

The Leadership Forum

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

From the Editors Hello, Forum Readers!

We have good news, more good news, and bad news for you. The good news—you continue to develop inspiring and innovative presentations and articles on leadership. The bad news—the *Leadership Forum* cannot publish them all!

In this issue, we bring you a synopsis of the E-Consult project pre-

sented at the 2017 Winter Summit and updates from ACLGIM's strategic leadership discernment process. Future issues will cover presentations from the Hess Leadership Institute. The other good news—we are pleased to welcome two new members of our editorial board next issue: Maureen Lyons, MD, St. Louis Uni-

versity, and David Margolius, MD, The MetroHealth System!

Happy Reading and Happy Fall 2018!

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



Neda Laiteerapong Elisha Brownfield

President's Corner From the President: ACLGIM 2018-19 Plans

Carlos Estrada, MD, MS, and Jillian Gann, BA

Dr. Estrada (cestrada@uabmc.edu) is professor of medicine and chief of general internal medicine at the University of Alabama at Birmingham and at the Birmingham VAMC. Ms. Gann (gannj@sgim.org) is the director of leadership and mentoring programs at the Society of General Internal Medicine and the Association of Chiefs and Leaders of General Internal Medicine.

In December 2015, the ACLGIM Executive Committee outlined the following strategic goals and priorities:

- define core community;
- enhance internal GIM advocacy;
- synergize with key SGIM strategic priorities;

- enhance physician wellness;
- deliver value as a member organization.

Thanks to the work by members, leaders, and staff, much has been accomplished in alignment with these

goals and priorities. The Hess Institute and the Winter Summit are examples of well-established leadership development programs that have grown in attendance over the past three years. Since 2014, the LEAD

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Carlos Estrada Jillian Gann

President's Corner

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Program has trained 80 early- to mid-career physicians in leadership skills. ACLGIM developed the WELL Program in December 2016 and has since trained almost 50 individuals in physician wellness. Membership in ACLGIM has grown in response to these valuable opportunities for training, peer-to-peer best practices and advice sharing, and networking.

The range of interests and scope of responsibilities of our members is broad. There is a reason why we entered the profession of general internal medicine—we love to learn, teach, explore, discover, and serve. At the same time, we must be mindful that our work provides value to our constituencies and that we align our resources appropriately to support this work.

In the months ahead, ACLGIM will evaluate and update its strategic priorities. We intend to align our efforts closely with the recently updated SGIM goals and to solidify strategic purpose and priorities to provide the most value to our members.

During the coming year, we will also work to achieve the following goals: a) promote the professional development of leaders, including women and under-represented minorities, b) define a process to match new and prior ideas with strategic goals, and c) celebrate our successes and understand our strengths

to continue delivering value to leaders in GIM.

References

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Gregory Rouan

View from the Hess Institute 2018 Translating Health System Finances to Departments and Divisions: Show Me the Money

Gregory Rouan, MD

Dr. Rouan (rouangw@ucmail.uc.edu) is the Taylor Professor of Medicine and chair, Department of Internal Medicine at the University of Cincinnati College of Medicine and UC Health.

The role of a chair continues to evolve over time and is dependent, to some degree, upon local norms and governance and operational constructs of their academic health center. If leaders are to succeed in these matrixed organizations, they at least need to be informed, adaptable, accountable and collaborative. Drs. Gregory Rouan, Thomas McGinn, and Gary Rosenthal have a combined experience of 20 years as chairs in their respective departments at the University of Cincinnati (UC)/UC Health, Hofstra University/Northwell Health, and Wake Forest University/Baptist Health. They shared their insights regarding effectively working with their administrators and other leaders in their organizations during their Hess Leadership Institution presentation. Dr. Valerie Stone, chair at Mount Auburn Hospital in Boston moderated the session.

Highlights of the session included an appreciation of: (1) differences across academic medical centers and health systems in governance, struc-

ture, reporting relationships, and funds flow and how these differences impact departments and divisions, (2) the evolving roles and purview of the chair in their organizations to include service lines, macro-finances and funds flow, and (3) mission-based contributions of their departments.

Tying the contributions of each department to the missions of their system was noted to be a best practice for each chair. The retention of fellows and residents as new clinical faculty members in the health system, and the reputation of a department's research enterprise were described as a way to bolster the credibility and viability of a health system, contributing to its margins. Aligning with the health system's priority of delivering advanced subspecialty care to the community based upon its affiliation with the Department and College of Medicine, Dr. Rouan described such a best practice from the University of Cincinnati with

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a \$20+ million return on investment since 2013 based upon support of faculty research careers.

Dr. Rosenthal outlined clinical funds flow at Wake Forest Baptist Health based upon budgeted RVUs, hospitalist purchased services, ramp-up funds for newly recruited clinical faculty, and RVU productivity bonus. He also described research funds flow, again based upon salary for faculty and staff on external grants, re-

search salary match, and research start-up and bridge funding. Finally, he outlined the basis for stipends of faculty academic and clinical leadership roles, administrative funds for staff support, chair and division chief start-up funds, and endowment income.

Dr. McGinn described the single unified governance and administrative and clinical leadership structure at Northwell Health. Its approach focuses on a service-line tactic to care delivery and integrated continuum of care and utilizes common, system-wide met-

rics. The system is committed to transparency, consumer- and patient-focus, and team-oriented care. He also described how Northwell is committed to innovation and transformation.

Each related how they became department chair and encouraged attendees to consider this position. They described opportunities and challenges at their respective institutions and closed with a Q&A session. As chair roles evolve, coming together to review best practices will remain an important resource for leaders.

View from the Summit Transforming Medicine through E-Consults

Report by Neda Laiteerapong and Elisha Brownfield



Alpesh Amin



Mohan Nadkarni



Robert Ernst



Scott Shipman

Project CORE (Coordinating Optimal Referral Experiences) is an intervention targeting the patient referral process between primary and specialty care to improve patient access and foster collaboration and communication among physicians. In 2014, the Association of American Medical Colleges (AAMC) received the Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award to work with 5 academic medical centers (AMCs) to implement the Project CORE model. CORE addresses health-care delivery by focusing on the interface between primary and specialty care in an ambulatory setting. Scott Shipman, MD, MPH (director of clinical innovations at AAMC and principal investigator of Project CORE) conducted a survey of programs to see what was being done, and identified E-Consults as a tool to address the rapid increase in the volume of referrals from primary to specialty care, wide variations in referral patterns between physicians at different centers, poor communication and coordination between physicians, and poor access to care.

In 2016, the model was expanded to 7 additional practices and is now at 18 centers across 14 states and has affecting care for about 2 million pa-

tients. In total, 20,000 E-Consults have been completed. At the ACLGIM Winter Summit 2017, Scott Shipman, MD, MPH, Mohan Nadkarni, MD (University of Virginia Medical Center), Rob Ernst, MD (University of Michigan), and Alpesh Amin, MD, MBA (University of California-Irvine) spoke about the program and its accomplishments. The *Forum* brings you this synopsis.

Mohan Nadkarni, MD, University of Virginia Medical Center. (mmn9y@hscmail.mcc)

Process Considerations:

- Benefits for generalists: faster specialist input, less hassle for patients, formalization of curbside consults.
- Benefits to specialists: enhanced access by reducing lower acuity clinic visits, initiating work-up by generalists, and decreased need for specialty follow-up; increased referrals from non-academic sites, fewer inappropriate referrals.

Outcomes:

- 2,995 E-Consults completed in the last year.
- More than 61% of E-Consults completed within 24 hours.

- 86% were completed without converting to an office visit.

Lessons Learned:

- Need for early and frequent re-engagement of generalists.
- Align goals between specialists and program.
- Co-management conferences helpful.
- Need to drive use of the program.
- Need for constant marketing and re-marketing.

Challenges:

- Significant impact to the referral process.
- Few incentives for decreasing referrals and increasing quality in current fee-for-service models.
- Creating buy-in for specialists and PCPs.
- Determining the payment model post-grant.

Future Directions:

There are plans to add new specialties, expand to pediatrics and partners/outside networks. They are considering specialist-to-specialist E-Consults, and developing condition-specific referral pathways that start with E-Consults and

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progress as needed, possibly with telemedicine visits.

Rob Ernst, MD, University of Michigan. (robernst@med.umich.edu)

The program incorporates E-Consults and Enhanced referrals (condition/problem specific structured guides to referral), built-in decision support to improve information capture and transfer, and co-management expectation-setting.

Process Considerations:

CORE implementation began in March 2016 and is now on “wave 4.” Initial steps included the following:

- CORE 101 training.
- Provider engagement.
- IT build and data infrastructure.
- Specialty selection.

Key Elements of the University’s Model:

- EMR-based point of care decision support tools and enhanced clinical workflows.
- Incentives that align PCPs and specialists.
- A culture that breeds collegiality.
- Shared values and mutual respect.

Outcomes:

- E-Consult uptake among primary care - 80%.
- 90% of E-Consults are completed within 72 hours.
- Only 15% converted to an office visit.
- Each consult takes 10-20 minutes, on average.

Challenges:

1. Access issues for various specialties.
2. 25% “inappropriate” consults.
3. Curbside consults continue.
4. Pressure from patients for

specialist involvement.

5. Limited interaction between primary care faculty and specialists.
6. Highly variable primary care referral rates

Future Directions:

The program is now working to revise metrics of performance—moving from fee for service to quality/population health; including uptake of E-Consults or alternative care as a performance metric, right-sizing referral rates, reducing variation in the pre-referral evaluation, and improving communication and coordination between PCPs and specialists.

Alpesh Amin, MD, UC Irvine. (anamin@uci.edu)

Process Considerations: E-Consults do not necessarily have to be EHR-specific. Their team meets weekly for process improvement and/to decide how they will maintain the E-Consult program. Path to success (referred to as “Smart Referrals”):

1. Plan—steering committee; clinical champions.
2. Design—E-Consult workflow defined and template adapted.
3. Build—E-Consult workflow, specialty in boxes, and specialist notification system created.
4. Test—identify failure points and get user feedback.
5. Go Live—done within 5 months.

Outcomes: PCPs and specialists are paid \$50 for every completed E-Consult. If the E-Consult is converted to an in-person visit, neither are compensated.

- 17 specialties are now on board, and 642 E-Consults have been completed.
- 66% of E-Consults completed within the same business day; 80% within 1 business day.

- On average, E-Consults take less than 20 minutes for specialists.
- 86% of patients do not need an in-person visit following an E-Consult.
- Other outcomes include improved access to specialty care, improved practice efficiency, cost savings, growth for referrals, and patient and provider satisfaction.

Q&A:

1. Are patients satisfied with E-Consults?

Shipman and colleagues from UCSF have surveyed patients and found that most are generally satisfied with E-Consults, especially with the convenience. Patients need an orientation in order to understand the purpose of E-Consults and what to expect. The University of Michigan’s template includes: “Is your patient aware they are getting an E-Consult?”

2. What is the financial impact of E-Consults?

The level of coding in specialties has increased for in-person visits. There is a higher ‘bang for the buck’ in a capitated or value-based system. In a fee for service model, E-Consults enable a reduction in low acuity referrals and make room for higher acuity—finding more space for procedures, less “return visits” and more business, and fewer no-shows because of reduced wait.

The programs have found this process to be an excellent platform for building relationships. In fact, a key principle in the CORE model is for AMCs to focus on the culture between PCPs and specialists, which is at least as important as the development of the technology of E-Consults.

If you are interested in the possibility of implementing the CORE model at your institution, you can learn more at www.aamc.org/econsults or by reaching out to Scott Shipman at sshipman@aamc.org.