clinic (TLC) began appearing in our neighborhoods, in King Soopers and Kroger grocery stores. These walk-in clinics are generally staffed by nurse practitioners who offer a discrete set of services, driven by protocol, for minor acute problems and some preventive services. The Little Clinic was eager to establish a relationship with a health sciences campus to improve its credibility and quality, to help refine its algorithms and keep them current, and to gain access to additional services for their patients beyond their scope of practice. We, on the other hand, wanted these patients to have access to a continuity clinic for chronic diseases, and wanted reassurance that these patients were receiving high quality care. We also just wanted these patients. So the first and most important conceptual shift is to imagine that all of our family medicine clinic patients and all the TLC patients are one panel—one practice.

Q How do we reorder our resources and services to get the best of both for all?

A FIRST we began with clinical faculty appointments. We offered regular faculty appointments to about 60 NPs working in 15 TLCs. At their request, we have provided 10 collaborating family physicians as partners with these NPs; who are available to answer questions during the day, review a set of visit records each

month, and offer clinical consultation and feedback to the NPs. We are paid fair market value for this service.

SECOND we have created read-only access to our respective clinical records, and are in the process of establishing a common electronic health record (EHR).

THIRD we agreed to be available for each other's patients: they send about 30 patients a month to us when those patients need continuity or follow-up care, or simply don't have a primary care provider (PCP); and we send about 30 patients a month to them when we have no clinic openings for a problem that is covered by their protocols.

FOURTH we review their protocols and update them in light of emerging improvements in standards of care. We also discuss these protocols and the evidence supporting them with the NP clinicians to make sure they are understandable and implementable.

FIFTH we have visited each other's clinics. We've seen where they work and what it's like to work there; they have visited our department, visited our flagship clinic, and have become acquainted with our staff and clinicians. They are invited to all our educational offerings and can remotely access our grand rounds.

SIXTH we reduced our clinics' copay for TLC patients to the cost of a TLC visit, which levels the decision of where to get care to issues of convenience, continuity, and quality; and not a cost differential. Finally, we market our practices together, and as a result both of us have enjoyed practice growth.

SEVENTH we have committed to closely evaluate this partnership and the care that we provide under the terms of this partnership.

We have been gratified to learn that the quality of care and the outcomes of care have been of the highest order, in no place inferior to our own clinics. We have also noted that the patients referred to us from TLC tend to come from affluent neighborhoods and carry adequate health insurance. Many are young adults who have not established a usual source of care, and some are glad to have found us for that.

Some of this is more difficult than we anticipated. Some of our collaborating physicians do not fully understand their role in this partnership; and careful, repeated education on roles, respect, communication, and partnership is essential. The same can be said of some of the NPs. This takes time and expertise. The NPs have been baffled by our labyrinthine system, and how to actually contact the various clinicians and resources they need in our system. We have had to simplify and customize access for them.

Q Now that we have these acute care protocols down, how about we add a few simple chronic disease conditions?

A The TLC clinicians get regular requests to check blood pressure or hemoglobin A1c (HbA1cs), and make minor adjustments if necessary. Is it possible (or desirable) to develop protocols for these simple interventions? Do we need a different kind of relationship with the patients and NPs for these kinds of problems?

Q Now that we've got this working here in Denver, can you also partner with us in Colorado Springs?

A What about across the state? Can we use this model of collaborating physician partnership when we are physically distant from one another? Does telehealth technology offer a solution to the problem of geographic separation?

JOIN THE CONVERSATION

Retail clinics and our relationship with them have generated extraordinary interest recently. For specific questions about The Little Clinic, email Colleen Conry at colleen.conry@ucdenver.edu.

The topic will also be discussed from the podium at this year's **Association of Departments of Family Medicine (ADFM) winter meeting, February 2015** in Savannah. We will host our first salon to discuss these issues in more depth at that meeting. **Please join us there.**

“IMAGINE THAT ALL OUR CLINICS’ PATIENTS AND ALL THE LITTLE CLINICS’ PATIENTS ARE ONE PANEL—ALL CARED FOR BY ONE PRACTICE.”



Colleen Conry, MD, is the Senior Vice Chair for Quality and Clinical Affairs in the University of Colorado Department of Family Medicine. ►

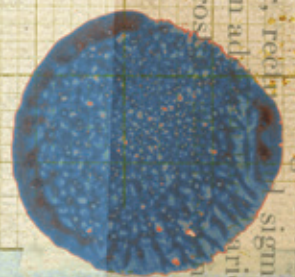


Fig. 1

1. Front view of the trunk showing subdivisions of the ventral
Organs of the thoracic cavity C. Organs of the abdominopelvic ca-

on. The abdominal portion contains the liver, gallbladder, stomach, spleen, pancreas, and small and large intestines. The pelvic portion contains the bladder, rectum, sigmoid colon, uterus, and ovaries. The pelvic portion has in addition the testes and uterus in the male, the prostate gland and uterus in the female, and the ductus deferens.

Disciplines



200 220 240 260 280 300 320 340 360 380 400 420 440 460 480 500

Fig. 16



TRAINING THE PRIMARY CARE WORKFORCE

HOW DO WE TRAIN A TEAM TO PRACTICE GREAT PRIMARY CARE?

We're still trying to figure that out. For starters, we know that most of our patients have “invisible” problems we don't record, or see, or even look for: behavioral problems (mental disorders, substance use disorders, problematic health behaviors, and psychosocial and family problems) that are painful, disabling, common, and expensive—and complicate everything else in their lives. If we aspire to comprehensiveness, if we wish to be effective in our doctoring, if we wish to win the Primary Care Effect described so compellingly by Barbara Starfield, or the Triple Aim championed so passionately by Don Berwick, then we have to incorporate into the fabric of normal primary care the management of behavioral problems. We also know that you can't just add behavioral content as another element into the curriculum and expect results: *how* you practice is as important as what you know. Comprehensive, integrated care requires registries, care managers, and a team of clinicians...especially behavioral clinicians, working together. So we should train a family physician to competently manage common clinical problems in an integrated practice as part of a team of clinicians. We must train the teams to work as teams.

“WE’RE NOT IN THE BUSINESS OF JUST TRAINING FAMILY DOCTORS. OUR JOB IS TO TRAIN THE PRIMARY CARE WORKFORCE. THAT IS OUR PERSONAL RESPONSIBILITY.”

IS THIS ENOUGH?

Recently, we’ve had reason to think not. It doesn’t make sense to train *teams* and then release *individuals* out into the world, in hopes that they’ll find their way onto a team. In fact, our early Patient Centered Medical Home (PCMH) graduates were not finding team-based PCMH practices, or even partners who understood how to practice with them. In other words, we were releasing family docs into a workforce that was not prepared for them.

REFRAMING OUR EDUCATIONAL MISSION

We’re not in the business of training family docs; our job is to train the primary care workforce. That is our personal responsibility. No one else will do it if we don’t. We train the primary care workforce to work together as a team, to create *together* personal care plans and quality practices.

If we believe this is our mandate, the implications are that we train teams of family docs, psychologists, psychiatrists, addictionologists, social workers, care managers, and the other core team members. We train them and we train them to work together. This doesn’t

mean that we train a psychologist to be a psychologist, but it does mean that we train a psychologist to become fluent and competent in primary care behavioral issues, and to practice that competence in the context of a primary care team. We cannot leave this part of their training to others. No one else can do this. It takes a team to train a team. Thus, our training mandate and our faculty expand.

WHAT “NEW” DISCIPLINES DO WE TAKE ON?

> **The ones that we need the most. The ones that no one else is addressing.** We have brought into this department a primary care psychology internship, and faculty to support it. If this internship had not already existed, in another form in another department, we would have had to develop it de novo. We gave a primary faculty appointment to the internship director, ported the program into our department, including the Health Resources and Services Administration (HRSA) grant that supports it, and are transforming it into a primary care psychology internship. Six interns a year. So far they are not all in primary care settings, but that transition, which requires

supervisors and curricula and a properly functioning PCMH, is underway and should be complete in a couple of years. We expect to train our psychologists as core partners with our family docs, and even to send them out into practice together.

> **We have developed an addiction medicine fellowship**, and started our first fellow in July of 2014. This took a willing university hospital partner, a successful substance abuse program with an energetic and visionary executive director, a successful addiction psychiatry fellowship application, and a highly competent new fellowship director.

> **Despite our current stable of behavioral clinicians**, we still have a small percentage of patients who belong in primary care but whose behavioral problems are so confusing or complicated or intractable that our primary care team is out of its depth. This is the “deep end.” For these patients we need additional help to manage them—for these patients we need a psychiatrist and the resources found in specialty psychiatric settings.

> **We have hired two psychiatrists into this department**, and are recruiting two more, one of whom will be boarded in family medicine and psychiatry, and will practice in both settings.

Sometimes it is best to simply borrow or buy psychiatrists from, say a department of psychiatry. In our case, we had difficulty finding exactly what we needed for this niche, and judged it better to hire our own. This has produced a certain tension across departments that must be actively managed. Perhaps we have bitten off more than we can chew. It remains to be seen whether this will result in a primary care psychiatry training program, but it has already resulted in the development and placement of a telepsychiatry service in one (soon to be two) of our residency practices. We believe that the work of creating a multidisciplinary primary care behavioral team is complicated, and accordingly we have partnered with our institution's depression center (where telepsychiatry lives) to help us with this.

> This is not all of the core primary care team. For example, we are not training care managers. We could do this by partnering with a nearby FQHC system that trains its own care managers, or by partnering with a nearby community college that has indicated willingness to work with us to train care managers, or by partnering with HealthteamWorks, a local 501c3 that trains practice coaches, care managers, and others for team-based care. *How should we proceed?*

> Finally, we are having trouble paying for these teams. We are working against policies and rules that make it difficult to share information, bill for services, work within our workflow, and otherwise provide the care patients need. We see the need for a policy center to help us focus and magnify

our advocacy efforts, and we have developed one (this development will be discussed in a later edition).

JOIN THE CONVERSATION

For specific questions about this article, please email Frank deGruy at Frank.deGruy@ucdenver.edu.

This educational and training initiative will also be the subject of a salon we intend to hold at the **2015 annual spring meeting of the Society of Teachers of Family Medicine (STFM)**. Please join us there for this conversation.

QUESTIONS WE ASK OURSELVES:

1

What are we doing so far outside the traditional boundaries of our department?

2

Is our premise sound? Are we really responsible for training the primary care workforce?

3

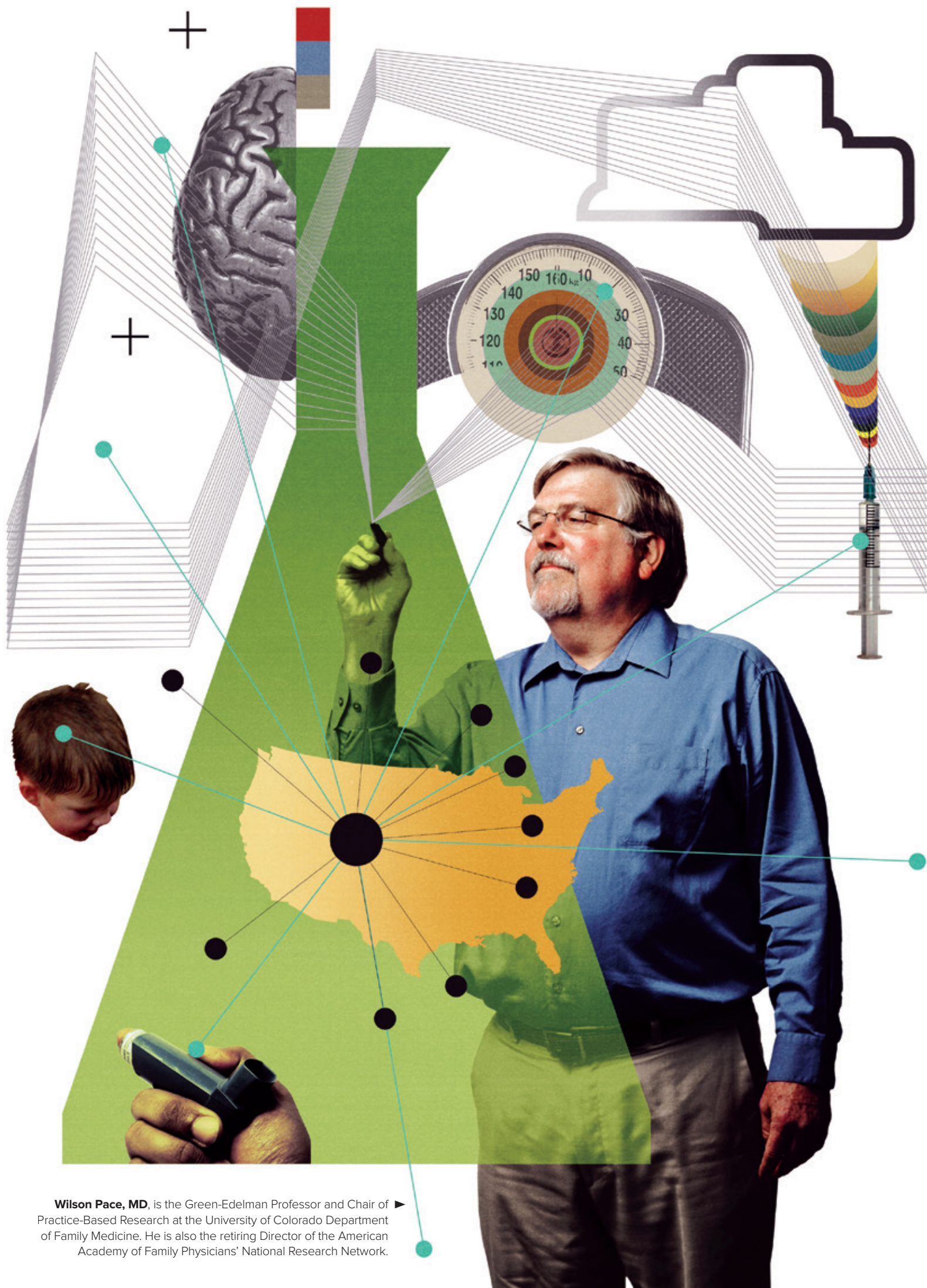
How do we incorporate this into our undergraduate interprofessional education programs?

4

What additional disciplines should we include?

5

Can we create community team training centers for students?




Wilson Pace, MD, is the Green-Edelman Professor and Chair of Practice-Based Research at the University of Colorado Department of Family Medicine. He is also the retiring Director of the American Academy of Family Physicians' National Research Network.



RESEARCH SOLUTIONS

A NETWORK OF NETWORKS

When it comes to research, we seem to have a chain of insufficiency. There's no national institute of primary care. Family medicine commands 0.1% of the National Institute of Health (NIH) research budget. We don't have enough money. We don't have enough principal investigators (PIs). We don't have enough staff. We don't have enough expertise. We don't have enough faculty members. We don't have enough fellows. Maybe we're looking at this wrongly. A department is an appropriate size to teach medical students about a discipline, and a department's clinics are an appropriate size to render outstanding care to primary care patients. It does not follow that a department, especially a small department, is an appropriate size to answer important research questions. It will never have the full investigator team necessary to address the full range of challenges associated with a large, complex research problem. A small department cannot maintain the methods expertise, the analytic resources, the informatics capacity, the grant writing and manuscript-producing engine sufficient to take on the big questions. Even Practice-Based Research Networks (PBRNs) are proving to be insufficient, and networks of networks are becoming the norm. Maybe a department is the wrong unit to tackle big, important research questions.





“TO WORK IN THIS MODEL, YOU HAVE TO ADOPT A ‘COMMON PROPERTY’ MENTALITY. WE CAN ALL DO BETTER IF WE WORK TOGETHER AND LEARN FROM EACH OTHER; THE PIE IS BIG ENOUGH FOR EVERYONE.”

What if we think of the collection of all our departments as one enormous department, or a few very large departments? Is that big enough to tackle tough questions? Is that enough resources to attract big grants?

Think of what we have together. Millions of patients. Thousands of practices. Networks of practice-based and community-based networks. Scores of PIs and mentors and methodologists and data collectors and analysts and grant writers. Teams of them. Moreover, we have pockets of innovation going on all over the nation. People with specific experience, developing improved practices, new methods, and new strategies.

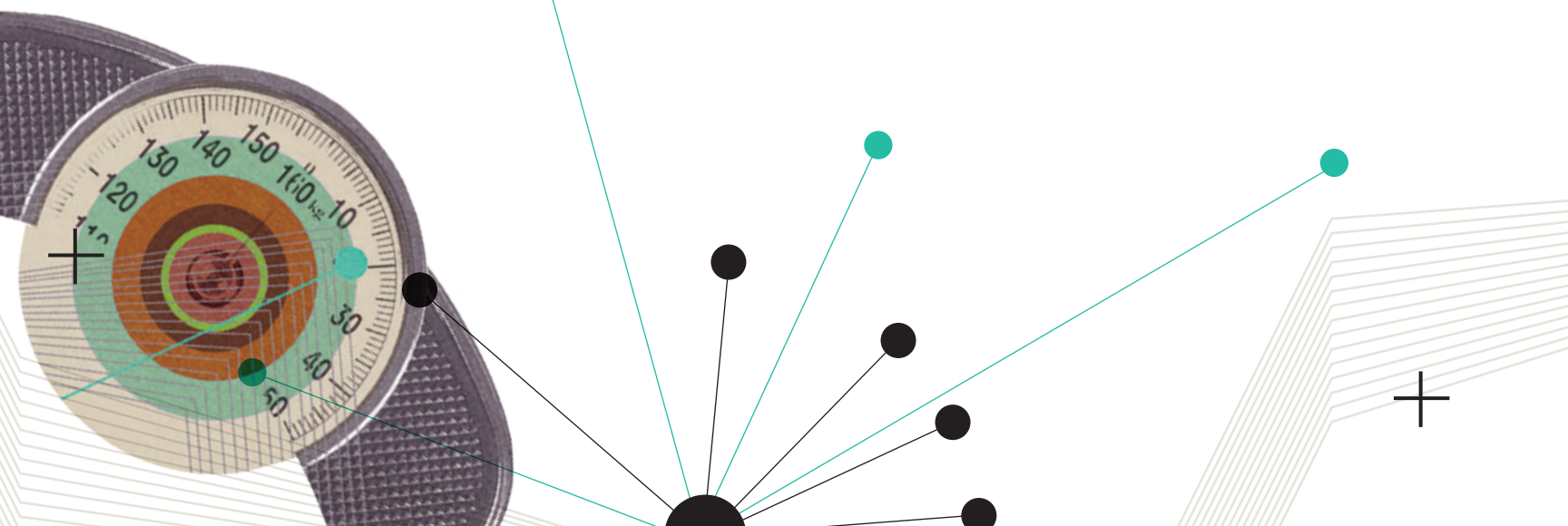
But this is an archipelago. We are scattered across this nation, from Seattle to Miami. How do we bring all these resources together into one or a few coherent teams that can address a coherent set of studies? How do we even think of ourselves as a single shop?

Wilson Pace has some good ideas about this. For the last decade he's been working on practice reorganization, new PBRN research methods, electronic data collection and management, patient safety, and comparative effectiveness research. He is interested in answering big questions that take a lot of practices, thousands or even millions of patients, sophisticated data management capacities,

and high-end design and analysis resources. No one has all of that—no department, and not the National Research Network (NRN). But Wilson has figured out a way to draw people from everywhere together into teams that seem to work well together, get big projects done, and want to do it again.

Examining This Work:

FIRST let's think of our collective assets not so much as a superdepartment, but as a set of discrete, but confederated departments that can offer components to a research team that could be assembled specifically for the research problem at hand. These components, whether PIs or evaluation teams or data repositories or PBRNs, remain under





the auspices of the host department. If this first gesture can be done properly, then departments can make meaningful contributions to extremely difficult, large, and important research projects, can retain their own identity and integrity, and can receive funding for the research and credit for the results. They will also meet new high-end research partners. In principle, this is no different from ordinary research subcontracts.

SECOND It would take a certain kind of leader. The leader of such an arrangement must have the vision to see through to the architecture of large multi-site, multi-participant projects. He or she must understand what components are needed, who and where they are, and just how much of each is necessary. He or she must see how these people can be fit together into a harmonious whole with good work chemistry. He or she must be completely transparent about the work, the budget, unanticipated problems, and other complications along the way. With projects this size, he or she must be willing to deputize and encourage individual initiative—micromanagement is impossible and counterproductive. He or she must be quick to take the blame and even quicker to give the credit, which encourages problem-solving and investment in success.

THIRD It would take a certain kind of platform. One that attracts large projects. One with access to an advanced responsive institutional

review board. One with sufficient inherent credibility to attract the best partners. One with latitude about facilities and administrative costs (F&A) and their disposition.

FOURTH It would take a certain kind of study. Trials that require practices as the unit of intervention or measurement. Ones that compare communities. Large comparative and research studies. Studies of unusual but catastrophic clinical conditions. Studies where small differences in cost or clinical outcomes are very important.

FIFTH It would have to cover the cost of the infrastructure. Well, that's what F&As are for. If this can be done such that F&As can be returned to the project (or the project home), it should be sustainable.



QUESTIONS WE ASK OURSELVES:

1

How many large research centers do we need, and where should they be located?

2

How can we encourage the participation of more departmental faculty?

3

How do we retain a department's research identity, if our researchers join a large research center?

4

What does it take to sustain such a large infrastructure?

5

What should be the priorities of the next NRN director?



JOIN THE CONVERSATION

These are very difficult and high-stakes questions for us, and we are exploring several models. For specific questions or comments about this article, please email Wilson Pace at Wilson.Pace@ucdenver.edu.

Please join our conversation around this research initiative at a salon we intend to hold at the **North American Primary Care Research Group's (NAPCRG) Annual Practice-Based Research Network Conference** on **June 29-30, 2015** in Bethesda, MD.

“THINK OF THESE PAGES AS
THE SEED OF OUR SALON—
THE START OF A PASSIONATE,
UNCENSORED, CONVENTION-
BREAKING, PURPOSEFUL
RUNNING CONVERSATION
ABOUT OUR HARDEST
AND MOST IMPORTANT
PROBLEMS.”

-Frank deGruy, MD, MSFM



ABOUT THIS PUBLICATION:

This publication was prepared by members of the **Department of Family Medicine** at the University of Colorado School of Medicine with design, layout, and production help from **Anabliss Design + Brand Strategy**. The content herein belongs to anyone who cares to use it for the furtherance of health, the improvement of healthcare, or the development of your own programs. It was prepared to inspire and instruct us to become more effective health professionals.

CONTACT US:

inquiry@precipiceonline.org

FIND US ONLINE:

www.precipiceonline.org

JOIN THE CONVERSATION

We will host salon conversations at the annual Association of Departments of Family Medicine, Society of Teachers of Family Medicine, and North American Primary Care Research Group PBRN meetings. We expect these conversations will also run on these organizations' respective list serves, and locally at faculty, clinician, and practice meetings. Please tell us if this stimulates something that should be shared with the community organized around these ideas.

SALONS

ADFM 2015 Winter Meeting
February 18–21, 2015 | Savannah, GA

STFM Annual Spring Conference
April 25–29, 2015 | Orlando, FL

NAPCRG PBRN Conference
June 29–30, 2015 | Bethesda, MD