

## ANNUAL MEETING UPDATE: PART I

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## SGIM Plenary Speakers Reflect on Population Health

Francine Jetton, MA, and Karen R. Horowitz, MD

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**S**SGIM's 2016 Annual Meeting theme is "Generalists Engaged in Population Health: Improving Outcomes and Equity through Research, Education, and Patient Care." Population health focuses on the health outcomes of a group of individuals, including the distribution of outcomes within the group. General internal medicine sits uniquely at the nexus of caring for individuals and populations, demanding us to achieve innovation and excellence in the education, research, and patient care of populations—one patient at a time.

Our plenary speakers will highlight the meeting theme throughout their presentations. Marshall Chin, MD, MPH, SGIM president and the Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine at the University of Chicago, will open the 2016 SGIM Annual Meeting with his presidential address titled "SGIM and the Developmental Life Course: Current Challenges and the Path Forward." The Friday plenary session keynote address and Malcolm L. Peterson Honor Lecture will be delivered by Timothy G. Ferris, MD, MPH, senior vice president of Population Health Management at Massachusetts General Hospital, Massachusetts General Provider Organization, and Partners HealthCare. His presentation is titled "Progress in Improving Healthcare Delivery."

SGIM recently asked the plenary speakers to reflect on the following questions as they prepare for the annual meeting. Their answers illustrate just how exciting this era is in our field and how engaging in population health will change the landscape of general internal medicine (GIM).

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## Hooray for Hollywood! Ten Reasons to Attend #SGIM16, May 11-14

Steven R. Simon, MD, MPH

*Dr. Simon is chair of the SGIM Annual Meeting Program Committee.*

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As the highlight of the academic year for many of us, SGIM's annual meeting will kick off on Wednesday, May 11, at the Diplomat Resort and Spa in Hollywood, FL. Here are ten reasons to attend this showcase event, whether this is your first meeting or your 39th:

1. *Population health.* This year's meeting theme, "Generalists Engaged in Population Health," reflects our shared commitment to improving outcomes and equity in our professional work. Late-breaking sessions will include a special symposium on alternative payment models, with Darren DeWalt, director of the Learning and Diffusion Group, Centers for Medicare and Medicaid Services, and a summit on the new Centers for Disease Control and Prevention (CDC) guidelines for prescribing opioid medications in the setting of chronic pain, with several CDC staff members participating.
2. *CaREER: Cultivating Care, Resilience, and Excellence in Education and Research.* Responding to SGIM members'

calls for richer offerings in career development, CaREER is the pilot of a new series intended to present workshops and other sessions that will form a curriculum over several years of annual meetings. This year's capstone will feature an interactive conversation over breakfast on Saturday morning with Bob and Suzanne Fletcher, Jada Bussey-Jones, and Brita Roy all discussing challenges of balancing work and the rest of life at different career stages. In addition, various workshops and panels throughout the meeting will offer opportunities and resources for acquiring knowledge, developing new skills, and learning strategies for navigating careers as clinicians, educators, or researchers in general internal medicine (GIM). For more details, see <http://tinyurl.com/AM16CS>.

3. *Fellowship.* More than 2,000 general internists, residents, students, and others attended last year's annual meeting in Toronto, setting a new attendance record. All signs suggest that this year's meeting will draw similar numbers of SGIM members and friends from across the country and around the world. Networking with colleagues is the most frequently cited highlight of the meeting, according to past attendees.
4. *Clinical acumen.* Attend clinically oriented Workshops and Updates in a broad range of clinical fields, such as geriatrics, primary care, and perioperative medicine. The meeting will feature more than 400 of your colleagues presenting Clinical Vignettes, ranging from bread-and-butter

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## The Cutting Edge for Achieving Health Equity

Marshall H. Chin, MD, MPH

Addressing ... social determinants of health has gone from a distant aspirational goal to a priority policy and business issue.



SGIM members are driven by a sense of social mission. Caring for the underserved and attempting to reduce health disparities have been long-standing hallmarks of the organization. For example, of scientific abstracts submitted to the 2016 SGIM Annual Meeting, by far the most abstracts were received in the Health Disparities/Vulnerable Populations category. The health disparities field has moved beyond purely documenting disparities and explaining their causes. We are now immersed in the solutions phase. I'd like to highlight three areas that I believe represent the cutting edge of solutions for achieving health equity and link those to SGIM's ongoing efforts in these areas. These three frontier areas are: 1) implementing payment reform to enable and incentivize reduction of disparities, 2) addressing the social determinants of health, and 3) improving our training of clinicians about how to reduce disparities.

Aligning payment and delivery system reform to reduce disparities is crucial. At the University of Chicago, we have experienced first hand the challenges of caring for our predominantly working class South Side African-American patients under the current reimbursement system. Like many academic medical centers in fee-for-service markets, a relatively small percentage of patients, roughly 5%, accounts for the profit that subsidizes the remaining clinical, research, and educational activities. These patients are recipients of tertiary/quaternary care—for example, organ transplantation, orthopedic surgery, gastrointestinal procedures, and cancer chemotherapy. Therefore, for many years our hospital's strate-

gic plan, similar to many other medical centers, prioritized increasing its market share of these complex specialized patients. The medical center has simultaneously sought to improve the health of the South Side of Chicago community, such as with an Urban Health Initiative that considers how clinics, community hospitals, and the academic medical center can best coordinate their care. However, these community and prevention-oriented efforts have received relatively fewer resources as governmental and private reimbursement systems have continued to incentivize tertiary and quaternary care.

Today the landscape for health equity is transitioning in Chicago and across the nation. Our current dean, who is also in charge of the medical center's operations, was brought in five years ago, and he and his team have launched intensive initiatives to increase diversity, inclusion, and equity in the medical center and improve the health of the South Side's African-American population. In fact, population health is a cornerstone of the new strategic plan. Why did this transformation occur? The dean deeply understands the importance of achieving health equity. He grew up in South Africa during the apartheid era and saw first hand the human costs of health disparities and social inequities. And the marketplace is changing. While Chicago still is mostly a fee-for-service health care market, global and bundled payment schemes are growing. The governmental payers Medicaid and Medicare are increasingly shifting to capitated at-risk contracts. Tax laws require a community needs assessment and the demonstration of com-

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munity benefit to justify non-profit status of medical centers. The University of Chicago and other Chicago-area medical centers realize that they must develop expertise in population health to survive. These new pressures are palpable and have penetrated to frontline clinicians and staff.

However, current changes in the marketplace that raise the importance of reducing disparities are not sufficiently powerful. In a 2016 commentary in *JGIM* titled "Creating the Business Case for Achieving Health Equity," I outline six key steps payers can take to achieve equity. These steps are requiring health care organizations to stratify clinical performance data by race, ethnicity, and socioeconomic status; incentivizing preventive and primary care; explicitly incentiviz-

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## What the Passover Seder Taught Me About Diabetes Care

Karen R. Horowitz, MD

**W**e are each inseparable from our experiences, the lessons we have learned, and the people we meet. Our families, mentors, and communities influence our outlook and our chosen paths in life.

Every year at this time, with the holiday of Passover approaching, I reflect on my family traditions, my Jewish identity, and how lessons from my faith inform my personal *and professional* vision. The Passover Seder is celebrated by more Jewish families than any other holiday. It is a milepost in the calendar that binds me to the generations that have come before me. Every sound, taste, and smell on this night is enriched by memories of those I have loved and with whom I have shared this holiday.

On Passover, we are instructed to tell the story of the Exodus, the birth of freedom from slavery. We are not supposed to just tell the story as if it was someone else's experience. We are to internalize the events—to identify with the history as if we were the ones being freed. One passage in the Haggadah, the guidebook or script followed at the seder, has always fascinated me and has grown in meaning for me with each passing year. It is a passage known as the Four Sons, a story that reflects and informs us about human nature and the way we learn.

The story tells of four sons: one who is wise, one who is wicked/contrary, one who is simple, and one who cannot even ask a question. When children hear this passage, they are drawn to the characterization of the brothers in the most literal terms and compete to label each other wise, wicked, simple, or dumb. The lessons, however, are really for the adults and focus on how to engage children in the Passover story no matter where they are in their readiness to learn.

We not only teach the wise, open, engaged students but also adapt to the intellectual level of a broader audience to create meaning and inspire learning.

Sound familiar? As a physician and sometimes student of educational theory (pedagogy), I have heard this lesson in many forms: Kolb's "Learning Styles," Prochaska's "Readiness to Change," identity formation, patient activation, patient empowerment, etc.

So, what does this have to do with diabetes? Everything! Let's see...

How do *you* feel when you hear:

- "John is here to follow up on his diabetes,"
- "Sally forgot her glucometer,"
- "His last A1C was 9%," or
- "Mary really doesn't try..."?

These are the patients I most want to see. Why? Because I know I can make a difference. Let's compare them to our "Four Sons" and see what we learn.

Everyone wants to see the "Wise Son." He is fully invested in his diabetes care. He has learned about diabetes management and internalized the lessons. He is adherent to medication. He tests his glucose and brings his meter to his medical appointments. He has his labs drawn in advance of the appointment. He arrives in the office ready to learn and to continue to make positive changes. As the Haggadah story tells us, for this son "you shall explain to him all the laws [of Passover], to the very last detail..." To me this means continue to teach him and move him forward in his self-care and his understanding of his diabetes.

The "Contrary/Wicked Son" is also easy to spot. He arrives at the appointment without meds or meter. He is non-adherent to the care plan. He refuses to test and in-

sists that, as his physician, his diabetes is your problem—not his. We are taught that, "by excluding himself...he denies a basic principle." The lesson here is that although I care about his health, the problem is his to fix. I am here to guide those who are willing to accept responsibility for their self-care but cannot do it myself. I tell him that I cannot improve his health until he is ready to change. (Sound familiar?)

The "Simple Son" asks, "What is this?" He is the patient who really has not had the opportunity to learn about diabetes. He is open to learning but naïve (i.e. has not been taught). The story teaches us to recognize this need for information. We should start from the beginning and teach him the basics. We should engage him in a process of diabetes education and allow him to grow at his own pace.

Many fail to recognize the son who "does not know how to ask." His A1C has hovered between 9% and 11% for years. There seems to be a lot of passive-aggressive behavior going on. He says nothing helps, so he has stopped trying. He often skips insulin doses and testing. He somehow keeps coming back to appointments, but nothing ever seems to change. This patient lacks an understanding of the big picture. I often ask these patients, "Do you know why it is important to me to treat diabetes?" "Do you know *why I care?*" Patients are often dumbfounded by this question. The big-picture answer is that I can *change the course of your future health* by treating your diabetes. It is not about me; it is about you. I have tools for reducing your rates of complications that I can share with you, but I can only coach you. You are the one who needs to do the hard job of self-care. Now I have his attention. I segue into the ABCs of diabetes, negotiate

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## Mentoring at the 2016 Annual Meeting

Tanvir Hussain, MD, MSc, MHS; Mohan Nadkarni, MD; and Jillian Gann

*Dr. Nadkarni is chair and Dr. Hussain is co-chair of Mentoring Programs on the 2016 Annual Meeting Program Committee. Ms. Gann is Director of Membership for SGIM and can be reached at [gannj@sgim.org](mailto:gannj@sgim.org).*

There is a rich tradition of mentorship in academic medicine, which starts in medical school and remains essential through faculty promotion. The counsel of a trusted mentor is invaluable, and the opportunity to coach a mentee to success is as rewarding. As part of its mission to mentor future generations of academic generalists, the Society of General Internal Medicine (SGIM) offers structured mentoring opportunities at the annual conference for all attendees, including the One-on-One Mentoring Program, several mentoring panels, and the Mentoring Interest Group.

The One-on-One Mentoring Program offers students, residents, fellows, and faculty at all levels the opportunity to speak privately with a more senior SGIM mentor from a different institution. By connecting mentees to mentors outside their home institution, the One-on-One Mentoring Program allows mentees a fresh perspective on their professional goals and challenges and expands their mentoring network. Mentors enjoy the opportunity to provide counseling and guidance to potential future faculty and SGIM colleagues. All participants in the One-on-One Mentoring Program will be asked to identify areas of interest—reported through the brief match survey and mentor and mentee resumes—to ensure pairs are matched according to their needs. Mentor-mentee pairs meet in person during the annual conference and are encouraged to continue an ongoing relationship afterward. Topics for discussion are largely guided by the individual mentee and mentor but may include early- or mid-career advice, research, job responsibilities, and professional challenges. Mentees may also request mentors to attend their research presentations during the conference so mentors can provide feedback. Over the last several years, 90% of participants surveyed—

mentors and mentees—responded that the One-on-One Mentoring Program surpassed their expectations. The program draws an equal number of trainees, assistant professors, associate professors, and professors, with many participating both as mentor and mentee.

The mentoring panels offer another opportunity for students, residents, fellows, and faculty attending the SGIM conference to access mentors in a more public forum, have their questions answered on practicing general internal medicine (GIM), and learn from other attendees' questions and reflections. Panelists will answer questions from both the moderator and audience, making it an interactive and informal session. Five panels will be offered at this year's annual conference: Career Mentoring Panels in the Clinician-Investigator and Clinician-Educator Pathways, Parenting in Medicine, Disparities Mentoring Panel, and a new panel for students and residents interested in learning more about careers in GIM.

The Career Mentoring Panels in the Clinician-Investigator and Clinician-Educator Pathways bring together two groups of seasoned leaders and successful young faculty who will share advice with audience members pursuing careers in clinical investigation or clinical education. Topics discussed often include the job search, promotion, switching pathways, and keys to success. These two panels will be held at different times for those who may be interested in attending both. The SGIM Disparities Task Force has an established record in mentoring clinician-investigators and clinician-educators with a career focus on health disparities and health equity. The Disparities Mentoring Panel is a group mentoring session in which faculty at all ranks have the opportunity to par-

ticipate in discussions with senior faculty mentors in health disparities. Balancing being a parent with a career in medicine is an ongoing challenge for general internists regardless of career path. Panelists on the Parenting in Medicine panel will share their perspectives, answer audience questions, and address issues around the working parent and work-life balance. The new #ProudtoBeGIM Panel on Career Planning for Medical Students and Residents invites medical students and residents to learn about careers in GIM. Panelists will include fellows, chief residents, and program directors who will discuss career opportunities in GIM, describe fellowship programs, and answer audience questions.

The Mentorship in Academic Medicine Interest Group gathers individuals interested in the various aspects of mentorship, including mentoring for clinician-educators and researchers, preparing mentor evaluations and assessments, peer mentorship, and distant mentoring programs. One of the objectives of the interest group is to develop a repository of resources, guidelines, or toolkits that can be disseminated or made available on websites to improve mentoring.

Besides these structured mentoring opportunities, members are encouraged to connect with each other during poster sessions and throughout the annual meeting to form new friendships, meet new colleagues, and hopefully develop ongoing relationships. The diverse expertise of senior members coupled with the enthusiasm of up-and-coming junior members creates exciting opportunities for both mentors and mentees.

*Pre-Register for the 2016 Annual Meeting and sign up to attend mentoring panels by April 28, 2016: <http://connect.sgim.org/sgim16/register/reg-online>*

## ANNUAL MEETING ANNOUNCEMENT

### 2016 VA Special Series at the SGIM Annual Meeting

David Atkins, MD, MPH; Kristina Cordasco, MD, MPH, MSHS; Erin Krebs MD, MPH; Donte Shannon, CAE

*Dr. Atkins is director, VA Health Services Research & Development; Dr. Cordasco is core investigator at the VA Center for the Study of Healthcare Innovation, Implementation & Policy and associate clinical professor at UCLA; and Dr. Krebs is associate professor at the Minneapolis VA Health Care System and University of Minnesota.*

**S**GM and Veterans Affairs (VA) have had a long and mutually beneficial partnership, reflecting the strong VA presence among SGIM membership and leadership. General internists have been critical to the growth and success of VA's health services research program. The SGIM annual meeting is an outstanding opportunity for VA researchers to share their research and get feedback from the nation's top health services and policy researchers, clinicians, and educators. VA is proud to have been a long supporter of the annual meeting and of *JGIM*, through regular VA-oriented *JGIM* supplements.

Each year the Veterans Health Administration supports the "VA Series." These symposia highlight VA research and educational initiatives

that are of interest to both VA and non-VA SGIM annual meeting attendees. All of these sessions are great opportunities for VA and non-VA clinician-researchers, educators, and administrators to learn about important initiatives, projects, and findings happening in VA! Research-focused symposia are supported with funding from VA Health Services Research and Development Service (HSR&D), and this year will include "Population-Based Intensive Management Programs For High-Risk Patients: Experiences in the VA System" Thursday afternoon (Session E); "Using 'Big Data' to Improve Population Health: The VA Homeless Program 'Hotspotter' Initiative" Friday morning (Session G); and "Generalists and Chronic Pain Care: Research and Innovation to Optimize

Population and Personal Health" Friday afternoon (Session J). Education-focused symposia are supported with funding from VA Office of Academic Affiliations (OAA) and this year will include "Using Shared Medical Appointments (SMAs) to Translate Interprofessional Learning to Practice: Lessons Learned from the VA Centers of Excellence in Primary Care Education" Thursday morning (Session D) and "Panel Management: Tools To Move From Visit-Based Care to Proactive Population Management" Friday afternoon (Session L). Finally, there will be a "don't miss" lunch with VA leadership on Friday, from 12-1 pm, which is an opportunity to hear about and discuss current research, education, and operations' issues relevant to SGIM members.

**SGIM**

## ANNUAL MEETING SGIM BOOK CLUB

*The book club will take place at the*  
**National SGIM Meeting**  
**on Thursday, May 12,**  
**from 11:30 am-12:30 pm.**

We will be discussing the book *Creativity, Inc: Overcoming the Unseen Forces that Stand in the Way of True Inspiration* by Ed Catmull & Amy Wallace. It is a "New York Times Bestseller" that has received uniformly positive reviews. We discussed it in our general internal medicine fellows' book club, and all thought it was terrific.

This wholly interactive session will focus on creative leadership and management. We hope that you will read or listen to the book (or parts of it) soon. (It can be purchased at a discount from Amazon: <http://www.amazon.com/Creativity-Inc-Overcoming-Unseen-Inspiration/dp/0812993012>.) If you cannot read it in time or have already done so and need a refresher, please watch this brief review: [https://www.youtube.com/watch?v=Iji1\\_YGYvOM](https://www.youtube.com/watch?v=Iji1_YGYvOM)

Please contact Manasa Ayyala at [manasa.ayyala@jhmi.edu](mailto:manasa.ayyala@jhmi.edu) with any questions.  
*We'll see you in Hollywood!*

## Improving Care: A Primer on Bundled Payments

Lindsay E. Jubelt, MD, MSc, and Martin J. Arron, MD, MBA

*Dr. Jubelt is assistant professor of medicine and Dr. Arron is associate professor of medicine and medical director of Clinical Variation Reduction and Clinical Documentation Quality Improvement at the Icahn School of Medicine at Mount Sinai in New York City.*

Imagine you are renovating your house and want to modernize the kitchen. Would you rather pay the contractor a single price, agreed upon in advance, or pay an open-ended price for time and materials, with the total determined only at the end? Increasingly, health care is using the former fixed-price approach—the chief example being the “bundled payment.” Given the growth of the bundled payment in health care today, it is important that physicians understand its history, structure, and goals.

The bundled payment sets a fixed price for all services during a single *episode* of care. It is a middle ground between “fee for service,” in which all services are billed separately (e.g. the contractor who charges for time and materials), and capitation, in which the insurer pays a fixed amount per patient each year, regardless of what services are performed.

For example, a typical bundle may cover hip replacement, providing a single all-inclusive payment for physician fees, hospital fees, and rehabilitation. If providers coordinate care as efficiently as possible, the savings accrues to them (i.e. the difference between the bundled price and the actual cost). Likewise, providers bear any costs in excess of the bundled price. By using a fixed payment, the payer thereby incentivizes the provider to manage costs.

The bundled payment is not a new concept. In 1983, Medicare introduced the Prospective Payment System (PPS), a hospital payment system based on the diagnosis-related group (DRG). While formerly hospitals were reimbursed for each item or service they provided, the PPS provided a single predetermined “bundled” price for all services a patient received during a hospital encounter, with the exception of

physician fees, which were billed separately. This bundled structure had profound effects. First, it gave hospitals a direct incentive to manage costs. Second, in turn, it led to substantial savings for Medicare. Once the PPS system was implemented, hospital expenses went from growing faster than all other Medicare spending to growing slower than Medicare spending.<sup>1</sup>

In the 1980s, PPS was considered a success in terms of cost containment, but its scope was narrow. The bundles included hospital fees but did not include physician fees or services occurring after hospitalization. Because hospitals were incentivized to lower costs, many shortened length of stay by shifting care to the post-acute care setting, which was outside of the scope of PPS. From the mid-1990s to 2009, post-acute spending became the fastest growth area for Medicare.<sup>2</sup>

Today’s bundles cover more categories of spending than before: hospital fees, physician fees, and post-acute services. With this widened scope, the goal is to lower costs and improve coordination across the entire episode, including post-acute care.

Implementation of bundled payment is growing quickly. In the public sector, the Center for Medicare and Medicaid Innovation (CMMI) launched a *voluntary* version of bundled payment called the Bundled Payment for Care Improvement (BPCI), which offers bundles across 48 clinical conditions.<sup>3</sup> Practice bundles are implemented differently depending on the payer and provider. In the BPCI, for example, there are four models of bundled payment. “Model 2” bundles the index hospitalization, physician professional fees, and the post-acute period.

Further, in April 2016, CMMI launches its first *mandatory* bundled

payment program—Comprehensive Care for Joint Replacement (CJR)—for major lower extremity joint replacement. CJR will apply to hospitals not participating in BPCI in 67 metropolitan statistical areas.<sup>4</sup> If successful, it is estimated that bundled payment initiatives could save Medicare \$4.7 to \$29 billion.<sup>5</sup> The private insurance sector is pursuing bundled payments as well. For example, the Employers Centers of Excellence Network, a coalition of large employers that includes Walmart, Lowe’s, and McKesson, has partnered with hospitals around the country on hip and knee replacement bundles.<sup>6</sup> Having seen the cost savings of government-led initiatives, private employers are hoping to achieve similar results.

The first question physicians ask is whether the bundled payment can both lower costs and provide high quality care. Early results suggest the answer is yes to both. Regarding costs, an evaluation of the BPCI initiative demonstrates that widening the bundle to include the hospital stay and post-acute care can decrease expenditures.<sup>7</sup> Regarding quality, physicians had concerns about the effect on readmissions. A recent study from NYU Langone Medical Center provides evidence to the contrary. In that study, NYU reduced its rate of discharge to post-acute facilities by 34% for lower extremity joint replacement and 49% for cardiac valve surgery with no corresponding increase in readmission rates.<sup>8</sup> This finding is not surprising given how bundled payments are structured. Typically, a bundle encompasses complications related to the condition, such as revisions, infections, or readmissions. If such complications occur, providers are required to treat them with no additional pay-  
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## Make Your Medical School #ProudtobeGIM: Our Experience at Johns Hopkins

Paul O'Rourke, MD, MPH; Eva Tseng, MD, MPH; Jeanne M. Clark, MD, MPH; and Scott M. Wright, MD

*Drs. O'Rourke and Tseng are general medicine fellows at Johns Hopkins University; Dr. Clark is professor of medicine and director of the Division of General Internal Medicine at Johns Hopkins Hospital; and Dr. Wright is professor of medicine and director of the Division of General Internal Medicine at Johns Hopkins Bayview Medical Center.*

The Society of General Internal Medicine (SGIM) formally launched the #ProudtobeGIM campaign in September 2015 to promote interest and discussion of general internal medicine (GIM) careers among medical trainees. In conjunction with the campaign website ([proudtobe-gim.org](http://proudtobe-gim.org)) where medical learners can access GIM resources and connect with other interested students and mentors, medical schools also applied to host promotional events at their institutions to spread interest and passion in GIM. With much enthusiasm and support from SGIM, we embarked on implementing a #ProudtobeGIM event for our medical learners at Johns Hopkins to showcase the many wonderful opportunities available in GIM careers.

### Planning the Event

Our principal objective for this event was to educate our medical students about the multitude of exciting GIM career paths. This was done with the hope of potentially sparking or augmenting student interest in GIM. Early in the planning process, we solicited input from the medical students to ensure that the event was planned with their needs in mind. The students desired an interactive format where they could informally meet with general internists and learn about their work, lives, and passions. In order to demonstrate the variety that exists in GIM, we invited general internists with various career interests from Johns Hopkins medicine as well as outside of our institution. We were fortunate to be able to include many general internists working in diverse settings: outpatient primary care, hospital medicine, health care leadership, academic research, government, and nonprofit organizations.



With financial support from SGIM and both GIM divisions at Johns Hopkins, we catered the evening event with food and drink for all attendees. We also purchased three small raffle prizes, which we distributed at the end of the event, and secured a medical student rock band to perform. We advertised our event through the student and resident e-mail listservs, social media, and a Johns Hopkins newsletter. The food, drink, and en-

tertainment were instrumental in both creating a festive atmosphere and attracting a large student turnout.

### Event Time!

We hosted our #ProudtobeGIM Johns Hopkins event on Friday, October 30, 2015. A diverse group of 42 general internists from Hopkins and local institutions came and actively participated. More than 115 medical  
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## FROM THE SOCIETY

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students and medical residents attended. Students were randomly assigned to one of five groups at the start of the evening: “GIM Clinical Opportunities,” “GIM Research Opportunities,” “Leadership and Advocacy Opportunities in GIM and Public Health,” “GIM and Medical Education,” and “GIM and Work-Life Balance.” Our general internists were evenly distributed among these groups. Students were able to speak with general internists in these small groups about their careers and lifestyles while rotating every 15 minutes among the five groups. By the end of this group mingling experience, each student had the opportunity to speak with at least five GIM physicians about many topics. At the

conclusion of the scheduled activities, many students continued to socialize with GIM physicians as the band played on.

On tables there were flyers about available opportunities for students to participate in GIM research or clinical work as well as #ProudtobeGIM brochures courtesy of SGIM. In addition, we had a #ProudtobeGIM campaign video playing in the background.

### After the Event

In order to turn the momentum of this event into a longitudinal experience for interested students, we created a GIM Mentorship Program at our institution, inviting medical students and internal medicine residents

to voluntarily join. Twelve students and residents applied for the program and were paired with general internists who shared their professional interests. In conjunction with individual mentor-mentee meetings, we plan to host two to three events annually for everyone involved in the mentorship program to nurture these relationships and facilitate ongoing support.

The feedback we received after the event from all attendees has been exclusively positive. The students truly enjoyed the interactive nature of the event and the opportunity to speak with general internists in a personal informal setting. One second-year medical student wrote, “Such a fun and great event, loved being able to meet and talk to so many faculty and learn from their unique paths.” The general internists who came to the event similarly loved sharing their experiences and passions with the students and trainees. One said, “The #ProudtobeGIM event was a lovely way to expose our trainees to all of the fantastic contributions that general internists are making. Hopefully, some of these talented trainees will choose to join us in GIM.”

It is our intent to make this an annual event and to expand the GIM Mentorship Program.

### Take Away Points

We would strongly encourage other academic medical centers to implement their own #ProudtobeGIM events and programs. Reflecting on our event experience, we would advocate that interested parties consider the following suggestions for programmatic success: obtain institutional support from your division or medical school; solicit early event suggestions from your medical students; involve a diverse array of general internists to expose students to a variety of GIM opportunities; and finally utilize #ProudtobeGIM brochures, videos, and other resources to equip your students with valuable tools to further explore our field.

## ANNUAL MEETING UPDATE: PART I

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### What is population health?

*Dr. Ferris:* I define population health in two different ways. It is both aspirational—"How should we deliver care that is both higher quality and lower cost?"—as well as practical—"What are the specific tactics and programs we should implement to be successful in alternative payment models?"

*Dr. Chin:* In its purest sense, population health represents the challenge and opportunity of optimizing the health of persons in a given geographic area. Thus, it is critical to examine and intervene on both community and health care system determinants of health and to reach out to persons who are not accessing care or who have been lost to follow-up. Currently, many health care organizations operationalize population health using narrower definitions; they focus on the patients who are part of their health plan, those who actually seek care at their sites, or patients who are attributed to them by the rules of the given payment system (e.g. accountable care organizations).

### Why is population health the theme of the 2016 SGIM Annual Meeting?

*Dr. Chin:* SGIM must be at the cutting edge of health care delivery and policy issues if we are to provide the best possible care to our patients and make the greatest contributions with our unique skill sets as academic general internists. Population health has the attention of health care administrators and policymakers, and the field is rapidly evolving. We all need to gain expertise in population health if we are to help our local health care organizations and national policymakers make the best decisions to improve the care and outcomes of our patients. I am particularly excited that Tim Ferris is the 2016 Malcolm Peterson Lecturer. Tim is a distinguished leader and thinker who has extensive practical experience designing and implementing innovative population health programs.

### What is your area of study, and how does it fit within the field/area of population health?

*Dr. Ferris:* Like many generalists, my areas of study have been wide ranging. I have mostly focused on improving care for patients with chronic illnesses, though I was less focused on the illnesses *per se* and more on the systems used to support physicians and patients in managing them. Four themes run through my research. First, a recurring theme has been the study of performance metrics because metrics that are sensitive to what matters to patients and physicians are essential for tracking the changes (hopefully improvements) that come when implementing new delivery systems. Second, once you have metrics, then you need to consider risk adjustment. Understanding the strengths and limitations of risk adjustment has been a theme in my research, though rarely explicit in my publications. Third, evaluating the impact of changes in the delivery of care—both barriers and facilitators of adoption and ultimate effectiveness—has consumed much of my time. Fourth, I have focused some attention on incentives to the adoption of new technology. This last theme connects the more practical systems' change work to the fields of policy research and economics.

*Dr. Chin:* I have focused my career on improving the care and outcomes of vulnerable patients with chronic disease, especially in safety-net settings, and reducing health care disparities. Adopting a population health perspective is crucial for achieving health equity because the community and social determinants of health are such important drivers of outcomes. It is critical to integrate payment and delivery system reform and address social determinants to achieve health equity. I have also collaborated with federally qualified health centers for years, and they have a holistic philosophy that incorporates many principles of population health.

### How does your perspective as a general internist inform your approach to population health?

*Dr. Ferris:* Being a general internist means seeing the entire spectrum of illness—from upper respiratory infections to transplant rejection both in outpatient and inpatient settings. This breadth of human suffering and the diversity of care delivery options that have grown up to meet them reinforces my perception that meeting the health care needs of the baby boomers in an affordable way will not be simple—that heterogeneous problems (both health problems and care delivery problems) will require multiple solutions. The solutions therefore seem much more likely to come from teams of people working toward a clear set of goals rather than a "big design" engineering approach where a few really smart people draw the solution on graph paper and then ask the delivery system to implement. Just like a detailed and thorough examination of a patient, the key to our delivery system problems is understanding our objectives and then building the solutions that address the problems. For too long, US physicians have built solutions that the payment system encouraged rather than the ones that best meet patient needs.

*Dr. Chin:* General internists have a holistic patient-centered perspective that is invaluable when thinking about systems' challenges such as optimizing population health. Whether we are inpatient, outpatient, or home care general internists, we understand that patients are individuals and that it is essential to address the full spectrum of medical, social, economic, cultural, and neighborhood factors impacting health outcomes. We appreciate that it is important to address the system and that health care organizations need to support the clinician-patient relationship and community partnerships necessary for persons to lead healthy lives.

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## ANNUAL MEETING UPDATE: PART I

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### **What are the tools used to study population health? What skills, training, and preparation do you recommend to GIM trainees who might be interested in this field of study?**

*Dr. Ferris:* The core skills are the same as those used in clinical effectiveness—statistics (especially risk adjustment) and study design and epidemiology. I see young people rush to the sexier business school topics of change management, quality improvement, financial analytics, and behavioral economics. These are certainly an important part of population health research, but they are secondary.

*Dr. Chin:* The tools of the typical research-oriented GIM fellowship or similar training are a strong foundation: learning to think like a researcher, rigorous study design, epidemiology, statistics, and health services research. These skills need

to be complemented with training in individual and organizational behavior change, community-engaged research, sociology, and economics. Reading broadly about current events and policies (e.g. read both the *New York Times* and the *Wall Street Journal*) is extremely helpful. Population health is a great area for people who love to learn.

### **What are the big questions in population health yet to be answered?**

*Dr. Ferris:* If the future of delivering care will depend on teams (and I think it will), how should those teams be organized? How will a group of people with different skills and training work together effectively to provide the trusted care that has traditionally been provided by an individual physician? And if computers are about to get a whole lot smarter as tools in health care delivery (and I think they are), what will the revised role of the physician look like?

*Dr. Chin:* How do we effectively integrate the strengths of the health care system and community? What types of interventions and payment reforms can successfully address the social determinants of health? How do we ensure that diverse patients, including those at highest risk for poor outcomes, thrive within population health systems? What are the best ways to transform the organization of health care and the culture of the healing professions as we integrate the traditional focus on the individual patient with the health of populations?

*Join us at the 2016 SGIM Annual Meeting, "Generalists Engaged in Population Health: Improving Outcomes and Equity through Research, Education, and Patient Care," May 11-14, 2016, in Hollywood, FL. For more information, visit <http://connect.sgim.org/sgim16>.*

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## ANNUAL MEETING BRIEFS

### **PCORI**

This year, the Patient-Centered Outcomes Research Institute (PCORI)-funded project, Engaging PCORI Priority Stakeholders through SGIM, continues with two initiatives. The aims of this project are to: 1) increase the opportunities for clinicians and clinician-educators to participate in PCORI research and 2) share the perspectives of SGIM members with PCORI in order to improve the research process. We are conducting an assessment of SGIM physicians and patients regarding their attitudes and knowledge about patient-centered outcomes research (PCOR) and also sponsoring a series of educational opportunities at the annual meeting in Hollywood, FL.

*Assessment.* We invite those who have not yet taken the five-minute survey to do so. Your participation will help inform our activities in this last project year. Please go [https://www.surveymonkey.com/r/PCOR\\_Survey1](https://www.surveymonkey.com/r/PCOR_Survey1) to take the survey. As an expression of our appreciation, those who take the survey will be included in a drawing for \$250 in prizes.

*Annual Meeting.* Our workshop series continues with a keynote panel titled "Engagement Strategies in PCOR: Making it Work for Patients and Providers." We also are sponsoring targeted sessions on Health Disparities, PCORNet, and other key networks for research.

### **Join us for an interactive UpToDate Session!**

UpToDate (UTD) is a primary point-of-care resource for medical knowledge. UTD topics are evidence based,

peer reviewed, continually updated, and present actionable recommendations. SGIM has partnered closely with UTD over the past 15 years to bring the general internist perspective to UTD topics through scholarly review of chapters. Many are written primarily for specialists but have important primary care implications with clear need for general medicine input. The full contents of UTD are widely disseminated to institutions and individual physicians through a variety of platforms, including online and mobile applications.

A group of SGIM reviewers consistently participates in this editorial process to ensure that the content and recommendations in UTD topics are relevant for the general internist, when appropriate, and that important generalist questions are addressed by specialists. Each year, these SGIM reviewers provide key feedback for more than 100 UTD topics, both in GIM and the subspecialties. Their recommendations are incorporated into the final knowledge tools produced by UTD.

Come join us on Thursday, May 12, at 12:30 pm for an UTD training session and a meet-and-greet session with UTD staff, our SGIM review leaders' group, and reviewers. This will include an interactive training session on the UTD review process—a great experience for current reviewers and for those who are interested in becoming a reviewer! Lunch will be provided.

If you have questions about PCORI or UTD events at the annual meeting, please contact Leslie Dunne at [dunnel@sgim.org](mailto:dunnel@sgim.org).

## PRESIDENT'S COLUMN

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ing the reduction of disparities; implementing the same equity performance measures across all payers; assisting safety-net providers; and conducting more payment demonstration projects designed to reduce disparities. Payers can do much more to achieve health equity.

Addressing the social determinants of health disparities is another cutting edge issue. We have tended to focus on health system factors that contribute to health disparities—clearly an important lever. However, social determinants such as poverty, poor education, inadequate housing, and crime drive most health inequities. Addressing these social determinants of health has gone from a distant aspirational goal to a priority policy and business issue. A key question is how to integrate initiatives to improve social determinants with efforts to reduce disparities in the health care system. The recent call for proposals from the Center for Medicare and Medicaid Innovation for Accountable Health Communities is emblematic of the importance of this issue and the strong interest by public and private funders to catalyze innovative models. That initiative provides

funds for community-based organizations and health care organizations to address health-related social needs of patients. The Robert Wood Johnson Foundation's new emphasis on a Culture of Health is another prominent example of the emerging focus on social determinants of health.

The SGIM Disparities Task Force is currently developing a toolkit for measuring social determinants of health. The Disparities Task Force has finalized a conceptual framework for social determinants of health, identifying more than 60 instruments that measure economic, cultural, health system, sociodemographic, and psychological factors. The task force is aiming to create a searchable tool on the SGIM website and write articles about these efforts for dissemination. In addition, the 2016 SGIM Annual Meeting theme of population health will help us learn more about social determinants of health and ways to integrate health care-community solutions to reduce disparities.

Determining the best way to train learners and practicing clinicians how to reduce disparities remains an exciting growing field. In last month's column, I described the seminal work of the SGIM Disparities Task Force in creating recommendations for health disparities courses that are crucial for moving the field beyond a sole focus on cultural competency training. Some challenging ongoing issues include how to: 1) incorporate health disparities curricula longitudinally across the four years of medical school, 2) teach students about population health and social determinants of health, 3) incorporate advocacy training into curricula, and 4) determine what curricula and teaching methods are most effective for reaching a broad audience rather than only those self-selected students particularly interested in disparities, and 5) combine didactic instruction with active experiential learning about how to reduce disparities.

Cultural competency is a field that is also evolving. One of our University of Chicago research team's current projects examines how to improve

shared decision making between clinicians and lesbian, gay, bisexual, transgender, and queer (LGBTQ) racial and ethnic minority patients. Our team has members experienced in racial/ethnic disparities and LGBTQ health. However, we were rapidly humbled by how complex the issues are for multiple identity patients working at the intersection of race, ethnicity, sexual orientation, and gender identity. This project has given us additional insight into the issues of all of our patients as everyone has multiple identities that are not immediately obvious but that impact care. Our team has written four initial articles from this LGBTQ racial/ethnic minority shared decision making project that will be published in *JGIM* in 2016.

Key lessons include that clinicians should be aware of these multiple identity or so-called intersectional issues as they approach patients and that clinics can improve their organization, procedures, and culture to make high-quality shared decision making more likely for their LGBTQ racial and ethnic minority patients and other multiple identity patients.

Advocacy is also essential for advancing health equity. Disparities are health and social justice issues. It will require advocacy to get policymakers to devote more attention and resources to payment reform that reduces disparities as well as initiatives to address social determinants of health. On a local level, advocacy is necessary to increase the breadth and depth of health disparities training for our medical students and house officers, including state-of-the-art training in culturally competent communication, shared decision making, behavior change, patient empowerment, and systems' solutions for achieving health equity.

Today's opportunities to improve health equity are the best in my lifetime. SGIM's strengths in research, education, clinical care, health policy, and advocacy will all contribute to these exciting advances. We look forward to working with you as we advance health equity along all these fronts.

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## ANNUAL MEETING UPDATE: PART II

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- not-to-miss stalwarts of internal medicine to some exciting and exotic cases that will offer generalizable clinical pearls. See if you can make the diagnosis when mystery cases are presented in “clinicopathologic conference” style, revealing the work-up and diagnosis only after consideration of all the patient’s presenting findings.
5. *Skills for educators.* Clinician-educators will find a vast menu of selections from which to choose, including sessions dedicated to Innovations in Medical Education, Scientific Abstracts focused on research in medical education, and offerings under the aegis of SGIM’s TEACH program (<http://www.sgim.org/communities/education/sgim-teach-program>).
  6. *Clinical innovation.* The number of abstracts submitted as Innovations in Clinical Practice has skyrocketed over the past few years (N=81 in 2014, N=157 in 2016!), likely reflecting general internists’ pivotal role in quality improvement and system redesign. Visit posters and hear oral presentations from frontline colleagues who are transforming the way health care is delivered.
  7. *Cutting-edge research findings.* Boasting a record number of Scientific Abstract submissions (N=724), #SGIM16 will feature research findings from across the broad landscape of investigation important to general internists. In addition to plenary presentations, oral abstracts, and posters, the meeting will highlight several poster walk-and-talk sessions, during which a leader in the field will “make rounds” among several posters and then assemble for a mini-wrap up discussion to synthesize findings.
  8. *SRF: Nurturing the next generation of leaders in GIM.* SGIM’s annual meeting welcomes students, residents, and fellows (SRF!) to come, explore, and experience the excitement of GIM. (Be sure to check out [www.ProudToBeGIM.org](http://www.ProudToBeGIM.org).) Sessions of particular interest to SRF are online at <http://connect.sgim.org/sgim16/general/srf>. Chill in the new SRF Lounge, a place where students, residents, and fellows can catch up with old friends and make new ones.
  9. *Podium power.* Plenary sessions at our annual meetings are always popular, despite the early morning hour! Last year set records for plenary session attendance, with more than 1,300 caffeinated souls at the opening session. This year’s podium speakers include SGIM President Marshall Chin offering the Presidential Address (Thursday at 9:15 am) and Tim Ferris, senior vice president of Population Health Management at Partners HealthCare, delivering the Malcolm L. Peterson Honor Lecture on Friday at 8 am. Thursday’s plenary session will feature oral presentations of the highest-rated Clinical Vignette, Scientific Abstract, and Innovations in Clinical Practice and Medical Education submissions. Friday’s plenary session will similarly include four of the most highly rated Scientific Abstracts.
  10. *Relaxation.* The meeting’s South Florida location provides a perfect opportunity to combine scholarship and professional development with personal relaxation and renewal. Meeting attendees will enjoy The Diplomat’s spectacular views of the Atlantic Ocean, the Intracoastal Waterway, golden sand beaches, and a one-of-a-kind infinity-edge pool with two waterfalls flowing into a 240-foot lagoon pool. The property has a two-story 24-hour fitness center and offers spa discounts for SGIM attendees. Championship golf and tennis are just a mile away. After all that exercise, indulge at one of the six restaurants on the property or go “off campus,” maybe taking your talents to South Beach. And yes, baseball fans, the Marlins and Giancarlo Stanton are in town on Wednesday evening, May 11, hosting the Milwaukee Brewers.
- Of course there are more than ten reasons to attend the 2016 annual meeting. Post your favorite(s) on Twitter using the hashtag #SGIM16. Looking forward to seeing you in Hollywood (Florida)!

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## FROM THE EDITOR

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short- and long-term goals, and plan a follow-up appointment to reinforce these behaviors.

Slavery is a fitting metaphor for the shackles of ill health and the burdens that chronic disease management imposes on my patients. I am here to stand by them, to empower them, to bear witness to their suffering, and to celebrate their successes.

I will not give up because the stakes are too great.

The story of the Four Sons was written more than 2,000 years ago. I always think about the rabbis who passed the story down through the ages: *How did they know?*

Wisdom and insight about human nature were not invented in our lifetime. They are a universal gift from

generation to generation (*l’dor vador*) and withstand the test of time.

In this season of freedom, I encourage each of you—whether you are celebrating Passover, Easter, Nowruz, Holi, or American Independence Day—to take a moment, reflect on the lessons of your holiday, and share them with those you love. Happy holidays.

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## SIGN OF THE TIMES

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ment. As a result, providers are incentivized to promote high quality and reduce complications in addition to lowering costs.

While these early results are promising, further research is needed if we are to transition more of health care to this payment model. Moreover, how we measure quality achieved under bundled payments is itself an open question.

Today, quality assessment is commonly based on hospital-focused measures such as readmission and complication rates. Many are advocating that we should broaden the assessment to include more patient-centered measures such as functional outcomes and quality of life. Future evaluation of bundled payment is an opportunity to include patient-centered measures in addition to traditional measures of quality.

Looking to the future, physicians are key players in leading positive change under bundled payment. This is especially true for internal medicine physicians. Many of the clinical conditions for which hospitals receive bundled payment are medical and rely on the general in-

ternists or hospitalists who provide inpatient care. In addition, successful transition of the patient to the community after a hospitalization is typically dependent on a patient's primary care physician. If physicians lead the way and outcomes continue to improve, bundled payment could prove to be an early success of 21st century health care reform.

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## MENTORING SESSIONS AT THE 2016 SGIM ANNUAL MEETING

**THURSDAY, MAY 12, 2016, 11:30 am – 12:30 pm**

### **CICMP: Clinician-Investigator Careers**

Moderator: Eric Bass, MD, MPH, director, Johns Hopkins Evidence-Based Practice Center, Johns Hopkins University  
Panelists: Kirstin Bibbins-Domingo, MD, PhD, MAS, director, Center for Vulnerable Populations, San Francisco General Hospital; Tabor Flickinger, MD, MPH, assistant professor, Division of General, Geriatrics, Palliative Care and Hospital Medicine, University of Virginia Health System; Jeffrey A. Linder, MD, associate professor of medicine, Brigham and Women's Hospital; and Monica Peek, MD, MPH, associate director, Chicago Center for Diabetes Translational Research, The University of Chicago

### **DTFMP: Disparities Task Force Mentoring Panel**

Coordinators: Eboni G. Price-Haywood, MD, MPH, FACP, director, Center for Applied Health Services Research, Ochsner Health System; LeChauncy Woodard, MD, MPH, FACP, associate professor of medicine, Baylor College of Medicine and the Michael E. DeBakey VA Medical Center

**FRIDAY, MAY 13, 2016, 12:00 PM – 1:00 PM**

### **CECMP: Clinician-Educator Careers**

Moderator: Mohan Nadkarni, MD, chief, Division of General, Geriatrics, Palliative Care and Hospital Medicine, University of Virginia Health System  
Panelists: Stewart Babbott, MD, director, Division of General Internal Medicine and Geriatrics, Kansas University Medical Center; Carol K. Bates, MD, associate dean for faculty affairs, Harvard Medical School; Brigid Dolan, MD, assistant professor of medicine, General Internal Medicine and Geriatrics, Northwestern University Feinberg School of Medicine; and John B. Schorling, MD, MPH, professor, Section of General Internal Medicine, University of Virginia School of Medicine

### **PIMMP: Parenting in Medicine Mentoring Panel**

Moderator: Rachel B. Levine, MD, MPH, associate professor of medicine, Johns Hopkins University  
Panelists: Melissa McNeil, MD, MPH, chief, Section of Women's Health, University of Pittsburgh Medical Center; Shin-Ping Tu, MD, MPH, chair, Division of General Internal Medicine, Virginia Commonwealth University; and Craig Pollack, MD, MHS, co-director, General Internal Medicine Fellowship Program, Johns Hopkins University

### **SRFMP #ProudtobeGIM: Panel on Career Planning for Medical Students and Residents**

Moderator: Andrea Christopher, MD, fellow, General Internal Medicine, Harvard Medical School, and Emily Mullen, MD, associate program director, Moses Cone Health System  
Panelists: Dianne Goede, MD, ambulatory chief resident, University of Florida; Christina Phillips, MD, chief medical resident, Cambridge Health Alliance; Melissa Wachterman, MD, MPH, MS, instructor at Brigham and Women's Hospital and Boston VA Healthcare System; and William Weppner, MD, MPH, assistant professor, Department of Medicine, University of Washington

**FRIDAY, MAY 13, 2016, 3:00 – 4:00 PM**

### **IK 10: Mentorship in Academic Medicine Interest Group**

Coordinator: Michi Yukawa, MD, director of the Community Living Center at the University of California, San Francisco

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