

BIG IDEAS

to Help Your Practice Thrive

2004 FPM
Reader Challenge
Finalists

Your family physician colleagues share their best ideas for energizing and strengthening the practice of medicine.

In late 2003, a year marked by rising malpractice insurance premiums, HIPAA compliance deadlines, ongoing reimbursement struggles and questions about the future of family medicine, the editors of *Family Practice Management* decided enough was enough. Determined to counter the tumultuous times, we issued a reader challenge – a call for big ideas that have energized and strengthened family physicians' practices. One year later, we offer this issue filled with our 18 finalists.

These ideas demonstrate that innovation doesn't have to be excruciatingly scientific to have value. In fact, simple, everyday innovations centered on big ideas, designed to solve practical problems, rooted in common sense and carried out with conviction are often the seedlings for greater change.

What's more, this issue's big ideas remind us that family physicians are resilient and resourceful individuals who care deeply about what they do and are dedicated to finding better ways to practice medicine. These big ideas are just a sampling of the solutions waiting to be discovered in family practices all across the country, and they offer hope that the larger transformation of health care is indeed possible.



The finalists

The top three finalists in our reader challenge, as selected by our panel of judges, are featured on pages 39, 45 and 51. You'll find other big ideas sprinkled throughout this issue and the remaining baker's dozen presented below. We hope they inspire and challenge you to build a practice you can be proud of and to accomplish big things in your corner of the health care system. ▶

1

Get off the hamster wheel

L. Gordon Moore, MD

Ideal Health of Brighton, Rochester, N.Y.

High overhead seemed to be driving most of the dysfunction and pain in my former practice and was leading to awful finances. We tried to solve these problems through increased productivity, testing, procedures and products, but it never worked. Finally, I realized that if I could dramatically reduce my overhead, I could get off the hamster wheel and focus on delivering excellent care.

The big idea was to use technology to the fullest to achieve a simple practice with minimal or no staff so that my overhead was dramatically lower. I opened my solo practice on Feb. 26, 2001, renting an exam room at a local practice and doing everything myself – including answering the phone. I have removed everything from my practice that is not essential to the doctor-patient interaction. I started with almost no patients following from my old practice but ended up closing to new patients within the year (without any marketing). I offer same-day access to any caller (except

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when I'm out of town), typically spend 30 minutes per patient visit, come in at 9 a.m. and am home by 5:30 p.m. And the finances are great.

As of April 2004, I started working with a nurse so that I can do the kind of planned care taught within the Improving Chronic Illness Care Collaborative (<http://www.improvingchroniccare.org>).

Take-away lessons

Costs and overhead are the most dysfunctional aspects of health care that we can control. When we remove them as obstacles, we can achieve the unbelievable in service and quality. I'd never go back to the old way – and neither would James Sturgis and Terry Merrifield in Kansas; Linda Lee, Jeff Arpsandel, Lisa Harris, Naureen Mohammed and Tom Mydosh in New York; Michelle Eads and Shaun Thompson in Colorado; Luis Gonzalez in Texas; Chris Patin in Nevada; Brent Habrik in California; Larry Lyons and Nancy Guinn in New Mexico; Greg Hinson in Massachusetts; Gordon Thompson in South Carolina; Kelly Rothe in North Carolina; Cindy Cote in Washington; Rian Mintek in Michigan; and a host of others. For more information, visit <http://www.idealhealthnetwork.com>.

2

Approach chronic illness care as a team

Kellie Takashima, FNP, and Samir Patel, MD

Kaiser Permanente Nanaikeola Clinic, Oahu, Hawaii.

Our clinic is located in a rural community on the Waianae Coast of the island of Oahu. Most of our patients are of Native Hawaiian descent and have multiple comorbid chronic disease problems heightened by poor adherence rates. Realizing that the traditional model of care (one-on-one, 15-minute appointments) was not meeting the needs of these patients, we developed the Population Team Care Management project to support physicians in providing high-quality, evidence-based medical care.

We use a registry that tracks specific measures important in chronic disease care (e.g., A_{1c} rates for patients with diabetes) for each of our patients. Each month, a multidisciplinary team consisting of a physician, nurse practitioner, medical assistant, registered nurse, certified diabetic educator and receptionist meets to review each patient's chronic disease status using the most current patient data, including medication, labs and anything else. We then agree on a plan of care, with the use of evidence-based standards and goals for each patient.

To help educate team members on each chronic disease, we held one-hour educational sessions at the outset. Interactive sessions using "Jeopardy"-style questions were the most popular teaching tools. We also made PDA-compatible guideline summaries available for quick access and reference.

Utilizing each team member's strength is critical to the success of the project. We systematically reviewed all roles and duties, making changes as needed, which has maximized both capacity and responsibility. For example, work that was previously done by the registered nurses but that could be done by the medical assistant was shifted accordingly.

We use quarterly performance reports to monitor our progress. We have been able to increase our statin use in patients with diabetes and coronary artery disease (CAD) from 36.9 percent to 72.7 percent in just one year. In addition, we have increased the target dose of ACE inhibitor use in patients with diabetes from 53.7 percent to 68.4 percent and in patients with CAD from 47.7 percent to 63.3 percent. We also increased beta-blocker use in post-MI patients from 65.5 percent to 90 percent.

Take-away lessons

With a systematic team approach, patient care can be proactive and consistent, rather than reactive and unreliable. Patients who would otherwise be lost to follow-up can be identified immediately, and an individual plan of care can be developed.

3

Put everything within arm's reach

*Paul H. Buller, MD
Goshen, Ind.*

In 1995, I made the mistake of selling my solo practice and moving into a hospital-owned multiphysician office. The hospital “unsold” us in 1999 and closed the building, and I had the good fortune of returning to my former space across town (a rented stand-alone office built to my specifications in 1992 on a nursing-home campus). Upon my return, I saw what a big idea I’d had originally.

In the large hospital-owned building I had left behind, a phone request from a patient was taken in the phone room. The written note went into a slot and was picked up occasionally by someone in the chart room, who later delivered the note and chart to my cubbyhole where I dictated, usually in large batches of charts. After I reviewed and answered the phone message, it sat in my outbox until the phone nurse picked it up on her rounds and called the patient. A good turnaround was two hours; the average was about four hours, which didn’t please our patients. Similar problems involved finding charts and lab results and locating a staff person to help in the exam room.

In contrast, my solo office space is designed with all work within arm’s reach and all colleagues within eye contact. Charts are on the wall to the left of the phone nurse, just behind the receptionist and the biller. I stand just across the hall at the entrance to the lab area, where the clinical nurse is to my right when not rooming a patient. When the phone nurse pulls a chart, she places it immediately (in terms of time and location) to my right where I dictate. After I dictate, I review all current phone messages (not too many can accumulate during one or two office visits). A turn and a glance or a soft word brings the phone nurse to clarify any issues or respond quickly to an urgent problem, and the call is returned.

Through the course of the day I walk only from my exam rooms to my dictation spot (and occasionally to the break area for a cookie). We have not misplaced a chart for longer than three minutes in the last four years. Because our staff members are located near one another, most business is taken care of on the fly with brief gatherings; we have office meetings for only one hour every two months, and they are relaxed. The result of all of this is remarkable efficiency.

Take-away lessons

Any break in communication or any nonproductive activity repeated endlessly (such as walking back to the office to dictate) turns the physician’s attention away from patient care and results in decreased patient, employee and physician satisfaction, inefficiency and dollars lost.

4

Stick together

*David A. Lynch, MD
Family Care Network, Bellingham, Wash.*

The family physicians in our community were feeling the stress – stress from declining reimbursements, time pressures caused by unreasonable insurance company demands, increasingly complex paperwork, and the struggle to maintain clinical quality while managing all the day-to-day business in our offices. As individual doctors, we felt unable to tackle the huge issues that threatened our practices and seemed impossible to address.

Several family physicians in our community had been working together for several years as an independent practice association for the purpose of sharing risk while contracting with a local HMO. Over the years, we learned from each other and began to realize that our “cottage industry” style of organization prevented the type of cooperation that would really allow us to tackle our problems. This led us to our “big idea”: form a single medical group, for the purpose of organizing ourselves to work together on all the aspects of practice that felt overwhelming to us. After much discussion and planning, 42 family doctors, along with their staff, working in 12 locations throughout our county, came together, and Family Care Network (FCN) was born.

Because our doctors were all used to being in charge and managing problems in different ways, there was a great risk that we would spend all of our time trying to amalgamate our differing systems and never get to the reasons that inspired us to join together, but we’re over that hump. From the very beginning, we established a management committee and agreed to decide all of our critical issues through consensus. Three of our members were chosen for part-time, paid positions of leadership; they maintained reduced clinical practice time. Their areas of focus are business and financial matters, clinical process improvement and quality performance.

We have rolled out a number of innovations, including preplanned visits and a patient registry for diabetes care, an anticoagulation service, and a practice Web site to support patient education. We are implementing a new electronic medical record, which will eventually allow us to standardize clinical processes, improve patient recalls, prescribe drugs more safely and monitor our quality of care.

Take-away lessons

Building a larger group practice can be complicated, scary and expensive. On the other hand, with mutual respect, consensus-driven decision making and patience, the rewards for family doctors and their patients can be well worth the trouble. The result can be an organization with the strength and resiliency to practice an improved brand of family medicine in the 21st century.

5

Manage the urgent

*Julie Vails, MD
Elk Grove, Calif.*

Before opening my solo family medicine practice, I worked for several local urgent-care centers, emergency rooms and medical offices where I cared for a large number of frustrated patients who couldn't get a timely appointment to see their regular doctor for acute care. I listened to sick patients who were either squeezed into their doctor's already full schedule, seen by a doctor, nurse or physician's assistant they hadn't met before, or referred to an urgent-care center where they spent hours in the waiting room and were seen for 10 minutes. Mostly patients complained that their personal physician was just too busy to see them.

In my solo practice, I have ensured that every patient who calls for a same-day urgent care appointment is seen that day, with new patients scheduled for 60 minutes and established patients for 30 minutes. I offer group urgent care appointments called "ACCESS" appointments.

ACCESS appointments are incorporated into my daily schedule starting at 4 p.m. The rest of my schedule is reserved for prescheduled visits. If a patient calls for a same-day appointment, my office staff explains our group urgent care system and adds them to the ACCESS schedule.

All patients complete a confidentiality agreement, and spouses or partners may attend as well. Regular co-pays and deductibles apply. My medical assistant meets privately with each patient, documents vital signs and reason for the visit, asks about work or school notes, completes any appropriate testing and assesses the need for private exams. The patient then joins the others in the conference room.

I review all patients' chief complaints ahead of time and combine those with similar complaints. This allows me to explain treatments, medications, signs and symptoms for follow-up, and self-care only once. My medical assistant brings my computer and the ACCESS box filled with medical equipment, work notes, prescription pads, lab sheets, etc., and joins me in the group. The sickest and youngest patients are addressed first. Patients with concerns of a sensitive nature are seen privately last.

Group urgent care appointments are not for every medical need and are not meant as a replacement for individual appointments. Patients who are reluctant to try this innovative appointment method are asked to try it just once. We elicit feedback from our patients and invariably find them happy with the group visits, in part because they learn from one another's experiences.

Take-away lessons

When faced with challenges such as urgent care needs, get creative and offer innovative options to your patients. By doing so, you will exceed expectations and build the practice you want.

6

Charge a fee

*Michael O'Neal, DO
Center for Family Health and Prevention,
Palm Harbor, Fla.*

The average primary care physician coordinates the care of approximately 3,000 patients, making it difficult to provide optimal, personalized care to every patient. Our practice was designed to eliminate or reduce this problem, in part, through an annual membership fee, which financially supports a low-volume practice. Our physicians care for an average of 350 patients, or eight patients per day, and spend approximately 40 minutes with each patient. While we are not totally independent of insurance providers, all potentially reimbursable services rendered are the responsibility of the patient or his or her insurance plan. Only nonreimbursable services are included as components of the retainer (or membership) fee. Although the intent is to complement insurance, our viability is not dependent on managed care reimbursement.

The low-volume environment has allowed us to offer home visits, 24-hour direct access to the physicians, same-day appointments regardless of need and after-hours care. By functioning within a more manageable environment, we are more capable of providing pro bono care to underserved and uninsured nonmembers. We have also markedly reduced the incidence of hospitalizations and emergency department visits. We also are able to optimize the concept of collaborative care by attending subspecialty appointments with the patient, as well as treating select patients incident-to an established care plan with our clinical pharmacist or clinical psychologist.

Our practice emphasizes end-of-life preparation. Through our use of a secure Internet repository for the storage of "do not attempt resuscitation" orders, advance care directives and medical histories, this information is made promptly available to hospitals and emergency departments nationwide.

Another original aspect of our membership practice is that we did not transition from an existing practice, a first in the United States. Therefore, there is no perception of patient abandonment because patients were accumulated without reducing a pre-existing patient population. Our effort targeted the middle socioeconomic class rather than only upper income individuals, so we have attracted a greater variety of individuals than most membership practices, maintaining diversity within this family practice.

Take-away lessons

The success of this effort should encourage other physicians to explore unique practice opportunities. Such career choices allow entrepreneurial minds to pursue new options and promote positive change in our health care system.

7

Let your nurse help you

*Jonathan Swartz, MD, MBA,
Noel Brown, MD, and Sandra Barnaby, RN
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Managing patients on warfarin is a challenge in any practice but particularly in a teaching practice because of the large number of part-time physicians. We developed a model in which a registered nurse uses a hand-held computer database and date-book reminders to manage anticoagulation patients for a 24,000-visit-per-year family medicine residency teaching practice. We use an anticoagulation flow sheet to document key data (e.g., warfarin dose, target international normalized ratio (INR), primary physician and the patient's phone number), which is housed within the patient chart. Results are tracked in HanDbase (a Palm OS database) by the nurse. The day after the INR is drawn, the nurse checks the results and pages the physician, if necessary, to discuss dosage changes and testing intervals. She then contacts the patient to investigate medication and dietary adherence, educates the patient with immediate feedback, and communicates any dosage change and the date that the next INR is to be drawn. Results, changes and phone calls are documented on the flow sheet. The nurse sets Palm date-book reminders for all patients and contacts them immediately if they fail to show for a scheduled INR check.

A more sophisticated analysis is planned, but an initial review of six patients who received warfarin treatment both before and after the nurse-managed program was initiated found that the period during which these patients were lost to follow-up dropped from an average of 14.3 weeks per patient per year to 4.3 weeks per patient per year. All patients had a target INR of 2.0 to 3.0. Patients were out of range for an average of 15.7 weeks per year before the program and 10.8 weeks per year after the program began.

The system had other benefits as well. The nurse, who is present in the practice full time, has taken on considerable follow-up and management responsibilities from the physicians. Phone tag is lessened, and patients frequently reach the nurse on their first callback. Involvement in this program has led to increased job satisfaction for the nurse. Patient education regarding adherence and diet is reliable and consistent. INR values that are suddenly outside the therapeutic range are addressed promptly and appropriately. Patients perceive the practice as competent in this area since they are no longer frustrated by efforts to speak with their physician.

Take-away lessons

To care for patients who require close monitoring and follow-up, utilize your nurses to their fullest potential, with technology as an aid. This allows you to retain ownership and control of the process, improves the quality of care provided and eliminates communication difficulties inherent in disease management programs that use off-site nurses.

8

Bill for it now

*Alan Falkoff, MD
High Ridge Family Practice, Stamford, Conn.*

Cash flow is critical to any healthy business, and medical practices are no exception. Unfortunately, in many practices, it takes weeks or months to get paid for services provided, which can severely affect a practice's ability to grow and prosper.

To optimize cash flow in my practice, I bill for charges as soon as they are incurred through the use of integrated computerization. I use an electronic medical record (EMR) system that develops the charges for a visit at the

Through integrated computerization, you can bill for your services sooner and dramatically improve cash flow in your practice.

same time it generates the documentation. This allows those charges to be sent out much more quickly than waiting for piles of superbills at the front desk to be processed or waiting for transcription to return before we can bill and document properly. In contrast, after my EMR system generates a record for each visit, it automatically sends a charge to the practice management component of my system, which then electronically sends the bills to Medicare, Medicaid and other insurance companies. This cuts claims receivables from weeks or months to 10 to 14 days (in some cases, four to six days).

Although relatively few physicians have adopted this technology, it is readily available. I use Practice Partner (<http://www.pmsi.com>), but there are many other computer systems to choose from. In addition, many clearinghouses will expedite and scrub claims for very low costs. These systems can potentially turn a practice around.

Another benefit of integrated computer systems is that charge capture is maximized; you can get paid better because the system captures every charge (including small charges that offices tend to overlook) and helps you document office visits to their highest level (instead of downcoding your services). Although computerization does have a short period of learning, which can cause a slowdown in an already busy practice, it will markedly increase speed, efficiency and quality in a very short time.

Take-away lessons

Through integrated computerization, you can bill for your services sooner and dramatically improve cash flow in your practice. This will improve your ability to maintain your office, retain quality staff, upgrade equipment and take home a more reasonable income.

9

Stop renting

Annette M. Chavez, MD
Carillon Family Practice, Kettering, Ohio

I was warned not to do it by the administrator of my former group. I was told that I could invest my money in the stock market with greater financial return. I was also told that medical buildings are hard to maintain and sell. But I knew I would spend the rest of my life in Dayton and did not want to lease office space until I retired. I calculated that my four-physician group had spent \$450,000 on rent during the seven years we were together and extrapolated future lease costs of \$2 million for the remainder of my career if we stayed in the same office.

So I started my own practice in a brand new building that I own. Because of a covenant not to compete with my former group, I had to move over eight miles away. I drove around my target area until I found a derelict vacant lot where a restaurant had been torn down. I paid \$87,000 for 1.3 acres on a hill, engaged an architect and a builder, and secured a construction loan and a line of credit for my

Most people don't rent their houses for their whole lives, so why should physicians lease office space for 40 years?

operating expenses. My husband and I put down about \$90,000 of our own money (saved over the years by living below our means). We did our own landscaping and outfitted our office with equipment obtained at auctions and from hospital surplus. I sewed my own exam room curtains and re-covered my exam room chairs (\$10 each). My husband is my office manager and does all the building maintenance, which is minimal as the building is new.

I now practice in a beautiful new office with the patient flow and staff logistics exactly as I had planned. The area in which I constructed my office has turned around, with new retail shops, housing and physician offices locating in this first-tier suburb of Dayton. We now owe \$480,000 on our building and plan on paying it off within 15 years, which will give me the option of practicing part-time at that point. When I decide to retire, I can either sell the building and the practice or lease the office space if I can't find a buyer immediately. For now, I am proud to be the owner of my practice and the building that houses it.

Take-away lessons

Most people don't rent their houses for their whole lives, so why should physicians lease office space for 40 years? If you know you are going to stay put, take advantage of the benefits of ownership. You can deduct your mortgage interest while gaining equity and practice rent-free and (eventually) mortgage-free.

10

Practice what you preach

Michelle May, MD
Phoenix

The treatment of overweight and obesity is a significant challenge confronting society and family physicians today. For me, this was a personal as well as a professional concern. I had yo-yo dieted my way through high school, college, medical school and residency. As a family physician, I gave the usual diet advice to my patients, but most of them didn't seem to fare any better than I had. I felt discouraged and bewildered.

I then realized that my husband and children never dieted and never struggled with their weight. They ate whatever they wanted but rarely more than they needed. There was a fundamental difference in the way they thought about food. In fact, they didn't really think about food at all – unless they were hungry. They simply ate instinctively.

I recognized that the problem wasn't as much about what I was eating as why I was eating. After years of trying to follow the latest expert's rules about food and eating for other reasons, I learned to use hunger to determine when and how much to eat and finally stabilize at a healthy weight. I also learned to meet my other needs and cope with stress in more effective ways than eating. It was nothing short of life changing.

Determined to offer my patients an alternative to ineffective dieting, I met with Lisa Galper, PsyD, an expert in this field, who introduced me to the "non-diet" concept, which is well respected among eating disorder professionals.

I now have patients ask themselves "Am I hungry?" before they eat. This teaches them to recognize when the desire to eat is due to hunger or other triggers (for example, thirst, fatigue, boredom or anger).

Encouraged by the response, I developed a weight management system called Am I Hungry?[®] (<http://www.amihungry.com>). Through eight-week workshops, participants learn to eat instinctively, live a more active lifestyle and balance eating for enjoyment with eating for health.

Seventy-eight percent of participants reported that they ate healthier than before, and 63 percent reported significantly increased activity. Weight loss is somewhat less dramatic than might be seen with a restrictive diet. However, 80 percent of participants lost an average of 0.7 pounds per week, 4 percent maintained their weight, and 16 percent gained weight (an average 0.25 pounds per week). Participant satisfaction is high as evidenced by a remarkable completion rate of 85 percent.

Take-away lessons

Patients who struggle with an ongoing health care problem may require an alternative approach. By asking "Am I hungry?" overweight patients can change the way they think about food and eating and begin to make sustainable lifestyle changes. This approach can also aid physicians who need help practicing what they preach.

11

Practice outside of the box*Andrea L. Brand, MD
Longboat Key, Fla.*

Over a year ago, I found myself out of work on a beautiful barrier island on the Gulf of Mexico. I had moved from New York after a colleague offered me the directorship at his newly purchased medical center on the island. But six months after my arrival, he sold a half interest in the practice to another family physician, who took my job. Unemployed, I decided to look at my priorities (family, freedom, helping people, enjoying the outdoors and making my own decisions). In doing so, I discovered what might be part of the answer to our health care crisis: eliminating the office.

In many practices, as much as 70 percent of collections goes to overhead costs. By lessening that, I could eliminate many of my dislikes about medicine and lower my fees so that more patients could afford to see me.

My big idea was to eliminate the office and reduce my overhead to a medical bag (stocked with a stethoscope, blood pressure cuff, etc.), hand-held computer, cell phone, and marketing expenses (an ad in our weekly newspaper). A local lab supplied me with free Pap test supplies, culturettes and sterile specimen containers, and a local supplier gave me a free nebulizer.

I saw my first patient within one week of losing my job and haven't seen the inside of an "office" since. I wake up to sunshine instead of an alarm clock, and I've had the pleasure of visiting patients in their homes (in one case, a boat).

Insurance, filing claims and Medicare are all gone. There are no accounts receivable or bills. Each patient

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pays me at the time of service, and I fill out a CMS-1500 form for them to file. I see several Medicare patients who have elected to contract with me independently.

I do not do invasive procedures or injections, but about 90 percent of what I did in a traditional office can be done in the patient's home. The practice model works for all ages, from kids to the elderly, and is well received by patients. Since my overhead is low, I keep more of what I earn. This means lower fees for the patient, and everyone wins.

Take-away lessons

We can deliver high-quality health care at a reasonable cost if we strip away all practice overhead that does not add value. Day-to-day family health concerns can be addressed in a simpler way with patient and doctor meeting on common ground. It puts the joy back in medicine.

12

Tame your phone*Charles H. Stern, MD, Michael Reis, MD,
Richard Naser and the family medicine staff
Scott & White Clinic, Waco, Texas*

Our family medicine group recently adopted a modified open-access scheduling system to meet the needs of our growing clientele. Nevertheless, we continued to see the number of patient phone calls and messages increase. Our patients complained of prolonged "hold times" and difficulty reaching an appointment clerk or nurse. Patient satisfaction surveys demonstrated the need to improve our appointment scheduling procedures, phone accessibility and promptness in returning calls.

To do this, we divided our large clinic into smaller teams, each operating as its own practice with direct phone lines to appointment clerks and nurses. Each team has a common room where appointment clerks, registered nurses and physicians work side by side, which streamlines our processes and helps reduce phone call volume (including repeat calls), hold times, length of calls and turn-around time in returning calls. All staff are empowered to address the patient's needs and concerns at the time of the initial phone call. Patients are also provided with direct phone access to other departments (e.g., referrals, business office, radiology) to eliminate unnecessary transfers.

We also instituted a computerized phone message system, which allows the phone clerk or nurse to type messages and send them directly to the physician's computer. This improves the flow of messages and makes them more legible. Each message is directly linked to the patient's computerized chart if information is needed to provide an accurate answer. This limits the need to pull paper charts, thereby saving time and money. The messages are also linked to our pharmacy, which facilitates the processing of new prescriptions and medication refills.

In addition, we educated our patients on our phone policies, providing guidelines for when to contact the office by phone. For example, for medication refills, patients are asked to contact their pharmacy rather than the clinic.

After we implemented these changes, the number of phone calls per month dropped to 293 per full-time-equivalent provider, compared to 398 a year earlier. Hold times and call transfers also decreased. In addition, patients' ratings of our phone access improved. On a five-point scale, with 5 meaning "very good," our patients rated us, on average, a 4.44 for ease of scheduling appointments, 4.05 for ease of reaching a clerk by phone and 4.41 for promptness in returning calls. As patient satisfaction improved, so did staff morale. ►

Take-away lessons

Don't underestimate the importance of your phone. By streamlining your phone access through patient-centric, team-generated operational changes, you will positively affect other areas of your practice, including patient and staff satisfaction.

13

Put eight pregnant women in the same room

*Kathy Trotter, CNM, FNP, Laura Sterling, MD, Carmen Strickland, MD, and Ellen Chetwynd, RN
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About 18 months ago, we got the big idea to pilot group prenatal care visits in our academic family practice. This endeavor looked formidable not only because it is counter to traditional care but also because an academic practice in a state institution is a cumbersome setting in which to negotiate any change. However, after months of planning and pilot groups, it is now an established program.

CenteringPregnancy™ was developed in 1993 by Sharon Rising. As part of the program, women are grouped by due dates and gathered for prenatal visits monthly and then biweekly until delivery. Standard prenatal assessment of each individual is complemented by group interaction and support. Patient education is provided through didactic or discussion formats depending on the material, and support between the group members develops as they meet regularly until delivery. We use Rising's curriculum (<http://www.centeringpregnancy.org>) but tailor it to each group's needs.

Implementing this program required a champion with the energy and willingness to iron out the details of applying the model and to market the concept to administration and clinicians. Other challenges involved explaining the model to patients, educating staff and recruiting nurses to help. Gaining the interest of two family physician fellows as well as the clinic perinatal nurse coordinator proved key to developing a core of willing facilitators and proponents. We also received a March of Dimes grant of \$1,075, which helped with the costs of educational materials, snacks and training of facilitators.

Now in our second year, we are enrolling our ninth group. Patient satisfaction is high with evaluation scores consistently above 9.5 on a 10-point scale. Clinicians have also found it fun and challenging. Although to be more cost-effective we need to increase our group sizes, we believe the popularity of this program will spread as women tell others in the community about it.

Take-away lessons

You can make a difference in your practice by offering innovative choices to your patients. Pregnant women immediately benefit from prolonged contact with each other and their physicians, receiving education and support as well as prenatal assessment. This group model should be marketed as an innovative and patient-centered alternative.

Editor's note: Do you have a big idea that has improved your practice? Send comments to fpmedit@aafp.org. 