Defining the Value of GIM in Academic Health Systems at the University of Michigan

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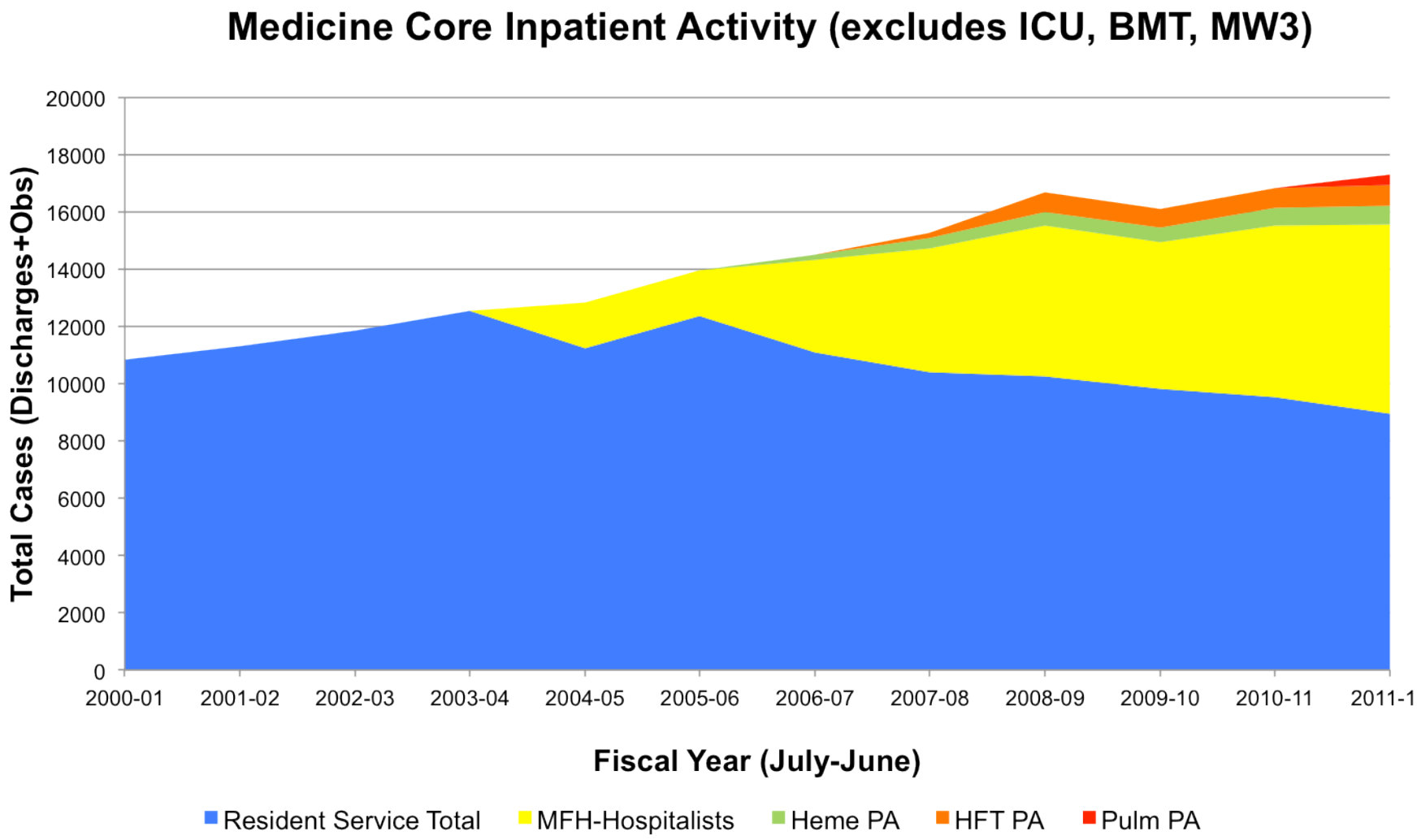
John M. Carethers, M.D.
John G. Searle Professor and Chair
Department of Internal Medicine
University of Michigan

GIM at Michigan

- 180 faculty (out of 700 faculty paid in Department), Division Chief: Larry McMahon, MD
  - ~35 are health services researchers
  - ~75 are hospitalists (Director: Scott Flanders, MD)
  - ~70 are “ambulists” involved in outpatient care
- Division generates a margin for the department
- GIM Health Services Research
  - Occupy ~11,000 sq ft
  - ~$8M in direct/indirect grants, mostly federal, excluding VA
  - Ann Arbor VA HSRD, led by GIM faculty (Eve Kerr, MD)
  - RWJ Clinical Scholars Program, led by Rod Hayward, MD
  - Part of new Institute of Health Policy and Innovation at NCRC (former Pfizer campus), led by John Ayanian, MD

Evolution of Internal Medicine Inpatient Services: All resident-based to multiple models of care



Hospitalist Medicine at Michigan

- Program ~ 8 years old
- Growth led by changes in ACGME, volume at Michigan
- Hospitalists cover MFH service (no GME); some attend on GME services
  - MFH and non-GME services: ~10,000 admissions
  - GME services: ~9500 admissions
- New program at Ann Arbor VA commenced in 7/2012, faculty hired through University of Michigan as part of the program
  - 5th Internal Medicine service, volume growth at VA, duty hour changes
- Hospitalist Fellowship created in 2011 to grow research
  - Leads to Masters, takes advantage of RWJ structure
- Program has >$1M in research, largely from insurers for quality

Hospitalist Medicine at Michigan-2

- Funding:
  - Pro fees
  - Hospital (through contract, paid through Faculty Group Practice to Department)
  - Allows salary, academic funds, loan repayment program, signing bonus
  - Contract revisited every 3 years (just renewed for 2013-2016)
- Issues/Challenges
  - Growth of research (stability of core group of faculty)
  - Division vs. portion within division
  - Coordination with UM/IHA Pioneer ACO
    - Readmissions, LOS, implementation of outpatient plans
    - New ACE Unit
    - Chelsea Hospital
  - Coordination with quality with hospital
    - M-PLAN; Quality Associate Chair
  - EPIC inpatient coming in June 2014
  - Subspecialty wants and needs (i.e. nighttime coverage)

Ambulatory Internal Medicine at Michigan

- Cover multiple locations within health system
  - East Ann Arbor, Brighton, West Ann Arbor, Canton, Briarwood, Livonia/ Northville, Taubman (main hospital)
- GIM (non-specialty): ~180,000 patient visits/year
- Part of Primary Care ACU (Ambulatory Care Unit)
  - Includes Med-Peds, Family Medicine, OB, Peds
  - Each location has ACU director paired with manager
    - On site management of resources
  - GIM utilizes an “Ambulatory Council” to coordinate and solve issues specific to GIM

Ambulatory Internal Medicine at Michigan-2

- Challenges:
  - Recent EMR Implementation
    - Greatly affected ambulatory activity/volume
    - Has taken ~6 months to catch up to prior year's volume
  - EMR revenue cycle billing mishaps
    - Dropped bills, uncoupled diagnoses/providers, lost in "ether space"
    - improved, but not caught up yet
  - Survey
    - Under-appreciated in research-based system
  - Time for other items, such as EMR, increased over face time with patients, with targeted volumes/wRVUs
  - Quality measurements and documentation with Pioneer ACO
    - Primary care "key" to success of ACO
  - Access/Proximity to subspecialists at practice sites
  - Coordination with inpatient initiatives (ACE, Chelsea)
  - Northville site and growth of GIM faculty

Ambulatory Internal Medicine at Michigan-3

- Initiatives Performed:
  - EMR: better training of physician champions to help faculty to streamline workflow
  - Increased salary 10-20% for current work
  - Consideration with Pioneer ACO and payment per member per month for non-wRVU portion of salary
  - Started Clinical Excellence Society within Department
  - Consideration of Quality Associate Chair to coordinate quality issues, not only for reporting purposes at patient level, but also MOC part IV, etc.
  - New practice sites (Northville) to have both GIM and key subspecialties; examining other sites for subspecialty clinics
  - Chelsea inpatient option for GIM direct admissions from west side of Ann Arbor
  - Consideration for incentives for new hires (e.g. loan repayment)
  - Primary care track in core Internal Medicine Residency

Summary

- Hospitalists
  - Growth due to ACGME and volume issues
  - Research (in academic settings) slowly growing
  - Key group for quality issues and initiatives in hospitals
  - Hospitals/Health Systems have to be major funders of this group
- “Ambulists”
  - Disruptive technology (e.g. EMR implementation) will disrupt flow of an already tightly-run, high volume system
    - Not easy fix after system spending $290M
  - Key group for quality and ACO accountability in outpatient setting
  - New models for salary coming with ACOs
  - Number entering field for future workforce is challenging
    - Need to make primary care rewarding and financially stable and equitable

Thank You!