Honoring
Harry R. Kimball, MD
President Emeritus
American Board of Internal Medicine
and ABIM Foundation

Inaugural Lecture

Leadership in Quality of Care and Changing the Future of Medicine

Risa Lavizzo-Mourey, MD, MBA
President and CEO
The Robert Wood Johnson Foundation

ABIM Foundation Forum
August 1, 2004

Harry R. Kimball, MD
President and Chief Executive Officer
American Board of Internal Medicine
and ABIM Foundation, 1991–2003

John M. Eisenberg, MD, MBA (1946-2002)
Director of the Agency for Healthcare Research and Quality
The Kimball Lecture presented on August 1, 2004
is dedicated to Dr. Eisenberg.

Mark Kelley, Chair, ABIM Foundation, and Douglas Zipes, Chair, ABIM Board of Directors (2002-2003) surprise Harry Kimball, President, ABIM and ABIM Foundation with the announcement of The Kimball Lecture at his retirement dinner on June 9, 2003.

THE KIMBALL LECTURE

On June 9, 2003, Mark Kelley, MD, Chair of the ABIM Foundation announced the creation of The Kimball Lecture to honor Harry R. Kimball, MD, President and Chief Executive Officer of the American Board of Internal Medicine and ABIM Foundation, for his remarkable leadership and numerous contributions to the Board, the specialty of Internal Medicine and the profession of medicine.

The accomplishments of Dr. Kimball are too numerous to list comprehensively. They include leading the Board's efforts in bold and visionary strategic planning, the creation of the ABIM Continuous Professional Development Program for maintenance of certification, a new defined role for the ABIM Foundation to advance medical professionalism and physician leadership in quality improvement and assessment, the recognition of certification in five new disciplines, expanding and relocating the Board's office across from Philadelphia's historic Independence Hall, the annual publication of residency program pass rates, the listing of diplomates' certification status on the ABIM web site, and the recent implementation of computer-based testing. Internationally, he also established a unique collaboration between the ABIM Foundation, ACP Foundation and the European Federation of Internal Medicine that resulted in the Physician Charter on Medical Professionalism and its subsequent widespread endorsement.

The inaugural Kimball Lecture is dedicated to Dr. John Eisenberg. To quote Dr. Jordan Cohen, President of the Association of American Medical Colleges and Trustee, ABIM Foundation, "John's death in 2002 left internal medicine and indeed, all of medicine with a gapping hole. As a member of the ABIM Board of Directors from 1987-1993, John was a star. As Director of the Agency for Healthcare Research and Quality from 1997-2002, he was an entire constellation -- illuminating the whole field of quality improvement. As a former member of the ABIM Board of Directors and a close colleague of both John and Harry, Risa Lavizzo-Mourey is the perfect person to symbolize the connection between Harry and John and, hence, to deliver the first Kimball Lecture." It is also fitting that DD Eisenberg and her son, Michael, are participating in this inaugural event.

Harry R. Kimball, MD, MACP served as President and Chief Executive Officer of the American Board of Internal Medicine and the ABIM Foundation from 1991 to 2003. Dr. Kimball was elected to the ABIM Board of Directors in 1983 and served as Chair from 1989-1990. Dr. Kimball received his medical degree from Washington University School of Medicine in St. Louis and completed residency training in internal medicine at the University of Washington School of Medicine in Seattle. He served seven years at the National Institute of Allergy and Infectious Diseases and 14 years in the clinical practice of internal medicine and infectious disease in rural Washington State. Currently, Dr. Kimball is serving as the Senior Advisor to the Dean, University of Washington School of Medicine were he also is a Clinical Professor of Medicine. Dr. Kimball was Professor of Medicine at Tufts University and Chief of General Internal Medicine at the New England Medical Center in Boston, and Adjunct Professor of Medicine at the University of Pennsylvania. He is a Master of the American College of Physicians, Fellow of the Royal College of Physicians (London), distinguished Fellow of the European Federation of Internal Medicine, and holds an honorary degree of Doctor of Science by Jefferson Medical College of the Thomas Jefferson University.

Risa Lavizzo-Mourey

Dr. Lavizzo-Mourey is the fourth President and Chief Executive Officer of The Robert Wood Johnson Foundation, a position she assumed in January 2003. She originally joined the staff in April 2001 as the Senior Vice President and Director, Health Care Group. Prior to coming to the Foundation, she was the Sylvan Eisman Professor of Medicine and Health Care Systems at the University of Pennsylvania, as well as Director of the Institute on Aging. She served on the ABIM Board of Directors from 1996–2001. Dr. Lavizzo-Mourey has served on numerous federal advisory committees including the Institute of Medicine's Panel on Disease and Disability Prevention Among Older Adults; the National Committee for Vital and Health Statistics; and the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Risa Lavizzo-Mourey, MD, MBA
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The First Kimball Lecturer

She recently completed work as co-director of a congressionally requested Institute of Medicine study on racial disparities in health care resulting in the publication of Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care. The recipient of numerous awards, Dr. Lavizzo-Mourey has been recognized by the Harvard School of Public Health, Department of Health and Human Services, The National Academy of Sciences, American College of Physicians, National Library of Medicine, American Medical Women's Association, National Medical Association and University of Pennsylvania. She is also a member of the Institute of Medicine of the National Academy of Sciences. She earned her medical degree at Harvard Medical School followed by a Masters in Business Administration at the University of Pennsylvania's Wharton School. After completing a residency in internal medicine at Brigham and Women's Hospital in Boston, Massachusetts, Dr. Lavizzo-Mourey was a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania where she also received her geriatrics training. Her lecture, *Leadership in Quality Care and Changing the Future of Medicine*, is published on the following pages.

THE KIMBALL LECTURE

LEADERSHIP IN QUALITY CARE: CHANGING THE FUTURE OF MEDICINE

Thank you, Mark. And good morning. And thank you, Chris Cassel for inviting me to join you. When Chris told me that my job is to wake you up with The Kimball Lecture, I thought - "Yes!"

Harry was Chair of the American Board of Internal Medicine (1989-1990) and then President and CEO for 12 years. He supported my joining the ABIM Board of Directors - of course no one got on the board unless Harry supported them - but he was particularly welcoming to me. He and Nancy have been good friends to Bob and me ever since.

Harry, I bet that you really love this. First, they actually name a lecture after you. Then they invite me, of all people, to give it. And if that's not intimidating enough - they make me give your lecture with you sitting in the audience! Sort of like Simon, that scary judge on "American Idol" that my kids tell me about.

And, Harry, you also scared me a little bit when I was brand new on the ABIM Board. Something about how you're able to see over the horizon, to look into the future, to understand what's out there, waiting for us. How do you do that?

As I think about it, you're the best soul to follow Bob Petersdorf at the University of Washington up in my old hometown, Seattle. Harry even reminds me of Bob Petersdorf.

When I was a medical student at Harvard I did my third-year rotation at Brigham and Women's. Bob Petersdorf was already a legend there - and a bit of a curmudgeon to boot - and he intimidated me the same way you do, Harry. I can't seem to escape either one of you. And I'm grateful for it everyday.

Last fall, Jordy Cohen asked me to give the Petersdorf Lecture at the Association of American Medical Colleges (AAMC) annual meeting. And just like Harry this morning, Bob was sitting right out front.

Kimball and Petersdorf - still teaching all of us in their own ways.

There's another legend who should be here - John Eisenberg. What a wonderful gift his life gave us!

I have a particularly fond memory of a dinner I had with Harry and John, the three of us analyzing the state of internal medicine and what it was going to take to make health care better for all patients.

Well, John's not with us, but DD Eisenberg is - and DD, it's great to see you, and your son, Michael. John was a colleague, a friend, and a mentor to many of us. For me he was all of those things, and a hero, as well.

I don't think I've known anyone with such a voracious intellectual appetite. John underlined and annotated anything and everything he read. Books, journals, newspapers, memos, reports - his scribblings recorded how he saw the world around him.

DD, I remember the day in your home when John was so ill and you got me to read aloud from a book that was crammed with John's notations. From the bookshelf by his bed I pulled a volume called *The Wisdom of Jewish Sages.* Inside, I found this beautiful simple passage. I'd like to read it to you.

> *We are here to act.*
>
> *We are life's way of getting things done.*
>
> *The reward for action?*
>
> *The opportunity to do more.*

This morning, John would probably quote something like this himself, wouldn't he? He'd say, isn't this exactly why we're here? To act. To get things done. To do more. I certainly think so. And I know many of you do, as well.

Just consider the theme of this meeting. How are we going to cross this quality chasm, anyway? My word, it seems like a very hard job. Maybe that's because it is a very hard job. The barriers are formidable, they are systemic, and they are mostly of our own making. They obstruct the work of each of us.

We get so used to them, we accept them. They become normal. But when you pile all the roadblocks in one place, you see how overwhelming an obstacle they really are. Just consider:

- Racial, ethnic and gender disparities persist in just about every corner and cranny of our health care system.
- And patient safety? A majority of Americans say they are afraid that if they go in the hospital, something bad is going to happen to them.[1] And just the other day here comes a new study saying medical errors are killing twice as many patients a year than the IOM estimates which, if true, would make medical mistakes the third-leading cause of death, next to heart disease and cancer! [2]

  The public's fear is so real, it is part of our popular culture. Go to the web site of the TV show "ER," where most people get their health information. There you'll find a link to the home page of John Eisenberg's own Agency - AHRQ - and a list of "20 Tips to Help Prevent Medical Errors."

- There's more: Despite all our clinical technology, health care's information technology is weak, worn and wanting. Jiffy Lube does a better job managing its customer information.

  When is the last time you got a postcard from your doctor reminding you to come in for that mammogram or colonoscopy? Most doctors' offices don't even have an information system to help them take better care of their patients.

  The hard truth is that there is a strong disincentive to do anything differently. Systems are expensive and hard to maintain. Any cost savings go to the insurance companies, and not to any practicing physician's bottom line. No wonder health care's put off putting in a sophisticated, integrated IT system for so long.

- Meanwhile, our health care financing system is so unfair that it allows more than 44 million people to go without any health insurance coverage at all, and then hospitals charge the uninsured more than they charge anyone else.

- Of course, overall costs keep rising. Prescription drugs up nearly 30 percent in three years, some jumping five and six times the annual rate of inflation last year alone.[3]

- And health care's share of our gross domestic product - now about 15 percent - and will push to at least 18 per cent by 2012[4] if nothing happens.

There is one more serious barrier to change. Its shadow looms over this entire meeting.

I'm talking about the ponderous way we educate, train and certify medical students, residents and physicians - in a system that, frankly, reinforces process, procedure and the pursuit of the research dollar with more vigor than it promotes the quality of care and positive patient outcomes. The truth is, the breach between medical academia and the quest for quality of care is so great, it is a chasm all of its own.

Remember what the IOM told us three years ago? It said, "The current system cannot do the job. Trying harder will not work. Changing systems will." It was almost a relief to hear this, "Trying harder will not work. But changing systems will."

This liberated us, you know. It gave us permission to stop doing things the old way. It freed us to start doing things a new way. And it inspired us to create that new way ourselves. And just in time, too.

As Chris Cassel wrote in the *Annals of Internal Medicine* just a few weeks ago:

> The pressure is on...from payers and consumers alike, for academic medical centers to demonstrate their excellence rather than merely assert it.[5]

So - where do we begin? How do we do this?

It is reassuring that the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committees (RRCs) are on the same track. What's broken can be fixed, but only with profound, transforming, lasting change. More on that in a minute.

First, I want to tell you about some of the systems changes The Robert Wood Johnson Foundation is supporting, and what we have learned about medical education in the process. Then I want to show you how some of our work at the Foundation dovetails with the "back-to-basics" movement in medical education that is becoming the new accreditation model for internal medicine's residency programs.

The IOM told us that our system operates out of hardened silos, with little exchange of patient information, with poor coordination among health providers and settings, and with a dangerous discontinuity of care. Just look at the fractured, ineffective way we care for people with chronic conditions, they said. And if any part of our system needs restructuring right now, it is chronic care.

So at the Foundation, we said, "OK, we can do that." After all, 100 million people in America suffer from chronic conditions.

And improving the quality of their care is one of our four goals - along with covering the uninsured, promoting healthy communities and lifestyles, and reducing the harm from substance abuse.

And there is another reason we decided to act on chronic care.

At The Foundation, we are guided by a fundamental principle. That principle tells us that we are stewards of private resources that must be used in the public's interest, particularly to help the most vulnerable in our society.

Who among our patients is more vulnerable then those burdened with chronic conditions that so drastically diminish the quality of their lives and so severely strain our health care system? That is why when it comes to chronic care, we will stay on mission until the solutions are clear, momentum is ours, and progress is secured.

Our program is called *Improving Chronic Illness Care*, or ICIC. We're spreading a model of high quality care for chronic conditions to hospitals, HMOs, medical practices and health care clinics. The lessons we're learning are spot on with the issues you're addressing at this meeting.

Many of you know Ed Wagner. He is director of Seattle's MacColl Institute for Healthcare Innovation. He's also ICIC's national program director. As Ed sees it, shortcomings in the system are usually treated as shortcomings in individuals.

Conventional wisdom says, “Just try harder, and do better.” Give doctors more training, hospitals more nurses, clinics more preventive care programs, and you will fix the system. The problem is the conventional wisdom is wrong.

Ask yourselves this: If we have all these well-trained doctors, nurses and pharmacists working their buns off trying to do the best they can for these patients, why are patients’ needs still not being met? The answer is obvious: It is a problem with the system.

To fix it, Ed Wagner’s team developed a model that more than 900 collaborative health care teams have been putting into action in every region of the country. The aim is to see how hospitals, HMOs, medical practices and clinics can dramatically improve care for people with chronic conditions by restructuring their systems.

What we are trying to do is jump start quality improvement. And to jump start it...

√ With clinical competence and improved outcomes at the point of service.

√ With objective measurements of performance.

√ With changes in infrastructure.

√ With intense regard for patient safety.

√ And with a heightened imperative for accountability.

The results are compelling:

- More communities are providing more services for more patients with chronic conditions.
- Primary care physicians and specialists are, at last, on the same page.
- Office practice priorities are shifting from output and process to outcomes and patient progress.
- And though patient visits are increasing, the cost of chronic illness care is decreasing.

The Bureau of Primary Health Care has embraced the Chronic Care Model and is using it to elevate the quality of care for tens of thousands of patients at the Bureau’s 700 federally funded health centers. This sends a message that this is, arguably, the largest, most important health care quality improvement initiative in the country.

I think they’re right, because just last Wednesday I saw it at work myself. After three-years out of the action, I’ve gone back into clinical practice at a community health clinic in New Brunswick. My first day in the clinic, I discovered they’re implementing the chronic care model for their diabetics. They’ve grouped the patients in a diabetes registry, they keep running track of key indicators, and they pro-actively manage each patient.

That’s what they do inside the clinic. But outside the clinic, there’s no other integrated part of the system to plug into. Much of their good work withers and wilts because there’s simply no one else to pay attention to it.

I watched one attending spend a half hour on the phone trying to get just one patient an appointment with a specialist. That’s nuts - and our patients go through that on their own all the time. How in the world can doctors take care of patients if so much of their time and energy is chewed up fighting a system that seems hell bent to make their job harder, not easier?

We want to change that.

At the Foundation, we are investing heavily to improve both systems and patient outcomes dramatically. One important program of ours is called *Pursuing Perfection*. We competitively selected a group of hospital and physician organizations to provide care far better than the accepted norm. We want them to deliver the kind of high-performing, outcomes-based programs the IOM says we need, and we believe they can become the new norm.

When we put the program together, we assumed that clinical institutions affiliated with academic health centers would run way ahead of the pack of the 226 competitors. But, to our great surprise, that’s not what happened at all. With one lonely exception, academic health centers failed miserably. Cincinnati Children’s Medical Center was the only one to make the final cut.

We were shocked. What happened? Why did academic health centers fare so poorly? It was a real mystery.

To get the answers, we turned to David Blumenthal from Massachusetts General Hospital. We hoped the answers would solve the mystery, and teach us how to better promote quality improvement in academic health centers in the future. David and his staff interviewed dozens of experts - from CEOs to staff nurse managers to professors, physicians and quality improvement project managers. Some of you offered your own insights.

Then we assembled a panel of 17 more experts for even more feedback - a confirming form of “peer review.” The results were jarring, especially for someone like me, who has committed the better part of a whole career to academic medicine. It was hard to take.

But upon reflection, the findings are a trouble-shooter’s guide to what needs to be fixed.

First, the experts found that quality improvement is “orders of magnitude harder” in academic health centers than in any other care setting. No one’s got it tougher than you guys. Academics and health care professionals are so overwhelmed by research, teaching and patient care missions that little “mind space” remains for anything else.

Second, incentives to correct quality failings range from few to none. Some academics look down on quality initiatives - to quote David - as the "hobgoblin of little minds." Many institutions avoid self-examination and actually seem incapable of acknowledging failure when it occurs. In other words, the resistance to change is unbending. Sound familiar?

Third, the experts confirmed that in the academic world patient care is not highly valued. Research rules. Research is what attracts the big money, the world wide recognition, the professional celebrity, and the choice space on campus. The pressure for government-funded research is so intense that patients are viewed merely as a means to a monetary end. My word, how can we even think of improving the quality of patient care when patient care itself doesn't even count in the first place?

Fourth, the old way of doing business makes it tough for leaders to truly lead. As you know, in the academic environment, the real power is dispersed throughout a star system of elite researchers, celebrity clinicians and tenured faculty - as in each for one and none for all.

What's missing is a sense of "mission management," or of a team working in unity, or of common cause. Any kind of mission-driven effort to improve the whole is beaten back by a culture that values individuals more than the whole. Talk about self-sabotage. No wonder the system churns out generation after generation of medical and health care professionals who don't have a clue how to improve the quality of care, or that it needs any improving at all.

And, finally, the missionary zeal of some quality advocates hurts their cause more than it helps. "True believers" are a turn off for academics that see more of a cultish movement than an evidence-based necessity. What's missing, the academics say, is adequate empirical proof that change actually works.

At RWJ, we couldn't agree more. To fix what's wrong, the best solutions must be based on solid evidence, just like the best patient care. This is where our *Pursuing Perfection* program comes in. We want to uncover, and then apply, the latest, most relevant knowledge - not just of medical science, but of the other sophisticated disciplines necessary to accomplish near-perfect patient care.

If this sounds familiar, it should. It tracks much of what's been published the past few months in the *Annals of Internal Medicine*. It also tracks the trailblazing recommendations coming out of ACGME and the Residency Review Committee for Internal Medicine. Many of you've been part of the committee's remarkable effort. It's an incredible contribution you're making!

What you've set in motion will bring about nothing less than a revolution, and I use the word advisedly. This really will be a revolution, because it will bring about a radical change in what transpires between medical teachers and medical learners, between performance and accountability, between quality and patient care.

What's exciting is that your revolution - or should I say our revolution - will, indeed, liberate this hide-bound medical education system of ours. Just think of the legacy our medical generation can leave to the next. We can release today's trainees from outdated attitudes that tell them - erroneously - that more medicine automatically means better medicine.

Last year, Fisher and Wennberg's seminal study on regional variations in Medicare spending convincingly showed us that more intensive practice may actually lead to lower quality care, less safety for patients and as much as 30 percent in higher costs. Lower quality. Less safety. Higher costs. Something's wrong.

I believe that it's absolutely essential that residents learn this - and learn it well - so they will ask what's enough medicine? What's too much?[6] What's just right?

We agree wholeheartedly with the RRC that the only way to make sure those questions are asked the right way at the right time is to strategically transform the way we train residents. And for me, the issue is no longer abstract, because - as I said - I've returned to my clinical roots.

Like many of you, my job demands that I view our health care system's problems from 30,000 feet. But we need to get a lot closer to the ground to stay in touch with how things really are. That's why I was so excited when I started supervising residents last week. I'd been away so long I was eager to discover not just what the resident's know, but also what do they do with what they know. And I wanted to see if they are open to a change in approach and attitude.

At The Foundation, we believe residents can be important agents for change. We set out two years ago to see if we could apply web-based teaching technology to transform medical residents at 18 academic health centers scattered across the country.

The program is known as ACT - for *Achieving Competency Today*. It's a four-week course in how to change the system by learning new competencies. It's interactive, with real world assignments, real live faculty preceptors, and an entrepreneurial charge to redesign their own program's curriculum. Then they get to teach it to other residents and other faculty, too.

All the residents need to do to is what I've done, power-up their laptops and download ACT's curriculum off the Internet.

First, they learn about the health care system itself and how it affects the care they deliver. Next, they learn who pays for care, and why that matters to the work they do.

They learn how to improve the care of individual people, populations and practices. And they learn how to spot systems failures and quality problems and, then - now listen to this - how to fix them.

What really counts is how they translate learning into action.

Listen to some of the actions they have taken to improve the quality of their own systems:

1. Reduced patient waiting times.
2. Set up a call-in time system to ensure a resident was always available for patients.
3. Figured out why so few patients were getting flu shots - and corrected it.
4. Set up their own plan to deal with work hour limitations.

This is just a smattering of the things the residents - the learners - have done.

There's another reward from unloosing residents as change agents. They change their teachers in the process. Some faculty report learning almost as much from ACT as the residents learned.

Now I have to tell you, at The Robert Wood Johnson Foundation, we're a pretty optimistic crowd. But the excited response to ACT surprised even us. Residents told us the experience is eye-opening, empowering, even life-changing. They said it was the first time they'd felt included in the design and execution of their own education.

A resident in Boston said: "ACT was inspiring. Usually people dictate what we learn. This is a model for change that incorporates the insights of many people - and results in better outcomes."

At Johns Hopkins, one of David Hellmann's residents told us that ACT had motivated her to seek a fellowship in internal medicine with a focus on national health policy. Isn't that what we want? ACT, she said, was "career transforming."

The residents' excitement is so contagious that it literally jumps off the pages of their reports. It's like a snapshot of our revolution. Perhaps one of the most profound lessons of our revolution is what happens when the learners teach, and the teachers learn.

Now that's a real systems change.

A final observation: It's become apparent to us that when you tear down the old obstacles to change, you can get to a new place, a place where the delivery system and medical education and patient care all converge to show us what good quality care should look like.

And right there, where you didn't expect it, is where you will find that long-sought common ground. The place where culture and attitude, knowledge and learning, and the forces of change can coalesce.

This is a place where the wise elders of medical education and the raucous new generation of medical learners can discover together just how much they have to learn from one another and to give to one another. This is a place where your vision as medical leaders becomes clear, where your vision becomes shared, and where the future of medicine on the other side of the quality chasm becomes reality.

I guess you could call this a teachable moment. It's a moment John Eisenberg would treasure.

In that book of wisdom of his that I read from before, there was another passage that seems to fit this moment just right. In my reading it to John that day, it became John's last gift to me. This is what it says:

> *One who learns in order to teach*
> *Will be granted the opportunity*
> *Both to learn and teach.*
>
> *One who learns in order to do*
> *Will be granted*
> *Not only the opportunity to learn and teach,*
> *But also the opportunity to do and be fulfilled.*

This is my wish for all of us that we seize this teachable moment. That we each be granted the opportunity to do. And to truly be fulfilled. And to know with quiet confidence that we are, indeed, making our particular corner of the world so much better for those around us.

Thank you.

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[1] Health Pulse of America Survey, May 2003, Center for Survey Research, State University of New York - Stony Brook. Results posted on the Center for Survey Research Web site at: http://ws.cc.stonybrook.edu/surveys/HPAMay03.htm

[2] Allen, S. Higher Toll Cited from Hospital Errors, *Boston Globe*, 27 July 2004:A9.

[3] Kaufman, M. and Brubaker, B. Higher Prices Erode Value of Medicare Cards. *Washington Post*, 25 May 2004;E01.

[4] Centers for Medicare and Medicaid Services, Health Spending Projections for 2002-2012, *Health Affairs*, Web Exclusive, 7 February 2003. Abstract available at: http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.54v1

[5] Cassel, C.K., Editorial-Quality of Care and Quality of Training: A Shared Vision for Internal Medicine? *Annals of Internal Medicine*, 2004: 140: 927-928.

[6] Phelps, C.E., Editorial-What's Enough, What's Too Much? *Annals of Internal Medicine*, 2003; 138: 349.

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The mission of the ABIM Foundation is to advance medical professionalism and physician leadership in quality assessment and improvement.

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