

# The Leadership Forum

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



April Fitzgerald

## From the Editor

The ACLGIM Leon Hess Management Training and Leadership Institute (aka Hess Institute) occurs each year just prior to the SGIM annual meeting. This past April at the Hess Institute, three leaders in General Internal Medicine led an interactive panel discussion to address the topic, Leading Academic Medical Centers into Accountable Care Act (ACA) Waters.

The June issue of the *Leadership Forum* featured articles from two of

our three panelists discussing ACA impact on the academic mission and primary care. This September issue rounds out the ACA discussion by featuring our third panelist, Dr. Larry McMahon of the University of Michigan, addressing opportunities for GIM research in the ACA era.

Accompanying Dr. McMahon's piece in this issue is a "Perspectives" written by a first-year medical student who finds medical school to be full of

potential leaders. Also timely and applicable to the ACA changes is our third column, a nice summary of a Harvard Business Review article about leading in times of change.

Your feedback and discussions help sustain, improve, and develop the *Leadership Forum*. We both welcome and encourage your contributions. Correspondence may be sent to [afitzg10@jhmi.edu](mailto:afitzg10@jhmi.edu).

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## Words of Wisdom

### Affordable Care Act: Opportunities for General Internal Medicine Research

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Larry McMahon

One area of the Affordable Care Act (ACA) that hasn't received much attention is the research opportunities afforded to academic General Internal Medicine (GIM). A principal theme of the ACA, value-based purchasing, presents potential research opportunities for academic GIM.

Value-based purchasing under the ACA has three principal areas of focus: hospital, physician, and health

system. Of the three, the most robust is hospital value-based purchasing, with major programs attempting to enhance the value of care for Medicare beneficiaries.

**Several important issues are worthy of further research by members of our society.**

### Hospital Value-based Purchasing

There are four hospital-based purchasing programs. Several important issues regarding these programs are worthy of further research by members of our society.

*The Hospital-Acquired Condition Reduction Program*—denies payment for selected hospital-acquired conditions.

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**Words of Wisdom**  
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The program will decrease total Medicare payment by 1% for all hospitals in the top quartile of hospital-acquired conditions using a “total hospital acquired conditions score.” Each hospital’s score is determined by the sum of two domains. The first domain (35% of total) uses the AHRQ patient safety indicator composite 90 (PSI 90). The second domain (65% of total) uses the CDC’s national health safety network measures for such hospital-acquired conditions as central-line-associated bloodstream infection,

catheter-associated urinary tract infection, same-site surgical infections, etc. Potential areas for research include the validity of the scores at the hospital level, the different “special populations” to which the scores are applied, the need for more sophisticated risk-stratified scores, and geographic segregation of hospitals and populations affected by this program.

*Hospital-based Quality Reporting Program*—a program in which hospitals receive a penalty if they do not report specific quality indicators related to such things as acute myocardial infarctions, heart failure, surgical care, mortality, as well as survey-based measures related to patient satisfaction, immunization rates, etc.

*The Hospital Value-based Purchasing Program*—a program in which the measures reported in the inpatient quality reporting system are then used to rank hospitals in terms of their quality. The hospital inpatient quality reporting system has grown from a starter set of 10 quality measures in 2004 to the current set of 72 quality measures. These measures are used to redistribute 1 to 2% of Medicare payments.

*The Hospital Readmission Reduction Program*—will reduce hospital payment for excess readmissions from 1% of base operating payment of fiscal year 2013 to up to 2% of payment in fiscal year 2014. While currently focused on three patient groups – heart attack, heart failure, and pneumonia – the expectation is that this program will expand to include other types of readmissions. Potential areas for research include how to determine whether readmissions are justified, which populations are most likely to be readmitted, the influence of non-hospital factors. For example, patient sociodemographics, social support, and disease severity are all important factors that may affect readmissions and present research opportunities.

reporting system identifies clinical quality metrics such as the control of high blood pressure, LDL-C screening, and the attainment of lower LDL-C, preventive care and cancer screening, etc. Beginning in 2015, payment adjustments are made to eligible providers who do not provide quality measures for covered professional services. Critical research questions include the validity of these “quality” measures, their applicability to subsets of the population, the interaction with patients’ other chronic conditions, and their appropriateness in different practice settings.

**Members of SGIM ... are uniquely suited to tackle the special challenges afforded by this new law**

**Health System-based Value-based Purchasing**

The final value-based purchasing focus is actually the health system itself. The development of accountable care organizations are designed to create incentives for healthcare providers to work together, to lower the growth of healthcare costs, to meet standards of quality of care, and to share savings with Medicare. While laudable goals, many of these have not been rigorously assessed. Lessons from the more formal HMO organizations in the 1990s identified the difficulty in reaching some of these goals, especially given that the association of patients with healthcare providers in accountable care organizations can be tenuous and is only known retrospectively.

In sum, these ACA value-based paradigms to decrease cost, limit unnecessary care, and improve quality raise critical research questions. Members of SGIM with expertise in special populations, disease management, clinical risk stratification, and clinical economic analysis, as well as skills resident and medical student teaching and patient communication, are uniquely suited to tackle the special challenges afforded by this new law and its sweeping vision of value-based purchasing.

**Physician-based Value-based Purchasing**

An additional ACA-associated value-based purchasing program is focused on physicians. The physician quality

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Jacob Light

## Perspectives in Leadership

This Leadership Forum “Perspectives” article highlights a medical student’s perspective on leadership. Written during his first year in medical school, the author, Jacob Light, describes the importance of promoting a pro-social environment which integrates each person’s strong individual abilities into a cohesive team working collegially. We welcome submissions from leaders and followers, both physicians and staff members. Please send your submissions for Perspectives in Leadership to [afitzg10@jhmi.edu](mailto:afitzg10@jhmi.edu).

### Leading among Leaders: Taking on Leadership as a Medical Student

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When you put yourself to the task of applying to medical school, the concept of leadership quickly reveals itself not just as a recommended quality for candidates, but as a prerequisite for admission. “What have you done to demonstrate leadership? In what activities have you taken the role of a leader? How have your experiences influenced your ability to lead?” Questions like these are ubiquitous in application essays and interviews. It is hard to ignore the fact that medical students, putative physicians-to-be, are expected to be leaders, and as such, that they have gone to great lengths to demonstrate their leadership qualities. But this begs a fundamental question about leading as a medical student: how does one lead among so many leaders?

In my experiences as a medical student, that question is difficult to answer. We medical students often assume ourselves to be leaders. We believe our ideas to be critically important, our communication skills to be top-notch, and our capacity for organization and persua-

sion to be highly developed. After all, how else did we get where we are? However, as I have interacted with classmates in collaborative settings, I have found that these assumptions can often lead to conflict and uncertainty. Is it simply the strongest personality that becomes the de facto leader? If I disagree, am I better off doing the task on my own? Or perhaps, since there already are so many “leaders” in the room, maybe I should disengage and let others take over? The result of such uncertainty is often to default to autonomy and independence, not cooperation and unified direction.

At a time when medicine is moving so strongly toward team-based care and collaboration, it is essential that we reevaluate our assumptions about leadership and acknowledge our need to carefully and thoroughly develop skills that can be effective at creating vision, promoting teamwork, and aligning people in a shared direction. A leader in medicine must integrate the myriad talents around him or her, aware that opin-

ions will often be strong and dissent commonplace. Shifting thinking from “How can I assert my leadership?” to “How can I promote a social environment in which communication is open, goals are clear, and team members’ unique contributions are valued?” is the first step toward ending the illusion of the leadership we assume to have and creating the real and effective leadership we want to embody. Leading among leaders means having a strong ability to negotiate, knowing that negotiation demands different strategies at different times. It means finding creative solutions, or perhaps even more importantly, finding others with creative solutions to adopt into the team, aiming to stay on top, if not one step ahead, of the rapidly changing and vitally important field that is medicine. The sooner we medical students incorporate active appreciation and development of leadership skills such as these into our already multifaceted medical education, the better equipped we will be to lead, even in a field full of leaders.



Minal Kale

## Harvard Business Review Corner

*Leading Change, Why Transformation Efforts Fail* by John Kotter, Harvard Business Review, January 2007

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The United States healthcare system is undergoing a structural transformation that is unparalleled in its scale and scope since the inception of the social health insurance program, Medicare. Accountable care

organizations (ACOs) represent a significant shift in how physicians are organized and reimbursed. Successfully ushering in the changes associated with ACO organization and delivery will require significant leadership that

avoids potential missteps. In his article, *Leading Change, Why Transformation Efforts Fail*, John Kotter outlines eight critical success factors for change.

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## Harvard Business Review Corner

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- 1. Establish a great enough sense of urgency.** Kotter proposes that the most successful transformation efforts begin with a purposeful and dramatic communication of the opportunities (or crisis) as an impetus for employee buy-in and motivation. In the case of the ACO creation and operation, GIM leaders must effectively communicate the ACO quality metrics that will be measured. Conveying the quality metrics information, the opportunities for improved patient care management, and the possible revenue implications for primary care physicians will help relay the urgency in order to generate momentum for behavioral change.
- 2. Create a powerful enough guiding coalition.** A successful transformation requires a leader who actively supports the change, and it also requires creating a powerful guiding coalition. A coalition should bring in members from outside the normal hierarchy. For example, a medical coalition may bring in nurses, administrators, informaticians, stakeholders, and physicians.
- 3. Create a vision.** A successful guiding coalition creates a vision or picture of the future that can be easily communicated. A vision

### John Kotter outlines eight critical success factors for change.

should be grounded in the reality of the changes and should not include extraneous details. It should be understandable to everyone, including physicians and patients.

- 4. Communicate the vision.** Kotter advises that every possible channel, including newsletters and meetings, should include messaging that broadcasts the vision of transformation. It is important to “walk the talk,” and he advocates that words and deeds together create the most effective message.
- 5. Empower others to act on the vision.** Look for and get rid of obstacles to change; encourage nontraditional ideas and actions. In the primary care setting, this might involve encouraging team-based mini-demonstration projects or quality improvement initiatives that are in line with the goals of the ACO.
- 6. Plan for and create short-term wins.** Short-term goals are necessary for sustaining momentum and boosting the credibility of the transformation

process. For example, monthly ACO quality metric report cards can serve to maintain a sense of urgency and can also highlight discussion among staff about improvement opportunities.

- 7. Consolidate improvements and produce still more change.** Leaders should avoid declaring victory too soon and should use the momentum and credibility gained from short-term wins to tackle bigger systems and structures that have yet to be incorporated into the transformation process.
- 8. Institutionalize new approaches.** Kotter suggests that transformation will be truly successful only if it is rooted in overall institutional cultural changes and behaviors. To that end, changes that are associated with ACO creation must be connected to overall performance improvement to demonstrate that new approaches, behaviors, and attitudes have helped.

The creation of ACOs provides primary care physicians the opportunity to improve patient care and also offers opportunities to practice important leadership skills. Using Kotter’s eight principles could provide a framework for a less disruptive transition into this new healthcare world.