

The national demonstration project
nears the halfway mark with many
hard lessons already learned.

TransforMED

TRIES TO REBUILD FAMILY MEDICINE

Drew Sullivan

Myrtue Medical Center in Harlan, Iowa, was a busy place before its April 2006 selection to be a part of the TransforMED national demonstration project. Somehow, it's been much, much busier ever since.

In the last six months of 2006, the group's physicians worked on installing a new electronic health record (EHR) system. They also implemented a new scheduling system. And upgraded their telephone system. And began accepting same-day appointments.

Seventeen other family practices, working closely with TransforMED's facilitators and consultants, have similar stories. They're all participants, along with 16 additional "self-directed" practices that are working largely on their own, in the two-year TransforMED project, which is experimenting with how a new model of care inspired by the Future of Family Medicine initiative works in the real world.

Some call the massive and rapid overhaul that the participating practices are making "total practice transformation." Others have dubbed it "the TransforMED effect." Those who are most closely involved, the doctors and the TransforMED team, simply call it "intense."

"We have both the privilege and the burden of totally revamping the way we do things," says project participant Robert Eidus, MD, of Cranford Family Practice in Cranford, N.J.

TransforMED, which was started with \$8 million from the AAFP, is being watched intently by many who believe that family medicine needs to change in order to survive.

"It's something we have to do," says TransforMED CEO Terry McGeeney, MD, MBA, "The reality is that it's really, really hard. It's not just something that can be fixed by ordering a CD."

From theory to reality

Plans for TransforMED began coming together after the Future of Family



**“My sense is that in the real world
it’s going to be even harder.”**

Medicine report was published three years ago. Specifically, TransforMED’s origin lies in this recommendation from the Task Force 6 report on financing the new model of family medicine:

“A national demonstration project should be launched immediately, involving 10 to 20 family medicine practices of varying sizes, locations and patient populations, to implement fully all elements of the New Model. This 24- to 36-month project should be an ‘in vivo’ exercise focused on demonstrating proof of concept.”¹

The TransforMED model of care is based on the new model of care and four overarching concepts: a personal medical home, patient-centered care, continuous relationships and whole-person orientation. TransforMED has identified 42 tangible sub-components of the model, such as offering lab results online and advanced-access scheduling. These are organized under eight core elements that TransforMED is working to implement in each of its 18 facilitated practices. (See “TransforMED’s model” on page 27.)

“In the past, others have taken these ideas and tested them one at a time,” McGeeney says. “But they didn’t try to do all of these things at the same time in one practice.”

When TransforMED began, the 18 facilitated practices had less than half of the components of the TransforMED model in place. None were doing group visits or systematic chronic disease management. In February 2007, nine months into the project, the 18 facilitated practices had about two-thirds of the components in place.

“We thought we were getting the more high-performing practices in general,” McGeeney says. “We’ve found that that probably is true, but even they are very

ill-equipped to do this stuff. My sense is that in the real world it’s going to be even harder.”

Initial evaluations

Representatives from the 18 facilitated groups got their first sense of what they had gotten themselves into in June 2006, when the demonstration project kicked off with a two-day meeting in Kansas City.

They had made it through an extensive application process just to be in the room that day. Eidus says he was inspired to get involved when he read the following conclusion from the Future of Family Medicine report: “Unless there are changes in the broader health care system and within the specialty, the position of family medicine in the United States may be untenable in a 10- to 20-year time frame, which would be detrimental to the health of the American public.”²

A TransforMED committee made up of family physicians and health care leaders considered 337 applications before naming the demonstration project’s 36 participants in April 2006. “We wanted practices that knew about the Future of Family Medicine and had the ability to make changes and make decisions,” McGeeney says.

From there, the practices were randomly assigned to two groups of 18 practices. One group became the project’s self-directed practices. They were pointed toward some practice improvement tools and services, and left essentially on their own to try to implement as much of the TransforMED model as they could. That group of 18 has since dropped to 16. One practice withdrew after going through some internal changes, and a second practice found the data collection required for the project to be too burdensome.

The second group became the “facilitated” practices and were assigned a facilitator who works with them every step of the way, via e-mail, phone calls and site visits, to tailor their implementation strategies. They also are given discounted software technology.

■ The TransforMED national demonstration project is a two-year test of how a new model for family medicine works in real practices.

■ TransforMED, which was started with \$8 million from the AAFP, is working with 18 “facilitated” practices on implementing its model, which is based on the Future of Family Medicine report.

■ In addition, 16 “self-directed” practices are trying to implement the TransforMED model on their own.

About the Author

Drew Sullivan is senior associate editor for *Family Practice Management*. Author disclosure: nothing to disclose.

At that first meeting in Kansas City, they met their facilitators and heard the project outlined in detail.

“We brought them in and inundated them with information – by design,” says James L. Arend, MBA, one of the project’s three practice facilitators. (The other two are David V. Garrett, MHA, and Barbara C. Johnson, PhD.) “We wanted to make their heads swim and understand just what was going to be involved.”

TransforMED’s three facilitators made their first site visits shortly afterward. This in-person look gave TransforMED its first true evaluation of the offices and where each one stood in relation to the TransforMED model components. In many of the practices, three things quickly became clear:

1. Key decision makers weren’t on board. For the TransforMED facilitators, figuring out which practice leaders to work with wasn’t as simple as looking back to see who had sent in the group’s application. “We found that there were one or two physicians who filled out the application,” McGeeney says. “They were gung-ho, but their partners may not have been, or the business directors weren’t.” Arend says that he and the other facilitators had to figure who in the practice could approve of the changes that were to come and then gain their trust.

2. Office communication was lacking. On their first site visits, the facilitators tried to sit down with as many employees as possible to get a sense of the practice’s people and processes. Many practices seemed to underestimate the importance of communication within a practice.

“We had many practices that weren’t having meetings at any level,” McGeeney says. “The doctors weren’t talking to each other. They weren’t talking to their staff. And the staff wasn’t meeting regularly.”

3. The practices thought they were doing better than they actually were. Garrett says that sometimes the practice he walked into did not match the one he had read about on the application. “They might think they have advanced access, or they might think they’re utilizing their EHR to optimization, but when somebody objectively looks at it, the reality is often different,” he says.

These three things helped steer the facilitators’ early agenda for the practices. “We spent

the first few months just working around the culture and the change issues,” McGeeney says.

What they’ve learned

Although the bulk of the project’s evaluation work will take place when the two-year demonstration ends in June 2008, TransforMED is sharing lessons learned along the way. Its first batch of advice to other family practices was released in December 2006, six months into the project:

1. Change needs to be anticipated and aggressively managed. The facilitated practices quickly learned that real change happens only after everyone in the practice is on board and actively involved. “You have to manage the change around every process,” McGeeney says. “You can’t just announce one day that you’re changing the way something is done and assume that the new process will run smoothly from that moment on.”

Most of the facilitated practices spent a lot of their time initially figuring out how best to prepare their practices for the dramatic changes that the TransforMED model calls for. “We had to do a lot of team building at all levels, so that as new processes and technologies were later introduced, the culture of our organization was ready for change and supportive of the new initiatives,” says Don Klitgaard, MD, of Myrtue Medical Center in Iowa. ►

■ The TransforMED practices are medical groups of all sizes, including solo physicians, from all over the United States.

■ TransforMED employs three facilitators, each of whom works with six facilitated practices.

TRANSFORMED’S NEXT TWO PROJECTS

TransforMED is preparing to take part in two more demonstration projects. One is called Preparing the Personal Physician for Practice, or P⁴. The six-year P⁴ project and its 14 participating residency programs will explore new ways to train future family physicians. The American Board of Family Medicine and the Association of Family Medicine Residency Directors have pledged about \$1.75 million to fund P⁴. For more on P⁴, visit <http://www.transformed.com/p4.cfm>.

A second TransforMED demonstration project will involve IBM and the American College of Physicians and start this summer. The goal will be proving that a patient-centered medical home can lead to higher quality of care with lower cost. It will take place in a handful of practices in Austin, Texas, and will involve employees of IBM, which will fund the project. The project is slated to include real-time payer data on things like hospitalizations, emergency department visits and medication costs, as well as population-based registries to track quality.

THE 18 FACILITATED PRACTICES

<p>Solo</p>	<p>Cranford Family Practice, Cranford, N.J. http://www.cranfordfp.com</p> <p>Harbor of Health, Memphis, Tenn. http://www.harborofhealth.com</p> <p>Indian Land Primary Care, Indian Land, S.C. http://www.indianlandprimarycare.com</p> <p>James J. Meyer, MD, Littleton, Colo. http://www.jamesmeyermd.com</p> <p>Stephen J. Veit, MD, Cherokee, Iowa http://www.sjveit.com</p>
<p>Small (two or three physicians)</p>	<p>Trinity Clinic Whitehouse, Whitehouse, Texas http://www.trinityclinicwhitehouse.com</p> <p>Family Health Center of Joplin, Joplin, Mo. http://www.fhcjoplin.com</p> <p>Bay Crossing Family Medicine, Annapolis, Md. http://www.baycrossingfamilymedicine.com</p> <p>Family Medicine, Geriatrics and Wellness, Lower Gwynedd, Pa. http://www.fmgwmed.com</p>
<p>Medium (four to six physicians)</p>	<p>Wood River Family Medicine Clinic, Hailey, Idaho http://www.haileymedical.com</p> <p>Family Practice Partners, Murfreesboro, Tenn. http://www.familypracticepartners.com</p> <p>LifeScape Medical Associates, Scottsdale, Ariz. http://www.lifescapemed.com</p> <p>MHS Primary Care, Middletown, Conn. http://www.c1c.com/clients/MHSPC/middletown</p> <p>Central Oregon Family Medicine, Redmond, Ore. http://www.cofm.net</p>
<p>Large (seven or more physicians)</p>	<p>Henry Ford Family Medical Center, Troy, Mich. http://www.henryford.com/body.cfm?id=37162</p> <p>Westshore Family Medicine, Muskegon, Mich. http://www.mghp.com/primarycare/westshorefamily.shtml</p> <p>Myrtue Medical Center, Harlan, Iowa http://www.myrtuemedical.org/clinics/harlan.asp</p> <p>Hays Family Medicine, Hays, Kan. http://www.haysmed.com</p>

Many of the facilitated practices had to work on culture changes, such as improving internal communication, before they could start implementing components of the TransforMED model.

TransforMED has pushed the physicians in the facilitated practices to be more active on the business side of their practices.

TransforMED has also encouraged the practices to look for relatively easy ways to reduce office overhead.

Another practice learned that one person can have a hard time managing change alone. “Initially, I wanted to micromanage and direct the change, and change seemed to come slowly and painfully,” says solo physician Stephen J. Veit, MD, of Cherokee, Iowa. “Now, we are trying more group empowerment, letting everyone initiate and direct change.”

Having the right team members is critical to managing change, as one TransforMED practice found. “We filled our administrative

manager and nurse supervisor positions with leaders who were ready to implement and embrace change,” says Earlexia M. Norwood, MD, of the Henry Ford Family Medical Center in Troy, Mich.

2. Communication is critical to success. TransforMED’s facilitators say the practices have improved their communication by implementing planned meetings and daily huddles that include physicians and staff. Intended to be quick and efficient, the

huddles are limited to seven minutes during which everyone stands.

Johnson found that one hospital-owned practice has embraced the huddles after initially resisting them. “The staff members were telling me: ‘It’ll never work. The doctors will never go for it.’ But I talked to the

doctors, and they agreed to make it happen,” she says. “The huddles have been so successful at bringing the practice together that the hospital has mandated that everybody start doing huddle meetings like this practice.”

Joseph F. Mambu, MD, of Family Medicine, Geriatrics and Wellness, Lower Gwynedd, Pa., credits early

ONGOING CHALLENGES, IN THEIR OWN WORDS

The doctors in TransformMED’s facilitated practices talk about the biggest challenges they are facing as the demonstration project nears the end of its first year.

“We’re trying to find time to improve and plan while continuing to do our day-to-day activities.”

– Robert Eidus, MD, Cranford Family Practice, Cranford, N.J.

“Group visits are still a challenge. We have had from four to 12 patients per group but would like to have 10 to 12 patients consistently. We have decided to schedule one group visit every month at the same time so that our providers can promote them and our patients can learn when to plan their visit.”

– Susan Nelson, MD, Harbor of Health, Memphis, Tenn.

“In our new and growing practice, the greatest challenge we see now is how to continue this patient-focused care at the same time we are faced with the challenge of seeing adequate patient volume to generate revenue to cover overhead costs as well as satisfactory income.”

– Lee Thomas, MD, Indian Land Primary Care, Indian Land, S.C.

“Our biggest challenge is generating the patient base to provide the data needed for the TransformMED collection and study process. Along those lines, doing group visits is difficult when you have a small patient panel size.”

– Ramona G. Seidel, MD, Bay Crossing Family Medicine, Annapolis, Md.

“We are trying to manage our day-to-day operations while at the same time improving the care we provide. We have a time and energy problem. We are trying to structure and manage our team and office meetings better.”

– Stephen J. Veit, MD, Cherokee, Iowa

“Chronic disease management is our biggest challenge at this point. We all have a sense that taking care of a chronic disease, such as asthma or diabetes, is not best done with four 15-minute, point-of-service office visits in a year. However, lack of payment and time in daily schedules to do what is required is a hindrance. We will try a multidisciplinary approach with teams, dietitians, registries and a lot of in-between visit care, but only because we are in the TransformMED project. In the real world, without reimbursement for this process change, I have a hard time seeing how it will work.”

– Melissa Gerdes, MD, Trinity Clinic Whitehouse, Whitehouse, Texas

“We’re trying to make optimal use of our electronic tools. Although we had the basics in place before TransformMED, there is a large remaining challenge in getting them optimally functioning, knowing when to use them and training our patients to make use of them when it is proper to do so.”

– Randall C. Rickard, MD, Family Practice Partners, Murfreesboro, Tenn.

“Achieving financial success is extremely difficult in a payer system that does not reward – and, if anything, discourages – quality, experience, patient-centered care, service, innovation or technology.”

– Susan S. Wilder, MD, LifeScape Medical Associates, Scottsdale, Ariz.

“Our biggest challenges are providing care proactively to patients who don’t come in for regular visits and upgrading our EHR’s functionality and capabilities.”

– Earlexia M. Norwood, MD, Henry Ford Family Medical Center, Troy, Mich.

“Getting all our processes streamlined with an EHR has been a huge challenge on several levels. Some frustrations come from learning the specific constraints and limitations of your EHR product, so that workflow can be designed within those constraints. In addition, getting staff all up to speed has been and will continue to be a challenge.”

– Don Klitgaard, MD, Myrtue Medical Center, Harlan, Iowa

communication efforts with early successes in his practice. “We worked hard to communicate the TransforMED timeline and strategy to our staff. After only six months, it had become part of our practice’s daily consciousness,” he says.

3. The business aspect of your practice must be managed to the fullest. “Many family physicians don’t approach their practice as a complicated business,” McGeeney says. For example, they don’t know where their income comes from, they don’t know what their overhead is and they don’t understand how to use financial benchmarks.

McGeeney recommends that someone within each practice must assume responsibility for business and financial management, and he acknowledges that it’s not a job most doctors want to sign up for. He also recommends developing a budget for your practice as a first step. (For help, see “Three Steps to an Effective Practice Budget,” *FPM*, January 2004, <http://www.aafp.org/fpm/20040100/46thre.html>.)

4. Many common sense efficiencies that reduce office overhead are often overlooked. TransforMED’s facilitators looked for relatively easy things practices could do early on to increase their efficiency and to feel like they’d had success as a team. For example, they encouraged the practices to work on making their Web sites more interactive (e.g., offering online scheduling and patient information links), making e-visits available to patients for minor problems or follow-up visits, and using their EHRs more fully (e.g., using well-designed EHR templates, which reduced transcription costs). Reaching these “low-hanging fruit” made the practices more accessible to patients and freed up some staff and physician time, which could be devoted to providing more robust office visits and chronic disease management.

At the same time, at least one TransforMED practice has found that it takes time for patients to adopt and accept the new technologies. “The virtual office visits have been slow to catch on,” says Melissa Gerdes, MD, of Trinity Clinic in Whitehouse, Texas. “Our physicians have been actively marketing them directly to patients, and still, we only do about two to three per week among three physicians. We thought they would be more popular, but I think they are just so different from the usual world of medicine.”

5. Provide as many services as possible within your practice. TransforMED wants

its practices to maximize every opportunity to offer ancillary services, such as labs, X-rays and stress tests, within the practice. Not all practices will offer the same services. It’s important to offer those that are appropriate to your practice. Doing so makes good economic sense and is part of providing excellent patient-centered care, McGeeney says.

Nearing the halfway mark

As the TransforMED national demonstration project nears the halfway point, most of the early challenges have been worked out, allowing the practices to focus on implementing the bulk of the TransforMED model.

“We’re getting into the daily functions,” Garrett says. “This is where the rubber is hitting the road.”

Stories and data streaming back from the facilitated practices offer glimpses of success. For example, an EHR company was so impressed by one practice’s potential to rapidly implement their system that it sent a film crew out to document the process. Another practice just enjoyed its two most financially successful months ever. A third practice received a huge response from patients when it lowered its price on e-visits from \$35 to \$25.

“The practices are all happier. They’re all doing better,” McGeeney says. “Their productivity is going up. Their staff turnover is down. It’s all working. But it’s just very complicated.”

There are fewer anecdotes from the self-directed practices. “We’re trying to leave them alone,” McGeeney says. The monthly data coming in from the 16 remaining self-directed practices indicate that they are doing well, so far.

“They’re actually more aggressive and self-motivated than the facilitated practices,” McGeeney says. “The facilitated practices are developing a little bit of a ‘Help us do it’ culture. The self-directed practices don’t have that option, and it seems to be forcing them to be more active.”

It’s already clear that not all of the practices will have the TransforMED model fully implemented when the demonstration project concludes in June 2008. In many cases, it’s for reasons beyond the practice’s control. For example, one practice’s EHR is being held up because it’s part of a large health care system that has its own multiyear EHR rollout planned. ►

■ TransforMED has directed its physicians to offer patients as many ancillary services as they can, as long as they make sense for their practice.

■ As the two-year TransforMED project nears its midway point, many of the practices have moved beyond their early challenges and are focused on implementing components of the TransforMED model.

■ Asked about their biggest remaining challenges, physicians in the facilitated practices mentioned attracting patients to group visits, implementing chronic disease management and optimizing EHR use.

TRANSFORMED'S MODEL

When the TransformMED facilitators visited the participating practices for the first time, they were looking at where each practice stood in eight areas and 42 subcomponents that constitute TransformMED's model of care. For more information, visit <http://www.transformed.com>.

Access to information	<ul style="list-style-type: none"> • Lab results by phone or online – Allow patients to access results securely rather than waiting for a call from the practice. • Nurse line – Provide a 24-hour line for patients to call with questions. • Web site – Create a Web site that allows patients to schedule appointments, initiate e-visits, etc.
Information systems	<ul style="list-style-type: none"> • Affordability – Consider actual cost as well as cost of lower productivity during implementation and training. • Chronic disease management – Utilize a disease registry that integrates with the practice's EHR. • Compliant with guidelines from AAFP's Center for Health Information Technology. • EHR implemented. • Follows clinical guidelines – Make sure physicians are able to pull up clinical guidelines on an EHR during a patient visit. • Interoperable – Use software that allows physicians to transmit clinical information within the practice, to connected hospitals, to outside labs or to other providers.
Patient access to care	<ul style="list-style-type: none"> • Access to all – See all patients, regardless of insurance status. • Advanced-access scheduling – See patients when they want to be seen; details are unique to each practice. • Call coverage – Provide 24-hour, 7-days-per-week coverage, usually by negotiating call coverage with other family physicians. • E-visits – Offer encrypted e-visits. • Group visits – Enable patients with the same condition to see the doctor at the same time. • Multilingual approach to care – Offer multilingual care or access to an interpreter if language is a barrier. • Multiple venue appointment scheduling – Let patients schedule visits by phone or online, or by just walking in.
Point-of-care services	<ul style="list-style-type: none"> • Acute sickness and injury treatment – With advanced-access scheduling, treat patients with acute illnesses and injuries the same day, instead of referring them to the emergency department. • Ancillary services – Allow patients to receive additional services (labs, X-rays, stress testing, etc.) within the medical home at the same time as the office visit. • Chronic care model – Take a proactive approach to managing the chronic disease population. • Disease prevention and wellness promotion – Put an equal emphasis on prevention and treatment. • Procedures – Do as many in-house procedures (mole removal, colonoscopies, simple fractures, etc.) as the market supports.
Practice management	<ul style="list-style-type: none"> • Active leadership – Have a clear vision as the leader but trust staff members to be responsible for significant projects. Leader is often a physician but does not have to be. • Change management – Recognize the importance of managing change. • Disciplined financial management – Be involved with the practice's financial aspects. • Optimized coding and billing – Avoid undercoding. Understand coding and do not rely on EHRs alone to provide the codes. • Tracking revenue and overhead – Track both to be financially strong.
Quality and safety	<ul style="list-style-type: none"> • Best practices – Stay current with best-practice guidelines. • AAFP's Practice Enhancement Forum – Understand clinical quality improvement principles, as taught by this program. • Patient feedback and satisfaction – Ask patients for feedback at every visit, as well as in more extensive surveys. • Outcomes analysis – Measure and track specific outcomes.
Redesigned offices	<ul style="list-style-type: none"> • Facility redesign – Maximize practice space by identifying multiple ways to use it. • Idealized offices – Match the practice's design to its vision and its income. • Optimized patient flow – Use the least amount of wasted steps for patients, providers and staff members. • Optimized space use – Make sure the practice has no unused or wasted space. Lease out any extra space.
Team approach	<ul style="list-style-type: none"> • Collaborative relationships – Build relationships outside the practice to ensure the best possible care for patients. • Communication – Use all three of the following to improve communication: <ol style="list-style-type: none"> 1. Daily huddles 2. Effective meetings 3. Teams • Hospital care – Avoid fragmented care by allowing doctors to follow their patients directly or indirectly. • Maternity care – Be part of the maternity team when a patient is pregnant and, ideally, deliver the baby. • Multidisciplinary team – Recognize that everyone in the practice, from the receptionist to the billing manager, plays an important part in patient visits. • Nurse practitioners/physician assistants – Use midlevels to enhance the practice's team and its patient care.

■ When the project concludes, the Center for Research in Family Medicine and Primary Care will evaluate qualitative and quantitative data that TransforMED is collecting from the practices on an ongoing basis.

■ TransforMED is involved in two other projects; one will explore new ways to train family physicians, and the other will try to prove the value of giving patients a medical home.

“We’re still committed to trying to get as many of the components of the model implemented in every practice,” McGeeney says. “Two years is very, very aggressive. Task Force 6 recommended either a two-year or a three-year demonstration. We opted for two.”

Making sense of it all

The responsibility for evaluating everything that transpires during the two-year TransforMED national demonstration project rests with the AAFP Center for Research in Family Medicine and Primary Care. Its principal investigator is Carlos Jaén, MD, PhD, of the University of Texas Health Sciences Center at San Antonio. The group will independently evaluate both the facilitated and self-directed practices on things such as patient satisfaction and other patient perspectives; physician and staff satisfaction and quality of the working environment; clinical process and outcome measures for quality of acute, chronic, preventive and mental health care; and practice revenue and physician income. The evaluators’ work received a boost from the Common-

wealth Fund, which granted nearly \$240,000 to the research center to examine patients’ perspectives on the TransforMED model.

Whatever the final result, McGeeney says that the TransforMED participants already have two messages for their fellow family physicians: Moving to the new model is tough work, but it has its rewards.

“Not all of them are going to want to do it, but they should at least understand it and make that conscious decision either way,” McGeeney says. “TransforMED creates a clearly defined model and vision of what family medicine should be. It will not only improve your patients’ and your own satisfaction, but it will also make your practice economically viable. It’s creating a situation where family medicine can survive and actually thrive.” **FPM**

Send comments to fpmedit@aafp.org.

1. Future of Family Medicine Task Force 6. Report on financing the new model of family medicine. *Ann Fam Med*. 2004;2(Suppl 3):S1-S21.

2. Future of Family Medicine Project Leadership Committee. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med*. 2004;2(Suppl 1):S3-S32.