

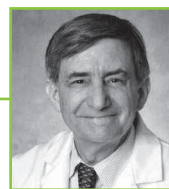
The Leadership Forum

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

Words of Wisdom

Health Reform and Care in the Safety Net: A Breakout Session. Policy Brief from the ACLGIM Winter Summit, 2010, supported by the Commonwealth Fund

Mark Linzer, MD, Hennepin County Medical Center, Minneapolis MN (mark.linzer@hcmcd.org); Andrew Bindman, MD, University of California, San Francisco (abindman@medsfgh.ucsf.edu); and, Elizabeth Jacobs, MD, University of Wisconsin, Madison (ejacobs@medicine.wisc.edu).



Mark Linzer



Andrew Bindman



Elizabeth Jacobs

During a special breakout session at the Summit, Dr. Bindman discussed lessons learned while a Robert Wood Johnson Health Policy Fellow in 2009-2010, Dr. Linzer shared changes occurring in Minnesota in response to state legislation, and Dr. Jacobs described an effort to develop a safety-net research consortium.

Dr. Bindman explained how safety net investments will now be targeted toward community clinics. The Affordable Care Act (ACA) adds \$11 billion for funding Federally Qualified Health Clinics (FQHCs). This is a key component of adding capacity in primary care. Hospitals that have depended on disproportionate share hospital (DSH) funding for care of the uninsured will experience a \$14 billion reduction over the next decade. Safety net providers will need to compete for patients who have increased care choices, and demonstration projects with collaboration between FQHCs and safety net hospitals are anticipated.

Dr. Linzer shared how a state budget shortage in Minnesota led to safety net hospitals initiating Coordinated Care Delivery Systems

(CCDSs). At Hennepin County Medical Center in Minneapolis, 7500 pa-

Affordable Care Act (ACA) adds \$11 billion for funding Federally Qualified Health Clinics (FQHCs).

tients were placed in three tiers based upon prior utilization. Those with multiple hospital stays (about 300 patients) were designated for a high intensity Tier 3 clinic with social services, care management, an MD, NP and RN, and a disability specialist. Patients with one or two annual hospital stays were placed in Tier 2. The 6000 remaining patients were referred with advanced access to medicine clinic. Future plans include health care home strategies such as care management and patient-centered primary care. Preliminary results show a marked impact of Tier 3 practices on hospitalizations and emergency department visits, with very high patient satisfaction.

Although there are limited resources to study safety net programs, it is essential to know more about "best practices" for safety net patients

and providers. Dr. Jacobs is proposing a safety net research network to rigorously evaluate the impact of health care reform on safety-net institutions and their patients (contact Dr. Jacobs if interested in participating).

In the Q & A session, colleagues described model programs such as Denver Health where all outpatient care is run through FQHCs. A patient navigator model for high utilizing vulnerable patients was described by University of New Mexico. Several hospitals (Charleston, Boston Medical Center) described the "one waiting room" model for insured and unin-

Dr. Jacobs is proposing a safety net research network to rigorously evaluate the impact of health care reform on safety-net institutions

insured patients. Focus group (qualitative) research was suggested to learn more about how patients perceive their care during development of integrated delivery systems. The consensus was that this is a time of opportunity and increased resources for the safety net.

Perspectives in Leadership

The Patient Centered Medical Home—

A foundation for Health Care Redesign: A Breakout Session. Policy Brief from the ACLGIM Winter Summit, 2010, supported by the Commonwealth Fund



Karen B. DeSalvo



Eboni Price-Haywood



Thomas McGinn

Karen B. DeSalvo, MD, MPH, MSc, Health Commissioner, City of New Orleans (karen.desalvo@gmail.com); Eboni Price-Haywood, MD, MPH, Tulane School of Medicine (eprice@tulane.edu); and, Thomas McGinn, MD, MPH, Chair of Medicine, North Shore-LIJ Health System, Hofstra North Shore-LIJ Medical School (Tmcginn@NSHS.edu).

The Patient Centered Medical Home (PCMH) has become a part of practice and policy lexicon as a promising model of care that at its core is “good

primary care.” PCMHs has gained momentum as leaders and policy-makers sought to halt the decline of primary care and slow rising health care costs. Knowledge that communities with strong primary care have better health, lower cost and more patient and provider satisfaction grounded this movement. Ongoing demonstrations are adding to the mounting evidence about the cost-savings and positive health impact of the PCMH model.

In February 2007, professional societies joined forces to develop a set of Joint Principles characterizing the PCMH as being led by a personal physician, whole-person orientation, coordinated care, quality and safety, enhanced access and adequate payment. The National Committee for Quality Assurance (NCQA) developed a recognition program to serve as a road map for providers, payers and policy-makers. At its best, the NCQA recognition program can transform practice structure, function and culture as care teams implement best practices in patient care. This transformation requires financial, intellectual and human capital investment. Long-term maintenance of the transformation must be supported by expanded infrastructure, payment reform, and training to develop a prepared workforce.

The Affordable Care Act (ACA) supports expanded infrastructure of primary care safety-nets through investment of \$11 billion in the Federally Qualified Health Center (FQHCs) program to expand access to primary care for traditionally underserved populations. The FQHC Advanced Primary Care Practice Demonstration is a special opportunity for FQHCs to take the PCMH model to scale. FQHCs will

have the opportunity to lead physician workforce development through the Teaching Health Center Program.

The ACA will help support PCMHs integration in to the larger health care system, particularly as part of Accountable Care Organizations. Multi-payer demonstrations in the ACA include the Center for Medicare and Medicaid Services Innovation (CMMI), the Multi-payer Advanced Primary Care Demonstrations and the Health

The Affordable Care Act (ACA) supports expanded infrastructure of primary care safety-nets through investment of \$11 billion in the Federally Qualified Health Center (FQHCs)

Innovation Zones which focus on the role of academic health centers in the health care landscape. The Medicaid Home Health State Plan Option will support State Medicaid program expansion of the PCMH for Medicaid beneficiaries.

The PCMH holds promise as a fundamental building block for a re-designed health system grounded in high quality, accessible primary care strengthened by a payment model that both invests in and supports primary care. Data will continue to accumulate about the benefits of the PCMH. Critical to the future of the PCMH is the need to integrate the model in to the broader health system and to identify better, more sustainable payment models.

This piece was reviewed by Dr. Anne-Marie Audet at Commonwealth, and with editorial support by Sara Poplau and Mark Linzer at Hennepin County Medical Center.

Officers

Thomas McGinn, MD, MPH

New York, NY
President

Russell S. Phillips, MD

President-Elect
Boston, MA

Karen B. DeSalvo, MD, MPH, MSc

New Orleans, LA
Past President

Laurence F. McMahon, MD

Ann Arbor, MI
Secretary-Treasurer

Patience L. Agborbesong, MD

Winston-Salem, NC
Council Member

Ex-officio Council

Alpesh Amin, MD, MBA

Irvine, CA
Communications Chair

Stewart F. Babbott, MD

Kansas City, KS
ASP Liaison

John A. Flynn, MD, MBA

Baltimore, MD
Membership Chair

Gary Rosenthal, MD

Iowa City, IO
SGIM President

Mark Linzer, MD

Minneapolis, MN
Development Chair

Christopher N. Sciamanna, MD, MPH

Hershey, PA
ACLGIM Summit

Melissa A. McNeil, MD, MPH

Pittsburgh, PA
Management Institute

Carlos Estrada MD, MS

Editor

Sandra A. Buckley

Managing Editor

April S. Fitzgerald, MD

Associate Editor

Neda Laiteerapong, MD

Associate Editor

Harvard Business Review Corner

Neda Laiteerapong, MD is Fellow in General Internal Medicine at the University of Chicago, Chicago, Illinois (nlaiteer@medicine.bsd.uchicago.edu) and an Associate Editor for the Leadership Forum



Neda
Laiteerapong

How to Keep Your Top Talent

Martin, J, Schmidt C. Harvard Business Review. 2010;88:54-61.

The fate of the primary care workforce in the U.S. is considered dire. Not only do studies show that medical students are not choosing primary care specialties,¹ but also mid-career physicians are at risk for leaving at enormous rates.² In this “negative sum game, given the enormous costs of recruitment and lost productivity, retaining superior junior physicians may be essential to establishing the next generation of institutional leaders. In this article from the *Harvard Business Review*, six common errors are introduced in order to provide practical strategies to maintaining the top talent.

The first mistake is to assume that the top talent is highly engaged.

The first mistake is to assume *that the top talent is highly engaged*. Instead, the top talent may expect more from their institutions than others since they have been very successful and are courted by competitors. To keep these superior junior physicians engaged, explicit recognition is necessary. One strategy for providing recognition beyond the standard “congratulations letter” is to help them network up the ladder by formally introducing them to senior leadership outside of their circle.

The second mistake is to *equate current high performance with future potential*. Instead of assuming that current top talent has great potential, 3 key attributes should be assessed since they correlate with “rising stars”: ability, engagement, and aspiration. To get the pulse on these attributes, one-on-one conversations between superior junior physicians

and physician leadership are necessary and could be accomplished through a structured mentorship program that partners superior junior physicians with senior physician leaders.

The third mistake is to *delegate down the management of top talent*. Oftentimes, junior physicians are paired with mid-level physicians for mentorship; however, promising junior physicians may be limited by their expertise. Instead, senior physician leaders should consider personally mentoring their superior junior physicians.

The fourth mistake is to *shield top talent from early derailment* by giving them “safe” projects. However, top talent may not grow to their full potential without challenges. This problem may occur, for example, when junior physicians are expected to take the lead for regularly scheduled meetings, like Journal Club. A lot of effort may be spent managing Journal Club, but superior junior physicians may become more engaged and better leaders by leading more challenging projects, like quality improvement initiatives.

The fifth mistake is to *expect the top talent to share the pain*. Even though leaders may be able and willing to suffer for the organization, junior physicians may have less personal and financial investments available to survive a “drought.” Thus, even in lean times, senior leaders may benefit from leaving the options of bonuses or salary increases open, in addition to developing alternative strategies for recognizing superior junior physicians, e.g. networking up the ladder, public recognition of local successes, etc.

The last mistake is *failing to link the top talent to the corporate strategy*. Understanding their organiza-

tion’s mission helps all employees realize the purpose of their tasks. The mission is even more important to top talent. In addition to standard

solving these common mistakes will lead to the identification, development, and retention of superior junior physicians

email updates from the leadership, one strategy is to include junior physicians in discussions with senior leaders about the mission of their organization.

During these lean economic times, maintaining superior junior physicians can be pivotal to the growth of a medical practice or institution. According to this article, solving these common mistakes will lead to the identification, development, and retention of superior junior physicians.

Common Mistakes About Top Talent

1. Assuming Top Talent are Highly Engaged
2. Equating High Performance with Future Potential
3. Delegating Down the Management of Top Talent
4. Shielding Top Talent from Early Derailment
5. Expecting Top Talent to Share the Pain
6. Failing to Link Top Talent to the Corporate Strategy

1. Newton DA, Grayson MS. Trends in career choice by US medical school graduates. *JAMA*. 2003;290:1179-1182.
2. Spickard A, Jr., Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *JAMA*. 2002;288:1447-1450.

Perspectives in Leadership

Nathan Spell, MD, Emory University Hospital (nspell@emory.edu) and Richard Gitomer, MD, Emory University Hospital Midtown, Atlanta, GA (rgitome@emory.edu).



Nathan Spell



Richard Gitomer

As of mid-2009, fewer than half of eligible patients in our hospitals were being vaccinated against pneumococcus and/or influenza. This was in spite of all sorts of awareness-raising, protocols and electronic reminders having been thrown at the problem over several years. We are pleased that now, from the beginning of 2010, more than 90% of patients are being appropriately vaccinated.

What has made the difference? The most important ingredient was attention. As the Chief Quality Officers for our hospitals, we had been involved in past efforts yet observed little progress. We knew the real work of vaccinating patients happened on the nursing units. Amid all the tasks in the care of complex inpatients, vaccination was getting dropped. Recognizing the major role played by nursing, our Chief Nursing Officer prioritized vaccine administration in her leadership role. To assist in responding to this priority, we scheduled regular conference calls between our hospitals with a

multidisciplinary team from nursing, hospital medicine, pharmacy and informatics.

The real ideas came from the front line staff. The momentum came from having one or both of us on the call each week for several months, joined frequently by a senior nursing leader, hospital COO, or other administrator. Leaders mentored, provided process improvement expertise and asked, "What are the barriers we can help to remove?" Between conference calls we visited the nursing units to thank staff for their hard work to vaccinate patients.

When Heifetz describes attention as a resource available to leaders, it is not so much the attention of the leader to a challenging problem as it is the leader's ability to effectively focus the attention of others. When the leader happens to be "the boss," focus on the problem may flow through lines of authority. However, in our positions at Emory no one reports directly to us. Creating attention in others when the leader does not

have direct authority requires a different approach. For those of us in academic medical centers, lines of authority are complex, often parallel or intersecting (think academic department v. hospital or clinic staff, employed v. private practice). We may talk of the administrative matrix or grid. We lead by persuasion, partnership, and good will.

In the case of our vaccination problem, the personal attention by leaders did matter, empowering and coaching the staff to create innovative solutions, while removing barriers that they encountered. Recognition goes a long way, too—we asked staff members to present the improved results at leadership meetings and assisted them to submit the work for local and state awards. In the end, though, there was no substitute for showing up and rolling up our sleeves.

Heifetz RA, Leadership Without Easy Answers. "Attention is the currency of leadership." Harvard University Press, 1994.

This **Perspectives in Leadership** article highlights an important skill in leadership, developing a vision and motivating individuals to achieve it. In the case of the Emory Hospitals, the vision was to achieve a better immunization rate. In the role of Quality Improvement, Dr. Spell and Dr. Gitomer knew what they wanted to achieve but could only effect the change by sharing their vision with the front-line, the nursing staff. They describe how they drew attention to the problem with a team approach, identified obstacles to overcome, and relied on referent power to exert influence.

Our vision is to bring real-life leadership scenarios and lessons to you. 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.