

Changing Horses Midstream: The Promise and Prudence of Practice Redesign

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ABSTRACT

An emerging vision for primary care calls for the adoption of information technology and a strong business model to save a dying health care system. The authors are participants in the National Demonstration Project (NDP), a study sponsored by leading organizations in family medicine and directed by a for-profit subsidiary of the American Academy of Family Physicians, TransforMED. The NDP embraces the Future of Family Medicine Report and seeks to test the ability of existing practices to implement its basic tenets. The NDP will conclude in June 2008, but its findings and observations will likely ripple out for years. Our report is a personal reflection that looks beyond the question of whether busy practices and practitioners can change horses midstream. We ask, "Is this primary care, and is this what it needs?"

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CRISIS AND RESPONSE

The problems in primary care are obvious to any of its practitioners: our patients are scattered across consultants and clinics in a specialty-laden health care system. We are spending less time on patient care and more on nonreimbursable busywork—authorizing referrals, petitioning for nonpreferred medications, signing treatment plans, and filling out endless forms and applications that require the stamp of a primary care clinician. We are so overbooked that acute care visits are bled to emergency departments and retail clinics. We can no longer find younger colleagues to assist or replace us, even if we could afford them, especially if hospital or obstetric skills are required.

Grim statistics tell us why. Family medicine is the lowest paid of the American medical specialties.¹ Results of the 2007 National Resident Matching Program² show that the number of US senior medical students matching in family medicine residency programs declined for the ninth year in a row, as did the number of family medicine residency positions. Fewer than one-half of current residents graduated from a US medical school, and one-fifth are international medical graduates without citizenship. We are consoled only by sharing our misery with the other primary care specialties.

In response to the crisis, government, industry, and primary care organizations have launched joint initiatives aimed at rejuvenating primary care.³ Independent practices across the country have begun to implement technologies and system changes that promise better care, greater patient satisfaction, and new hope for the front lines. In June 2007, the National Demonstration Project (NDP) merged these impulses by choosing 36 practices from a pool of 337 to study how well and under what circumstances they can be retooled. The authors represent 2 of the selected practices, both randomized to the self-directed, or control, group. As did the facilitated practices, we agreed to assist with data collection, unlike our colleagues, however, we had no access to periodic retreats, on-site consultants, discounts on new technology, or continuous telephone assistance.

Conflicts of interest: The authors are participants in TransforMED's National Demonstration Project, Self-Directed Group, but otherwise identify no conflicts of interest.

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"We're trying to leave them alone," observed Dr Terrence McGeeny, the new director of TransforMED.⁴

Indeed, most of us in the self-directed group felt left out. Yet we knew that all eyes were watching and that our original selection spoke to our demonstrated desire for change. Thus was hatched the idea for a self-directed retreat.

CONFERENCE STRUCTURE

In June 2007, a dozen family practices from around the county met at the Dartmouth College Minary Conference Center in Holderness, New Hampshire. Ours was not a typical practice management conference. First, it had a high rate of voluntary attendance. Twelve of 15 remaining practices in the self-directed group attended. Second, the retreat was self-directed, as were the practices themselves. We organized the retreat, sought financial support, and served as speakers and discussants. Third, one-half the attendees were office managers, not just physicians, reflecting our instinctive approach to collaborative change. Last, we examined the values and assumptions of the Future of Family Medicine Report and injected our own voice. Awareness and ownership of the change process for self-directed practices everywhere may prove to be the unexpected pearl of the NDP.

Presentations were given by representatives of more than one-half of the attending practices on such topics as advanced access scheduling, Web portals, chronic disease management, health promotion and disease prevention, clinical microsystems (smaller teams within the larger practice),⁵ group medical visits, and expansion of the "basket of services."⁵ All the attending practices reported using an electronic health record; most had explored or adopted some of the 41 additional subcomponents for change outlined in the Future of Family Medicine report. One-half the time allotted for each presentation was reserved for discussion, which proved invaluable. We also learned more about the NDP and the experiences of the facilitated group from a member of the evaluation team. Our final session allowed for discussion of varying philosophies and concerns regarding the future of family medicine.

What We Learned

Before the retreat the participants were strangers. We recognized in each other a mutual thirst for change—a primary factor in our selection to the NDP. We shared an identity as foot soldiers in primary care. As such, we knew the plight of the average patient and the frenzy of our workplaces. We saw primary care as the lynch pin for a broken US health care system. But to fulfill that hope, primary care must attract new

graduates, meet the public's needs, and gain control over the outcome measures by which we are judged.

Our unease with the term *patient-centered medical home* was a recurrent thread throughout our discussions. Though the scope of family medicine is fluid and wide, its main current involves people within relationships. Physicians prove it to themselves during countless encounters and years of practice. Healing happens within relationships. Doctors contribute to and draw from them; we cannot genuinely attend to the needs of patients if we ignore our own. In this context, patient-centeredness is as unbalanced as physician-centeredness. A nuanced shift toward relationship-centered care seems critical for a specialty named after the fundamental unit in human relationship, the family.

A member of the NDP evaluation team was invited to the conference.⁶ She suggested that there were differences between the self-directed and facilitated practices. Some in the facilitated group suffered from change fatigue—the nervous exhaustion that comes from doing too much, too soon. This was less an issue for the self-directed practices, who were under no obligation to adopt all the practice changes urged by the New Model. Nor did we feel as obliged to remain in the NDP; indeed, 3 of our members dropped out. Furthermore, we discovered that self-directed practices, on average, moved more quickly toward innovation than did the facilitated practices, which often waited for consultants to lead them.

The importance of the electronic health record to the New Model of medical care delivery could not be overstated. It is the foundation upon which other practice innovations are built. One innovation includes the use of Instant Medical History (Primetime Medical Software, Columbia, South Carolina), a software program that allows patients to enter their histories or problems electronically—at home or office—by branched logic interviews. An unexpected benefit of this technology is that patients are often more comfortable answering sensitive questions generated by a computer than a human interviewer.

Some practices adopted Web portals, which allow patients to view personal medical records online. Web portals enhance the portability, accessibility, and accountability of the health record, but they also expose errors and tardiness. Patients were excited about this option; one practice is now conducting a patient survey to assess current uses, preferences, and frustrations regarding the Web portal. We discussed the problems of open (or advanced) access for appointment scheduling in established practices and concluded that no system, however well-designed, can accommodate an oversubscribed patient panel; remedies include the adoption of panel size limits and a reliable supply of primary care physicians.

Group medical visits were used in some practices not only to improve patient education and self-care, but also to create a more collaborative work environment for the entire team. Billing techniques for group visits were discussed as a means of insuring viability. Some groups regularly welcome site visits by other clinicians and visit practices where planned innovations have already been implemented. Cross-pollination is in large part what our 2-day retreat would accomplish.

A detailed report of what the self-directed practices have accomplished is posted on the TransforMED Web site.⁷

Ingredients for Change

The goals of our retreat were to build a sense of shared mission, to air grievances, to douse smoldering cynicism for the NDP, and to promote continued innovation. We began to identify attitudes or habits that seemed most conducive to change. First, we saw the importance of identifying a project leader to shepherd projects over their inevitable bumps and hurdles. We have found that change required regular communication; everyone must be on board, especially nurses and front-office personnel who form the leading edge of change. Table 1 displays 10 pearls for practice improvement.

Change takes time. It often helps to break projects into steps so that success is palpable and adjustments can be made. It is also prudent to begin with an easy project that fills a practice need. Often dramatic results flow from minor changes, such as reconfiguring staff into smaller teams using microsystem³ principles and team huddles (brief meetings that allow team members to coordinate their response to the schedule's anticipated demands). Medical care is inevitably a team sport, and members must know their roles to function best. Office staff are usually willing and able to do more; cross-training helps to widen interests, quicken change, improve job satisfaction, and retain staff.

Most self-directed practices were eager to move beyond the disappointments and delays of the first

year. Some were preoccupied with the challenge of setting up a new office. Others had to overcome the frustrations of replacing staff, learning new technologies, and changing their offices while running them. Most looked forward to testing innovations that were promoted at the retreat. In a survey undertaken after the retreat, each practice committed itself to making 1 or 2 changes in the coming year. Group medical visits and open-access scheduling attracted the widest interest. Other goals included the adoption of practice Web portals, patient-interviewing software (eg, Instant Medical History), chronic disease management, team-based care reduced to its smallest unit, and waiting room design that promoted the feeling of a medical home (eg, comfortable and relaxed surroundings, water and coffee dispensers, computer access).

WITHER THE HORSE?

Our retreat, like the NDP itself, raised more questions than it answered. These questions were hotly debated in our closing sessions. Many believed that the recommendations of the Future of Family Medicine Report were too narrow in scope, more of a business plan for a branded product called Family Medicine than a prospectus on the future of primary care. We all realize that our ranks are diminishing, schedules pressed, waiting rooms overcrowded, and earnings jeopardized. We agree that something must be done. But a renaissance in family medicine seems possible only through individual idealism and inclusive politics, not practice makeovers weighted toward consumer satisfaction and savvy business plans.

More apropos, we wondered what a 2-year research project could tell us about lasting change. Or whether selling the 42 subcomponents of the New Model to physicians really mattered if the decision to implement them lay in the hands of corporate executives. Shouldn't the specialty of family medicine band with other primary care partners—including nurse-practitioners and physician's assistants—to lobby for radical health care reform, especially now, when reform has moved to the center stage of national politics?

In the end, we agreed that human relationships are the centerpiece of family medicine. At best, the New Model is a toolbox, and tools alone cannot rebuild the specialty. The focus must stay on relationships; they are the source of our greatest joy, frustration, insight, and leverage for change. Our patients need comprehensivists—that is, generalists—who put the broad needs of patients before diseased organs or disease registries.

The very act of getting together, far away from our busy practices, led to a renewed sense of optimism

Table 1. Ten Pearls for Practice Improvement

1. Be the leader
2. Choose a project that fits your practice
3. Learn from the experience of others
4. Get your coworkers invested and involved
5. Communicate with them regularly
6. Break your project into small, sequential steps
7. Budget for the added expense; bill for the added service
8. Test your assumptions and modify your plans
9. Tell your tale: share your experience with others
10. Find joy in the irrepressibility of change

and commitment rather than more grumbling and despair. The self-directed group discovered itself to be a loose federation of change leaders, not unlike the bulk of our colleagues in primary care. We welcomed the chance to help others change more effectively and less painfully. We vowed to stay together long enough to taste the fruits of our labor. We saw our role in the NDP as more than a control group—we were the study arm that could question the horse we climbed on. As can every family practice outside the study, we could choose what was both achievable and desirable in the New Model while preserving our passion to practice it.

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