ACP Workforce Summit

1. What is your table number? *

2

2. What current workforce problem do we want to solve? *

Too much time spent operating at bottom of license (administrative tasks)

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

AI agentic admin solutions like ambient scribing, email inbox management/triaging

4. **What is the novel application of how you could use that model to address this problem?**

Studies (guidelines?), building evidence/financial case for investments

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

- Cost (uneven, distribution of funding/investment capabilities)
- Fear/AI illiteracy
- Change resistance

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

- Study and assess, drive inter-system dissemination of highest yield, best-evidence-based solutions
- Increase general AI literacy to lower barrier of resistance/fear
- Leverage power of community to influence accessibility and affordability?

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

- Technology partners?
- Other societies, regional organization partnership
- CMSS, other inter-society collaborators

ACP Workforce Summit

1. What is your table number? *

6

2. What current workforce problem do we want to solve? *

The need for more seamless communication method between IM specialitsts and sub-specialties with better care coordination methodologies.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

The Stanford team-based care model and the ECHO model expanded to other specialties.

4. **What is the novel application of how you could use that model to address this problem?**

The novel application is reskilling.

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Upskilling will only happen if the physician wants to be upskilled.
Primary Care Physicians are beyond saturation and overwhelmed with information overload in their inbox.
Ensuring that eConsult requests to specialists have specific expectations included in the request.
Make the EHR the facilitator and not the barrier through interoperability. Work with stakeholders to improve interoperability across the EHRs.
Supporting team based care.
Payment lack of reimbursements for econsults
Lack of reimbursement for the number of team members.

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Integrating technology into the process
Engage the full team by delegation to reduce the information overload. Create a higherarchy of delegation.
Collaboration between patient advocacy groups.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

Societies can advocate for a code for the ECHOS so it can be billable and trackable
Collaboration with all other medical societies

ACP Workforce Summit

1. What is your table number? *

16

2. What current workforce problem do we want to solve? *

- The work doesn't match the calling (solving for How physicians work). Figure out how to optimize the work environment, use physician skills more for patient care and less for admin burdens etc., optimize physicians working at their license level. This applies to both generalists and subspecialists. Will help solve for burnout, quality of life.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

- It takes a team to care for people at the population level. Provide/develop a system that supports team-based care, builds in supports, and is collaborative and respectful and educates all team members (such as what we heard from Anna Flatteau, Dr. Lin and Brian Brady).
- Co-create with a local community organization/organizations served

4. **What is the novel application of how you could use that model to address this problem?**

- See #2 for examples of this

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

- Leadership with good change management skills (and support from leadership)
- Resistance to change
- Resources and resourced communities
- Hiring the appropriately trained people for the roles, and having them available (clinical pharmacists, psychiatrists, case managers, etc.)
- Having training available
- Language barriers
- Large underserved populations
- Anticipating potential downsides and mitigating them (eg, protecting the physician-patient time)

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

- Demonstrate the value of this model to their membership to help with scalability
- Facilitate learning collaboratives
- Advocating for it and explaining it, generating awareness, interest and momentum. Reinforcing positive messages of clinical medicine and primary care.
- Advocating for changes to GME, etc. to support this model

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

- ACGME: Change internal medicine training to more whole person, outpatient, preventive care. Increase ambulatory time in IM training. Programs can add primary care and rural tracks to their programs.
- Federal government – GME funding
- ACHE: Practice administrators and C-Suite decision-makers need to be on board
- State chapters/societies affiliated with the national society can help advocate and implement
- Keeping abreast with technology to keep trainees engaged

ACP Workforce Summit

1. What is your table number? *

11

2. What current workforce problem do we want to solve? *

Maldistribution of physician workforce

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

Short-term solution is ownership of some primary care by subspecialists for conditions proximal to the primary conditions they are treating.
Longer-term solution is advocacy around the RUC with elimination of budget neutrality.

4. **What is the novel application of how you could use that model to address this problem?**

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Teaching hospitals and some subspecialty lobbies.
Funding needs to be tied to slots, curriculum (increase ambulatory training) and infrastructure and support.
Void of unifying organization; labyrinth of organizations who may only touch a certain aspect.
Unregulated mergers, extreme consolidations that drive up reimbursement costs.

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Educating Congress that they need to put conditions on distribution of GME funding.
Allocate more slots to primary care. Require slots to have increase ambulatory training.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

National statement to impact the local levels – ACP to serve as convener for consensus statement representing all medical societies.
Need to make the business case.
Share knowledge across groups rather than reinvent the wheel.

ACP Workforce Summit

1. What is your table number? *

1

2. What current workforce problem do we want to solve? *

How do we effectively engage sub specialist colleagues from a systems design perspective? Specialtists aren't always thinking about populations, their focus is on clinical excellence. Untapped opportunity to codesign.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

Registry based, similar to collaborative care model for behavioral health. There are payment mechanisms attached to it that pays for the care coordination aspect. Pays for the staff member who runs the registry.

Some FQHCs have figured out a way to integrate specialists due to the bundled payments they receive which gives them flexibility to pay a higher rate to specialists but it may not be scalable unless you are a teaching health center. Specific to a place that receives bundled payment.

4. **What is the novel application of how you could use that model to address this problem?**

FQHC/Teaching health center approach - Enrich primary care with specialty integration. Elevating skillset of the primary care physician. Bring the nephrologist in and have them guide the care plan for the highest risk patient. Bring the power of the specialist into the community rather than expecting the patients to go into where they usually went - which often is a hospital and these are shrinking. The community hospital becomes the hub rather than the hospital.

Collaborative care model approach - Virtual presence of the specialist. They don't necessarily need to be present unlike at FQHCs.

Interoperable shared care plan where specialist and primary care both have access.

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Getting a specialist into an ACO is difficult.

FQHC approach may not be applicable to other settings. Different models may be applicable to different settings.

Need to advocate for a pilot or funding of the proposed collaborative care model.

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Multisociety demonstration project.

At the society leadership and staff model, collaborate to support pilots - consider funding a pilot. Something with cardiovascular risk reduction, prostate cancer for example.

Joint advocacy for new bundled models that bring primary care and specialties into payment and risk together.

Start by looking at low hanging fruit.

Engage all payers, not just CMS/CMMI.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

Health systems, FQHCs, payers

ACP Workforce Summit

1. What is your table number? *

14

2. What current workforce problem do we want to solve? *

How do we prevent earlier than necessary retirement in our workforce that may be feeling intimidated by the pace of change and the pace of change in technology as well as burnout.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

Upskilling for established attendings, not just trainees or midlevel clinicians.

4. **What is the novel application of how you could use that model to address this problem?**

recognizing the needs of senior physicians and don't exclude them from the extent and breadth of the educational resources that are needed now and available. Make it evident that we value what they bring to the table. This will take a concerted effort to make these established physicians feel valued. Emphasize the value of the human aspects of care both within AI and beside it. The trainees use open evidence to bring information to the attendings but don't realize the value of the deep experience that their mentors can bring to the table.

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Need an administration that wants to retain and take care of staff. Time and money are needed, but the allocation, especially of time has to be prioritized by those that run the system. Addressing the faculty that are already feel they are defeated and make them feel heard. Allow the affected clinicians the agency to say what they need to thrive in practice. There is no accountability in the c suite for physician and clinician burnout. If they were held accountable they would be more creative in making the needed changes

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Need to establish senior physician group in each society. Establish CME dedicated to “wiser” clinicians to bring them up to speed on AI. Focus groups of older clinicians to find out what they need. Encourage senior physicians to teach about the diseases that are unfortunately coming back and they have experience that the current generations do not in evaluating and treating them. Think strategically about retaining skills.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

Health care executives, AAMC to help in implementation

ACP Workforce Summit

1. What is your table number? *

10

2. What current workforce problem do we want to solve? *

Number of qualified physicians practicing the full scope of primary care, and access to them.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

Culture change, management of drivers, and GME redesign:
Addressing drivers of physicians into or away from primary care
- Within the discipline: change how we message value/prestige "just a PCP"
- Externally: change messaging to/for patients "you have to see your PCP first" "give the paperwork to your PCP"
- Federal funding drivers – work to set primary care outcomes alignment with federal funds distribution

4. **What is the novel application of how you could use that model to address this problem?**

- Restructure residency for more flexibility to allow more extended exposure to outpatient practice.
- Align GME funding incentives to outpatient primary care settings and primary care workforce outcomes
- Improve the quality of outpatient faculty work, not just the quantity
  - Set expectations for independent clinical work and experience in the scope of practice for faculty supervising residents in outpatient clinical care
  - Address skill gaps for faculty who are unable to model the scope of care in outpatient [outpatient procedures, physical exam skills, interdisciplinary care, women's health, office orthopedics, wound management, counseling skills, etc.]
- Expose residents to rural health, suburban health, and other non-urban/non-academic care options
- Incorporate AI tools and skills and operations improvements into the workforce training environment

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

- Misaligned funding
- Accreditation and certification – perceived
- Academic medicine prestige/recognition hierarchy valuing research over clinical expertise

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

- Improve unity of the internal medicine physician voice by unifying specialty organizations. Current societies cost $500 for membership + annual meeting attendance costs, so physicians can't/won't join more than one organization. If organizations better collaborate rather than splitting up the population among multiple societies there can be a unified voice
- Advocate using a more effective voice with patients/constituents engaged so that the message is better heard.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

o Improve cognitive skills of PCPs for modern AI work

ACP Workforce Summit

1. What is your table number? *

15

2. What current workforce problem do we want to solve? *

How can we make the work better:
How do we give physicians TIME (and autonomy follows), can technology help with inbox management
-how do we fully map how we spend our time and reward for value added time spent
-how do we pay for models that screen out unnecessary consults
-we now can get knowledge v quickly about specialty issues from ai, but what we need the specialists for is to advise us if that ai answer sounds right given x, y, z

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

We liked Brian Brady's model of easy and efficient consults
Value based models and get rid of FFS so we can do intervisit care and coordination that helps patients but isn't patient facing/a visit per se
Cleveland Clinic gives their docs 30 state licenses and has this "Clinic by the clinic" model, but not clear how to scale that

4. **What is the novel application of how you could use that model to address this problem?**

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Advocacy for value based model structure, pay and dedicated time to participate in e-consults
Create models and opportunities to facilitate care between specialties and primary care, help build the collegiality and sense of co-creating solutions
Advocate for multistate licenses or a universal, national license
Help show the value of coordinated care

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

ACP Workforce Summit

1. What is your table number? *

8

2. What current workforce problem do we want to solve? *

We want to have a sufficient supply of primary care physicians going into practice to meet the demand of the aging, diverse, and complex U.S. population.
Need to rebrand and address the issue going back to UME and before.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

Early pathways, mentoring, coaching, why are they choosing medicine in the first place? Rebranding and stop using inflammatory language.
Develop a comprehensive longitudinal program that starts even before UME that follows people through their education and professional development, anchored by metrics at the medical schools – UME and GME.
Trying to create a new future state of the IM workforce.

4. **What is the novel application of how you could use that model to address this problem?**

Need metrics on what types of physicians are being produced out of medical school. Need some incentives for medical schools to "invest" in primary care. Invest in the faculty and others mentoring the students with interest in primary care.
Have more outpatient medicine options in UME for training. Develop pathways for PC training that can lead to faculty roles at an institution and pay off part of their loans as part of the program.
Also develop pathway programs even prior to medical school – at the local colleges
Want to get to a point where you don't need additional funding to get individuals to go into primary care/general IM.

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Need to address payment and administrative burden – underfunding at institutions can make it seem very dysfunctional
Facing the UME and GME worlds and getting them to change.
When you start to look at engaging colleges and even high schools, the volume/scale is challenging.
Need to address diversity – you want to ensure that the program you develop brings in individuals that look like the population (and will serve the underserved/underrepresented)

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

ACP scholarships – get the students to our meetings where they can get mentorship that makes PC/general IM more appealing
Policy, regulatory, and legislative solutions are needed – ACP can help with that.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

ACP scholarships – get the students to our meetings where they can get mentorship that makes PC/general IM more appealing
Policy, regulatory, and legislative solutions are needed – ACP can help with that.

ACP Workforce Summit

1. What is your table number? *

12

2. What current workforce problem do we want to solve? *

Reduce silos in care – increase collaboration and communication across subspecialties to create a more effective workforce, e.g., reducing unreimbursed “curbside consults.” Reduce silos in reimbursement models and moving away from fee-for-service.

3. What solution or model (that we heard of or that you know) would “more efficiently use the expertise of IM specialists and subspecialists” to address this problem?

ACOs

4. **What is the novel application of how you could use that model to address this problem?**

A fully integrated ACO that incorporates AI to improve communication, coordination, etc.

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

- Reimbursement models and payers
- “Food fighting” among specialty societies
- Too many problems facing healthcare – focus and resources get spread thin, difficult to get subspecialties to coalesce around common priorities

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

- ACP has an important role in convening the subspecialties together and identify a shared focus/priority. Is AI an opportunity? GME?
- Events like this, sharing case examples and real-world examples.
- Societies should recruit and engage medical students, residents, and early career physicians in the society meeting. A lot to learn from them.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

Payers. ACO is a great model when it works, but it doesn't always work.

ACP Workforce Summit

1. What is your table number? *

9

2. What current workforce problem do we want to solve? *

Make primary care the foundation of the U.S. health care system. Increase the number and distribution (geographic and community need) of primary care IM physicians practicing in an outpatient setting.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

- Align accrediting bodies' (LCME, COCA, ACGME) requirements to match societal needs for greater access to primary care.
- Adopt Recommendations from Hess Initiative Workgroup on Learner Experience in Primary Care
- Unbundle GME from hospitals
- Increase funding for THCGME and NHSC,
- Expand Hospital at Home.
- Remove hospitals' incentives to fill beds and benefit from facility fees.

4. **What is the novel application of how you could use that model to address this problem?**

- Securing federal health care agency and private sector buy-in for increasing role for primary care
- Secure federal funding for UME and GME outpatient primary care training
- Educate patient community on role and value for primary care
- Convene with patient community

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

- There is a lack of public awareness and engagement of patient community.
- Most conversations are internally facing and do not engage external stakeholders
- Need for combatting inherent protectionism
- There is a lack of true systems

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

- Lobby and engage with accrediting bodies (ACGME, COCA, LCME)
- Engage with AMA
- Engage payers

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

- AMA
- Hospital associations
- Payers
- Federal health agencies

ACP Workforce Summit

1. What is your table number? *

13

2. What current workforce problem do we want to solve? *

HOW TO FEED THE FUNNEL? How do we keep the initial interest?

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

-More longitudinal programs to provide more regular experiences in internal medicine (functional practices) starting in med school
-Incentivize community physicians to work with students/residents – national program (perhaps an add-on code for a preceptor physician to code that a learner was a part of the patient visit to get paid more) Federal and Local state tax incentives
Incentivize academic physicians with more time, or FTE or RVU

4. **What is the novel application of how you could use that model to address this problem?**

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

-Academic physicians have an advantage to take students/residents vs those who are not academic/community health centers
-Infrastructure – internal medicine attitude of “don’t go into it” commentary; general perception of “what we do”

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Advocate for these programs with legislators; standardized legal agreement in the GME and IMG space to work (rotations) at other locations and not just their institutions; IMGs limited to where they can do rotations

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

” Government funding and health system “stakeholders” and third party payors collaborations; ACGME need to be involved, IMGS regarding visa rules for IMGs.

ACP Workforce Summit

1. What is your table number? *

7

2. What current workforce problem do we want to solve? *

The need for more seamless communication method between IM specialitsts and sub-specialties with better care coordination methodologies.

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The Stanford team-based care model and the ECHO model expanded to other specialties.

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The novel application is reskilling.

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

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Primary Care Physicians are beyond saturation and overwhelmed with information overload in their inbox.
Ensuring that eConsult requests to specialists have specific expectations included in the request.
Make the EHR the facilitator and not the barrier through interoperability. Work with stakeholders to improve interoperability across the EHRs.
Supporting team based care.
Payment lack of reimbursements for econsults
Lack of reimbursement for the number of team members.

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Integrating technology into the process
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Collaboration between patient advocacy groups.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

Societies can advocate for a code for the ECHOS so it can be billable and trackable
Collaboration with all other medical societies

ACP Workforce Summit

1. What is your table number? *

3

2. What current workforce problem do we want to solve? *

At Issue: Supply, demand and distribution; finding ways to increase supply and adoption

- Solutions are not “one-stop shopping,” so singular areas of focus/attack probably won’t work
- Increasing the GME supply isn’t enough— for example scope of practice across the continuum of clinician team members is now a critical component to facilitate improving
- Moving away from language that diminishes the profession and contributes to a perceived lack of respect
- We’re not putting enough effort in addressing the gaps as a starting point while we work toward more long-term solutions

3. What solution or model (that we heard of or that you know) would “more efficiently use the expertise of IM specialists and subspecialists” to address this problem?

How to imbed the models described today (ex: Dr. Brady’s ideas on subspecialty medicine being imbedded in care teams); being more inclusive of other clinicians—pharmacists, NPs, nutritionist, Pas, etc.

4. **What is the novel application of how you could use that model to address this problem?**

- Taking projects or models like ECHO and testing it in alternative scenarios
- Accelerating the implementation of new technologies using roadmaps, processes and determining the value-add with some agreed upon outcomes
- Don’t get hung on the “model.” Try to tease out the value the solution will bring to you

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

- We don't have evidence of effectiveness, safety
- Yet to be agreed upon outcomes; lack of trust in the validity of the product
- The "know-to do" gap is probably larger than we think!

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

- Educate, share real information, evaluate and create communities to vet what we're hearing, expecting to invest in, etc.,

Socializing awareness of some of the frameworks used today--like those proposed by Bedi, et al

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

ACP Workforce Summit

1. What is your table number? *

4

2. What current workforce problem do we want to solve? *

Not enough people are going into primary care

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

1. Capping specialist slots/matching roles
2. Enhance reimbursements for cognitive specialists/primary care
3. Mandatory service in a PC Specialty - Legal contracting before choosing subspecialty

4. **What is the novel application of how you could use that model to address this problem?**

Better incentives for medical school loans; incentive pay bonus for high need areas
Salary Parity between Primary care and sub specialists

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Inbox fatigue
Rural cycles are 2-year whiplash of physician turnover NHSC
Specialists maybe unwilling

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Measure workforce (National and Regional)
Financial Modeling followed with Legislative Backing is required
Decide quality care vs. 200+ processes

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

Congressional Buy-in
CMS Help

ACP Workforce Summit

1. What is your table number? *

6

2. What current workforce problem do we want to solve? *

Imbalance of inpatient and outpatient experience during and after training.
Making primary care more attractive and hospital medicine less the default.

3. What solution or model (that we heard of or that you know) would "more efficiently use the expertise of IM specialists and subspecialists" to address this problem?

Hospital at Home

4. **What is the novel application of how you could use that model to address this problem?**

Have residents train in institutions that have hospital at home

5, **What are the Barriers to implementation / application and widespread dissemination of this solution?**

Limited institutions have feasibility to do this.

Reimbursement issues, for Medicare there is the same DRG for a limited time, some commercial insurers allow it at a modified DRG, but not widespread. Currently works best within an ACO.

Training the faculty to train residents for hospital at home

What about patients who develop subspecialty needs while in hospital at home? (tele-consults)

6. **Action items for Medical Societies to facilitate the success of these models and their dissemination?:**

Medical societies need to advocate for ACGME to require IM training programs to have HaH experiences.

Medical societies should develop educational programs on HaH.

Have FQHCs qualify for hospital at home.

7. **What other needs are there and from which collaborators in order to ensure success from Medical Societies?**

APC programs- to train APCs to administer hospital at home with physician back up.

AHA- needs to see this as a beneficial.

Tech companies- to make effective, affordable tech widely available

CMSS- advocate to them give GME funding for hospital at home