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

Frank Verloin deGruy III, MD, MSFM, Woodward-Chisholm Professor and Chair of the Department of Family Medicine at the University of Colorado

Dr. Frank deGruy has held academic appointments at the Departments of Family Medicine at Case Western Reserve University, Duke University, and the University of South Alabama College of Medicine. A member of the Institute of Medicine, he has served as president of the Collaborative Family Healthcare Association, and president of the North American Primary Care Research Network. He currently serves as an active member of the National Network of Depression Centers, member of the Council of Academic Family Medicine, the Chairman of the National Integration Academy Council, and the Chairman of the Family Physicians' Inquiries Network. His local activities involve Board service for the 2040 Partners for Health organization and the Colorado Institute of Family Medicine, as well as active membership on several distinguished strategic committees. Dr. deGruy has authored over 100 papers, chapters, books, and editorials, and has reviewed over 1,000 grant applications for the NIMH, AHRQ, and the Robert Wood Johnson Foundation. He is currently on the editorial boards of *Families, Systems and Health, the Annals of Family Medicine*, and the *Primary Care Companion to the Journal of Clinical Psychiatry*.

Responses to questions from Dr. deGruy are as follows:

1. **Employees seem to thrive in an environment where they are allowed to take greater ownership of their positions. MAs have a great deal of responsibility in our clinics yet their salary is relatively low. Have you experienced this dynamic and how has your organization addressed this issue (which ultimately leads to staffing shortages)?**

- I spend a lot of energy on how to pay people more, yet there still ends up being unhappy people. Focus on the cause, not on how much money you make.

2. How do you get staff on board with change when it's sometimes hard to get through the day to day operations?

- Change is painful, people don't like change.
- The motivation from change comes from remembering what we are here for – helping people be healthier.
- There are lots of ways we can help people be healthier:
    - Change the system: when the top down vision is made, ask those who have the "least voice." More times than not, they have the most valuable things to say to make it better.
    - Work hard to change the balance of voices.
    - Empower the least of us --- try ideas out until you get a little bit better at saying them, taking more seriously, and trying them.
    - Take a pod/team/clinic and give them people turn that job description into a person who really participates in a team. They will feel that their ideas get taken seriously and heard. These employees will lay down in front of a truck for the work that is going on in the clinic.
    - Be humble.
    - People who do the work have the best ideas, they also tend to be less vocal and need to be empowered – when they are the results are magic

3. How can we use Best Practices in an organization with so many types of sites, sizes of sites, and geographic locations, etc?

- Our department just finished doing a study – transformation of primary care integrated behavioral health care: systems/clinics/clinician to produce collaborative care.
- We used very diverse criteria selected for study.
- Abstract the things that are in common across practices and look at the differences between all of the practices.
- Value in and a method for finding what is common across all of the clinics – physically in separate places cannot do collaborative care.
- EHR does not help you do team-based care.
- Learn the differences between differences /similarities: what options are available
- Learn from best practices.

4. Describe how your behavioral health system works and does it include outreach to the community/outreach workers? To go to their home or work or local community centers to outreach and speak to patients?

- Mental health care for people in a primary care setting: health behavior change, substance use problems, stress. Health behavior change is deeply embedded in communities
- Predictors to success: the presence of a care manager and self-management of a chronic disease.
- Self-management tends to be community based with a lot of different types of activities such as: church basements doing diabetes education, the Y, boys and girls club.
- Community leaders care a lot about health.
- More employers are putting in work place health programs. This is community based.
- Trying to train the primary care workforce: for instance and occupational medicine residency program in FM residency.
- Till Farley has a school in an FQHC which has trained those in the community to do health promotion and self-management.
- Behavioral clinicians are needed to work in our clinics as part of our primary care team.

5. What did you do to get nimble? As such a large organization, what do we do to become open and flexible to a complex future?

- I am part of an institution that works in a University and they have committees, which in turn can take a long time to get things done.
- Two strategies:
  - Just do what needs to be done and take the hit and accept it. Offer an apology, but also know that you will probably do it again next time.
  - Work with competitors, which can feel scary/dangerous, but it's a good idea. It's important to help the primary care clinicians develop a patient-centered medical home. Then show the data to the University leaders. This is not a move for the "faint of heart". There is no choice but to do the right thing and suffer the consequences. Otherwise we can't move fast. Community colleges move fast.

6. How does this care team look in a smaller, community based clinic vs. an academic clinic?

- In an academic setting, half the energy had to go to curriculum; the other half had to go to figuring out care. Teams in smaller private clinic don't have as much coverage, are able to try stuff and fail. This happens a lot faster and there is a lot less damage. Smaller clinics tend to be used to having not much to work with. Use telemedicine in smaller clinics for things like psychiatry.

7. How do you keep laughter in the clinic in the face of such fast paced change?

- There is a lot of opportunity for laughter. Pursuing change by having symbolic leadership: speaking the vision, inspiring people to it. Leadership is responsible for establishing the rules for the culture, if not

the culture itself. We are going to prepare the primary care workforce, which will be good for this entire state, and can change the world, but we are going to have fun doing it.
- The creative act can manifest in a number of ways: improvement in quality, science, look at what is happening this creativity is intersection of two worlds. The third way is humor. Just remember to recognize that the worst camping trip makes really good stories.

8. How do you get your large organization (i.e. ours) to agree to let us innovate and fail – "to be a badge of honor?" When do you let the standardization stop to let innovation occur locally?
- Create local cultures of celebration of failures: at meetings with administration, search for the most interesting/valuable failure. It may not be very interesting, feels kind of boring to fit in to an institutional pattern, yet there are times when things need to be standardized. Family medicine is most valuable when it goes against the grain. Sometimes you need to go outside the lines to implement guidelines and other times stay in them.
- My most flagrant failure was missing my meeting with the Surgeon General about integrated care. I was delayed at airport and missed my initial connection. They got me on a different flight, which I did not realize was scheduled to go to Dallas, not Dulles… Once I arrived, I took a cab all the way to Arlington, TX – that's when I realized I was in the wrong state.

9. How can we have excellent primary care and treat our patients' needs?
- You are trying to convince someone how we can change the world
- Try to make people healthier and happier
- Ideas came from core staff not leaders
- Everyone can be a leader, inspire and facilitate the participation of everyone

10. What is the optimal care team (MD, RN, pharmacist, BH, nutrition) and what structure can ensure access to this full team at all sites?
- Make it up as you go along
- It depends on who you got around, what you are interested in, who is supporting you?
- Pharmacists and behavioral specialist and a care manager make a doctor's job easy

11. What are your ideas on how to make meetings more enjoyable and productive?
- Good hard work is good honest fun
- You have to be appropriate, help us have fun
- Give people time off to go work out
- Very generous hospital leadership

12. We claim that a big family medicine strength is how well we know our patients and can manage their needs uniquely well because of this. How does this balance against standardization of practices?
- The place where the clinicians work together is always up for ad hoc team based themes
- They hand off and others might finish the visit, at times noisy and impromptu

13. How do we get our faculty and staff involved with the community in such as health fairs in the schools, when they are overworked already?
- We expect faculty and staff to work however many hours and we divide the time according to the missions
- Community engagement that is not added to the university or the budget
- Takes senior leadership otherwise it doesn't work

14. In designing a future plan who should we be listening to the young adult with a vision for the future or the patient today? What gives us a better "future plan"?

- People are surprisingly clear. Listen to them
- Jobs and access to mental health care – most important to the poorest of the poor in CO, this directly contributes to someone's health

15. What new skills and competencies are we not addressing?

- Teach people how to practice is as important as seeing patients
- Integrative based care is new
- It is possible to clean up in terms of proficiency to get the basis in
- They offer a 4th year to any resident who wants it and all take it

16. How do we break down silos across functional areas of family medicine to empower and best leverage talent and become more nimble?

- Created 3 cross departments
- Evaluation. Everything gets evaluated
- Practice transforms practices
- Policies center for sustainability and development of new programs
- We don't do research that doesn't make practice better anymore

17. How do we create change towards a new practice model where we have more time with patients in an academic setting?

- Teaching practices and programming clinicians
- Research practice has a cost
- We need to be as playfully creative
- They lose half a million dollars a year but make up for teaching and finish 1 million ahead. If you wait unit you have enough it's too late

18. How has the legalization of marijuana in the state of Colorado affected the practice of medicine and do you see it becoming federal?

- For medical interests, legal two principals
- Lot more kids in ER overdosing on it
- Lot more money for our schools and roads from the tax revenue

19. How do you free up resources to make these big idea changes possible while still maintaining a high level of clinical care?

- Efficiency is a surge of creativity
- Do stuff without having any idea of how to do it
- Don't wait around to get paid. Just do it
- Not doing something because you don't have enough is not an excuse
- We should always do something without resources