

# The Leadership Forum

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

## Quality and the General Internist between Effecting Change at the Institutional and National Level: The ACGIM Summit in Review

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**A**CGIM recently finished the fourth annual Winter Summit at the Camelback Resort in Arizona. As always, it was a wonderful event filled with content relevant to leaders in General Internal Medicine and the opportunity to network with old and new friends. For those who weren't able to join us, we wanted to share with you some information about the program. This year we focused on "quality". We started the event with an overview by Jeffrey Norton, MSBE (Center for Enterprise Quality and Safety University of Kentucky Medical Center) on how organizations should prime themselves to be LEAN and improve their quality ratings on those key "dichotomous" thresholds that have been set.

Next, Bill Moran, MD, ACGIM past-president and current chair of the SGIM Health Policy Committee, brought us up-to-date on what payment for dichotomous quality outcomes were in the upcoming health reform bills and how this might change practice in the hospital and outpatient settings. Bill took a complex topic and made it relevant and meaningful.

Our final speaker that first day was Rodney Hayward, MD, Professor, Dept of Internal Medicine and Dept. of Health Management and Pol-

icy Director, Veterans Center for Practice Management and Outcomes Research (University of Michigan) who shared his views and data on why using these dichotomous outcomes for quality can sometimes be so detrimental to patients. He was provocative and inspiring.

The next day, Vikas Parek, MD, University of Michigan, and Ben Taylor, MD, MPH, Associate Chief of Staff for Quality and Patient Safety, UAB Hospitals, presented about the newly developed Quality Portfolio (QP). Developed by the SGIM Academic Hospitalist Task Force, the QP—the first of its kind—provides a framework for our faculty to document their work and scholarship in quality. The presenters noted that, increasingly, inpatient and outpatient general medicine faculty are spending their non-clinical time in quality improvement activities. However, in most institutions, there is not a formal path to promotion based on such activities. The presenters promoted the quality portfolio as a process for faculty to formally organize and document activities in quality improvement. They reported that the "design and function of the quality portfolio should parallel that of the educator's portfolio—which is widely used as an effective tool to document achieve-

ment and success in education." They described the structured framework of the portfolio as having six distinct categories: 1) QI leadership/administrative activity, 2) QI project activity, 3) QI education/curricula, 4) QI research, 5) QI honors/awards/recognition, and 6) QI training/certification. They said institutions, based on experience and expectations for promotion, may decide to modify or re-order these categories. Drs. Taylor and Parekh also noted that, while the quality portfolio "is intended to highlight activities in quality in a cohesive manner... (it) may include activities and accomplishments more closely related to patient safety." Lastly, they also said the quality portfolio is "not intended to replace, but rather augment the current methods of documentation of success" and they encouraged local adaptation and implementation.

Invited guests also included David Daikh, MD, PhD, (UCSF), a member of the Association of Special Professionals (ASP) Council. Daikh chairs an ASP Task Force on Teaching and Applying Quality Principles in the Ambulatory Setting. This group is developing a white paper on the application of quality work in the academic setting with the goal of

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highlighting the need for (and importance of) quality research and quality improvement activities by academicians. Daikh noted that there are parallel interests and priorities between the two organizations with respect to their interest in quality activities. He also pointed out that the focus of the General Internal Medicine leadership group on quality issues is impressive and demonstrates that GIM is taking a lead role in advancing this work. He also noted that the development of a Quality Portfolio, presented during the leadership forum, would be of value to faculty working in the quality arena. Such a tool would further the goal of raising the currency of quality

work in academic settings relative to traditional measures of research productivity. Daikh expressed enthusiasm for ongoing sharing of ideas and cooperation between generalists and specialists, and between ACGIM and ASP, including novel collaborative quality research projects.

In discussions related to alternative scholarship, reference was made to a book by Ernest L. Boyer: "Scholarship Reconsidered. Priorities of the Professoriate". The Carnegie Foundation, 1990. Jossey-Bass books (John Wiley and Sons). In a chapter on "Enlarging the perspective", Boyer defines four types of scholarship:

- Scholarship of discovery. The "usual". Grants and publications. New knowledge.
- Scholarship of integration. Transdisciplinary work: "serious, disciplined work that seeks to interpret, draw together or bring new insight to bear on original research".
- Scholarship of application. Because higher education must serve the interest of the larger community, this knowledge is applied to help individuals and institutions—social problems defining an agenda for scholarly investigation.
- Scholarship of teaching. Transforming or extending knowledge (includes curriculum development and transformation of the educational process).

Though one can interpret all of these as performing "original research", there is also substantial leeway in defining scholarship in ways that reflect the creativity and originality that we in GIM bring to education and transform the world around us.

We concluded with concurrent workshops. Eboni Price-Haywood, MD, MPH, Tulane University Community Health Centers, and Eric Warm, MD, University of Cincinnati, presented an informative and practical "how-to" on implementing better quality in the outpatient setting in the form of the Patient Centered Medical Homes. Their models target low-income populations and include trainees. Jeff Norton gave a terrific how to on tools needed to implement and conduct LEAN processes in the hospital setting. The presentations are available online on the ACGIM website at <http://www.acgim.org/Summit09.htm>.

The ACGIM Executive Committee, led by Karen DeSalvo, thanked the program directors, Drs. Chris Schiamanna and Missy McNeil, for organizing the Summit. We look forward to seeing you all on April 28th at the Spring Hess Management Institute preceding the SGIM meeting in Minneapolis. We are making final plans for the agenda, but intend to have programming focused on building your financial resources in these lean times.

ACGIM

## Leadership Training Opportunities: A Brief Overview

Patience Agborbesong, MD

Physician leadership in healthcare is never far from my mind. I reflect on it nearly every day, not just because I am in a leadership role, but because I am involved in the process of sorting out the most effective ways of recognizing, training and supporting physician leaders. I am also constantly on the lookout for opportunities to improve my own skills and expand my competencies for the benefit of those I lead and (ultimately) for the benefit of our patients. It has become increasingly clear since the In-

stitute of Medicine's 1999 publication titled "To Err is Human: Building a Safer Health System"<sup>1</sup> that, without physician involvement and leadership, it will be nearly impossible to make any improvements in patient safety, patient care delivery and quality. During this time of healthcare reform, I believe physician leadership has never been more crucial and, apparently, I am not the only one who thinks so.

I recently heard from a very savvy and politically connected attorney

friend of mine in Washington D.C. who made some observations as we talked about leadership and the current challenges surrounding healthcare reform. He said that physicians are and have been one of the most under-represented groups in Washington. In his experience, unlike other professional groups, physicians as a group tended to wait until the very last moment of a major crisis to be involved in critical debates and decisions about healthcare. By then it was often too late, with a lot of critical decisions made without important physician input. The remarkable thing was that, in the very same week, I ran into a former attorney general and one-time gubernatorial candidate for the state of Virginia (another attorney, I might add) who (unsolicited) made nearly the same observations as my friend in D.C.!

This is not a treatise urging you to get involved in public policy, even though I recommend involvement at both the local and national levels. The point is that even non-physicians have noted our general lack of leadership and involvement and its consequences on everything from healthcare delivery, available resources and their effect on our patients—for whom we all care very much. It is time for us to be more deliberate in the way we select and groom future physician leaders since there is so much at stake for our patients now and for the foreseeable future.

What is currently available for leadership training can be divided into two general categories that I have designated: **“content and knowledge”** and **“skills and application”** programs. The majority of available leadership training programs fall in the “content and knowledge” category. The area of “skills and application” leadership training is quite lacking. I will try to summarize each type of program.

### **Content And Knowledge Leadership Training Programs**

Content and knowledge leadership training programs tend to be made up of content areas not covered by traditional medical training. Topics such as healthcare finance, strategic planning, how to run effective meetings, re-

cruitment, managing disruptive behavior and communication are typical content areas. These sorts of programs tend to have a lot of classroom work or distance learning with lectures, readings, working through case studies with colleagues and occasional role playing. Exams are required if you are in a degree-granting program. With so many of these programs around, they are fairly easy to find. Sorting out what suits your particular budget and schedule are the two main decisions you will have to face.

Medical centers and health systems sometimes have “in-house” leadership training programs which may or may not be well-publicized, so asking around your institution is a good first step (you may be pleasantly surprised). Several state medical societies also have leadership training programs that may not be well advertised. These programs are intentionally broadly defined to allow for a wide variety of participants. For example, in North Carolina (where I live), the Medical Society has a year-long leadership training program. But keep in mind that medical societies often train leaders to adopt their particular causes.

The American College of Physician Executives (ACPE) <sup>2</sup> is the most established medical society whose raison d’être is to train and support physician leaders. Additional national medical societies also have leadership training courses. For example, the American College of Physicians (ACP) <sup>3</sup> has the LEAD (Leadership Enhancement and Development) certification pathway, and the Society of Hospital Medicine (SHM) <sup>4</sup> runs a leadership academy twice a year for young, early career leaders.

Other organizations, such as IHI (Institute for Healthcare Improvement) <sup>5</sup> and some universities also have leadership certificate programs geared towards physicians. There are leadership certificate programs offered by the ACPE (the Certified Physician Executive, CPE) and organizations like Gallup<sup>6</sup> and General Electric (GE.) <sup>7</sup> Universities such as Harvard have leadership certificate training programs including the Harvard School of Public Health’s<sup>8</sup> training programs for physician leaders in

academic medical centers, and The George Washington University has the Women’s Leadership Institute; [www.gwu.edu/wli](http://www.gwu.edu/wli)<sup>9</sup>.

The AAMC (Association of American Medical Colleges) <sup>10</sup> has a good summary of leadership training programs available to mid-level and senior career leaders on its website. Listed programs include the world-renowned Center for Creative Leadership (CCL) <sup>11</sup> in North Carolina, several of the Harvard Leadership training programs, and the Hedwig van Ameringen Executive Leadership in Academic Medicine Program for Women (ELAM) at Drexel University College of Medicine<sup>12</sup>.

Master’s programs geared toward physician executives, as well as mainstream MBA (Master of Business Administration) programs are becoming more and more popular as physician leaders seek ways to enhance their leadership and management knowledge and skills. These MBA programs can be found at most universities that include a business school. Geared towards busy working professionals, these programs still require a substantial investment of time and money.

The American College of Physician Executives (ACPE) has four masters’ degree-granting programs in leadership. These programs are administered in conjunction with several universities around the country. Three of the programs lead to Masters of Management (MMM) degrees and one leads to an MBA. The Harvard University School of Public Health also has a Master’s in Health Care Management (MS) degree which is geared toward mid-career physicians in leadership positions.

### **Skills And Application Leadership Training Programs**

Learning to lead by leading is obviously not sufficient if one wants to become an expert at leading. Simply acquiring more routine experience is not the answer, although it does have its place. K. Anders Ericsson<sup>13</sup>, who has studied expert performance for many decades, points to deliberate practice as a key component of skill acquisition. Characteristics of deliberate practice include: (1) effortful exer-

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tion to improve performance, (2) intrinsic motivation to engage in the task, (3) practice tasks that are within reach of the individual's current level of ability, (4) specific feedback that provides knowledge of results, and (5) high levels of repetition. Individuals who eventually reach very high levels of performance do not simply accumulate more routine experience—they actively extend their skill-building period for decades.

As previously mentioned, skills and application leadership training programs are rare. These kinds of programs are very costly to run in terms of time, resources and money. The best available resources are coaches. A coach can be very helpful with the deliberate practice of certain skills. He or she can observe you in action and provide real-time, very specific feedback. Currently this industry is unregulated, so you will have to do a significant amount of homework to find a reputable and effective coach.

Simulation training is another way to improve one's leadership skills and application. These are sometimes part of an "in-house" leadership training program. You can role play and practice things like giving feedback using different scenarios. These are usually video-taped and specific feed-

back is given by an expert observer and/or peers. These are often useful for practicing communication skills.

A mentor is often helpful and most leaders have at least one. Having a mentor observe you in action and give specific feedback about some aspect of your leadership performance can be useful if you are deliberate about your skill building and application.

My goal of this article was to provide the reader a brief summary of some of the available programs for leadership training. This was not (by any means) meant to be an exhaustive list. Looking further into the goals and offerings of the attached references will get you well on your way to planning your leadership development.

I would be happy to hear from you about your experiences—specifically what's worked for you and your recommendations.

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