PRECIPICE

PUSHING THE EDGE OF FAMILY MEDICINE

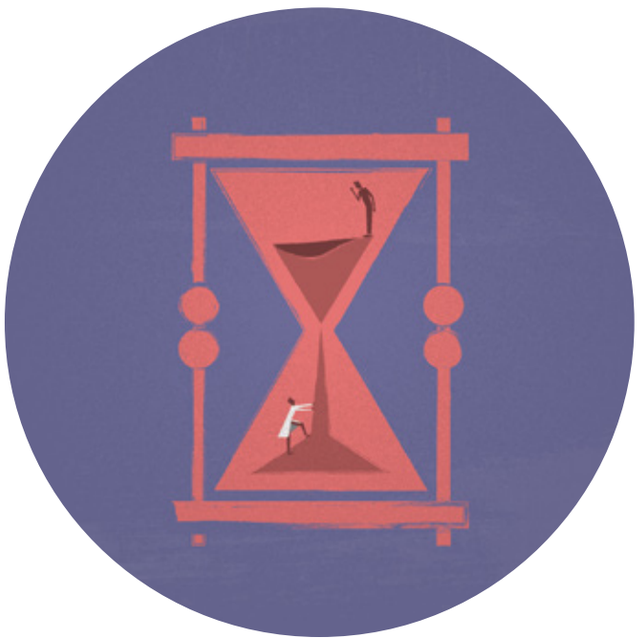
2017 NO. 03

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 University of Colorado Department of Family Medicine. 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 THIRD ISSUE OF PRECIPICE DISCUSSES TIME AND THE FUTURE OF FAMILY MEDICINE.



This is the third issue of Precipice, a journal written for leaders in departments of family medicine about hard problems in our field. We are raising these issues because they are consequential, and in their difficulty and complexity they surpass us.

We are asking you to read and reflect on what you find here, then join us in a conversation about how to think, speak, and act on these problems. We want to become useful and vested partners in people's efforts to become healthier. We need each other's help, and we should give to each other our best ideas, test each other's solutions, and make partnerships that can multiply our power and effectiveness.

So treat this like a staging area, a place to prepare your thoughts and review your experiences before we come together in our salons to probe for principles, priorities, and partnerships that might make us more effective healers, clinicians, educators, researchers, and advocates for the people we've pledged to serve.

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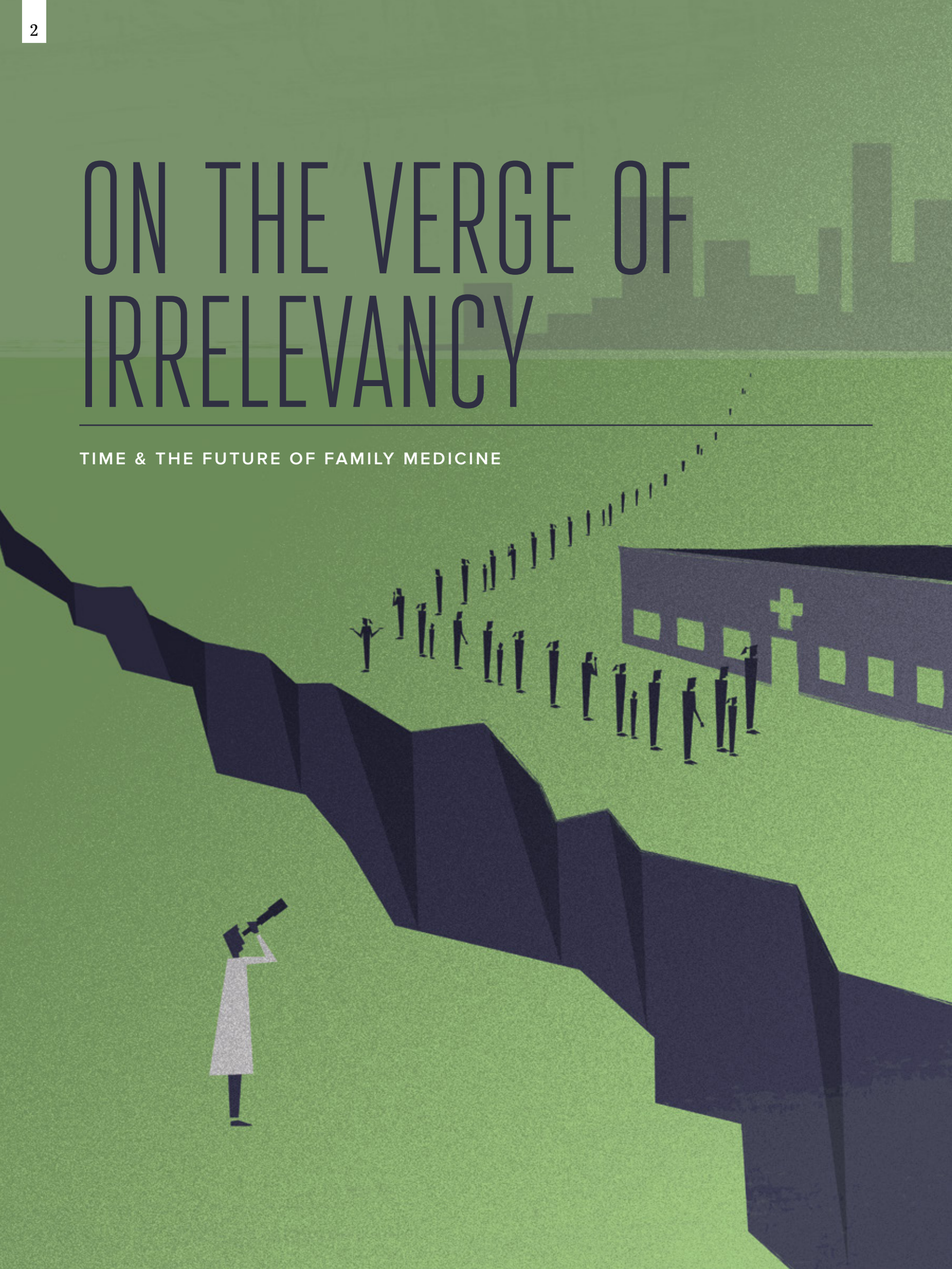
ON THE VERGE OF IRRELEVANCY

TIME & THE FUTURE OF FAMILY MEDICINE



Time is problematic for most family physicians. Many of our most painful professional difficulties and failures can be ascribed to a misunderstanding of how time plays into our effectiveness as healers, or perhaps to our complicity in the misuse of the precious minutes and hours of our professional lives.

So let's revisit the first principles of healthmaking in primary care, and gauge the extent to which we spend our professional time doing those things for our patients that we know help them to be healthier. Let's look for ways we can stretch, multiply, or otherwise transform time to augment these healing properties. Ultimately, we want a conversation about how we can change our field's fundamental relationship with time to brighten the future for our patients, ourselves, and the next generation of family physicians.

3 QUESTIONS ABOUT OUR FUTURE

Our working hypothesis is that if we do not come to terms with time in a fundamentally different way, our field is in danger of becoming irrelevant.

Where do we start? This need not be a highly abstract philosophical discussion about the ontology of time. We will be better served by practical, close-to-the-ground considerations, such as how time works for different parts of primary care, and what our limits of influence are within that. We'll break this into three sections:

Who needs the time? First, we look at the role of time in different types of primary care—both from our perspective as clinicians and from our patients' points of view.

Where does the time go? Next, we'll examine the daily demands on our time and the specific consequences for both us and our patients.

Can we make time to heal? For the most part, we operate as if time were a fixed and scarce commodity—the denominator of our productivity, the basis of our pay. But is it fixed? Can we leaven it to our, and our patients' advantage?

JOIN THE CONVERSATION See back cover for details on our upcoming salons.

WHO NEEDS THE TIME?

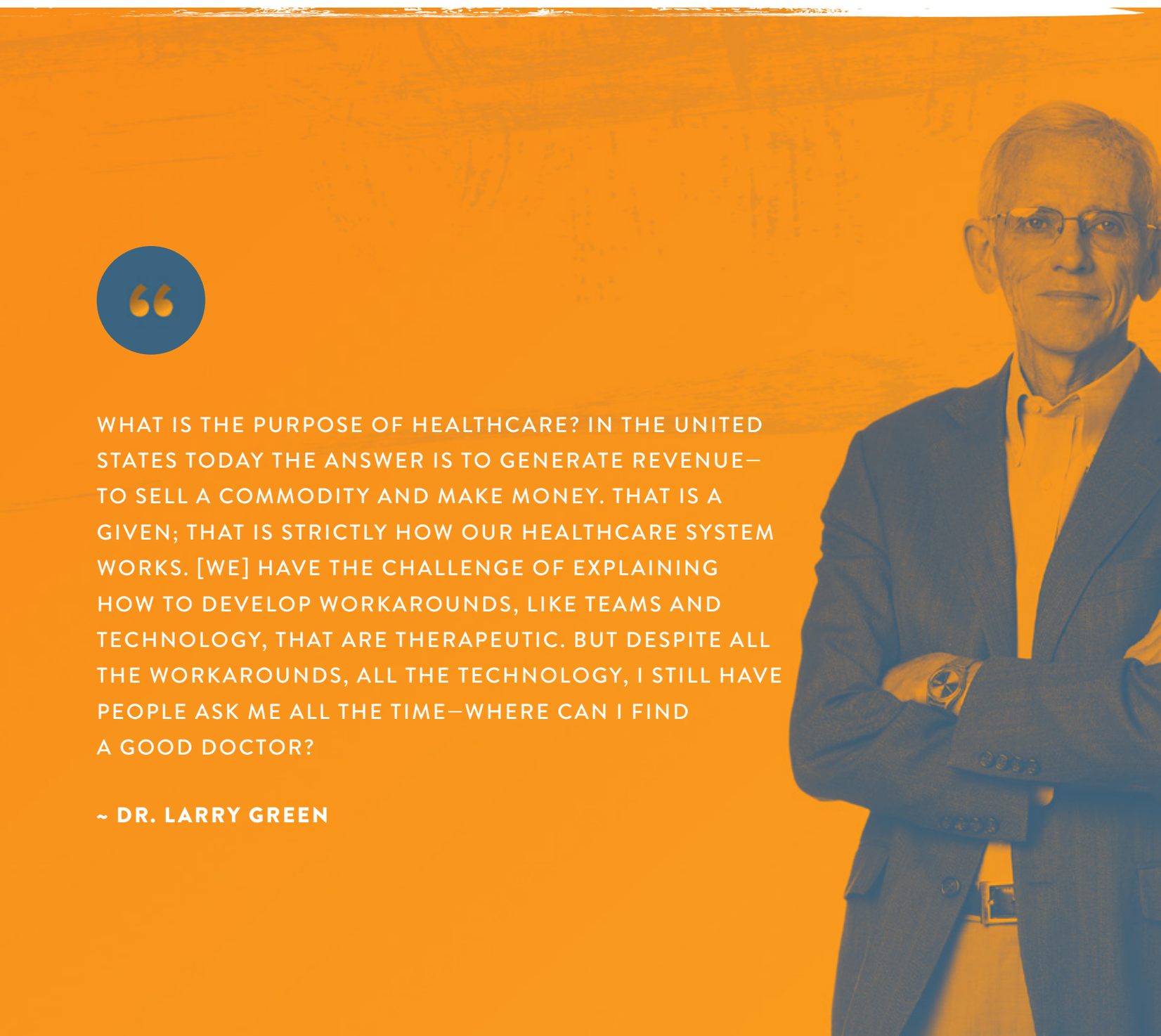
What do people need from us in primary care in order to become healthier? We already know that primary care's value turns on being available; on personally knowing our patients; on addressing most or all of their concerns in a coherent, coordinated fashion; and on understanding the context in which their problems arise and exist. The evidence that supports this knowledge is beyond dispute, but it's nuanced. If you look into a community for its primary care needs, you see a lot of people with chronic illnesses, with multiple problems.

That covers most of the work of primary care. These people prize a therapeutic relationship and coherent, competent care above all else. If we find time for that, we can attend to those features of care associated with better chronic disease outcomes, features such as a coordinated, coherent personal care plan and a self-management plan. But under our current norms of practice, we do not make the time to deal with these matters sufficiently. This is one place where time spent well could yield a rich return in better health outcomes, higher patient satisfaction, and less expensive care. This is well-nigh impossible under the conditions in which most primary care clinicians practice.

Then there are a smaller number of people who have acute problems. Some also have chronic problems, but many are otherwise healthy. They value immediate, convenient access above long-term personal knowledge. In fact, sometimes patients do not want to spend any time with us at all—they just want an answer to a question or a simple fix for a simple health problem. For such a minor problem or question, convenience—easy access—is the overriding priority. Right now we are grossly inaccessible to these patients when they need us, and access to us often requires major outlays of patient time—taking off work for an office visit, for example—and this produces a failure in primary care that reduces our value and creates expensive, fragmented workarounds, such as EDs, urgent care centers, and retail clinics. As a first principle we need to commit to accessibility, and then act on that commitment—we must be available. This does not necessarily mean in person, in the clinic. Can we commit to being available to our patients? Maybe for some of us that means halving our panel sizes; for others it could mean inviting in others to handle acute problems on our behalf; for others it may mean using technical solutions to respond to our patients' questions, concerns, and problems.

And then there's prevention. Preventive services sometimes resemble acute services (e.g., immunizations), and sometimes resemble chronic care (e.g., colon cancer screening, developmental assessments). Resources could be tailored to the specific preventive activity, but presently we seriously neglect prevention, sometimes citing insufficient time, and sometimes insufficient remuneration. In any event, it is fair to conclude that as a discipline we neglect preventive services, and it is to the detriment of our patients' health.

Irrespective of the makeup of our panel of patients, in primary care we have painted ourselves into a corner: the more patients we take, the less time we have for each, and the less access they have to us. But look at how many patients we claim to be caring for! We consistently practice far, far beyond the boundary of any possibility of proper comprehensive primary care, into the zone where we have many patients who are frustrated by how hard it is to get to us, or how little time they get with us, or how thin our attention to them is. We know we need to pull back. We don't have to get this exactly right before we move in the direction of more time for fewer patients. Every clinician on the ground cannot simply immediately decompress—that would have unpleasant consequences. But as leaders we can be clear and loud about this as pissing away the value of primary care, devaluing our entire health care system. We can be noisy about not accepting as a solution to this failure the further fragmentation of primary care into separate systems of urgent care, acute care, and non-emergent emergency care. How did it get like this?



WHAT IS THE PURPOSE OF HEALTHCARE? IN THE UNITED STATES TODAY THE ANSWER IS TO GENERATE REVENUE—TO SELL A COMMODITY AND MAKE MONEY. THAT IS A GIVEN; THAT IS STRICTLY HOW OUR HEALTHCARE SYSTEM WORKS. [WE] HAVE THE CHALLENGE OF EXPLAINING HOW TO DEVELOP WORKAROUNDS, LIKE TEAMS AND TECHNOLOGY, THAT ARE THERAPEUTIC. BUT DESPITE ALL THE WORKAROUNDS, ALL THE TECHNOLOGY, I STILL HAVE PEOPLE ASK ME ALL THE TIME—WHERE CAN I FIND A GOOD DOCTOR?

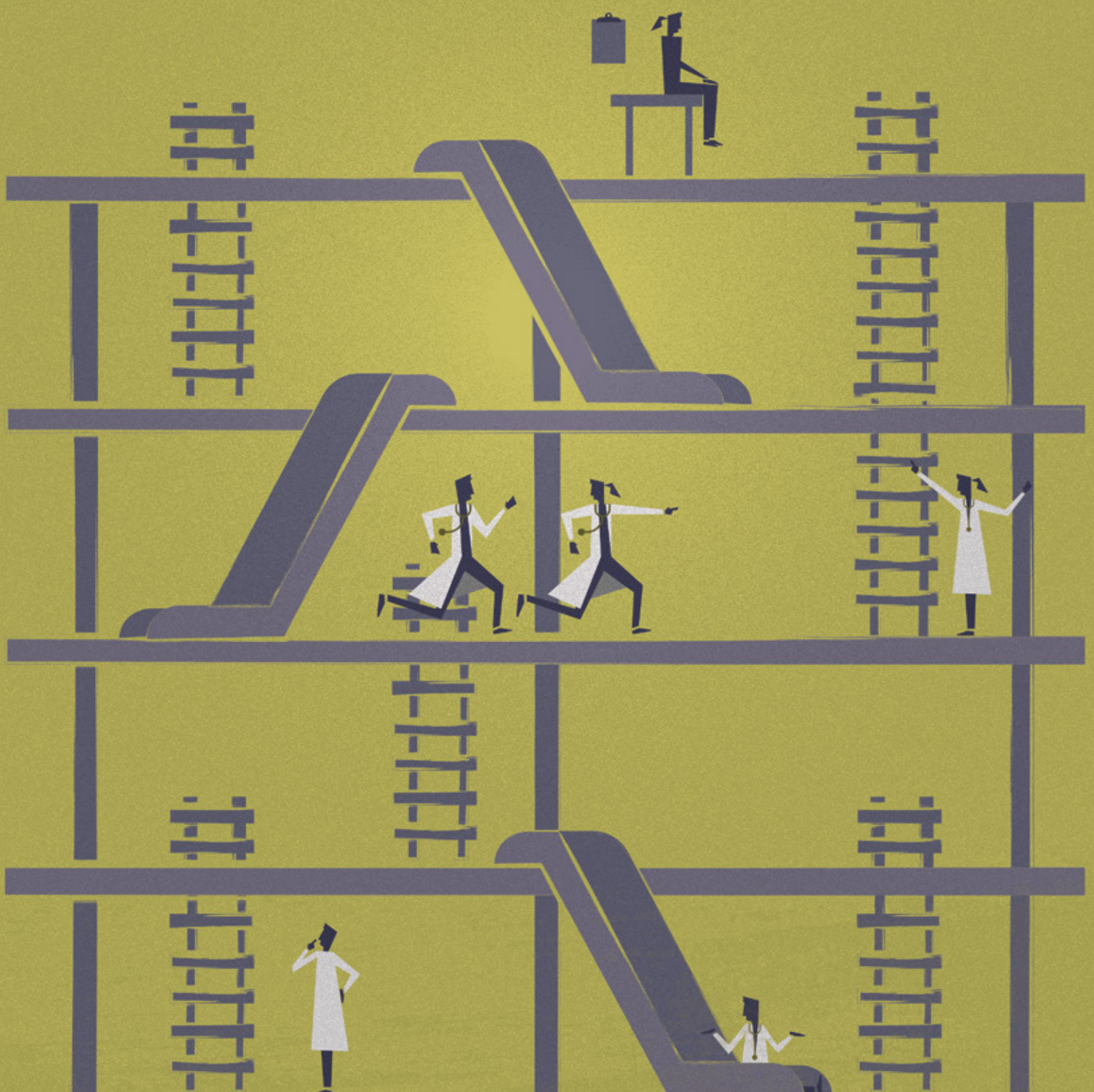
~ DR. LARRY GREEN

WHERE DOES TIME GO?

As to what we do with the time we do have, way too much of it is spent not as clinicians, but as clerks—documenting, billing, referring, certifying. There's no healing power in that. That is not what carefully (and expensively) trained health professionals are best suited for. By one means or another, this must be removed from the basic job description of the primary care clinician. There are several ways to do this, but it simply must be done.

Let's look more closely at whether the time must come directly from us; let's back up and look more closely at the nature of the therapeutic relationship. Humans are social animals who cannot become fully human without rich interpersonal connections. These must begin even before birth. Personal relationships can heal and can protect against harm. Isolation hurts and kills. There is major healing power in being known and understood. The power of a personal relationship with our patients is one of the most consistently effective weapons against illness in our therapeutic armamentarium. Several decades ago Don Ransom wrote a beautiful essay entitled "The Patient Is Not a Dirty Window," that changed our field and changed my life. In this essay he marshalled the evidence and made the argument that it was a mistake to be more interested in the disease than the patient—that such clinicians have a tendency to brush aside the whole person-in-context, the patient's personal uniqueness that is obscuring the clinician's view of the underlying disease, like so much dirt on a window. This gesture of brushing the personal aside to get at the disease within is mistakenly wiping away the essential substance, the very subject to which our attention and ministrations should be devoted. It is pushing away and looking past the very secret of our healing power. This is what's behind the so-called primary care paradox, wherein specialists' attention can lead to improved disease-specific outcomes, but generalists' clinical care leads to superior overall health even in the face of less disease-specific improvements. Problem is, we ourselves make this same mistake of insufficient attention to the patient, not because we overvalue the disease and undervalue the patient, but because we don't have enough time to deal with "most or all of a patient's problems" in a coordinated fashion! If we say this is where our time should go, we have to rethink what it means when we say we don't spend enough time with patients, or we can't be available when our patients need us at critical junctures, that we "have to" take care of too many patients. A competent primary care clinician with an average panel size of, say, 2000 patients, cannot even come close to addressing most or all of this panel's health problems. Our conventional practice structure is guaranteed to fail us and our patients. We are sure to be inaccessible. It would seem that inimical conventions of clinical practice and compensation have eviscerated our effectiveness. We have known this for years, for decades, and still we submit to these conditions. I believe this is morally and professionally unacceptable.

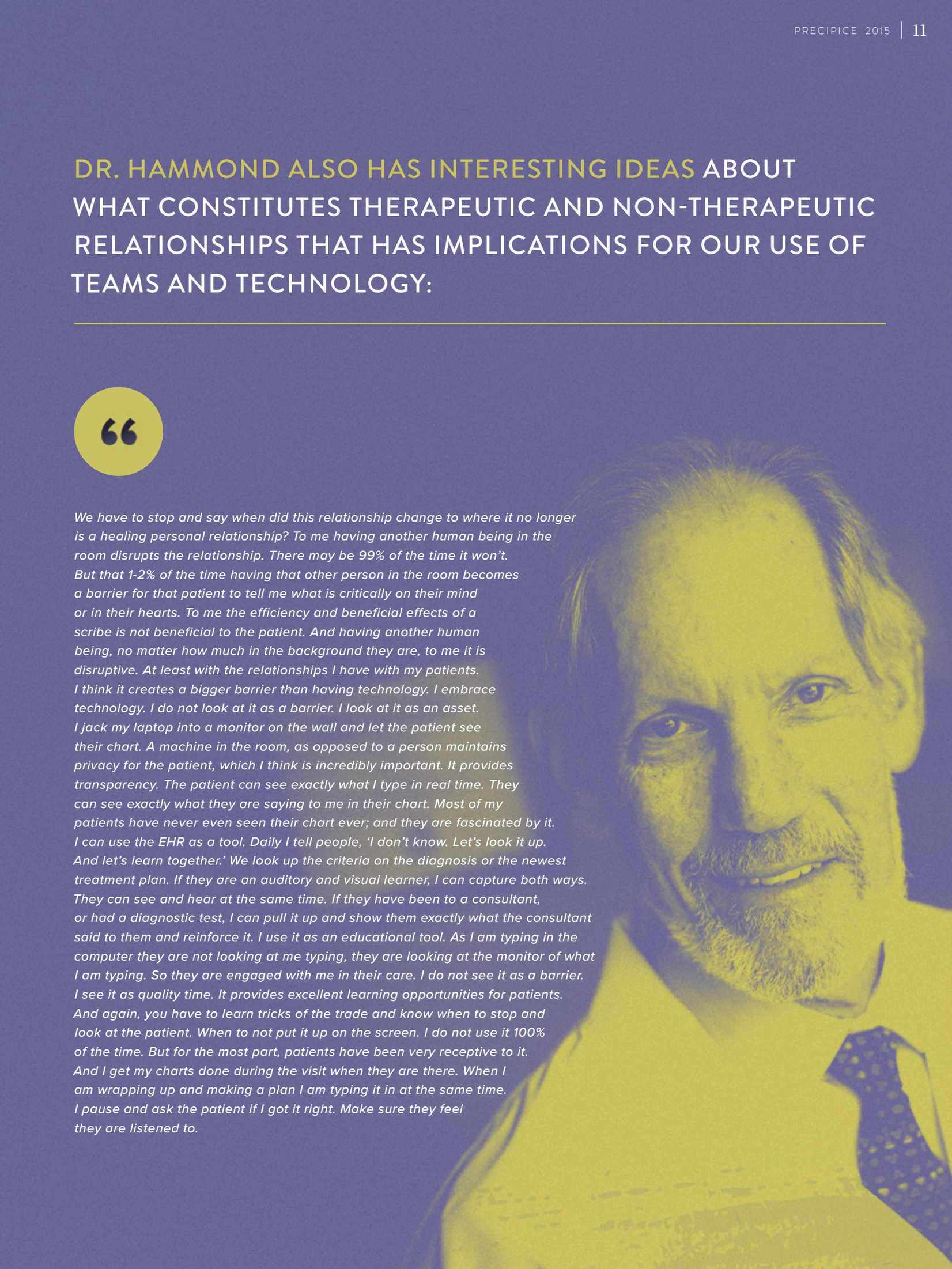
CAN WE MAKE TIME TO HEAL?



Let's set aside for the moment the problem of having accepted an impossibly large panel of patients, and look at possible ways to make the time we do have go further. Some times are more important than others for the health of a patient. As noted above, some problems, for some patients, do not require deep personal attention.

We do not need to reduce our panel size to personally attend to problems of this nature, we need to create new and more efficient ways of addressing these problems. We need to be creative in matching the time we spend, and the resources we deploy, to the problem at hand to achieve not only the best outcome, but also with the least waste of that which is most precious and expensive—the patients' and our own time. In the words of Bill Burman (CEO Denver Health, personal communication, August 30, 2016), this requires that we escape the tyranny of the 20-minute office visit. We want to give as much time as is appropriate to each patient, to know them well, activate our professional healing power, but above all to address the problem at hand. We must make sure the time we do spend with patients has as high a payoff as possible, by occurring at important points in their lives (e.g., births, important illness experiences, times of suffering, etc.), by not squandering that time on unimportant issues or with distractions, and by maximizing the "connecting power" of that time. Scott Hammond, a family physician in Westminster, CO, is piloting a patient health literacy questionnaire that is designed to more quickly and efficiently foster the kinds of conversations that help patients feel known and understood. Dr. Hammond: "We developed a health literacy questionnaire, which is more than just fundamental literacy that most people focus on: this is the social, cultural, scientific, and environmental aspects of that person and what is pertinent in their lives. So we can get a snapshot of their personality type. Their learning abilities. Their learning styles. How they like to be heard. What is important to them. What are their values. It is a short survey but is quite powerful. How do they learn. Are they visual learners. Auditory. Are they kinesthetic. So if we are teaching about a drug and its side effects in an auditory way, but they are visual people, they are not going to connect. Knowing how they learn and their learning style is very important in how we approach them."

DR. HAMMOND ALSO HAS INTERESTING IDEAS ABOUT WHAT CONSTITUTES THERAPEUTIC AND NON-THERAPEUTIC RELATIONSHIPS THAT HAS IMPLICATIONS FOR OUR USE OF TEAMS AND TECHNOLOGY:



We have to stop and say when did this relationship change to where it no longer is a healing personal relationship? To me having another human being in the room disrupts the relationship. There may be 99% of the time it won't. But that 1-2% of the time having that other person in the room becomes a barrier for that patient to tell me what is critically on their mind or in their hearts. To me the efficiency and beneficial effects of a scribe is not beneficial to the patient. And having another human being, no matter how much in the background they are, to me it is disruptive. At least with the relationships I have with my patients. I think it creates a bigger barrier than having technology. I embrace technology. I do not look at it as a barrier. I look at it as an asset. I jack my laptop into a monitor on the wall and let the patient see their chart. A machine in the room, as opposed to a person maintains privacy for the patient, which I think is incredibly important. It provides transparency. The patient can see exactly what I type in real time. They can see exactly what they are saying to me in their chart. Most of my patients have never even seen their chart ever; and they are fascinated by it. I can use the EHR as a tool. Daily I tell people, 'I don't know. Let's look it up. And let's learn together.' We look up the criteria on the diagnosis or the newest treatment plan. If they are an auditory and visual learner, I can capture both ways. They can see and hear at the same time. If they have been to a consultant, or had a diagnostic test, I can pull it up and show them exactly what the consultant said to them and reinforce it. I use it as an educational tool. As I am typing in the computer they are not looking at me typing, they are looking at the monitor of what I am typing. So they are engaged with me in their care. I do not see it as a barrier. I see it as quality time. It provides excellent learning opportunities for patients. And again, you have to learn tricks of the trade and know when to stop and look at the patient. When to not put it up on the screen. I do not use it 100% of the time. But for the most part, patients have been very receptive to it. And I get my charts done during the visit when they are there. When I am wrapping up and making a plan I am typing it in at the same time. I pause and ask the patient if I got it right. Make sure they feel they are listened to.

PERSONAL DOCTORING IN THE FACE OF TEAMS

One of the fundamental features of a patient-centered medical home is the presence of a team, rather than an individual clinician, with whom a patient will have a personal relationship. At its best, this broadens the expertise, increases the basis for access and personal clinical attention, and generally improves the odds that the salutogenic effect of primary care comes into play.

At its worst, it offers a dodge for accepting personal responsibility for patient care ("My partner will take care of it; I'm going home."), thereby compromising the healing power of the relationship. How can a patient have a personal relationship with a team?
We have accepted the value of teams without sufficiently addressing the conditions under which teams can be most successful and least harmful. Let's look at what works, and what doesn't, and see if we can make some rules about this. Cherokee Health Systems in East Tennessee has perhaps the most highly evolved and sophisticated team structure in primary care in the US today. Parinda Khatri is their Chief Clinical Officer.

PARINDA:

"I am going to share something from my husband who is a social psychologist. There is a concept called BIRG: Basking In Reflected Glory. That means if you have a clinician who is very connected with a patient, has a relationship, and then that clinician says I really like my colleague and really trust them, then the new colleague ends up automatically gaining the high regard of that first person. So when we start out on our relationship, there is already warmth and trust and a lot I already know about that person. I talk about this a lot, because our team needs to bask in the reflected glory of each other. Then the strength of that relationship is not based on one individual. It is conferred on an amazing group of people! So anything I do with a patient, really the team benefits from it."

FRANK:

"Do you have specific strategies to help people understand they must do that? To understand that this is not simply a way to go home early, or get out of after hours, or to duck out of responsibilities when it comes to a patient's welfare?"

PARINDA:

"I think culture. I cannot emphasize that enough. We create this as a cultural norm that we are continually reinforcing through language and behavior. We had to develop guidelines for communication. But [our new clinicians] do not learn this anywhere else. We had to develop this because no one was coming to us with that. You have to model it, tell people what you want from them, and then reinforce it over and over again. And we don't ever make assumptions that people get this; this is something we talk about when enforcing these guidelines. Don't make assumptions that something you have with the patient is just yours, is not really in someone else's territory, or that they do not need to know. This can be a real problem with behaviorists because they do not realize the impact it can have. For example, a behavioral clinician might see someone who is having trouble sleeping and it is because their tooth really hurts. You then assume because the patient is in so much pain they will tell the medical provider that. The patient does say to the provider, my tooth really hurts and I am taking BC powders. Well, BC powder has a lot of caffeine in it. So if you are taking that it will keep you up at night. So the PC is thinking, 'Oh sleep! That is a behavioral health issue. That is not something that a medical provider needs to know,' but in fact it is. This is a problem that both the medical provider and the behavioral clinician need to think about together. It really requires you to check your ego at the door. If you think that is something special that only you can do or that you need to know that attitude really hurts you and the patient."

FRANK:

"What about technology? How do you use it to augment the personal relationship?"

PARINDA:

"I think how you do it makes a difference. I think who does it makes a difference. In terms of how you do it, I think you need to make sure the technology is good.... make sure the lighting makes everyone look good. Those little things matter. It needs to feel good. You do not have the touch being in the same room as the person, so everything else needs to be done well. I think it is important to have a warm person on the other side. So all of our tele-health nurses are screened because we want to make sure they are warm. I want to make sure they greet the patient with a smile. The small talk they have with them is important because it is actually part of the visit. That walk from the waiting room to the exam room, that is one of the most important walks anyone in our system can have with a patient."

These are just a few easy examples of how teams and technology can be used to magnify the benefit of time for the primary care clinician, and how they must be used thoughtfully, to avoid compromising the value of the personal touch. It is time for us to establish as a first principle that our value is linked to our use of time, that the therapeutic value of time varies by problem and patient and occasion, that the value of teams and technology turn on features of their use that we are just beginning to understand. It is time to think hard about these features of our professional lives, to discuss them, debate them, systematically study them, and to deploy them most effectively. I look forward to discussing this with you in our salons, in our clinics, in our hallways, and in our literature.

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 and original illustrations by Brad Todd.** 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

SALONS 2017

On the Verge of Irrelevancy: Time and the Future of Family Medicine
ADFM 2017 MEETING
February 24, 6–8PM
Garden Grove, CA

Multiplying Time: Can We Make Time to Heal?
STFM ANNUAL CONFERENCE
May 6, 6:30–8:30PM
San Diego, CA

How Do We Invent More Time?
NAPCRG
November 19, 4–6PM
Montreal, Quebec

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