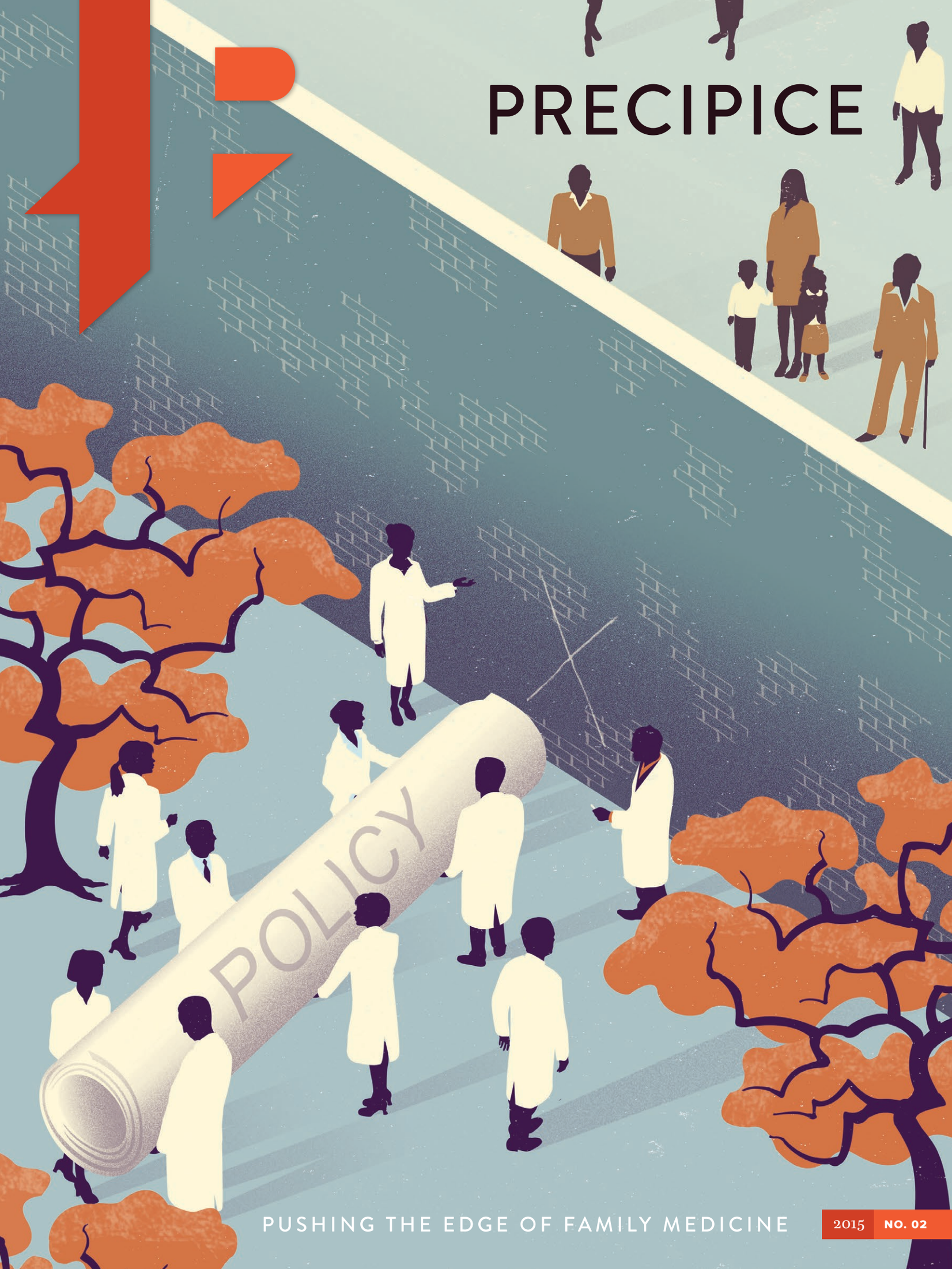

PRECIPICE

PUSHING THE EDGE OF FAMILY MEDICINE

2015 NO. 02

INTRODUCTION

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

Welcome to Precipice, a publication from the Department of Family Medicine at the University of Colorado. Precipice is designed to address hard problems in family medicine and primary care as we strive to help our patients and neighbors become healthier, and as we listen to the conversations at our national meetings and in our literature.

THIS SECOND ISSUE OF PRECIPICE PRESENTS THREE PROBLEMS WE ARE FACING TODAY.

Precipice is designed to galvanize our thinking about contemporary problems, and to push us to be better. It's also designed to stimulate a deeper dialogue through the agency of *salons*—hosted conversations during which this material is discussed in a relaxed but focused setting at our national meetings. This past year we hosted five salons—two at the Association of Departments of Family Medicine (ADFM) winter meeting, two at the Society of Teachers of Family Medicine (STFM) spring meeting, and one at the North American Primary Care Research Group's Practice-Based Research Network (NAPCRG's PBRN) annual meeting. They were well attended, inspiring, and instructive; we will report on the outcomes of these salons later in this issue.

This second issue of Precipice presents three problems we are facing today. But first, so you can better understand our problems and approach, a few words about the structure and operation of this department and campus. Our campus has new leaders: we have a new CEO of our hospital system, a new CEO of our university hospital, and a new vice chancellor for health affairs and dean of our school of medicine. This kind of leadership turnover can be unnerving, but we do not sense any diminution of interest in and support for primary care and family medicine here, which has historically run high. Thus, we are operating as if our leaders need us, like us, and want us.

This department of family medicine has continued to grow—we have about 300 regular faculty members and 700 clinical faculty members—and the department continues to consist of professionals from a range of specialties and disciplines. Our research portfolio has expanded substantially in the last year, our educational programs have expanded and stabilized, and our clinical programs are on the threshold of significant growth. We remain committed to disciplined risk-taking and innovation, and especially enjoy tackling impossible, or nearly impossible problems.

We will begin this conversation by describing how we are thinking about three hard problems: leadership, community and population health, and policy.

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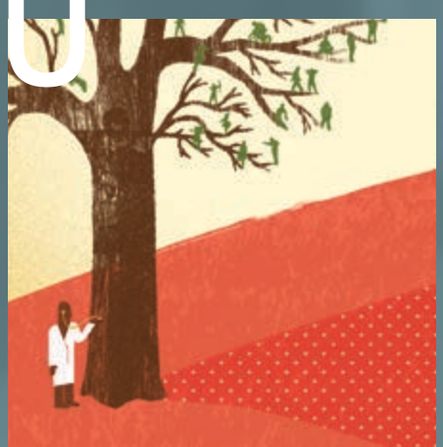

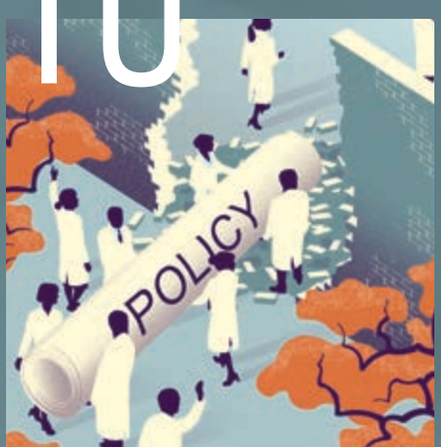

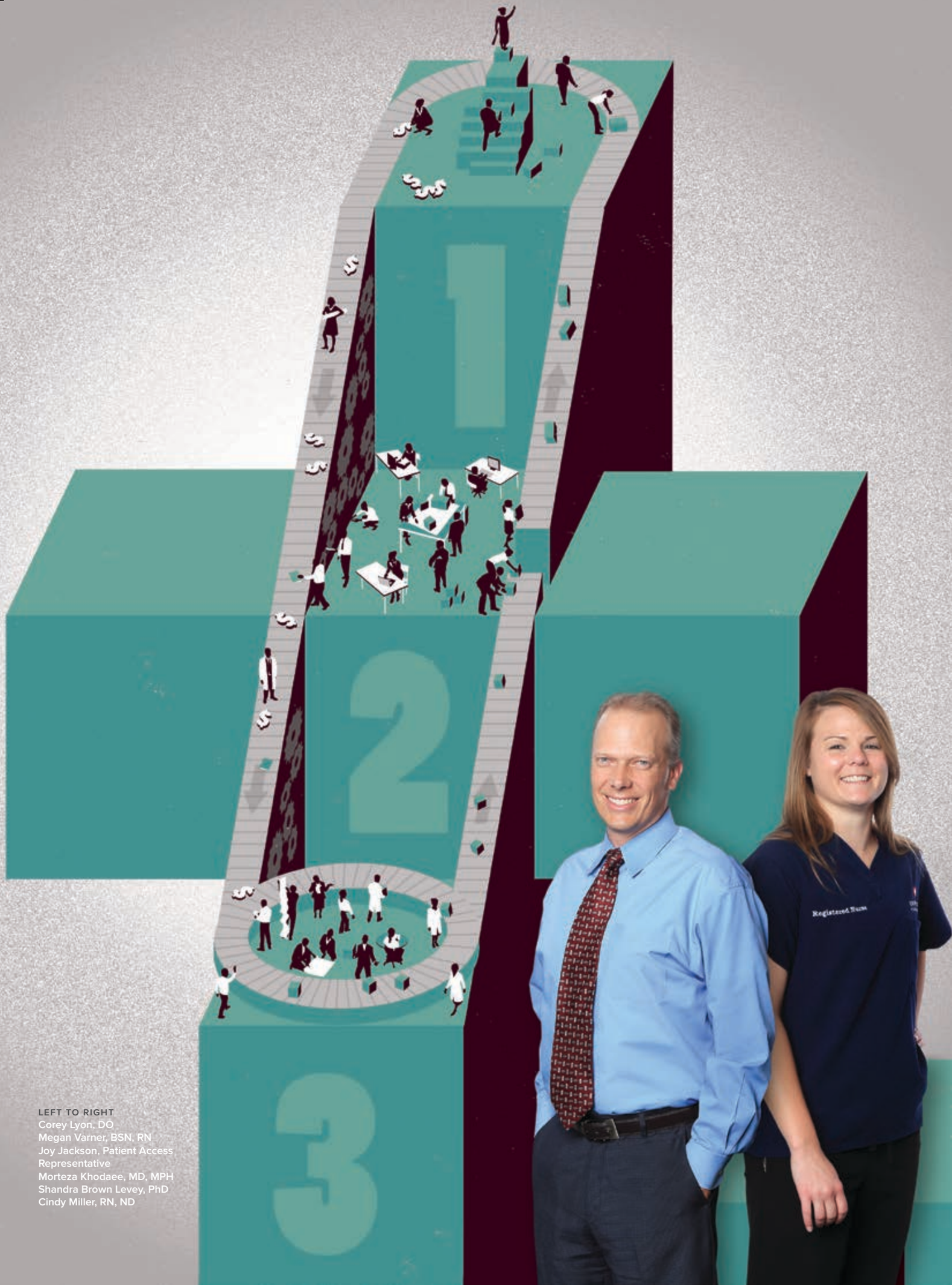

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Corey Lyon, DO
Megan Varner, BSN, RN
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Morteza Khodaee, MD, MPH
Shandra Brown Levey, PhD
Cindy Miller, RN, ND

LEADERSHIP

WHAT KIND OF LEADERSHIP BEST FITS OUR PROGRAMS AND DEPARTMENTS?

We talk about leadership all the time. We strive to be good leaders, constantly working to refine and extend our own leadership skills. We train future leaders and develop pathways for new leaders to emerge. We encourage great leadership wherever possible. We esteem it, cherish it, and value it. All this is good, but it would seem that we talk of leadership nonspecifically, according to our temperaments, training, and experiences.

PRIMARY CARE CLINICS ARE COMPLEX ADAPTIVE SYSTEMS THAT FACE A CONTINUOUS STREAM OF NEW PROBLEMS, MANY UNANTICIPATED, AND A CONTINUOUS NEED FOR UNIQUE SOLUTIONS.

Some of us have adopted the approach developed over the years by Kouzes and Posner; some aspire to be servant leaders or facilitative leaders; some prefer a command-and-control style. Those well versed in the field of leadership may apply different leadership frames or styles according to the objective or problem at hand, or even based on how the other leaders around us operate—thus, Bolman and Deal's organizational frames, for example, might equip us to manifest symbolic leadership when appropriate, or to operate within a political frame when the situation is overtly political.

But we learned something new about leadership from the Advancing Care Together project, and especially from the AHRQ-sponsored *Guidebook for Professional Practices for Behavioral Health and Primary Care Integration: Observations from Exemplary Sites*. We see in these studies a particular kind of leadership driving the most successful and highest quality practices. Primary care clinics cannot be operated as assembly lines. Primary care cannot be commodified. Primary care is not a product; it is a set of services organized and offered as personal care plans for people whose constellations of problems and needs are unique to them and always changing. Primary care clinics are complex adaptive systems that face a continuous stream of new problems, many unanticipated, with a continuous need for unique solutions. The clinic systems observed in these studies are as different from one another as primary care practices can be, but there is a striking similarity in the kind of leadership that works in these different settings. It is not quite a leadership *style*—it's more like a continuum of leadership behaviors that plays out differently according to where you are in the organizational hierarchy. Successful leadership at the level of a clinic with people who are actually taking care of patients is fundamentally different from leadership at the level of a medical director or a department chair—the tasks are different and effective behaviors are different (*see facing page*).

Leadership in a complex adaptive system might be called *complex adaptive leadership*, and is not applicable to just our clinics. This kind of leadership fits the education, research, and community engagement spheres just as well as it does the clinical mission area. We should strive to understand and use this kind of leadership. Teaching, fostering and encouraging adaptive leadership on the ground and at enabling and administrative levels may be one of our principal agendas for professional development, and an organizing operational principle for success—we just don't know yet.

THINGS WE WANT TO LEARN ABOUT COMPLEX ADAPTIVE LEADERSHIP

We hope to dig deeper into this issue at our salons, and learn more about how complex adaptive leadership relates to clinical effectiveness, productivity, morale, professional growth, and innovation. We want to learn:

1. What leadership skills or leadership actions work under what conditions, and for what problems.
2. How to teach leadership at the adaptive, enabling, and administrative levels.
3. How to balance structure against flexibility.
4. How to take risks so that wins are more likely and failures are not disastrous
5. When to act—this is as important as where or how to act.
6. How to think about teams and team-based efforts, how leaders fit together as a team, what complementarity of skills or aptitudes add up to great leadership teams in our various settings.

LEVELS OF COMPLEX ADAPTIVE LEADERSHIP

ADMINISTRATIVE LEADERSHIP

MAIN FEATURES

- Voice and protect the vision
- Acquire resources
- Lead strategic planning
- Manage crises
- Stay out of the way

EXAMPLES

- "We will do whatever it takes to give our patients the best care possible"
- Advocate for change in payment mechanisms
- Hire sufficient staff for team-based care

ENABLING LEADERSHIP

MAIN FEATURES

- Catalyze adaptive solutions
- Deploy resources
- Protect flexibility
- Provide structure
- Connect the administrative and adaptive leadership levels

EXAMPLES

- Open evening clinics
- Add home visits to services
- Migrate the EHR to cellphones
- Set appropriate benchmarks

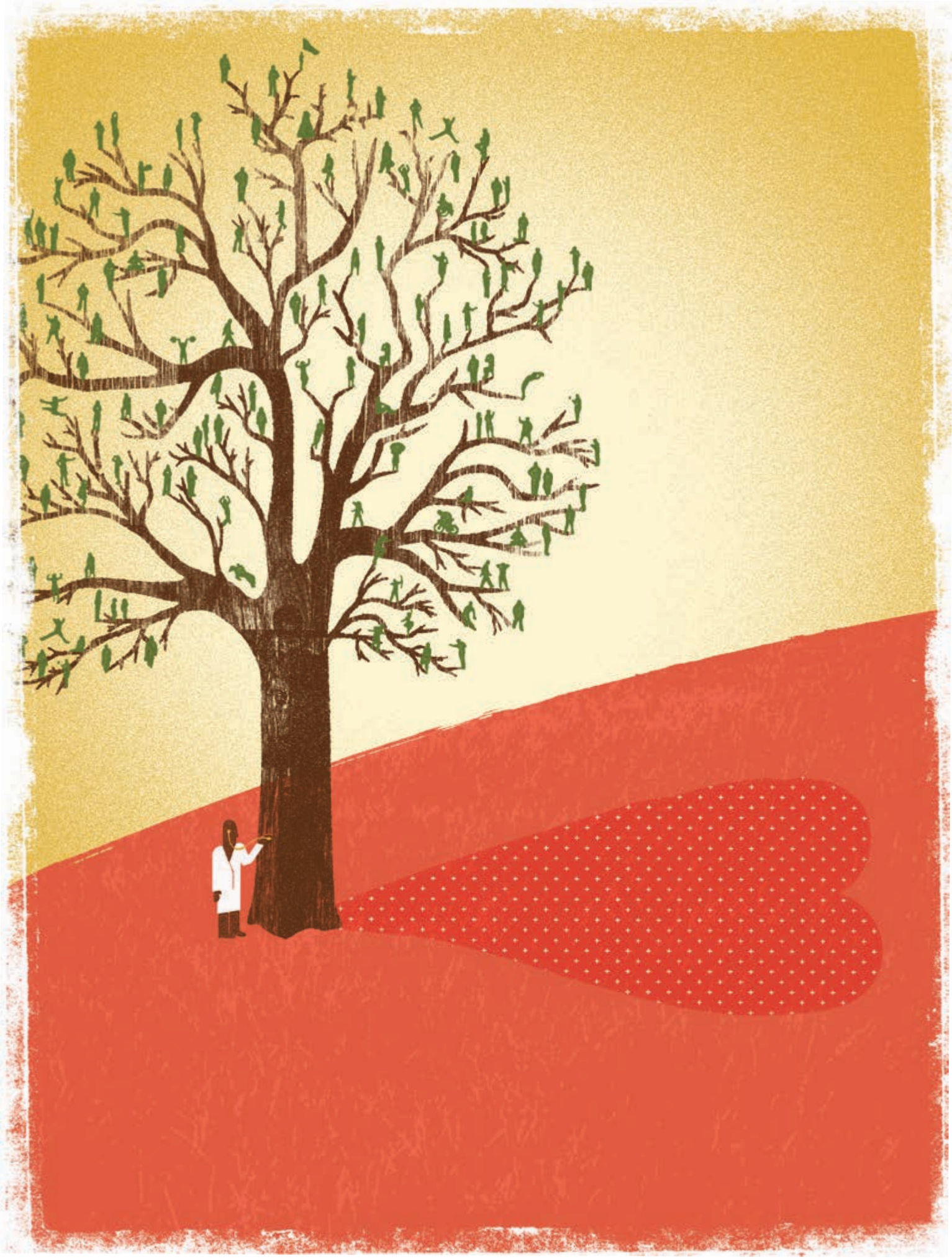
ADAPTIVE LEADERSHIP

MAIN FEATURES

- Be creative
- Be flexible and proactive in problem solving
- Take risks

EXAMPLES

- Adjust behavioral health clinician schedules
- Deploy care managers for home visits
- Develop new roles for appointment clerks



COMMUNITY AND POPULATION HEALTH

HOW DO WE HELP POPULATIONS BECOME HEALTHIER? WHAT IS OUR ROLE HERE?

We aspire as a nation to improve the health of the population, and to make healthcare less expensive and more effective. These three aspirations are the Triple Aim, and the first, improving population health, is the most important—it is the end toward which the other two are directed. It is also the most difficult to achieve for healthcare professionals, and the least developed as a field of scientific inquiry. Departments of family medicine have important responsibilities here.

IT IS UP TO US TO PRODUCE SOMETHING NEW UNDER THE SUN THAT BENEFITS THE PEOPLE OF OUR STATE, NATION, AND PLANET WITH A REWARDING AND MEANINGFUL ROLE FOR THESE PARTNERS.

IDENTIFYING WHAT WORKS

Of all the determinants of health, we know that the most important are social, which occur in communities and families, yet our knowledge about how to use these effectively is insufficient. We know communities harbor tremendous resources for promoting health, and for counteracting the effects of illness, but our knowledge about how to galvanize communities around these salutogenic factors is insufficient. We know that the healthcare system, particularly the primary care system, has an important effect on health, but our knowledge about how to focus this effect, and how to integrate it with community resources, is insufficient. Here and there, people are doing good work at improving population health, and these examples can serve as prototypes and inspiration, but too often these efforts don't fit our situation or for other reasons aren't helpful to us. Mostly, we just don't know enough about how to be effective here.

CREATING SOLUTIONS

To address this problem, we are trying to build a **Colorado Community and Population Health Research Institute** that will bring together investigators and stakeholders to solve the following problems:

1 Community health, population health, population medicine, population healthcare, and other such terms are fraught with imprecision and differences in understanding. This is the pre-empirical state of affairs for a scientific field. This field will advance more quickly when we agree on definitions. We will engage scientists versed in the principles of descriptive psychology to develop an agreed-upon lexicon of common terms, as we have done for the field of collaborative, integrated healthcare.

2 A set of radically new research designs and methods of analysis are emerging that we need here: designs and analyses that incorporate patients, families and communities as partners, that engage a wider set of stakeholders for setting outcomes, that move on accelerated timelines, that take advantage of natural conditions and local resources, and that can find generalizable principles from local solutions. We are creating a mixed-methods evaluation shop that further develops and uses these methods.

3 Implementation science has recently emerged as an extraordinarily useful method for fitting specific best practices or evidence-based recommendations into diverse clinical settings. We are attempting to translate this method into community settings, so that we can use three-way feedback loops and other novel strategies to reach diverse communities with successful prototypes.

4 Data for use by communities and populations is problematic. While we are witnessing the creation of new, large, comprehensive datasets—so-called "big data"—access to actionable information for individuals, practices, communities, and other stakeholders remains deeply problematic. Here, we are not so much interested in creating large, merged datasets as addressing fundamental measurement problems for personal health, community health, and quality healthcare in communities; extraction of data from sources relevant to local communities' needs; integrating, processing and presenting data in understandable and actionable form (think geocoding and infographics). There will be stewardship, privacy, and access issues that we will have to manage.

5 The real goal of this institute will be to produce communities of solution, or communities as learning systems for health, where health can be won in an environment that has effectively erased the boundaries among primary care, behavioral healthcare, public health, and other community agencies and resources. The idea of communities of solution is over 50 years old, but now we are within reach of realizing this idea, and are able to create and test interventions based on the use of an integrated and coherent set of data about and agents for personal health, neighborhood health problems, local

health resources, and agreed-upon priorities. We are prototyping and field testing. We have communities ready to take advantage of our work with extension systems, statewide practice transformation efforts, and other linkages to the healthcare system.

HOW WE MEASURE SUCCESS

Population and community health depends on a strong community/academic partnership, and the appetite for such partnerships has increased recently in light of the mandates of the Affordable Care Act and the focus on population health within the Triple Aim. We can find willing partners in our quest for population; e.g., the community engagement core within CTSAs; local CBPR shops; and local PBRNs. Also, there are partners throughout schools of medicine, nursing, public health, pharmacy, and dentistry. Many hospital systems have a chief population health officer who might be an ally and partner. Most AHCs are a veritable archipelago of people interested in and working on some aspect of population health. There are national partners that include: the American Board of Family Medicine, the North American Primary Care Research Group, the American Academy of Family Physician's National Research Network, the National Committee on Vital and Health Statistics, the Patient-Centered Primary Care Collaborative, The Robert Graham Policy Center, The Eugene S. Farley, Jr. Health Policy Center, Milliman, and CMS' State Innovation Models.

None of these expressions of interest guarantees success or even necessarily translates into partnerships, much less a living program. It is up to us to produce something new that benefits the people of our state, nation, and planet with a rewarding and meaningful role for these partners.

POPULATION AND COMMUNITY HEALTH DEPENDS ON A STRONG COMMUNITY AND ACADEMIC PARTNERSHIP.

QUESTIONS WE ASK OURSELVES

1

How do we organize such diverse partners, with a varied range of priorities and agendas, into a coherent, focused initiative? How do we avoid fights over territory and identity?

2

These partners come from different sectors of public life, and have their own structures, operating principles, and sources of funding. How do we create partnerships under such complex conditions? Who names? Who leads? Who pays?

3

How do we measure the effects of our initiatives? In communities where thousands of things are changing simultaneously, how can we tell whether our efforts are doing any good?

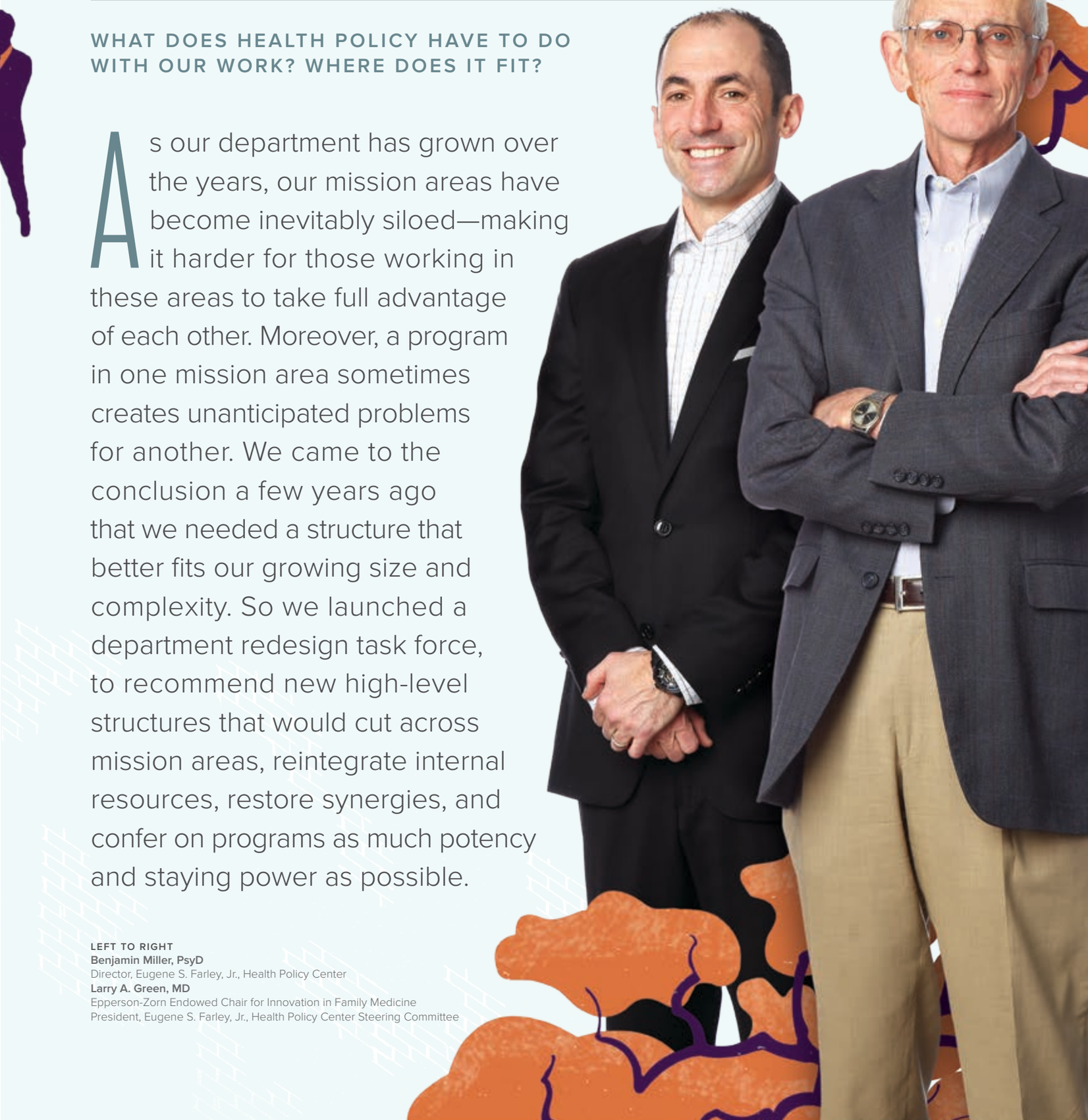
JOIN THE CONVERSATION This topic will be discussed at our salon at NAPCRG PBRN on July 11, 2016 in Bethesda, MD.


POLICY

POLICY

WHAT DOES HEALTH POLICY HAVE TO DO WITH OUR WORK? WHERE DOES IT FIT?

As our department has grown over the years, our mission areas have become inevitably siloed—making it harder for those working in these areas to take full advantage of each other. Moreover, a program in one mission area sometimes creates unanticipated problems for another. We came to the conclusion a few years ago that we needed a structure that better fits our growing size and complexity. So we launched a department redesign task force, to recommend new high-level structures that would cut across mission areas, reintegrate internal resources, restore synergies, and confer on programs as much potency and staying power as possible.



LEFT TO RIGHT
Benjamin Miller, PsyD
Director, Eugene S. Farley, Jr., Health Policy Center
Larry A. Green, MD
Epperson-Zorn Endowed Chair for Innovation in Family Medicine
President, Eugene S. Farley, Jr., Health Policy Center Steering Committee

WE ARE RECOGNIZING POLICY WORK AS ONE OF OUR CORE ACTIVITIES.

This task force recommended three new crosscutting cores or hubs: an evaluation hub, a practice transformation core, and a policy center. The policy center would ensure that all programs gave early and thoughtful consideration to sustainability, and to better alignment of resources with intentions. With the help of a national steering committee and a board of directors, the Eugene S. Farley Health Policy Center was launched, led by Ben Miller and Larry Green. The Farley Center is equipped to take on the policy dimension of any important problem in family medicine or primary care, and is particularly focused on addressing the common complaint that great work stops when the grant runs out. Here, as everywhere, beautiful innovative programs were demonstrating proof of concept, but were not sustainable because we hadn't proactively developed the policies that would perpetuate the program. To this end, the Farley Center strives to get relevant, targeted, timely information into the hands of decision-makers so they can set policy that sustains success. These decision-makers might be institutional leaders, elected officials, parents, patients, local clinicians or other health promoters.

The Farley Center focuses on primary care and behavioral health integration, workforce, payment reform, and prevention and community. It finds and synthesizes evidence, produces new evidence, hosts visiting scholars, and convenes events designed to discuss and discern the nature and possible remediation of important health and health care problems. The center helps prepare health professions fellows and students for leadership in developing and implementing proper health policy.

At this time, a principal focus of the Farley Center is on the integration of primary care and behavioral health. There are still substantial impediments to advancing integrated care: distinct professional cultures accustomed to working apart rather than together, rules and regulations made for a time gone by that are in need of revision, unsolved data problems, toxic payment systems, workforce insufficiencies, and knotty operational issues that impede adoption of integrated care. There is urgency in moving to implement evidence-based strategies that make big differences for individuals, families, and communities.

So now we have a policy center that can punch a hole in the wall between great innovations and our ability to sustain them. We are recognizing policy work as one of our core activities—as a way to break down barriers that impede our ability to do things better. The center convenes stakeholders, formulates action plans, produces maps, draws up policy briefs for legislators, drafts legislation, and makes recommendations about how to spend money.

For more information visit farleyhealthpolicy.org.

QUESTIONS WE ASK OURSELVES

1	2	3	4	5
What policies help local communities integrate behavioral and primary healthcare?	Who are our natural partners and allies in policy work?	What is the difference between policy and politics? Between policy and advocacy?	How do we partner with patients and other stakeholders for policy efforts?	What are the policy problems that only we can solve...that, if we don't address, will continue to get in the way?

JOIN THE CONVERSATION **This topic will be discussed at our salon at STFM, on May 2, 2016 in Minneapolis, MN.**

REVIEW

Last year's five salons were successful. They were held onsite during breaks in the meetings at several of our national conferences. Everyone was invited. Each salon attracted 10–30 participants, and the conversations were penetrating, candid, and spirited. The evaluations were positive. The executive directors of the three hosting organizations have encouraged us to repeat the process this year. We will. Our own department has requested internal salons.

BUILDING PARTNERSHIPS

The two ADFM salons focused on partnering with retail clinics. Our own partnership with the Little Clinics has deepened and matured, and this has become a stable model for us whereby we extend our access, and they extend their quality assurance and access. These discussions produced a short list of conditions under which such partnerships should be undertaken. A number of participants at other institutions reported that they are exploring or engaging with retail clinics, and this does indeed seem to be an emerging model of modern primary care we should continue to pay attention to. We also heard interesting possibilities for partnerships with libraries, churches, schools, department stores, food banks, barber shops, the basketball court, after hour clinics, and telehealth options.

The two salons at STFM focused on how we prepare and train the primary care workforce, rather than just training family physicians alone. We heard about efforts in other places where professionals from other disciplines, especially behavioral health professionals and clinical pharmacists, are trained to work in primary care. There are many ways to conduct such training, and more are emerging. But beyond these two professions, training other professionals to work in the primary care setting is decidedly less common. The idea is good, but the barriers are formidable.

One of the SFTM salons was attended by a number of physicians in military programs, and the conversation turned to leadership, followership, and innovation. This exhilarating salon provided part of the impetus for this year's topic on complex adaptive leadership.

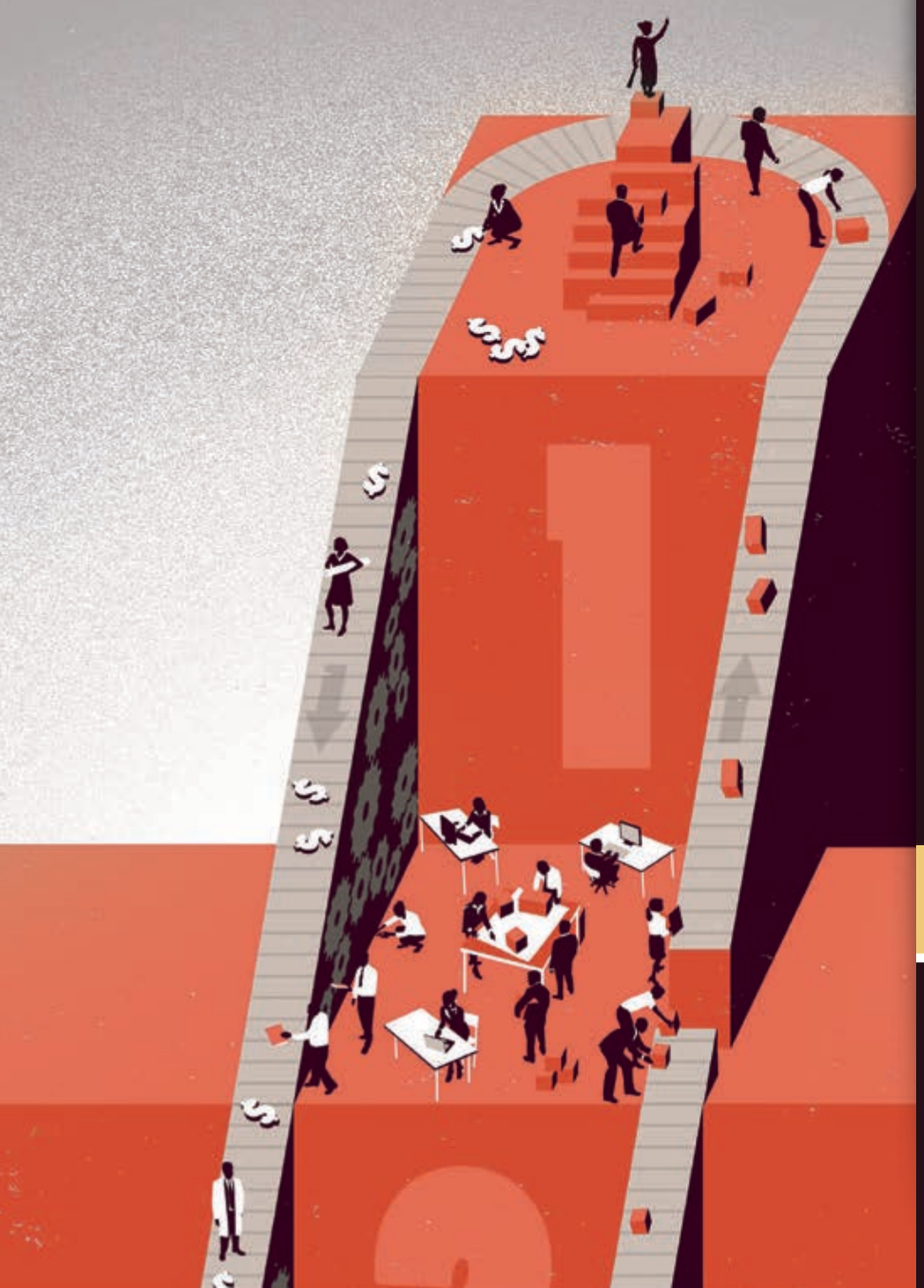
Our last salon of 2015, about creating supradepartmental research shops, was received well, but needs more time and development. This idea found its way into some of the recent recommendations in the FMAH reports, and may be the subject of a project jointly undertaken by NAPCRG and ADFM. This model needs further discussion before we are ready to test it out.

All told, these topics were judged worthwhile, and the salons considered useful. So we're back. Please enjoy this issue—it's yours, in hopes that it can help you help your patients become a little healthier.

It's really important to us to get your feedback and insights about this publication and the related salons. **Please visit PrecipiceOnline.org to tell us what you think.**

"IT'S A MISTAKE TO THINK OF SALONS AS ACTION GROUPS, BUT IT'S NOT A MISTAKE TO THINK THAT ACTION CAN ARISE FROM SALONS."

ERIKA SUKSTORF



University of Colorado
Anschutz Medical Campus

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 Digital Branding Company**. 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.

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SALONS 2016

Leadership
ADFM 2016 MEETING
February 19, 4–6PM
San Antonio, TX

Policy
STFM ANNUAL CONFERENCE
May 2, 6–8PM
Minneapolis, MN

Population Health
NAPCRG PBRN CONFERENCE
July 11, 6:30–8:30PM
Bethesda, MD

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