

The Leadership Forum

From the Editor



April Fitzgerald

This issue of the *Leadership Forum* highlights the Winter Summit held December 6–8, 2015, in Austin, Texas. In keeping with the theme—*Preparing for the New Age of GIM: Capitalizing on Opportunities*—discussions included aligning academic and clinical missions as primary care expands, population health and integration with the primary care mission, service lines meeting the

needs of academic institutions, and opportunities to advance our mission collaboratively to benefit patients and caregivers. ACLGIM would like to thank the presenters at the Winter Summit for graciously offering their words of wisdom for publication.

ACLGIM invites and encourages Chiefs and Leaders in medicine to attend and actively participate in our meetings—the Winter Summit in

December and the Leon Hess Management Training and Leadership Institute held prior to the spring annual SGIM meeting—where they will find useful resources, collaboration, and networking.

As always, we both welcome and encourage your contributions to the *Leadership Forum*. Correspondence may be sent to afitzg10@jhmi.edu.

The Leadership Forum

Words of Wisdom Revisiting Mission Integration in Academic General Medicine

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Katrina Armstrong

The current tripartite mission of academic medicine (patient care, research, and education) can be traced to the 1910 Flexner Report on medical education in the United States. Among the multiple recommendations to improve the quality of medical education, the Flexner Report strongly supported the integration of medical education with universities as well as hospital clinical services, in order to bring scientific discipline to training and clinical practice. Over the next decades, the ideal of a professor who excelled at patient care, investigation, and research became the currency for success at many academic institutions.

However, beginning in the middle of the century, this model of mission integration began to change. Biomedical research increasingly focused on basic science, making it harder for clinicians to succeed in investigation. Clinical pressures increased as the need to generate large financial margins by incentivizing clinical productivity became apparent. The increase in the regulation of graduate medical education created the need for faculty with specific expertise in educational administration. Together, these forces

led to increasing specialization of academic faculty within a specific mission—including the “80-20” model for investigator effort that was linked to increased productivity and widely advocated. As a result, many academic health systems now have high levels of “mission segregation” at the level of people, space, and money.

There are several reasons to consider whether this pendulum may have swung too far. Morale in academic medicine has fallen, in part because of the emphasis on standardization over individual opportunity. The subspecialization of clinical services has been linked to higher costs and care fragmentation. Despite the increase in research dollars and publications, relatively few discoveries have had a clinical or public health impact. Growing evidence suggests that diversity of experience and perspective is critical for innovation. While a segregated system is clearly easier to manage, these challenges have sparked debate about the potential downsides of the current approach and a growing interest in the potential benefits of mission integration. General internal medicine is particularly suited to experi-

ment in this area given its strong commitment to all three missions, comfort with ambiguity, and commitment to innovation.

These experiments can occur at several levels. At the level of the individual faculty member, support for clinicians to develop skills and experience in research and education may increase their ability to sustain engagement in those missions as well as provide connections to sources of salary support. The ability of research faculty to maintain an active clinical practice may be creatively remodeled with shared panels, advanced practice clinicians, and telemedicine. At the division level, incentives can be developed to encourage cross-fertilization including diverse participation in educational activities, inclusion of diverse faculty in research proposals, and integration of clinical and investigative activities. And at the level of the system, space planning can be used to encourage connections across individuals and infrastructure can be developed to support major priorities that reflect mission integration such as translational research, educational innovation, and the learning health care system.

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Thomas McGinn

Words of Wisdom Academic Medicine, Large Health Systems and Service Lines: Where Will We Be in 2016?

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As US healthcare delivery undergoes rapid consolidation, several large healthcare systems are evolving. These “new” systems face acute challenges as they seek to customize and implement optimal strategies for structuring and managing a complex, dynamic delivery system. In response, the service-line model has been adopted by several healthcare systems, especially those growing out of academic health centers. The service-line “solution”, raises a host of new questions: What are service lines? Why have they evolved? How should service lines be connected? Should they be organized by region or tertiary hospital, or should service lines stand alone? Who makes relevant decisions and allocates resources? Should academic leaders in departments and divisions lead or influence service lines across the system? These are all important questions that large health systems are facing.

The nation’s third-largest nonprofit healthcare system, North Shore-LIJ (soon to be Northwell Health), is also one of its most innovative. It is rapidly expanding its reach in the Northeast, one of the nation’s most competitive markets, from its traditional base on central Long Island eastward to encompass the remainder of Long Island, west into Manhattan and New Jersey, and north into Connecticut.

The system includes over 22 hospitals, several nursing homes, a large home care agency, one of the nation’s largest medical groups, an innovative new medical and nursing school, a research institute, the Center for Learning and Innovation, a health insurance company, a major lab servicing other health systems, and more. As Professor and Chair of Medicine and Senior Vice President, and now the service line’s first Executive Director, I helped to establish the service line infrastructure and am continuing to shape its interface with the academic department. This responsibility encompasses all of internal medicine and its related subspecialties with over 600 faculty and 1,500 support staff.

As North Shore-LIJ rapidly evolved through the acquisition of community-based practices and hospitals, it became increasingly urgent to determine how these new practices relate to traditional academic departments and to local hospitals. To create the best possible patient experience and value, we needed to create synergies, eliminate internal competition, reduce redundancy, and enhance communication and integration. To achieve these ends, leadership made a carefully considered decision not to separate the service line and the academic department,

thereby avoiding a counterproductive two-tiered system. Instead, each informs the other: each service line has an executive director and SVP who works closely with the academic chair. (In some cases, those positions are all filled by one person, such as today’s medicine service line under my leadership.) All hires and budgeting decisions within the service line are rolled up into one consolidated budget; the Executive Director signs off on all hires. Blending these processes forces academic departments, service line SVPs, and hospital administration to work together. This interaction moves medical groups, hospitals, and academic departments to build consensus and to truly integrate networks, thereby preparing us for value- and risk-based contracts.

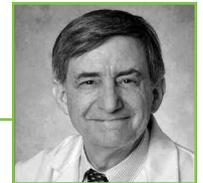
At the annual ACLGIM summit, we discussed the backdrop and continuing evolution of North Shore-LIJ’s service-line model, the interplay of academic departments and divisions with service lines, and possible resulting difficulties and tensions. While there may not be universal agreement on a single solution, it seems clear that traditional academic structures can no longer provide fully integrated, high-value care in the face of pressure by insurers, rapid growth, and the unpredictable evolution of health systems.

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Words of Wisdom

The ACLGIM Work-Life and Wellness Survey: Understanding our Work Conditions, Making Them Better

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Mark Linzer

It started as a hum after a talk at the 2013 ACLGIM Summit. It then developed into a buzz with support by SGIM President Bill Moran, ACLGIM COO Kay Ovington, and ACLGIM Presidents Tracie Collins and Stewart Babbott. It gained momentum with support from Russell Phillips and Harvard Medical School's Center for Primary Care, and culminated in a partnership between Hennepin County Medical Center's Institute for Professional Work-life and ACLGIM to field a national survey on work-life and wellness in GIM in 2015.

Many of us know the serious challenges of practicing in GIM. Time pressure because of short visits, complex patients, and documentation requirements are often seen as the largest problems GIM faces. Other problems include chaotic environments, lack of control of the workplace, and a lack of

clarity in the values of leadership and how those values relate to our daily workloads. For many of us, the workday never seems to end: after a 10- to 12-hour day, 2-3 hours of electronic medical record (EMR) work must be done at home. These work conditions result in high stress, burnout, and turnover, and portend poorly for the future of our discipline. ACLGIM leaders felt it was time to measure and address the conditions to improve the attractiveness and sustainability of our profession.

The ACLGIM Work-Life and Wellness (WLW) project began in the winter of 2015, with a survey of 15 GIM divisions, and concluded this fall with a second wave of 7 divisions. Close to 1000 general internists, both primary care and hospital-based, were surveyed in the two waves, with a combined response rate over 50%.

The 10-item mini Z survey (for Zero Burnout Program) was used to measure key work-life factors (stress, burnout, chaos, control, values, teamwork, time pressure, and EMR work at home), as well as stressors and solutions. Data were returned to division chiefs through a "chief's packet" containing their own division's data compared with national summary data, a list of potential interventions for their specific stressors, and suggestions for leveraging data with department chairs for resources, flexibility, and understanding.

Next steps will include preparing an abstract for the annual SGIM meetings and writing a manuscript for submission. These products will provide evidence for policy recommendations to make GIM a rewarding and sustainable career for all of us and for general internists for years to come.

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T. Shawn Caudill

Words of Wisdom Service Lines to Meet the Needs of an Academic Institution

Dr. T. Shawn Caudill is a Professor of Medicine and Chief, Division of General Internal Medicine and Women's Health, at the University of Kentucky College of Medicine in Lexington, Kentucky. Tscaud1@uky.edu.

General internal medicine (GIM) divisions provide essential clinical services for their academic institution including primary care for the local community, contributing to the local safety net, and access to their institution's health plans. They traditionally provide essential educational services such as teaching medical students, allied health professionals, and residents through continuity clinics, small group teaching, and core lecture presentations.

While these traditional GIM roles are valued by parent institutions, specialty service lines such as transplant and cardiovascular often receive higher financial reimbursement and more support. At the University of Kentucky (UK), we sought ways to improve what we were already doing and to move beyond the traditional GIM role to increase our divisions' value to the medical center by developing general medicine service lines to satisfy unmet needs of the institution.

Our GIM division collaborated with hospital leadership and service-line specialists to identify our opportunities. Two areas emerged: support for managing complex patients who were referred to specialty services (inpatient and outpatient) and increased access to primary care.

On the inpatient side, specialty hospitalist service lines were developed, including hospitalist teams for cancer care, co-management of orthopedic patients, and a soon to be launched hepatology co-management team. The GIM hospitalist service grew from four teaching teams in a single hospital to fourteen services staffing two hospitals, including non-teaching services and night coverage.

In the outpatient setting, we implemented collaborative service lines for the GIM ambulatory practice. The transplant service medical director works collaboratively with the GIM division's weight management team to improve obese patient weight loss, which is required for approval for renal transplantation. GIM also recently began working on a collaborative co-management clinic to provide non-cardiac care for ventricular assist device recipients in the cardiovascular service's heart failure clinic.

Working closely with the Family and Community Medicine Department and General Pediatrics we sought to improve traditional primary care access for new patient demand generated from local community growth, expansion of Medicaid, and growth of university health plan enrollment. Increased resident class

size and resident continuity time required additional GIM faculty practice expansion.

We also sought to improve non-primary care access. Our division repurposed provider FTE to implement an open-access schedule that increases the availability of short-term appointments to the GIM clinic. The open-access model allows discharge follow-up to hospitalists' patients and thereby can reduce institutional length of stay, improve the transition of care, and avoid reimbursement penalties. The clinic model also provides access for patients presenting to our Emergency Department (ED) with non-emergent conditions and thereby reduces ED utilization and unnecessary admissions.

Many centers are developing specialty service lines to provide individualized care of their patients, to improve quality and efficiency, and to avoid reimbursement penalties. GIM will always provide essential primary care and educational services for their academic institutions. We are well positioned to work collaboratively to develop unique GIM service lines that meet the needs of their academic institution and increase both their visibility and value to the overall health system.