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The Leadership Forum

a publication from the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM)

From the Editors

Neda Laiteerapong Elisha Brownfield

By now, our nation will have elected its next president, and we are certain that many of you have been thinking about effective leadership. What will the next four years bring, and what will be the role of GIM? We are pleased to bring you some opinions about the importance of leadership, whatever the future may hold. Our "Leaders in Action" series continues with Neda's interview with Andy Bindman, the director of the Agency for Healthcare Research and Quality. Andy brings us encouraging news about the future of GIM and the importance of ACLGIM's role. In advance of the ACLGIM Summit, keynote speaker Dr. Cathy Lazarus highlights opportunities for internal medicine leaders to advance the educational mission. Finally, Dr. David Nash presents an intriguing perspective on healthcare quality, safety programs, and the importance of leadership engagement on these issues.

We hope that you enjoy this issue of the *Leadership Forum*, and welcome your responses. Neda and I would also like to wish you a happy holiday season, and look forward to sharing news from the ACLGIM Summit in December in our next issue.

—Neda Laiteerapong, MD, MS, FACP,
and Elisha Brownfield, MD, FACP
Editors, ACLGIM *Leadership Forum*

Leaders in Action
An Interview with Andy Bindman

Andy Bindman

Neda Laiteerapong, MD, MS

Dr. Bindman (Andrew.bindman@ahrq.hhs.gov) is director of the Agency for Healthcare Research and Quality, Rockville, MD.

How did you get to be director of AHRQ?

The short answer is someone has to ask you! In my case, Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell called me about a position at the Agency for Healthcare Research and Quality (AHRQ). Frankly, she had me at "hello!"

I did have previous experience working with the department as senior advisor in HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) from 2010 to 2014. I also had a year-long experience as a Robert Wood Johnson Foundation health policy fellow on the U.S. House Committee on Energy and Commerce in 2009-2010 during the passage of the Affordable Care Act. In addition, I fundamentally believe in the agency, which is focused on improving health care quality, safety, equity, and affordability. It's *critical* to have an agency like AHRQ to help support these goals.

As thrilled as I am to be here, the logistics involved was not entirely easy. I had to move 3,000 miles from my family. My wife is extremely supportive, but I had to discuss the impact on our careers and relationship. She is a faculty member at the University of California, San Francisco,

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Leaders in Action

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and it made sense for her to remain there. Ultimately, her support made me feel very secure in my decision to take the position, even though it means being apart for weeks at a time. She and I both knew the opportunity was too good to pass up.

How have the major changes in academic health care had an impact on your decisions as a leader?

I'm hoping to bring my knowledge as a primary care physician who understands the health care system to AHRQ. I am also a health services researcher who understands the goals of academic medicine, and I want to promote the mission of educating the next generation of clinicians, pursuing research, and providing quality patient care. I am working to reinforce these goals at AHRQ.

Dr. John Eisenberg, who was the director at AHRQ when I was a junior faculty member and first learned about the agency, taught me that it can take 18 years for new evidence to change clinical practice. I found this astounding and unacceptable. I want to focus the efforts of AHRQ on decreasing this time and to ensure that the way evidence is translated into practice does not contribute to health care disparities. This should be a shared interest of academic medicine in general. Academic health centers, which are engines for evidence, need to become more effective at translating research findings into constructive changes in clinical practice. To support this effort, AHRQ has developed many online tools (www.ahrq.gov/professionals/prevention-chronic-care/improve/index.html) to help. We are looking for ways to make it easier for practitioners to take full advantage of them.

What do you see as the role of ACLGIM in shaping the future leadership? How can ACLGIM better support leaders?

I have been impressed by the power of the networking opportunities within the ACLGIM. The members have been very willing to share solutions and work together to solve problems as a group. That's something very special about the organization.

The ACLGIM is also an important voice in promoting improvement in translating evidence into clinical practice. AHRQ is seeking to do its part, too. The agency has embarked on an ambitious effort called EvidenceNOW dedicated to helping thousands of small- and medium-sized primary care practices across the country use the latest research to improve cardiovascular risk factors of millions of Americans. This initiative aligns with HHS' Million Hearts, a national effort to prevent 1 million heart attacks and strokes by 2017.

Further, primary care needs to evolve, and there are unique challenges for different sized practices. AHRQ welcomes the ideas and help of ACLGIM's leaders in promoting the movement of evidence into practice. We are seeking ways to speed the movement of best practices to the front lines of care by transforming primary care practices so that they have the capacity to implement evidence to improve quality.

What advice would you give our members as they go through these turbulent times?

My advice would be to stay calm, even in the flurry of daily activity and to trust in your amazing skills as a generalist to solve problems. I believe that general internists with the guidance of leaders in ACLGIM are capable of navigating the challenges of a rapidly changing health care system. Amidst the pressures to change, we shouldn't abandon the commitment to ongoing learning or to forget about the value of evidence to guide us.

I also think this turbulent time provides a tremendous opportunity. The health care system is rethinking the role of the primary care provider as part of a solution to deliver higher quality care to all. It's an important time for primary care providers to demonstrate the role they can play in population management and how their clinical, scientific, and communication skills can contribute to better outcomes for patients.

All this change can contribute to a feeling of lost control. A way to regain control and ultimately improve outcomes is to rely on those things that have always helped generalists to be successful. Step back, take a breath, diagnose the situation and take action with openness to feedback and in a way that is conducive to ongoing learning.

Any last thoughts?

AHRQ is eager to help. We have always had a strong association with the primary care and general internal medicine community. Many of AHRQ's staff are general internists and we are always looking for great people, such as those from SGIM and ACLGIM to join our team. AHRQ is a great place for internists to make an impact on the field.

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Words of Wisdom
Doing the Safety Dance at Graduate Schools in the United States

David B. Nash, MD

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Devoted readers of ACLGIM's *Leadership Forum* are keenly aware that health systems across the United States are struggling for solutions to the persistent issues of unexplained clinical variation, poor outcomes, and rising costs to payers and patients. In recent years, population health has emerged as a broad-based response to these challenges, with quality and safety as a key component.

Despite a decades-long focus on the issue of medical error, the healthcare system's response to the challenge has been mediocre, and according to the *British Medical Journal* medical error is now the *third* leading cause of death, after cancer and heart disease.[1] For years, quality and safety offerings were relegated to occasional 1-2 day conferences or special in-service workshops, which are just not rigorous enough to prepare health care professionals to provide the type of quality care patients expect and deserve.[2]

Formal academic programs in population health and quality and safety are finally becoming available across the country that will not only improve the quality of care for our patients but also lead to new and exciting career opportunities for ambitious mid-career healthcare professionals. Jefferson College of Population Health (JCPH), with certificate and master's degree programs in healthcare quality and safety, is one of six such degree-granting programs in the United States—the others are Harvard Medical School, George Washington University, University of Alabama at Birmingham, University of Toronto, University of Illinois at Chicago, and Northwestern University—with more on the way.

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These programs emerged in response to the infamous 1999 "To Err is Human" report published by the Institute of Medicine (now the National Academy of Medicine) and the patient-safety movement of the past two decades.[3] They have also been fueled by the mandates of the Affordable Care Act to "bend" the healthcare cost curve and to reduce hospital readmissions. Quality and safety programs provide an opportunity for career advancement for general internists and others with a passion to reform the system. Many graduates go on to satisfying careers, including chief quality officers, directors of quality and safety, and vice presidents of medical affairs at their existing institutions or elsewhere.

In a way, you might say that these schools are doing the "Safety Dance," to quote the title of a 1980s song by Men Without Hats, the one-hit-wonder pop group. To those readers of a certain age, the lyrics "we can dance if we want to/we can leave your friends behind" are familiar; "Safety Dance" even made a cameo appearance on the hit medical drama *House* (season six, episode six, "Known Unknowns"). Today, healthcare professionals who are *not* doing the safety dance are the ones who will be left behind if they do not get on the bandwagon and comply with the Centers for Medicare & Medicaid Services' mandated reforms to improve the health of patients and the overall patient experience.

During healthcare quality and safety programs, healthcare professionals learn important methods for improving quality and safety, including low-tech solutions—such as developing new and improved checklists (made famous by Atul Gawande)—and high-tech solutions, such as evaluating technology, electronic medical records, and information systems to support decision-making and workflow within and across healthcare settings. With specific guidelines to reduce central line-associated infections and unexplained clinical variation—and with the mandate to reduce hospital readmissions—the safety bar has been raised. Let's dance!

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Cathy Lazarus

Reflections from the Winter Summit

Keeping the Education Mission Alive

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As financial pressures grow on general internal medicine divisions, it can be challenging to maintain a focus on the educational mission when it does not generate the all-important RVU based clinical revenue. But as in academic divisions, it is frequently the faculty in general internal medicine who provides the leadership for graduate and undergraduate medical education—as program and clerkship directors, key clinical faculty, and leaders for clinical/basic science integration and for hospital programs in quality and patient safety. The following is a brief review of current trends and opportunities that can help support these educational roles:

1. The CLER (Clinical Learning Environment Review) of the ACGME. This review can be used to increase hospital administration awareness of the unique and critical role that residents and teaching faculty play in patient care and quality. If used effectively, the CLER visit and outcomes may be used to negotiate new resources to support residency training. The VA is already a leader in this area with the chief resident in Quality and Patient Safety programs. This year-long program includes a structured national curriculum and group projects along with local mentorship from VA experts in Quality and Patient Safety. There are currently 81 positions at 51 VA medical centers.

2. Federally funded programs to expand residency training positions in primary care. The HRSA-funded Teaching Health Center Graduate Medical Education program and the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) are funding 1,500 new residency training slots in internal medicine, geriatrics, family medicine and psychiatry.

3. Faculty Development. The presentation shared examples of three (3) faculty development programs targeting clinician researchers, medical educators, and clinical leaders that were done for a minimal investment using institutional resources. The research and education scholars programs targeted junior faculty and the clinical leaders program included both clinicians and administrators. All were well received and lead to increased grant funding, publications, and faculty/administrator satisfaction.

Education, including the training of residents and students, and faculty development are important missions for general internal medicine. Resources are limited, but chiefs and leaders can be strategic in leveraging several ongoing trends and opportunities to ensure that education stays alive and relevant; these include national trends in accreditation, partnering with VA leaders, expanding the primary care and geriatric workforce, growing leaders in quality and patient safety, continuing national advocacy, and supporting junior and mid career faculty already present within institutions.