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The Leadership Forum

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

"To be the voice of ACLGIM and communicate about leadership challenges and solutions in academic medicine to members, the SGIM community, and other stakeholders."

Rita Lee Michael Klein Sunil Sahai

Editorial Corner
From the Editors

Rita Lee, MD; Michael Klein, MD; Sunil Sahai, MD

"How lucky I am to have something that makes saying goodbye so hard"
—AA Milne

It is with mixed emotions that I write this final Editor's column for the ACLGIM *Leadership Forum*. For 16 years, the ACLGIM *Leadership Forum* has brought leadership pearls, new ideas, and thought pieces to support the growth and development of leaders across general internal medicine. However, as with times changing, so has our readership. As we transitioned to a fully online venue, our reach and readership has declined. Thus, as good leaders must do, we must acknowledge our realities and evolve to meet the needs of a changing world.

As Socrates stated, "The secret of change is to focus all of your energy not on fighting the old, but on building the new." As your editorial team for the ACLGIM *Leadership Forum*, we are not saying goodbye but instead are transforming our work into something new that improves reach and recognizes that all SGIM members are leaders. To that end, we will be integrating leadership content into the SGIM *Forum*, starting with the August 2024 issue.

In our final issue of the ACLGIM *Leadership Forum*, we further our conversations about improving our practice environment. Willens et al discuss the importance and strategies to operationalize and optimize team-based care. We also learn about the creation of a Division "float position" to decrease burdens with changing faculty roles and maintain access to care. Finally, we hear a call to leadership from Vineet Chopra, Chair of Department of Medicine at University of Colorado. As generalists, we possess a unique lens and skillset that is much needed in health care—we should step up to the challenge to lead the change we want to see.

We close the Web edition of this issue with reflections from our early leaders of ACLGIM and the history of the ACLGIM *Leadership Forum*. And we look both backward and forward with gratitude. Thank you for being part of the journey of the ACLGIM *Leadership Forum*. We could not have done this work without your contributions, your readership, and your support over the years.

We are truly grateful.

Vineet Chopra

Leadership
Leadership Reflections: The Generalist Perspective

Vineet Chopra, MD, MSc

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Let me begin by stating the obvious: it is becoming almost impossible to thrive as an academic generalist. It doesn't matter if you practice in the hospital or in the clinic, in an academic medical center or in the community, in group practice or solo—the pressure and demands of day-to-day work have gone from challenging to soul crushing. Our patients and health systems expect us to be constantly connected. Boundaries

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between work and home have faded. Salaries and workload are orthogonal. Our pipeline is drying up. There may not be enough of us to meet the demands of the population today. If the trend continues, there won't be enough of us to care for you and me tomorrow.

Is it a crisis? Yes. But behind this crisis is an opportunity. Your opportunity.

No one understands medicine like we generalists do. We are not restricted to the myopia of one organ system or disease condition. We think about the whole patient, their family, their socioeconomic situation, their physical and biopsychosocial environment, and all the complex interactions between these domains. We devise new ways to solve old problems, using values and principles that are not only true to us but also anchored within the patient and their loved ones when making clinical decisions. As described by Graves and Conigliaro, we are foxes rapidly evolving to the situation, not hedgehogs paralyzed by fear.[1]

This whole person, whole system approach isn't an isolated event. We do the same for our colleagues all the time. Getting crushed by the ER on a busy night shift? Hey, let me answer that next page. Running late in clinic and patients waiting? Hey, let me grab that next patient for you. Need to head out early for a family engagement? No problem, I will cover. We also do the same for our operational challenges. Templates out of whack? Let's optimize. Inpatient volumes spiking? Let's think about a swing shift or additional team. The examples of caring and problem solving are endless.

What I describe is an antidote to what ails general medicine—what business guru Bob Quinn calls a fundamental state of leadership.[2] When entering this state, we draw on our own fundamental values and capabilities to manage a crisis. We instinctively choose what is right instead of what is best for us. Core values emerge and our focus shifts from within (ourselves) to others. The result is generative: people move from compliance to committed. That extra mile no longer feels "extra." Solutions flow and creativity abounds, so problems are not only tackled but also brought along people with it.

I chose leadership as a path because it became clear to me that this fundamental state needed to touch more than just my clinic, my hospital team, or my immediate peers. My views as a generalist have uniquely shaped how I think about and react to daily conundrums. For example, when I meet with faculty who are underperforming, my generalist instincts wonder, "what else could be going on?" When I look at financial statements or negotiate with clinical partners, I remind the administrators of what the work looks like in graphic detail: pajama time, personal sacrifices, and academic misadventures combined.

Even though generalists outnumber every other medicine subspecialty, few have answered this call to leadership. And few have found that fundamental state of leadership. That is why I write to you: we cannot be architects of the change we want to see unless we rise to positions where we can make this happen and embrace leadership as a career path. Only then can we move beyond cogs in the system—to becoming the system.

To fix the system, you must lead the system. We need more generalist Department Chairs. It is your turn to accept the challenge.

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Clinical: Part I
Division Float Provider in Primary Care: A Novel Approach to Access Coverage in Primary Care

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Background

A significant challenge in General Internal Medicine is coverage for leaves of absence and unexpected provider attrition. Patient satisfaction suffers as access to care becomes constricted, thus leading to an increase in patient complaints. As providers leave the workforce or reduce clinic time, remaining providers bear the brunt of the increased workload leading to resentment, burn out, and disengagement from the workplace. To address these concerns, the Division of Internal Medicine at Cooper Health and Cooper Medical School of Rowan University implemented a Float Provider to cover absence.

Cooper General Internal Medicine provides primary care to a large area of

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South New Jersey and four subacute/nursing home facilities for a total of 72 providers and 12 primary care offices. The Division Float is a 0.5 clinical full time equivalent (cFTE) physician who provides coverage for our primary care clinics and nursing home/subacute facilities. In the clinic setting, the Float Provider schedule will book 12 patients per four-hour session and templated for sick visits, hospital follow ups, and annual wellness visits. Float Provider workdays will vary from month to month based on the needs of the division but never go over the expected hours for 0.5 FTE. Although, the division primary care providers have Saturday hours and nontraditional hours in the primary care clinics, the Float Provider is scheduled for only traditional workdays (Monday through Friday) and traditional hours 8am-5pm. The provider is required to manage their own in-basket and forward results to the PCP for further management and follow up. Physician compensation is based on RVUs which includes a quality portion at risk that guarantees our Float Provider will be a good citizen to help capture patients with overdue quality metrics during the visit.

Our division Float Provider is an experienced physician who was at an exit point in their career. This individual was not ready to retire completely from patient care and needed schedule flexibility. A Float Provider does not need to be seasoned or at the end of their career; but, the key qualities that make them successful is a willingness to be flexible with their clinical hours from week to week and a comfort in working in different or new clinical sites. Unlike per diem providers, the Float Provider was contracted to work a 0.5 cFTE which guaranteed a baseline quantity of access for our clinics.

We have had the division float position for three years. In 2023, we had a total of 33 weeks of leave of absence from Physicians and Advance Practitioners in the division. We had a total of one full time provider lost to attrition in 2023. The float physician provided 108 hours of clinic coverage and 16 weeks of nursing home coverage. The Float Provider generated approximately 3,600 RVUs in 2023 which aligns with RVU productivity metrics expected for a part time primary care physician. As compensation was based on RVUs, the position did not require additional financial support from the division. We did not replace every session that was lost through a leave of absence or attrition as that was too great for our 0.5 FTE Float Provider to fill. We found that adding one or two sessions per month in a clinical space experiencing attrition or leave of absence provided enough of a relief valve for patient access that the providers felt it made a positive impact.

The float position was an overwhelmingly positive intervention. Physician and Advanced practitioners in the division expressed their satisfaction and appreciated the "decompression" of the workload by this provider. We were also able to maintain patient access in the face of provider attrition. Thus, a Division Float model is a sustainable strategy to meet the continual challenges of provider leave and shifting cFTE.

David Willens   Anupama Nair   Sandra Maxwell

Clinical: Part II
Management to Drive Top-of-License Team-Based Academic Primary Care

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Primary care has an acute need for team-based care to tackle our outsized tasks: prevention, chronic disease management, acute care, and care coordination.[1,2] How many of our clinic leaders are equipped to recruit and retain the best clinicians and staff to sustain top-of-license work? Last year, ACLGIM launched several task forces to explore ways to improve primary care practice, one of which was "Enhancing Focus on Team-Based Delivery of Care." While this group's work is underway, we can start by devoting leadership time and talent to these best-practice management techniques.

Build a Team-Care Culture

A "share the care" culture means that physicians have confidence and trust in staff, and vice-versa, to work reliably at top of license, often with delegated authority. This requires a collaborative relationship between the clinic's business and physician leaders to align the financial *and* patient care impacts of operational decisions.

Staff Appropriately and Define Roles

Part-time clinicians and residents in academic clinics introduce inefficiencies that may require extra staffing, especially for inter-visit care. Benchmark staffing ratios assume clinicians are full time but may need to be adjusted to reflect the larger number of part-time faculty and residents common to academic clinics. Nurses should perform inbox triage for patient symptoms and also see (and bill)[3] patients for chronic disease management by protocol. Medical assistants (MAs) should focus on rooming, including screening questions, medication reconciliation, and teeing up orders. Office assistants and administrative staff can complete non-clinical tasks. Only high performing team-members can handle the breadth and complexity of academic primary care.

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Ongoing Recruitment and Onboarding

Getting the right people "on the bus" and providing ample training are critical jobs for leaders. Be transparent with candidates about the pace and complexity of primary care and the benefits and challenges of learners. Candidates should be interviewed by a panel of care team members from each discipline to build team culture. Investing in training staff and clinicians pays dividends in efficiency and effectiveness and detects underperformers early. MAs and nurses may train and work under supervision of another staff member for up to six weeks with advancing independence. Shadowing members of each clinic discipline is essential for staff and clinicians to understand everyone's unique role in the team. Anticipate higher turnover in staff, and be prepared for ongoing recruitment, interviewing, and onboarding. As these activities are time-consuming, ensure clinic leaders have the time and skills to build the best team of physicians and staff.

Retention and Accountability

Retaining the best team requires simultaneously investing in professional development, holding all equally accountable, and supporting psychosocial challenges. Leveraging financial assistance, tools for accountability, and psychosocial support is key to both engaging high-performers and managing those that may be a poor fit.

We can only fulfill our promise of healthier populations through effective team-based care. We must drive efficient and top-of-license direct patient care by all clinicians and staff. Appropriately accounting for the realities of academic primary care will foster improvements in team-based care, recruitment, and retention. Through intentional leadership, planning, and accountability, we can foster a primary care practice that meets our patients and our team's needs.

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