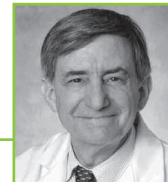


# The Leadership Forum

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



## Words of Wisdom

The 2010 ACLGIM WINTER SUMMIT: Health Reform and General Internal Medicine. Policy Brief from ACLGIM Winter Summit 2010, supported by the Commonwealth Fund

By Mark Linzer, Chris Sciamanna, Tom McGinn and Kay Ovington.

*(mark.linzer@hcmcd.org; cs19081@gmail.com; Thomas.mcgin@mountsinai.org; ovingtonk@sgim.org)*

In December, with much appreciated support by the Commonwealth Fund, over 50 leaders in GIM gathered to learn about the future of GIM under health reform. Atul Grover from the AAMC spoke of "bending the cost curve" while improving quality within Accountable Care Organizations (ACOs) and Health Innovation Zones. Andrew Bindman from UCSF spoke about expanding health care coverage under the Affordable Care Act, and Mark Schwartz, RWJ Health Policy Fellow, taught us about physician pay-

ment reform. Rick Lofgren from University of Kentucky reminded us that hospitals focus mainly upon income generated by very sick patients while Tim Ferris from the Massachusetts General Hospital suggested we focus on preventing readmissions and providing high quality chronic illness care. Breakout sessions focused on 1) the Patient Centered Medical Home and 2) new care models and future research efforts in the safety net. Past Presidents of ACLGIM suggested where we might point our compass for the

next 10 years. Plans included growing membership for "leaders in GIM" (we were ACGIM, and are now ACLGIM) and developing a diverse and sustainable leadership workforce.

The summit allowed us to build networks and position ourselves to be part of the changing landscape of health care in the US. Save time in early December for Winter Summit 2011. And if you are a GIM leader, please join us in ACLGIM so we can extend our support network to you and your institution!



## Words of Wisdom

Thoughts on the 10<sup>th</sup> anniversary of ACLGIM

Robert Centor, MD, is Associate Dean, UAB Huntsville Regional Medical Campus, Member, ACP Board of Regents, and Professor of Medicine, Division of General Internal Medicine, the University of Alabama at Birmingham. rcentor@uab.edu

In 1999, Wendy Levinson, Mark Linzer and I led a workshop that pitched the idea of an organization of division chiefs. We expected 10 or 15 attendees, but had over 40. The room quickly became electric, and we all

realized that we needed a formal organization. The next year, thanks to Sanky Williams (the SGIM President that year) we had a planning retreat in Chicago. Out of that meeting came

the plan that led to the creation of ACGIM (which morphed into ACLGIM this year). We had several specific goals that we verbalized. Quoting from our web page:

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## Word of Wisdom

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The most important meeting was the one held in January 2000 in Chicago. It was sponsored and paid for by the Society of General Internal Medicine. At this meeting we identified the *raison d'être* for such a society. The task force defined four goals:

1. Provide professional development through leadership and management training;
2. Provide forums in which to exchange information;
3. Provide personal development and networking for Chiefs;

4. Influence and educate institutional leaders about issues relevant to academic general internal medicine.

I believe that we can look back at those goals and state unequivocally that our organization has succeeded. While we should modify those goals slightly today, I believe they still stand as core principles.

Our organization has benefited from a series of committed thoughtful and creative leaders. We had 40 members in our first year; we now have 146 members. We had one short meeting in 2000, now we have a Management Institute each year prior to the SGIM meeting, and a winter session focusing on issues relevant to academic general internal medicine leaders. We have absorbed many hospitalist leaders, as the leadership issues and challenges cross over the breadth of academic general internal medicine.

**We will always have the challenges of leadership. We will always of challenges that we cannot predict.**

We will always have the challenges of leadership. We will always of challenges that we cannot predict. As a group we will continue to learn from each other and turn these challenges into opportunities.

As I view the 10<sup>th</sup> anniversary celebration, I see a vibrant organization that clearly is helping general internal medicine leaders work together to improve our field through education, research and patient care. As the 1st president of the organization I have great pride in the organization, although I can take little credit. The credit goes to the many members who work hard every day to make academic general internal medicine a great field.



## Perspectives in Leadership.

**The US Government Invests in Primary Care: The Patient Protection and Affordable Care Act of 2010. Policy Brief from ACLGIM Winter Summit 2010, supported by the Commonwealth Fund**

Andrew Bindman, MD, University of California at San Francisco, Division of General Internal Medicine, San Francisco General Hospital. [abindman@medsfgh.ucsf.edu](mailto:abindman@medsfgh.ucsf.edu)

The Patient Protection and Affordable Care Act (ACA) passed in March 2010 is designed to increase the percentage of the population covered by health insurance. The major expansion of coverage will begin in January of 2014. The Congressional Budget Office (CBO) estimates that when fully implemented, 94% of the population will have insurance coverage, with 16 million newly insured under Medicaid and 16 million newly insured through private insurance. Health insurers will no longer be able to exclude individuals due to pre-existing conditions. To eliminate the circumstance that individuals would only pursue health insurance when they are sick, there will be a mandate for individuals to demonstrate they have health insurance coverage

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with financial penalties except for those at the very lowest income levels. To assist individuals in purchasing health insurance, the government will provide subsidies of approximately \$5000-6000 per year on a sliding scale for individuals with incomes between 138% and 400% of the poverty level. Those below 138% of the federal poverty level will be eligible for Medicaid.

States with the highest unemployment and the most restrictive Medicaid

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eligibility requirements, predominantly in the southern and western regions of the United States, will experience the biggest increases in coverage.

The CBO estimates that following the implementation of health reform there will still be 23 million uninsured. These uninsured will be comprised of approximately one third who are not eligible for coverage because they are undocumented immigrants, one third whose income is below the individual mandate penalty threshold, and one third who are either unaware or unconcerned about the mandate. The CBO estimates that there will be 7 million who are eligible for Medicaid but not enrolled.

Previous studies suggest that when the uninsured gain insurance, their demand for care increases by approximately 40%. The ACA includes several provisions to support an expansion in primary care capacity, including: a re-authorization of Title VII training grants, increased funding for national health service corps loan repayments, increased funding for community clinics, a national workforce commission to address the imbalance

between subspecialists and primary care providers, and increased payment for primary care services through Medicare and Medicaid. The increased payments for primary care physician services in Medicare is over and above any payment increases the Center for Medicare and Medicaid Services establishes for all physician services. The Medicaid payment increases require states to reimburse primary care physicians at least at the Medicare payment rate for 2013 and 2014. Nationally, the average payment in Medicaid is currently only 60%-70% of Medicare's, and as a result only about half of primary care physicians accept Medicaid patients into their practice.

The ACA makes funds available to pilot test and scale up the patient centered medical home (PCMH) model for Medicare and Medicaid beneficiaries. The PCMH is likely to be the foundation of Accountable Care Organizations which Medicare and Medicaid have proposed as a new payment model to reward both high quality and decreased costs in the care of a defined population of patients. The increased reimbursement rates for primary care

physician services from Medicare and Medicaid in combination with funds available from the American Recovery and Reinvestment Act to support the purchase of electronic health records should make it more possible for primary care physicians to participate in a transformation toward becoming a patient-centered medical home.

For health reform to fully support primary care expansion and development, Congress will need to commit to finances for provisions not explicitly appropriated in the ACA. These provisions include primary care training grants, community prevention programs, health disparities data collection, and community health teams to support PCMHs.

The ACA represents an important opportunity for primary care to contribute toward improving our population's health. Professional societies in medicine should encourage rigorous evaluations of primary care's emerging role and impact. These studies can be used to confirm the value of the government's investment in primary care, and to advocate for additional resources if they prove to be necessary.

## Harvard Business Review Corner

Neda Laiteerapong, MD is Fellow in General Internal Medicine and Instructor of Medicine at the University of Chicago, Chicago, Illinois. [nlaiteer@medicine.bsd.uchicago.edu](mailto:nlaiteer@medicine.bsd.uchicago.edu)



## Employee Motivation: A Powerful New Model

Nohria N, Groysberg B, Lee LE. *Harvard Business Review*. 2008;86:78-84.

Recent studies have shown that practicing internists and trainees are burned out.<sup>1,2</sup> A recent study showed that at least one in four internists was burned out and three-fourths reported low control over their work.<sup>2</sup> Clearly, reducing burnout and improving work conditions for internists are important issues for all leaders in internal medicine. In a classic article from the Harvard Business Review, a model of employee motivation is introduced which emphasizes that satisfying primal drives can improve employee engagement. Each of the four drives is paired with organizational levers and strategies that can be utilized to fulfill each drive.

The first drive is "*The Drive to Ac-*

*quire*," to acquire scarce goods, both tangible and intangible, for example, promotion. The strategy employed by the business world is to align the reward system to performance. One strategy for rewarding excellent medical educators could be creating a measurable path to promotion for clinical educators, which is equivalent to that for clinical investigators. To align rewards to excellent patient care, standard expectations could be created, like timely response to abnormal lab values, and physicians who exceed this benchmark could be recognized. Examples to document clinician-educator scholarship are available elsewhere.<sup>3,4</sup>

The second drive is "*The Drive to Bond*," to bond with coworkers and

**...at least one in four internists was burned out and three-fourths reported low control over their work.**

the organization. Strategies include creating a family environment and sharing best practices. To create a family environment in the medical setting, leaders could foster collaboration and teamwork by scheduling meetings to review difficult patient cases or by developing an online discussion board that can easily be updated by all members of the medical team to share best practices.

The third drive is "*The Drive to Comprehend*," to comprehend job re-

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sponsibilities and be challenged by them. Aligning job responsibility to the skill level is key to this strategy. A common example of misalignment is physicians who spend much of their time on the phone or completing paperwork. Hiring additional staff may be challenging in this economic climate; however, streamlining and standardizing the process in which paperwork enters and exits the system could ease the burden on physicians. Also increasing patient awareness of the expected turnaround time could decrease phone calls.

The fourth drive is “*The Drive to Defend*,” to defend their job and accomplishments. This drive requires that each employee understands why he/she is at their level in the hierarchy. To address this desire, organizations should have a transparent and fair process for promotions and commendations. In medicine, regular meetings with senior mentors could help demystify the promotions process for junior faculty early in their careers and address this drive.

There are clearly many additional strategies to address these employee drives in the field of medicine. Most importantly, according to this article, employees will be more engaged, satisfied, committed and less likely to quit when these drives are met.

## Motivation Drives

The Drive to Bond

The Drive to Acquire

The Drive to Comprehend

The Drive to Defend

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## Division Head of Academic General Internal Medicine Detroit, MI

The Murphey Group, Inc. has been retained to recruit a Division Head of Academic General Internal Medicine, reporting to the Chair of Internal Medicine at Henry Ford Health System in Detroit. The Department of Internal Medicine is an integral part of the Academic system, training 120 residents per year. The department is seeking a “true” Internal Medicine physician to treat complex cases, and teach others to do the same.

This is an exciting time to join a program that is currently building an emerging delivery model of the “Medical Home”, and be a leader in teaching current and upcoming students. We are seeking a leader who has the desire to help build this program. The faculty provides most of the general internal medicine inpatient and outpatient teaching. They are a group of clinician-educators eager to improve their skills in teaching and research. Our client needs a leader who has personal experience in research and the skills to develop faculty, particularly their young faculty. We are seeking a physician with a unique set of clinical skills, program building & development and academic skills. Someone with interest in epidemiology, health disparity, community services, and quality measures would also be a plus.

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Jim Murphey  
President/CEO  
The Murphey Group, Inc.  
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Email: [jobs@murpheygroup.com](mailto:jobs@murpheygroup.com)  
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