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The Leadership Forum

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

Neda Laiteerapong

From the Editor

Neda Laiteerapong, Associate Editor

Each spring, ACLGIM hosts the Leon Hess Management Training and Leadership Institute (aka Hess Institute) prior to the SGIM national meeting. This year, the Hess Institute was held on April 23, 2014, in San Diego. Three leaders in General Internal Medicine led an interactive panel discussion to address a timely topic: Leading Academic Medical Centers into Accountable Care Act (ACA) Waters.

This issue features articles by two of the Hess Institute panelists, Dr. Katrina Armstrong of Massachusetts General Hospital (MGH) and Dr. Russell Phillips of Beth Israel Deaconess Medical Center (BIDMC). Dr. Armstrong's article focuses on sustaining and strengthening the academic mission in an era of accountable care, while Dr. Phillips addresses the role of primary care and generalists in a high-value health system.

Our third article in this issue is from our outgoing ACLGIM president, Dr. Stewart Babbott, as he takes a look at the year in review. Dr. Babbott is handing the reins over to Dr. Tracie Collins of the University of Kansas, who we will hear from in future issues.

Looking ahead to next September's *Leadership Forum*, our third Hess Institute panelist, Dr. Laurence McMahon of the University of Michigan, will be featured. Dr. McMahon will address opportunities for GIM research in the ACA era.

Your feedback and discussions help sustain, improve, and develop the *Leadership Forum*. We both welcome and encourage your contributions. Correspondence may be sent to our Editor, April Fitzgerald, at afitzg10@jhmi.edu.

Katrina Armstrong

Words of Wisdom

Sustaining and Strengthening the GIM Academic Mission

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The next decade is a time of substantial opportunity for academic medicine. Although there are many trends influencing this opportunity, three are particularly important.

First, more public attention is being paid to health care than has occurred for many years. Although this attention is sometimes negative and unsettling, it also enables change and leadership opportunities.

Second, the substantial investment in basic research over the past decades has yielded new knowledge and new tools that have major implications for medical care. Although the clinical impact of these advances has been relatively limited to date, the pace of discovery, translation, and dissemination has become sufficiently rapid that many areas of clinical care are likely to be transformed over the next few decades.

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Third, new models of health care financing are being implemented by federal and private payers, driven by concerns about the costs of care and renewed attention to the dysfunctional incentives of the current system. With a focus on patient outcomes and population health, these models provide more opportunity for innovation and for aligning payment with the missions of academic medicine.

Academic medicine is based on an unwritten social contract in which support from the private and public sectors is exchanged for improvements in health and health care. This social contract has been reaffirmed over time as academic medicine has led the country in new approaches to health care, including the creation of a highly trained physician workforce, the formation of clinical research units, and the linkage of basic science investigation to human disease.

We are again in a situation in which academic medicine can reaffirm and strengthen this contract by being the leaders to define the paradigm for high-value health care. Our response to this opportunity requires the best efforts from multiple disciplines, including academic general internal medicine.

The SGIM council outlined the potential contributions of academic general internal medicine to health care transformation in a recent *JGIM* article entitled "Academic general internal medicine: A mission for the future."[1] This article highlighted six key components of health care transformation and areas of focus for GIM: the development and evaluation of new models of coordinated and technologically advanced care, approaches to controlling health care costs, strategies to promote team-based care and a culture of trust and respect, innovation in health care financing, solutions to health care disparities, and support of lifelong learning.

Although these six components of transformation remain major areas of opportunity for GIM, I would like to highlight three additional areas of potential leadership for academic medicine.

(1) *Prevention in populations*: There is little debate about the desirability of prevention, but the necessary incentives, science, and interest have been largely lacking. The ability of providers to link their financial success to maintaining health among populations—and to receive adequate resources to achieve that goal—is a major opportunity to rethink the investment in preventive care. This opportunity also comes at a time when advances in human biology and in social sciences offer new tools for prevention and there is more and more interest in addressing the social determinants of health and health behavior among medical providers and health care systems.

(2) *Critical thinking in shared decision making*: In its essence, the best medical care uses critical thinking to evaluate the potential alternatives for an individual patient and shared decision making to engage the patient in the selection of the optimal strategy. The focus on evidence-based guidelines of the past fifty years has been indispensable for improving quality of care. However, the current pace of technological innovation and the growing use of individualized biologic and phenotypic profiling creates challenges for guideline-based medicine and an important opportunity to revisit the role of critical thinking and shared decision making in achieving high-quality, high-value care.

(3) *Social-value business models for medical advances*: The business model underlying innovation in health care has largely been based upon patent protection, which enables substantial profit from any effective new intervention. This profit-based model is increasingly at odds with the efforts to control health care costs and maximize population outcomes. Academic medicine has long been an engine of invention and innovation. We can be the leaders to define how to focus on transformative, high-value care, and how innovations can be incentivized and rewarded.

The mission of academic medicine is evolving, allowing for tremendous opportunities for leaders in academic internal medicine to transform health care into a system that emphasizes population management, individualized care, and high-value innovations. This opportunity may be time-limited. Never let a good crisis go to waste; now is the time to act.

1. *Armstrong K, Keating NL, Landry M, Crotty BH, Phillips RS, Selker HP, et al. Academic general internal medicine: a mission for the future. J Gen Intern Med. 2013;28(6):845-51.*

Russell Phillips

Words of Wisdom

Primary Care and Generalists in a High-Value Health System

Dr. Russell Phillips is a Professor of Medicine at Harvard Medical School (HMS). He practices primary care at Beth Israel Deaconess Medical Center (BIDMC) and leads the Center for Primary Care (CPC) at HMS in Boston, Massachusetts. Russell_Phillips@hms.harvard.edu

BIDMC is a Pioneer Accountable Care Organization (ACO) that has won shared savings through its Centers for Medicare & Medicaid Services (CMS) Pioneer contract and Blue Cross Blue Shield (BCBS) Alternative Quality contract. About 60 percent of our patients are in "risk contracts." We created an innovative model that aligns both physicians and the hospital in taking risk and earning savings so that both patient and physician will benefit from better care coordination. This creative model has allowed BIDMC to expand market share in Massachusetts.

The HMS Center for Primary Care works to "improve health of our communities through a transformation of primary care practice and education." One of our goals is to redesign our teaching practices into Patient-Centered Medical Homes (PCMH) so that they are optimal sites for education. To build such practices, we formed a primary care "learning collaborative" across 6 HMS hospitals and 19 primary care practices that collectively train more than 500 residents and care for more than 275,000 patients. We are two years into a four year effort in which we will have invested nearly $3 per patient per month—using support from HMS, our participating hospitals, and our malpractice insurer, CRICO—to transform practices. We embarked on this path this because we felt that payment systems would provide ways to support primary care more effectively if we could demonstrate a capacity to change in ways that address the triple aim—high-quality care, improved health, and reduced cost.

In Massachusetts, our early experience with health care reform provides several lessons. We found that by expanding Medicaid, offering subsidized insurance through an exchange, and expanding the capacity of our community health centers, we can provide nearly universal coverage and access to care. However, moving to "global payment" can make it more difficult to obtain the necessary resources for primary care because specialty-driven tertiary hospitals are taking the lead in ACO formation, and there are many demands on these institutions that compete with primary care. The global payment strategy of payers has put them on the sidelines as potential funders for primary care transformation. Finally, we learned that the creation of large ACOs can lead to market dominance and pricing that increases overall costs.

In order to deliver on the promise of primary care as the foundation for a highly effective health system, we need resources, a willing and prepared workforce, engagement of our patients, and to embrace team-based care. We need to create supporting evidence and demonstrate our own capacity for leadership and change. We are on a path of consolidation and integration encouraged by the Affordable Care Act and the expansion of PCMH. Whether ACOs and PCMH will be able to reduce costs remains unclear, but critical to that effort will be the ability to restructure payment in a way that is aligned with value, ultimately defined by improved health outcomes.

The ongoing transformation of care creates opportunities for leadership of newly designed practices, educational and research programs, divisions, and departments. This is a time of great opportunity, and we must find ways to deliver on the promise of primary care. Our patients and our trainees depend on us.

Steward Babbott

President's Corner

The Year in Review

Stewart Babbott, MD, 2013-2014 President ACLGIM, Professor of Internal Medicine, Director, Division of General and Geriatric Medicine, The University of Kansas, Kansas City, KS. sbabbott@kumc.edu

In my previous President's Corner column, I spoke of ACLGIM as a leadership home. My goal over this year has been to solidify a framework for this home through programs, enhanced web based materials, and communication using GIM connect. I'd like to make use of my final President's Corner column to highlight some of the programs and initiatives that add value to our members.

This past year, we continued to offer the ACLGIM site visit program. This unique program is initiated by a call to Kay Ovington in our office. She will help to define how ACLGIM can be of service. Then, ACLGIM

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colleagues who are ideally positioned with expertise to help address the site visit questions are recruited for the visit and to complete a written report. This program has proven very useful and efficient in helping our members assess and advance their programs while benefiting from ACLGIM pooled knowledge and leadership experience. More information is available at www.sgim.org/aclgim-tools—programs/site-visit-consultation.

The ACLGIM Unified Leadership Training in Diversity Program (UNLTD) program is now in its fourth year. Two UNLTD fellows were selected and will be mentored under the steady guidance of Dr. Tracie Collins, our incoming president. The UNLTD program continues to be successful and popular. For more information, please see www.sgim.org/aclgim-tools—programs/leadership-diversity.

Last October, we continued our SGIM and Society of Hospital Medicine (SHM) collaboration with the Fifth Annual Academic Hospitalist Academy (AHA). This was another success and popular event with over 70 participants. Looking forward to next October, early registration is already available for the AHA meeting in Denver, http://www.academichospitalist.org/

The annual ACLGIM Winter Summit "Building the GIM enterprise" held in December 2013 in Paradise Valley, Arizona, offered many informative sessions and discussion around the clinical, education, and research activities of our divisions and sections. Links to the sessions can be found at www.sgim.org/aclgim-meetings/summit.

In April, we held our annual Hess Institute prior to the SGIM national meeting in San Diego. This year's program had a few new dimensions—the establishment of the Fred Brancati Award in memory of one of our beloved past presidents and the first cohort of our ACLGIM LEAD program.

This is the inaugural year of our LEAD program, combining components of the Hess Institute, 3 workshops at the national meeting, and a year of ongoing distance learning with LEAD coaching to facilitate the development of leadership skills among our physicians. I'd like to thank Deb Burnett, April Fitzgerald, and Jen Smith for taking this program from concept to implementation over the past year.

This spring, the Association of Specialty Professors (ASP) Executive committee downsized, which resulted in consolidation of the ACLGIM and SGIM seats into one position. I would like to thank our ASP representative, Eileen Reynolds, for her work through the years to represent the members of ACLGIM.

Finally, I'd like to express my appreciation to all the members of ACLGIM who did so much during the year to organize, speak, write, and collaborate. The involvement of our members on GIM Connect, through committee work, or by participation in one of our programs is how we continue to be such a vibrant organization. I am grateful to all who support us in our office, most importantly Kay Ovington, our Chief Operating Officer, who steps up to each challenge and keeps ACLGIM running smoothly.

It has been my honor and privilege to serve as your president this year, and I thank you for the opportunity to lead such a great organization. Please join me in welcoming our new ACLGIM President, Dr. Tracie Collins.