

The Leadership Forum

*an ACGIM publication for leaders in
academic general internal medicine*

*"A community is like a ship, everyone
ought to be prepared to take the helm."*

— Henrik Ibsen

Leadership in a Time of Crisis: A Natural Role for General Internists

Karen B. DeSalvo, MD, MPH, MSc, *Chief of General Internal Medicine and Geriatrics, Vice Dean for Community Affairs and Health Policy, Tulane University School of Medicine*

Three years have passed since August 29, 2005 when record-breaking Hurricane Katrina slammed into the gulf coast of the United States launching a series of catastrophic levee failures. That event led to widespread flooding in New Orleans and left 80% of the city underwater with ordered mandatory evacuation lasting as long as four weeks. The flooding led to unprecedented destruction of the infrastructure across every sector—from sewerage to education to healthcare. It crippled healthcare delivery—leaving not a single hospital or ambulatory facility able to function in the city's core, including the major academic training centers of Tulane and Louisiana State University.

This crisis profoundly impacted our world (and our world view) and created a prolonged period of crisis. The experiences and lessons learned will forever change us and have altered my perspective on the world—particularly the academic world. As one would expect, there are lessons related to emergency preparedness. Unexpectedly, we learned about the complexities and flawed underpinnings of the health sector and policies that have profound effects on caregiving. When you are faced with recreating an entire system from scratch, you gain a great respect for its intricate workings.

However, I have had the unique opportunity to observe many rise to

the occasion, displaying remarkable leadership during our time of crisis. Originally I think I assumed that, in a crisis, conventional leadership structures and styles would hold up. In the chaotic environment of that acute crisis (plus the chronic aftermath that has followed for the past three years). I have been struck by how quickly traditional markers of academic "leadership" fell short in addressing the response, recovery and rebuilding needs that result from such a disaster. Though there certainly were a few examples of the success of the more conventional approach, overall the rules completely changed. This led to personal qualities and abilities as the determinants of successful leadership, rather than official rank.

Much has been written about essential leadership qualities during crisis and there are many traditionally identified qualities associated with strong leadership during a crisis. There is no doubt that preparation matters. An understanding of your assets, partners and revenue streams will give you the leg up. You must be able to communicate with your team, which mostly means having good contact lists and redundancy in systems. But, while there were certainly exceptions to the rule, in my view those who displayed extraordinary leadership in the post-Katrina time have the overriding qualities that can

be summed into a single term: "general internist".

Whether by nurture or self-selection, it has been clear to me that general internists seem uniquely suited to provide leadership in a time of crisis. We have the qualities and approach to problems that make us more comfortable and (frankly) more useful in a crisis environment. In large part, this is related to our comfort addressing complexity. We are also able to work in cooperation with other members of the professional team, with patients, and with the rest of the complex health sector. We are inherently collaborative, but capable of making the final decision and taking responsibility for implementation and result. We are comfortable with collaboration, but willing to be decisive. We think at the systems level and are ready and willing to respond and rework our tactics when those systems are rapidly changing.

It is worth noting that my models of this crisis leadership from the Katrina Disaster do not rest solely with faculty I observed in the past three years. Indeed, I continue to be most awed by the students and residents

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who stepped into the void. For example, I watched with admiration as a small group of our medicine/pediatrics residents stepped into fill the void in September 2005 to care for people left behind in our city, as well as first responders seeking to help them. These residents saw need, cobbled together resources and set to work. Most impressively, they were highly successful, serving about 10,000 people at their makeshift sites across a period of about three weeks. In point of fact, they created the largest care network in the city from their own imagination and will. Scores of our other house staff joined in. They never questioned or looked back, only forged ahead driven by what they knew to be the right goal.

And, they have gone on to become some of our best young general medicine faculty.

Crisis comes in many forms—natural, economic and man-made. Not everyone will need to endure a credible, severe event, but all of us will be faced with the ongoing crises of our changing world and broken health sector. The experiences surrounding

Hurricane Katrina have taught me many things, but one key lesson is that general internists are uniquely suited to leading in crisis presented in mega-disasters, as well as everyday needs of our patients.

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Patient-Centered Medical Home (PCMH) to be Discussed at Chiefs' Summit

David N. Rose, MD

The third annual "Chiefs' Summit," sponsored by ACGIM, is taking place this month at the Sanctuary in Paradise Valley Arizona. Patient-centered medical home is one of the two topics to be discussed. Participants will be reviewing these models and their implications for academic practice redesign, public policy, financing of primary care, and the research agenda. The PCMH is a care model that seeks to strengthen the physician-patient relationship by replacing episodic care based on patient complaints and illnesses with coordinated care and a long-term healing relationship. It is intended to improve health outcomes, enhance patients' involvement in their care and reduce avoidable healthcare costs through more efficient use of resources.

The concept is described in the Joint Principles of the Medical Home by the primary medical care societies, the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association. Central to these principles is each patient's ongoing relationship with their personal physician—leading a team that takes collective responsibility for each patient's healthcare needs and (when necessary) arranges for appropriate care with other qualified caregivers. A medical home typically has enhanced access that may include expanded hours and open scheduling clinic hours, easy communication, and staff that are trained to optimize each patient's chronic disease self-management skills and coordinate and integrate each patient's healthcare services.

The National Committee for Quality Assurance (NCQA) offers standards to

identify primary care practices that function as PCMHs and now has a program to recognize three levels of designation: basic, intermediate and advanced. The standards assess practice care in access and communication, patient tracking and registry, care management, patient self-management support, test and referral tracking, performance reporting and improvement, and communications.

However, this model does not place the patient's personal physician in the role of gatekeeper and patients may see other physicians of their choice (including specialists and subspecialists). Even so, the care model is constructed to encourage and reinforce the patient to first contact their care team for treatment needs and serve as a trusted source of information and advice regarding any required treatment outside of the PCMH.

The major primary care physician groups and the NCQA advocate a payment plan that combines the traditional fee-for-service for office visits with a monthly care coordination payment (risk-adjusted for illness complexity) and a performance-based component that recognizes achievement of quality and efficiency goals. The care coordination component should reflect the level of the practice's service capability based on the PCMH recognition process.

Public and private sector demonstration projects, including the three-year Medicare Medical Home Demonstration Project are studying the model's effect on health outcomes, patient satisfaction, and costs and reimbursements. Coalitions of payers, employers, governments, clin-

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 ician organizations, academic institutions, and consumer advocacy groups are in the start-up stages of pilot pro-

jects. The other topic to be discussed at the Summit will be issues around transitions of care, recognizing that hand-offs between varying care-

giveres is essential. In upcoming Leadership Forums, outcomes of the Summit will be discussed.

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Perspectives in Leadership

—Through the Eyes of a Medical Student

This is the first Leadership Forum “Perspectives” article highlighting leadership as seen through the eyes of a follower. Written by a second-year medical student at Johns Hopkins, the author finds leadership displayed in an attending with whom she interviewed but who does not have a formal role to act as the student’s leader. This em-

phasizes the fact that physicians act as leaders on many levels, regardless of official job descriptions.

We welcome submissions from leaders and followers, both physicians and staff members. Please send your submissions for **Perspectives in Leadership** to Dr April Fitzgerald at afitzg10@jhmi.edu.

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Leadership—Through the Eyes of a Medical Student

Beth Catherwood

“So, what made you want to become a doctor?” I felt well prepared for this question, but never dreamed my medical school interview would initiate a series of meetings that would help me survive my first year. In reply, I discussed with Dr. Sheila West (a professor of ophthalmology at Johns Hopkins) my motivations, aspirations, and goals for the upcoming four years. Later, after school had begun, she contacted me to see how I was faring; “I like to keep in touch with the students I interviewed who decided to come to Hopkins.” We have met twice since beginning school a year ago, and her gesture to take time over lunch has reaffirmed my decision to become a physician. I felt welcome to ask advice, encouraged to pursue my interests, and confident that I would be gently put back in my place if I got off track. She has been a wonderful model of medical leadership for me.

There is an unfortunate shortage of leadership examples and opportunities during the preclinical years of medical school. Strong emphasis is put on classroom instruction (rightfully), but this lacks sufficient focus on the principles and practice of leadership. Even though students may be involved in many extracurricular organizations, most efforts are trial-and-error rather than guided by a framework of knowledge.

Leadership skills are constantly needed once students reach rotations in the hospital. This training will make demands on a wide range of their skills, including teamwork, decisiveness, and openness to new ideas. These are all tenets of leadership that can be practiced before entering the halls of inpatient floors.

Illustrations of these desirable qualities can be made more accessible in many ways. A physician could display

leadership—even if only by a five-minute conversation with a student. If given more time, an informal mentoring relationship may be greatly beneficial. A physician who displays strong moral character, treats everyone fairly, and looks for feedback is an excellent example for any medical student.

We need students to feel comfortable seeking out leaders in the medical community, recognizing the importance of their experience and leadership skills. Additionally, we need those medical leaders to reciprocate by reaching out to physicians rising up their career ladder and strengthening the medical community, inspiring the next generation of medical leaders. Upon becoming a physician, I hope to provide the same guidance and assistance to medical students that I have enjoyed with Dr. West.

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Academic Hospitalist Academy

Andrew Auerbach, MD, PhD
 Jeffrey Glahseen, MD

The field of Hospital Medicine has seen explosive growth fueled by pressures to improve quality, standardize care and reduce resource utilization. These pressures have led many academic institutions to rapidly adopt and grow hospitalist programs employing young hospitalists in systems often lacking academic infrastructure. This has resulted in a myriad of chal-

lenges that conspire to limit the success of academic hospitalists.

According to the Society of Hospital Medicine statistics, the average age of a hospitalist leader and hospitalist are 41 and 37 years, respectively. The vast majority of these faculty members are at the instructor or assistant professor level—a shallow pool of experienced hospitalist

mentors. Further, most hospitalists have little or no formal training in education, curriculum development or scholarly activity.

Faced with these realizations, ACGIM, SGIM and SHM are collaborating on a groundbreaking faculty development program for hospitalists. The *Academic Hospitalist Academy* is
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a four-day meeting, offered in the fall of 2009, which will help young hospitalists achieve academic success through a variety of activities.

The Academy will utilize a core faculty of successful general internists in hands-on, interactive teaching sessions. Multiple break-out sessions with a 10:1 student-to-faculty ratio will assure that attendees have adequate time and mentorship for skills acquisition. Academy attendees will also have time to learn and demonstrate expert teaching skills. Additionally, attendees will learn how to develop and organize a bedside and didactic talk, effectively manage a team of learners, and give effective feedback.

The Academy will further prepare young hospitalists for the rigors of promotion by teaching them how to develop a good mentor-mentee relationship, develop a one and five-year plan and prepare their educator's portfolio. Additional sessions will overview options for scholarly activity and provide skills acquisition in peer review and preparation of a clinical vignette. Participants will also be taught the importance of (and how) to successfully network and establish a national reputation.

To address the often daunting need to effect system change and improve quality, several sessions will be devoted to the development of quality and systems improvement projects, as well as an understanding of how these projects can drive an academic business model.

Further training will give hospitalists the tools to lead and manage change in hospital systems. Finally, opportunities to network with national peers will abound, both during the meeting and through mentoring at distance activities led by Academy faculty.

The course will begin accepting registrants in March 2009. Due to its hands-on nature, the course will be capped at 100 attendees. Further details will be available at the ACGIM Summit or online at the SHM or SGIM websites.

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Associate Director, Section of Hospital Medicine

Due to unprecedented growth, Geisinger Medical Center, Danville, PA, seeks an Associate Director, Section of Hospital Medicine.

About this position:

- Exciting opportunity for emerging Hospitalist leader to assume leadership position in a premier academic hospitalist program in an integrated healthcare delivery system.
- This position reports to the Director, Section of Hospital Medicine, Department of General Internal Medicine.
- Program has 1386 Hospitalist FTEs; six inpatient teaching services; one inpatient non-teaching service, and one LTACH service.
- Qualities of the successful candidate will include: commitment to career in Hospital Medicine; proven leadership ability; collaborative leadership style; excellence in teaching/scholarship. Knowledge of performance improvement and experience with electronic medical record preferred.
- This program is committed to teaching residents and medical students; and performs the bulk of the inpatient teaching for onsite Internal Medicine residency program.
- Future expansion and growth in a non teaching service will include 24 hours a day, 7 days a week in house coverage.

Geisinger Medical Center:

- Is a 404 (licensed) bed, Level I tertiary/quaternary care center that includes the Weis Center for Research, Janet Weis Children's Hospital, and Geisinger Center for Health Research.
- Soon to be completed in 2010, is a major \$100-million building expansion project that includes a nine-story, 300,000 square foot building housing a heart hospital that includes cardiology, cardiothoracic and vascular surgery services.
- Utilizes a mature, fully-integrated electronic health record, connecting a comprehensive network of more than 40 community medical groups and an integrated network of over 700 Geisinger primary and specialty physicians.
- Is comprised of 75 medical and surgical specialties.
- Host thirty-one accredited residency and fellowship programs.
- Maintains regional clinical campuses with Philadelphia College of Osteopathic Medicine and Temple University School of Medicine.

Benefits include:

- Medical malpractice insurance with tail coverage.
- Three weeks CME annually (with stipend).
- Four weeks vacation.
- Teaching opportunities are available.
- Opportunities to conduct research including clinical trials, best practice and medical outcomes.
- Access to comprehensive health sciences libraries on both hospital campuses, and online access to many journals and other resources.
- Support for the pursuit of advanced degrees.
- Opportunities to practice medicine without office management responsibilities.
- Access to advanced information technology, including online imaging and a complete electronic medical records system.

A career at Geisinger allows physicians to practice leading-edge medicine while enjoying the benefits of living in a small town - good schools, safe neighborhoods, and a wealth of recreational and cultural activities. We are located in the scenic Susquehanna Valley, less than an afternoon's drive from New York City, Baltimore, Philadelphia and Washington, DC.

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