

Taking AAIM

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Imagine that you have the chance to address nearly all of the professionals in organized academic internal medicine in one place. I had such an opportunity when I was invited to deliver a plenary luncheon address during Internal Medicine Week in Philadelphia last October.

Internal Medicine Week represents the federation called the Alliance for Academic Internal Medicine (AAIM). Its constituent groups include the Association of Professors of Medicine, the Association of Program Directors in Internal Medicine, the Association of Specialty Professors, Clerkship Directors in Internal Medicine, and Administrators of Internal Medicine.

Ostensibly, I was asked to speak about the impact of health care reform on training programs in internal medicine. AAIM represents the single largest annual gathering of these teachers from around the country. Graduates of these programs will become P&T members of the future. Here is the gist of my talk:

My job today is a tough one—namely, to address this question: what is the impact of health care reform on academic departments of medicine and their affiliated training programs?¹

There are many smart people in the audience today, and I'm confident that all of you read the newspaper and watch television news. So, regardless of the specific legislative outcomes from our leaders in Washington, what, then, are the key themes that are emerging, and how should we respond?

First, some caveats. I do not have a crystal ball that is any clearer than yours. I do not have the recipe for the "secret sauce" of health care reform, nor am I directly connected with any of the specific individuals who are involved in writing reform legislation.

It's for precisely these reasons that I have an opportunity to analyze what is going on inside the Beltway and to interpret these possible changes with regard to the curriculum for academic departments

of medicine. Writing in *JAMA*, two major leaders, Dr. Edward Miller, Faculty Dean and President of Johns Hopkins Health-care, and Dr. Paul Ramsey, President of the University of Washington Health System, have declared that academic medicine has one overarching goal—to improve the health of the population.² I will use this as my jumping-off point.

I will describe what I call the four pillars of reform and then outline five themes that will enable us to operationalize these pillars. I will end with three critical challenges to academic medicine.

What are the four pillars? They are to create value in the system, insure everyone, change the pernicious payment system, and coordinate care.

We must create value because we currently spend more than any nation on earth, nearly \$7,000 per person per year, including children, and we do not score in the top 30 of any recognized worldwide measures of societal well-being.

In accordance with the Judaic concept of *tikkun olam*, "to heal the world," we now strive to insure everyone. This is the only way that we will be able to achieve an equitable distribution of resources and afford the changes ahead.

We must change the payment system and move away from piecemeal.

Currently, there are more than 16,000 CPT [Current Procedural Terminology] codes and none for coordinating care. Only through coordinating care will we make [health care] truly patient-centric.

How, then, might we operationalize these pillars? I believe that there are five critical themes that will enable us to make this dream a reality.

The first is to link the payment system to quality. Of course, the Centers for Medicare and Medicaid Services (CMS) is already moving rapidly in this direction with the advent, in October 2008, of a list of nonpayment events. This list has expanded in 2009, and now there are nearly two dozen nonpayment events. From a training program perspective, this means we must move from so-called eminence-based care to evidence-based care. We

must promote a culture of critical self-evaluation based on measurement and reflection. Dr. David Asch and his colleagues, writing in *JAMA*, have been able to rank obstetrics/gynecology residency programs based on maternal outcomes.³ I believe that a comparable model will move to internal medicine training programs.

The second theme is to encourage coordination and teamwork. These soft concepts, often ridiculed by our most senior leaders, are critical. How much formal training have our interns, residents, and fellows received in the area of teamwork? I believe many physicians falsely contend that teamwork cannot even be taught. We must be role models for the behavior that we seek. We must give away what we want most.

We must focus on [disease] prevention and wellness. How might this fit into the educational continuum? We must provide special experiences for trainees to follow chronically ill individuals throughout their training experience. We must promote a longitudinal and population-based view of health and wellness. Next, we must practice the tenets of disease management with our own employees in the temples of technology where most of us work.

We must promote comparative effectiveness research (CER). The way to do this is to study the Institute of Medicine's (IOM's) June 2009 list of top 100 priorities for CER. I believe that many aspects of this list would make wonderful house-officer research projects that could be led by teams of interdisciplinary faculty members. The IOM CER list ought to be the basis for a robust trainee research agenda.

Finally, we must implement quality-improvement tools and assume organizational responsibility for the patient safety agenda. We are faced with an epidemic of medical errors whereby hospital errors constitute the fourth leading cause of death in the U.S. In our training programs, we must make rectifying this our top priority. We could do that by embracing "crew resource management." Let's conduct a regular morning report based on the review of what went wrong last night.

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We must promote the scholarship of quality. For example, the entire December 2009 issue of *Academic Medicine* is devoted solely to this topic.

What, then, are the three challenges that lie ahead?

The first and most difficult challenge is our training culture. The messages of co-operation, teamwork, communication, quality improvement, safety, and evidence-based practice are all major threats to the status quo. There are insufficiently trained faculty members to help us change the extant culture.

The second major challenge is to create a cadre of physician leaders for the future. Wendy Levinson and colleagues, writing in *JAMA*, noted that there might be a new career pathway for clinicians in quality improvement.⁴ We must embrace this new thinking. We must prepare a curriculum for physician leaders, and that is one of our main leadership responsibilities.

The third challenge recognizes certain political realities. We must have the political will to implement these changes at the highest level. It must be sustained and executed appropriately. While certain organizations such as Geisinger, Mayo, and the Cleveland Clinic are held up as national examples, they are, regrettably, not nationally applicable. We need a new political reality.

Finally, colleagues, let me summarize: We have outlined the four pillars of reform, we have described five specific themes for action, and we must appreciate three critical challenges moving forward. In conclusion, to paraphrase the work of Dr. Frank Davidoff, all physicians have two jobs: the job of doctoring and the job of improving the first job. Every day, when we come to work, we must keep this admonition in mind.⁵

There you have it. A little bit of fire and brimstone, for sure, but my talk was met with sustained applause by more than a thousand individuals representing the current leadership of academic medicine from across the nation.

What is your P&T committee doing to work with trainees at all levels in your organization? How are you preparing your P&T committee members of the future? Who is tracking the possible implications of health care reform in your organization?

As always, I'm very interested in your views. My e-mail address is david.nash@jefferson.edu. Be sure to visit my blog at <http://nashhealthpolicy.blogspot.com>.

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