DFMCH ReCHARGED
BLUE SKY EVENT: Question and Answer Session
Wednesday, March 18 – 12:00-5:00 PM
Pyle Center – Madison, Wisconsin

Macaran (Mac) Baird, MD, MS, Head, University of Minnesota Department of Family Medicine and Community Health

Dr. Macaran Baird has been professor and head of the University of Minnesota Department of Family Medicine and Community Health since July 2002. He has been professor of family medicine and medical director of MMSI, an insurance arm of the Mayo Clinic; associate medical director for HealthPartners, a Minnesota HMO; chair of the State University of New York–Syracuse Department of Family Medicine; and residency director at the University of Oklahoma. In 1978-83 Dr. Baird was a rural family physician and family therapist in rural Minnesota. Dr. Baird is chairman of the board of UCare Minnesota, the fourth largest HMO in the state.. Dr. Baird's national involvement includes: past president of the Society of Teachers of Family Medicine (STFM); past president of the STFM Foundation Board of Directors; vice chair of the Association of Departments of Family Medicine Clinical Practice Committee; and past board member of the Collaborative Family Healthcare Association. He co-chaired the Institute of Medicine (IOM) Report on Health and Behavior and was a member of COGME from 1991-2000. In November 2008 Dr. Baird was co-recipient of the Donald A. Bloch Award for significant contributions to the field of Collaborative Family Healthcare.

Responses to questions from Dr. Baird are as follows:

1. How did you change a culture, particularly physicians, of not working as an individual, but rather to become part of a team or even a team leader?

- Leadership training provided by an outside expert.
- Individual time was assessed. How much time was allocated to management and clinical work.
- One of the key aspects of leadership is listening. We need to lead in interactive way that gives people a desire to follow. Others were engaged to contribute (i.e. the quiet person in the back of the room who hasn't spoken).
- Looked at quality improvement processes; realized that snap judgment may the wrong way to solve a complex problem.
- Listen for what is not being said
- Lead in a way that engages others to follow and contribute

2. We have been working hard at our clinic on "team" approach. Wondering what innovative things you do at your clinic?

- We chose to pick an issue – TAT(turnaround time) to improve on. They included every voice in the clinic from reception/nursing/etc. The right level of questions was asked amongst each other to address the whole cycle.

3. How do you balance local and central control to get both innovation and standardization?

- We learned from leadership training that they needed to honor both sides of the problem.
- Talk across the boundaries; pretty soon you earn respect in both directions.
- Informal, adaptive leadership is essential. There needs to be enough central sense of what is going on by being there, to have a direction, and enough local control to make it spontaneous and energetic.
- Interacting in clinical setting and affirm patient in front of us, connect with that person in an affirming way, let them know you are here for them.

4. With the changes in the health care landscape and family medicine being the gate keepers to the health care system, how do we make sure our voices are heard (adequate workforce, adequate funding support)?

- There are challenges ahead of us such as workforce, advocating for what's best for the patient, funding - not related to patient care.
- Primary Care is currently subsidized by a Medical Service Agreement. It is difficult to support education/research just on clinical dollars.
- Dr. Baird spoke about the tax the physicians are currently required to pay in the State of Minnesota which helps support those who are uninsured, have Medicaid, etc. When the ACA came in, it ended up providing the same insurance coverage to patients. He does not want the tax to go away, it will help with population based health, help save money and move into the things that primary care does.

5. When is enough change enough?

- Our job is to "keep this flickering flame of idealism alive and pass it on to the next generation, sometimes that's all an entire generation gets to do." The medical industry is built to make money, it also improves health sometimes. Somehow we have to keep our eye on the ball of improving health – and not medicalize everything. Keep the flame alive to pass on to the next generation – sometimes that is all you can do

6. In regards to Community Health, what resources are available? How do you balance corporate vs. public health needs?

- The challenge is to not medicalize things.
- We need to challenge the corporations to get together with someone, don't tear them down, but help them do the right thing. Family Medicine is about caring – connecting in smaller community and being organically connected. There needs to be balance amongst health care providers as to how to serve people as a health professional vs. work life.
- People can be trained to work on the balance and be more gracious.
- We need to be careful about the trust the public has invested in us; we cannot be money-focused.

7. How do you improve communications in such a large and complex organization?

- Communicate at a more deep level with patients. There is connection by meeting someone's gaze.
- Communication needs to be done one on one….believe in stories.

8. What are your ideas for outreach and partnerships in communities in which we work?

- Level the playing field with citizens not yet identified as patients, engage the community with training
- We can learn and do our best and over time get to what matters
- WREN is one way; it is its own community Teaching others – forums need to be engagement, focus groups, panels,
- Community based participation, physicians need to engage participation
- Set boundaries, determine who is in charge of what, then share results
- Always have a boundary within the discussion so you can settle the control issues and not get off topic

9. How do we boost staff morale and improve patient satisfaction in a metric-driven system?

- Alternatives to cost effectiveness
- If you are worn out and disgruntled you can't help the patient in front of you
- We have to stand back at the group level and ask what is the big picture
- Reach outside of our boundaries
- With a best idea one can make better logic
- Metrics now created at the corporate level, physicians are accountable now for so much more

10. What are your thoughts about the CVS Quick Clinic and if we should partner or how to compete?

- Nurses follow protocols. Physicians hate protocols
- We have to adapt to fast track and keep up with protocol based service
- They popped up because we weren't doing it

11. How can we get true university wide, state-wide, nation-wide buy into the importance of excellent care?

- University based systems are very slow. Population based primary care is the way to go.

12. How do you create a team structure when the players (staff including providers, MA, LPNs, RNs, reception, schedulers, etc.) do not want to be part of the team?

- There is something wrong with that. A team can do better than an individual, almost every time

13. How can we best meet the needs of a wide variety of communities (using engagement) without locking ourselves into rigid standardized processes? (McDonald's an example of standard processes)

- How do we do this when we don't have control over the variables
- Small groups which are site specific
- WAC (work after clinic)
- To help workload go down for provider someone has to pick up work
- Go through many processes to discover what standardized care means
- It's a journey

14. What in your department has been most enjoyable or risky?

- Faculty academic achievement program
- Faculty need to publish
- 14 weeks on 4 sites
- Lean model, 5 whys
- Process to make it easy, Toyota model people doing the task, not the supervisor, are to judge

15. How do we respond to economic pressures while improving quality and better meeting the needs and desires of those we serve?

- Do we ever find other parallel's to compare ourselves to and would it help to look at those models instead of Toyota?
- Paradigms
- We are a relationship based; dollar signs vs. patient care. We have to balance and there will always be tension. Are we relationship-based or money-based??

16. We have greater mental health needs than services available. How can we meet some of these needs in the primary care setting and should we really be expanding screening before we have services available?

- Screening is a mixed bag
- Need more community health workers
- We have way overdone the importance of medicine

17. Since there is currently a de-emphasis on family medicine hospital care how do we train hospital skills for residents who will go to smaller communities where they will be responsible for hospital care?

- Every specialty has kickbacks or required income
- It takes 30% support and the rest comes from somewhere else