Vol. 9 / No. 4 / Dec 17

The Leadership Forum

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

Neda Laiteerapong Elisha Brownfield

From the Editor
Hello, Forum Readers!

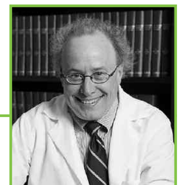
The end of a calendar year is often an occasion for reflection. When thoughtfully applied, reflection can cause leadership growth, especially if used to inform future practice.

This month, we find the contributors of the ACLGIM *Leadership Forum* reflecting on the past and looking forward to a promising future for General Internists. The issue features presentations from the Hess Leadership Institute this past April, and a preview of the ACLGIM Winter Summit coming this month.

You can learn how one author was able to influence leaders effectively, how a hospitalist group redesigned its work to address burnout, and how team-based care improved provider experience and increased patient access. Finally, Laurence F. McMahon, Jr., president, outlines current challenges and opportunities for GIM leaders. There has never been a more pivotal time to be a General Internist.

We hope that this issue will help inform your 2018 leadership year!

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


Laurence F. McMahon

President's Corner
Helping Academic Internal Medicine Address the Future

Laurence F. McMahon, Jr, MD, MPH

Dr. McMahon (lmcmahon@umich.edu) is a professor of medicine at the University of Michigan Medical School. He practices primary care at Michigan Medicine and leads the Division of General Medicine at the University of Michigan in Ann Arbor, Michigan.

The Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) is a diverse body that includes division chiefs (both General Internal Medicine and Hospital Medicine), clinic directors, hospital section leaders, education leaders, residency program leadership, etc. In sum, members of ACLGIM help shape the profile of academic General Internal Medicine across our nation's departments of Internal Medicine.

Our goal in ACLGIM is to enhance the opportunities for peer interaction among the leaders of the various missions of academic general internists. In particular, we believe it is critical to

continued on page 2

President's Corner
continued from page 1

highlight the importance of maintaining the relationship among general internists practicing in different locations in our academic health systems and who share a holistic approach to patients—mindful of their clinical as well as their social/economic issues. This common approach, whether it is occurring in the hospital or in the clinic, distinguishes academic general internists from specialty-focused internists in our nation's medical schools.

Clinical care faces many challenges, including: the development of accountable care organizations, the consolidation and expansion of health systems, the development of new payment models, the creation of advanced medical home practices, and the focus of clinical effort either in the hospital or the clinics thereby creating focused practice models based on location unique in academic Internal Medicine. These reflect a few of an accelerating set of changes in healthcare delivery, financing, and organization. Members of ACLGIM will be leading both the creation of these new clinical models as well as reacting to their dissemination.

The education of medical students and residents is a core focus of academic General Internal Medicine. Understanding how to teach the patient-centered holistic clinical paradigm of General Internal Medicine in the changing clinical delivery and financing environment—in either a clinic or in the hospital—is a key mission of academic General Internal Medicine. Finally, the research focus of academic general internists is also expanding; embracing the typical federally funded large-scale projects, research addressing new educational approaches and technologies, and research focused on quality/safety both in and out of the hospital.

We are excited and challenged by the changes currently taking place and those on the horizon. ACLGIM provides a unique home and resource for chiefs and leaders in our nation's academic departments of Internal Medicine. General Internal Medicine, serving as the bedrock for academic departments of Internal Medicine, is the foundation of all Internal Medicine clinical programs and education, as well as providing leadership to departments of Internal Medicine and medical schools in clinical care, education, care delivery and transformation, research, and increasingly population-based initiatives.

ACLGIM encourages all General Internal Medicine academic leaders; division chiefs, section chiefs, educational leadership, quality/safety leaders, clinic directors, hospital program leaders, research directors, to join with your peers in a membership-led organization, imbedded in the larger SGIM community, whose goal is to enhance the practice, education, and research of General Internists in our nation's academic departments of Internal Medicine.

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Perspectives on Leadership
Creating Urgency and Influencing Senior Leaders

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Valerie E. Stone

As president and CEO of Mount Auburn Hospital, Jeanette Clough has forged a uniquely effective working relationship with the hospital's physician staff, made famous in an oft-cited Harvard Business School case.[1] At the 2017 Hess Leadership Institute in Washington, DC, she shared the steps that she has taken to create and maintain this collegial culture, and how she fosters and sustains urgency around needed change. Jeanette shared in these stories the strategies that chairs and division chiefs have utilized that have been most effective in influencing her and creating a sense of urgency regarding their priorities.

In this session, I also shared the strategies I have found to be most effective in creating a sense of urgency for senior leaders of my hospital as chair of the Department of Medicine. I provided the following paradigm: Let's begin with the assumption that you want to influence a senior leader because there is a "problem" that you want their resources or assistance to "fix." If so, there are several critical first steps before attempting to influence your senior leaders:

1. Clarify the nature and extent of the problem through dialogue with

continued on page 3

Perspectives on Leadership
continued from page 2

affected physicians or patients, and/or surveys and town hall meetings.
2. Choose your battles carefully and strategically. Is this one worth your effort and personal capital?
3. Consider alignment—how well does fixing this problem align with your vision / mission? And, equally important, how well does it align with the goals of the senior leader you are hoping to influence?
4. Communicate and create an awareness of the problem by presenting data and/or stories at division, department, and leadership meetings and by writing about it in departmental (or hospital) newsletters.

I then related the following example: "Shortly after our primary care practices went live on Epic, it became apparent that the largest source of stress for PCPs was not using the new EMR, but rather the need to 'abstract' from the old EMR into the new one." I canvassed all of the practices and found that there was broad consensus about this problem's impact on efficiency and morale. By providing vivid stories of the experience of PCPs (including myself) dealing with this challenge at leadership meetings, I was able to negotiate for substantially more abstracting support for the practices than had been originally budgeted.

I further advised that when you are planning to influence senior leaders, use these steps outlined in John Kotter's book *A Sense of Urgency*[2] as a framework:

1. Bring "the outside in" by citing patient care experiences and/or the "lived experience" of doctors affected by the issue.
2. Behave with urgency every day.
3. Find opportunity in crisis.
4. Appeal to the heart as well as the mind—use "just enough" data.
5. Have a plan for dealing with the initial "No." I consistently "reframe" responses that sound like "NO" and remind myself that I am really being told "not now", or "not that much (money)" or "more specifics are needed" and I focus on modifying my "ask" accordingly.

I believe that these strategies are transferrable to other health systems and can be used to create the sense of urgency necessary to culminate in effective practice change and improved health outcomes.

References

1. McFarlan FW, Elias J. "Mt. Auburn Hospital." *Harvard Business School Case*. 397-083;October 1996. (Revised January 1997.)
2. Kotter J. *A Sense of Urgency*. Boston, MA: Harvard Business Press; 2008.

James Clements

Words of Wisdom: Part I
It's Not You, It's the System: Experiences in Physician Wellness

James Clements, MD

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Two years ago, the joy in our clinical hospitalist workroom was fading. We had gone into academic hospital medicine to help people and educate, but that's not what it felt like. Thankfully, we have a supportive leadership team who listened.

As we learned about burnout together, we worked to redesign our system. We started with a realization that we are all humans who will respond predictably to stimuli. Commitment to create a workplace that was sustainable for *all* of the faculty was key. Group practice wellness surveys allowed us to measure the impact of our changes and identify new areas for improvement. Strategic patient population expansion opportunities and negotiation allowed us to increase our rounders to decompress the days, add swing shift to increase predictable departure time, and improve nocturnal coverage. Work flow analysis has directed us to create a paging reduction program to decrease cognitive interruptions and a position for an administrative assistant for clerical work. We've increased emphasis on compassionate care delivery, created innovative teaching opportunities, and implemented a mentorship program.

In line with recent publications from West[1] and Shanafelt[2], we have been focusing first on the organizational forces that contribute to burnout and have seen decreased burnout rates in our division. Our next opportunity is to expand physician directed interventions to equip ourselves for the stresses that come in the practice of medicine.

Although our system is not yet perfect, it will not stop us from evolving to allow humans to provide compassionate care to other humans who are suffering in a system that doesn't intrinsically cause burnout.

References

1. West CP, Dyrbye LN, Erwin PJ, et al. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *The Lancet*. 2016;388(10057):2272-2281.
2. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med*. 2017 Sep 25. doi: 10.1001/jamainternmed.2017.4340.

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Joanna D'Afflitti

Words of Wisdom: Part II

Improving Provider Experience and Increasing Patient Access through Nurse Practitioner-Physician Primary Care Teams

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Burnout and dissatisfaction are well-documented challenges facing primary care providers. Team-based care is one potential strategy for addressing burnout, but few data support this approach. In the Department of General Internal Medicine at Boston Medical Center, we have created nurse practitioner-physician (NP-MD) care teams using NPs as team "anchors" (the NP Anchor Model) in an effort to address the issues of burnout and job dissatisfaction.

In this model, each care team consists of one nurse practitioner and three to four physicians (based on a ratio of 1 FTE NP: 1.5 FTE MDs). Currently, there are 31 physicians and 10 nurse practitioners participating. The nurse practitioner on the team spends 60% of his or her time in clinical sessions seeing patients on the care team for routine healthcare maintenance, chronic disease management, and urgent care visits. The remaining 40% is divided into two parts: 1) administrative time, which is standard for all clinicians in the practice, and 2) Team Anchor time. The latter is devoted to addressing between-visit patient care, including follow-up of abnormal lab results, telephone calls to check-in with patients about chronic disease management, and outreach to patients who have clinical questions or complex care needs.

Our two principal outcome measures are access to care for NP anchor team patients and experience of NP Anchor team providers. Early results are promising. After implementation of the NP anchor model, time to third next available appointment with a team provider decreased by nearly 20 days. Provider experience reports, measured through anonymous surveys, were also encouraging. Response rates were high, with 24/31 (77%) of MD's and 9/10 (90%) of NP's completing the surveys. Of the MD's surveyed, 79% reported that the NP Anchor model was very or extremely helpful in reducing the burden of work between visits. This does not seem to be at the expense of NP satisfaction; 100% of NP's reported that they were very or extremely satisfied with their current job.

Although still in the early phases of this model, we are optimistic that it has the potential to improve physician and nurse practitioner experience, reduce burnout, and increase patient access to care with a high-level clinician. Moving forward, we intend to expand the model to the entire practice and create a more robust system for measuring outcomes.