Leaders in GIM: Moving from Vicious to Virtuous Cycles

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UCSF School of Medicine
SGIM ACLGIM
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Abundance
Unraveling of the Flexner triple threat
Scarcity
Sendhil Mullainathan
Eldar Shafir

Scarcity
Why having too little means so much

“The finest combination of heart and head that I have seen in our field”
Daniel Kahneman, author of Thinking, Fast and Slow
Tunnel Vision
Dysfunctional Vigilance
Hoarding
Bandwidth Tax
Scarcity in GIM
Need more RVUs
Must see more patients
No time for academics
Faculty are unhappy
Faculty Leave
Budget is bad
Vicious Cycle
Patients Leave the practice

Budget is bad

Cut Support Staff

Phones don’t get answered

Appointments aren’t made

Patient satisfaction decreases

Vicious Cycle
Faculty are unhappy

Budget is bad

Need more RVUs

Must see more patients

Faculty Leave

Scarcity Elements

No time for academics

Vicious Cycle

Vicious Turn
THE ROLE OF GENERALIST LEADERS IS TO CONVERT VICIOUS INTO VIRTUOUS CYCLES
Improve Health and Reduce the Burden of Suffering from Disease

Start with Virtue
Unity of Purpose

- Patient Care
- Teaching
- Research
- Institutional Support
- Community Service
- Staff Satisfaction
- Professional Development
Open the Tunnel
Prototype New Approaches

From
Pay by RVU
Cut Costs
Clinical Teaching

compensation
Fiscal management
education

To
Performance Management
Invest
Workplace Learning

Cut Costs
Clinical Teaching
Pay by RVU
**Performance Management**

![Adapt Performance Management](image)

| Sample Modifications to Improve the Value Basis for Relative-Value Units (RVUs) in Cardiology.  
<table>
<thead>
<tr>
<th>Activity</th>
<th>Current Medicare Work RVUs</th>
<th>Proposed Value-Based Modification</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit</td>
<td>Smothing cessation counseling with documentation of target quit date</td>
<td>1.0–3.2</td>
<td>4.0–6.4</td>
</tr>
<tr>
<td></td>
<td>Positive reinforcement of tobacco-free status and relapse-prevention counseling within 30 days after smoking cessation</td>
<td>1.0–3.2</td>
<td>4.0–6.4</td>
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<tr>
<td></td>
<td>Initiation of a new medication supported by class I guideline recommendations for a diagnosis of heart failure, coronary artery disease, or atrial fibrillation</td>
<td>1.0–3.2</td>
<td>2.0–6.4</td>
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<tr>
<td>Population management</td>
<td>Supervision of a telephone-based care-management program for patients with high-risk heart failure or coronary artery disease (credited quarterly, per 50 patients enrolled)</td>
<td>0</td>
<td>20.0</td>
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<tr>
<td></td>
<td>Supervision of a quality-improvement program to reduce stroke risk and manage bleeding risk among patients with atrial fibrillation, using evidence-based care (credited quarterly, per 50 patients enrolled)</td>
<td>0</td>
<td>20.0</td>
</tr>
<tr>
<td>Procedures</td>
<td>Stenting</td>
<td>ST-segment elevation myocardial infarction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not otherwise specified</td>
<td>12.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Door-to-balloon time &lt;60 min</td>
<td>12.6</td>
</tr>
<tr>
<td>Chronic stable angina</td>
<td>AUC score of 7, 8, or 9 and conducted in catheterization laboratories with an approved AUC auditing process</td>
<td>11.2</td>
<td>14.0</td>
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<td>AUC score of 4, 5, or 6 and conducted in catheterization laboratories with an approved AUC auditing process</td>
<td>11.2</td>
<td>5.6</td>
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<td></td>
<td>AUC score of 1, 2, or 3; no AUC score documented; or conducted in catheterization laboratories without an approved AUC auditing process</td>
<td>11.2</td>
<td>2.8</td>
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<tr>
<td>Implantation of cardioverter-defibrillator</td>
<td>AUC score of 7, 8, or 9 and conducted in electrophysiology laboratories with an approved AUC auditing process</td>
<td>15.2</td>
<td>19.0</td>
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<td>15.2</td>
<td>7.6</td>
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<td>AUC score of 1, 2, or 3; no AUC score documented; or conducted in electrophysiology laboratories without an approved AUC auditing process</td>
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* Guideline and appropriate-use criteria (AUC) recommendations are developed by the American Heart Association and American College of Cardiology in association with other professional societies (www.cardio.org/science-and-quality-practice-guidelines-and-quality-standards.aspx). Class I guidelines are supported by the highest level of clinical evidence (or expert consensus in lieu of evidence). The AUC method was developed by RAND and the University of California, Los Angeles, to foster a hierarchical approach for rating the appropriateness of care for commonly encountered clinical scenarios. AUC scores range from 1 to 9, with higher scores indicating greater levels of appropriateness. Work RVUs are major determinants of physician remuneration in many payment systems. Note that the RVU values and proposed modifications are for illustrative purposes only. Additional RVU adjustment factors are applied to fee-for-service payments, and any value-based modifications would ideally be determined in a methodologically rigorous fashion.
Sample Modifications to Improve the Value Basis for Relative-Value Units (RVUs) in Cardiology.

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<tr>
<td>Door-to-balloon time &lt;60 min</td>
<td>12.6</td>
<td>25.2</td>
<td>+100%</td>
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<td>11.2</td>
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<td>−50%</td>
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<td>AUC score of 1, 2, or 3; no AUC score documented; or conducted in catheterization laboratories without an approved AUC auditing process</td>
<td>11.2</td>
<td>2.8</td>
<td>−75%</td>
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Invest
Workplace Learning: A Community of Practice

Time, Engagement Trust, Collaboration

Learners

Leaders

Patients

Take Steps to Turn Lurkers into Learners

Longitudinal, Sequenced, Authentic Roles
Work Place Learning Experiences

- Med 1a: Systems Improvement
- Med 1b: Systems Improvement
- Med 2a: Systems Improvement
- Med 2b: Systems Improvement
- Med 3a: Systems Improvement

- Patient Encounter Skills
- Patient Encounter Skills
- Patient Encounter Skills

a and b represent different longitudinal microsystem assignments

Turn Burden into Benefit
I think I've found a way out of here.

\[ v_e = \sqrt{\frac{2GM}{r}} \]
The Ultimate Virtuous Cycle
Physical Signs.—Dilated impulse, weak muffled sounds. Dilatation may be accompanied by a murmur, and the heart sounds may be absent. The pulse is small, weak, quick, and intermittent. On auscultation we hear emphysema, or gurgle rhythm. Murrays formerly present may disappear and murmurs may set in and disappear as the heart grows stronger to relative insufficiency, not to valvular lesion. One of the more common dilatations is an irregular and intermittent pulse.

of the thorax. Dilatation are often due to overexertion and alcohol, smokers.

A sense of distress is felt and a feeling of dyspnea, will be present. The latter may reassert itself on the slightest exertion or "wind broken."

Dilatation of the right heart results in an increase in the size of the heart, which may extend below the costal margin. The heart may be seen through the skin in the second and third intercostal spaces. The management of circulatory failure will be considered in the chapter on Valve Disease.

In acute dilatation from any cause, the following symptoms are associated:

ACUTE CIRCULATORY FAILURE AND HEART COUPLING

A sound and a damaged heart, due to direct injury, embolization, or hemolytic shock, may be present.