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To Promote Improved Patient Care, Research, and Education in Primary Care and General Internal Medicine

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EDITORIAL

The Bundling Nemesis within E/M Coding: We Need Payment Reform Now!

John D. Goodson, MD

Dr. Goodson is Associate Professor of Medicine at Harvard Medical School and physician at Massachusetts General Hospital.

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I was busy this week. I saw 60 patients as an 80% clinician, all members of the "village" of 1,500 or so who see me as their doctor.

So how much did I earn by doing my work? Here are the calculations. Let's assume that each patient was submitted at a 99214 level of E/M billing. (This is close to exact since there were a couple of short follow ups and one new patient.) I generated 85.2 RVUs, calculated at 1.42 work RVUs per visit. This is the work component of Medicare payment. There is a separate practice expense component, which covers part of my office overhead.

With the current Medicare conversion factor of around $37, this would mean an income of $3,252 for my week of work. For this income I spent 26 hours with my patients in face-to-face time. I spent an equal amount of time with 200 or so non-face-to-face encounters (reviewing labs, consult notes, answering calls from others "villagers"). So this equals 52 total hours. My fringe benefit rate is 30%, so my weekly "salary" was $2,207. This works out to $105,936 for a 52-week year (assuming a two-week vacation and another two weeks of holidays in the hospital schedule).

By comparison, the top take home salary for an adult nurse practitioner at my hospital is $145,000, after fringe. The nursing "market forces" in Boston have driven up the compensation for all nurses and nurse practitioners.

What has happened to the general internist? Why is it that I am paid so poorly compared to my specialty peers for each face-to-face encounter?

The CPT manual, a proprietary AMA product used by CMS as the official source of service code descriptions, stipulates what I must do and document to fulfill the requirements for the 99214 visit. It reads as follows: An "office or other outpatient visit for the evaluation and management of an established patient...requires at least 2 of these 3 key

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Coming to the VA

Daren R. Anderson, MD

Dr. Anderson is Assistant Professor of Medicine, Yale University School of Medicine, and Director of Primary Care at the VA Connecticut Healthcare System.

Why? This was the most common response when I told my colleagues and friends that I was taking a new position at the VA. This was a significant and unanticipated change that would take me away from an exciting career in primary care, community health, consulting, and health policy and transport me back to a place I had not visited since residency training. I soon would find, however, that the experience of coming to the VA from the outside can be overwhelming, mysterious, and at times downright strange.

But I came prepared, armed with *Best Care Anywhere*, a book by Phillip Longman,[1] and articles from *Annals of Internal Medicine* and the *New England Journal* that outlined the largely unheralded, high quality care provided by the VA healthcare system.[2,3] I came seeking the high quality described in these articles, a model of care emphasizing evidence-based medicine. But no article could prepare me for the assault on the senses as I entered the building on that first day. The old Georgian style buildings were framed with Corinthian columns that were shedding their paint in large flakes. The electric door haltingly swung open onto a corridor with worn carpets and a musty aroma. The carpet gave way to a broad tiled hallway and more peeling paint. Then I made a right hand turn and entered the main corridor that runs the length of the inpatient and outpatient buildings. The scene in the hallway was pandemonium. Patients and staff were everywhere, reminiscent of Chicago O'Hare Airport. The sounds of whirring electric scooter motors and the aluminum vibration of dragging walkers blended with tapping canes and overhead pages. It is disconcerting the first few times you hear pages requesting "Mr. Smith" to return to his unit, as happens several times per day. Such pages evoked images of Johnny-coated, foley-carrying patients wandering the halls never to be found again. Amidst this cacophony of sounds and kaleidoscope of images, a large mass of people shuffled, limped, wheeled, and walked about in pursuit of the best care anywhere.

The first thing one notices about the VA is that buildings are numbered. "Park near building 35a; then, enter building 5 and pass to building 6 which leads to building 1. Then follow the main corridor to building 2." Several months later I gave these directions to a visiting friend and realized how quickly I had come to view this as unremarkable. No buildings named after rich donors or famous faculty here—only utilitarian numbering. The VA is filled with such idiosyncrasies. My "Tour of Duty" refers to the hours I work each day. Primary care teams are "Firms." And then there are the acronyms. I reviewed EPRP, PCMM, CUSS, and DSS reports. I attending committee meetings called MSEC, SACL, and IPC while using VISTA and CPRS computer applications. More remarkable was the fact that even my more experienced VA colleagues didn't know what all these letters stood for.

The massive bureaucracy of the VA becomes apparent almost immediately. The VA can often feel like a

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Is Primary Care Disgraceful? Blaming the Shrinking Primary Care Work Force and a Response

Lisa Rubenstein, MD

It is fortunate that our patients provide us with an anchor. They are generally deeply thankful for the generalist care we provide, even if at times we must work on uncomfortable issues with them. They are more understanding than our colleagues about medical care system constraints on our care.

One of the painful things about practicing primary care these days is the extent to which we, as a few hardy souls trying to make it work, are blamed for the failures of the health care system by our brethren (and sistren?) in medicine. On a simple, everyday basis, we feel it when we read seemingly dismissive hospital or emergency room notes saying "the patient's hemoglobin A1C is unacceptably high; the PMD (primary medical doctor) should aim for better control." Hey, didn't they read the notes saying that the patient has refused insulin for years and finally (due to our skill) has accepted? That it's too early to expect a drop in the Hgb1C? That the endocrinologists dropped him because he lost his insurance and sent him to us with no records three visits ago? That starting insulin took extra effort because he lives on skid row and has no place to store it? Wouldn't it be nice for once to see in those notes, "PMD is making excellent progress on diabetes control given the challenges this patient experiences"? We write articles about being polite and supportive to patients but much less about being polite, supportive, and even encouraging to each other as physicians. Yet everything we know about human behavior suggests that positive feedback is the most motivating kind and that a continual absence of it has negative consequences.

Whether or not their incomes are higher than ours, most of our colleagues join us in feeling that something isn't right about medical care in the United States today. They are frustrated, as we are, by the "simple" things that don't go right. They too feel the discomfort of not being able to spend all the time it would take to fix the system-generated problems for each patient. All too often, they lash out at primary care clinicians.

It is fortunate that our patients provide us with an anchor. They are generally deeply thankful for the generalist care we provide, even if at times we must work on uncomfortable issues with them. They are more understanding than our colleagues about medical care system constraints on our care. And they provide an endless source of interest, challenge, and feelings of accomplishment. So who can blame primary care clinicians for hunkering down and focusing on patients (and research, quality improvement, and education when applicable), to heck with the rest? I challenge us all, however, also to engage in dialogue.

As an example, the SGIM Health Policy and Patient-Centered Medical Home (PCMH) committees identified an inflammatory emergency medicine article, and we responded quickly. This article, by Jonathan Glauser, MD, MBA, in *Emergency Medicine News,* was titled, "The Disgraceful State of Primary Care" (December 2008, available at EM-News.com). The article includes the following quotes:

Say what? Fund physicians to promote primary care? Why throw good money after bad? If ever there was a group that has failed in providing care, it is our primary care system. To fund such a venture for groups that are singularly inept at performing anything of value to society is pure folly and a waste of precious health care dollars...

I have my own ideas about what primary care should accomplish, but foremost among them is to see patients in a timely way when they get sick as opposed to the dermatologist who schedules an appointment three weeks later, by which time the rash has disappeared...

It is difficult in the face of such frustration to remain collegial. However, the strong message from SGIM's Council is

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SGIM Forum

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Two mentors weigh in on question facing midlevel faculty

Carol Ashton, MD, MPH, and Nicole Lurie, MD, MSPH, in conversation with G. Caleb Alexander, MD, MS

Dr. Ashton is Research Scientist at the Methodist Institute for Technology, Innovation, and Education in Houston, Tex. Dr. Lurie is Director of the RAND Center for Population Health and Health Disparities and Senior Natural Scientist and Co-Director for Public Health at the Center for Domestic and International Health Security.

What are the main unique challenges that mid-level faculty face? How are these distinct from those facing more junior or senior colleagues? Are there different models that mid-level faculty can look to as they develop their careers?

Ashton: I think some of the main challenges at mid-career are 1) waking up one morning and realizing that you have taken on too much and are desperately over-committed; 2) maturing into a successful, independent researcher; 3) worrying too much about promotion to associate professor and too little about the real mission of one's life; 4) failing to figure in the need for a sabbatical; and 5) self-centeredness-too much worry about me me me and not enough devotion to helping more junior colleagues. The solution to a lot of this is personal evaluation and development, planning, and listening to your mentor (if you are fortunate enough to have one).

Lurie: Midlevel people often face challenges transitioning from a role of "having to prove oneself" to leading and mentoring others. This often involves helping others achieve the recognition and credit that they have worked so hard to achieve for themselves, and making this transition can be challenging. In addition, mid-level faculty often begin to wonder about the options for further growth and leadership or for doing something else entirely. As they become more recognized, they begin to get recruited for other positions. Sometimes this is welcome, but it often comes at a time when they are juggling other family responsibilities or two-career issues that they may not want to disrupt. Mid-career staff may want to look at models outside of academia as they develop their careers or get exposure to other fields as part of their academic experience.

For a late junior faculty member, falling short of a proposed funding objective can be disappointing and stressful. What might you say to a faculty member who successfully got a career development award but now wonders if perhaps they aren't cut out for the job?

Ashton: Longer-range "what-if" planning about funding is key-multiple-year planning, with a three-year (at least) time horizon. A well thought out, sequential research agenda should serve as a guide for the "where" of funding applications and the "when" of application submission. Because of the uncertainty of that transition from career award to independent researcher, possible sources of safety net funds should be discussed well beforehand with the division chief. These bridge funds could come from additional clinical work, additional administrative service, or other sources, but they are meant to be temporary.

Lurie: I think it's important to keep in mind what you are passionate about and not to try to make yourself fit into a role or set of projects you don't really care about. You may need to find other ways to reach your ultimate goal-and not to let a funding setback dissuade you. I think its ok that your interests and passions change over time, too, and sometimes it means changing the nature of the job you are in. But I think you should always follow your dreams.

What are key sources of funding that mid-level faculty can pursue to build their research area?

Ashton: Research project grants, training grants, career development awards, and center grants are the main categories of external sponsorship. Within those categories the funding sources can be federal, state or local, or private (foundations, associations, etc.). And don't forget a basic principle I first heard articulated years ago by Lee Goldman: leverage your clinical responsibility.

A late Assistant Professor wants to build a "program" or "center" to help expand his research. What more do you need to know?

Ashton: I need enough information about the research agenda and program to assess its value to society, to the field, to the university, and to the division over the short, mid, and long term. Is this agenda worth the investment of human and financial capital? I need enough information about the individual to assess his or her suitability for leading others because that is what a program or center requires. I need enough information about the effort to see if and how it fits in with the strategic plan (and, in these days, the current financial situation) of the university and the division. For programs or centers that are to be established within a relatively small division, other issues that need attention are whether there's room within and how interpersonal dynamics will be affected.

Is it reasonable to expect one's institution to "step up to the plate" and help support the costs of such a program? What are key methods of increasing the visibility and impact of a "program" or "center"?

Ashton: All universities have some mechanism for awarding start-up funds for new programs, and it is worth talking to division and department leaders to determine what the mechanisms are. Some universities have very well developed and fair mechanisms for allowing faculty to compete for seed funds to begin new interdisciplinary centers. (The University of Alabama at Birmingham comes

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Top 10 Reasons Why You Should Attend the Annual SGIM Meeting

Carlos Estrada, MD, MS, and Alex J. Mechaber, MD, FACP

Dr. Estrada is Associate Professor of Medicine at the University of Alabama at Birmingham/Birmingham VAMC and Chair of the 2009 Annual Meeting Program Committee; Dr. Mechaber is Associate Professor of Medicine at the University of Miami and Co-Chair of the 2009 Annual Meeting Program Committee.

The Annual SGIM meeting is the premier venue for general internists to network and share innovative clinical, research, education, and policy work. The Annual Meeting theme, *The Art and Science of Generalist Care*, will address cutting-edge issues on health care delivery systems and policy, the medical home, universal health care, and medical education.

Osler once said, "To study the phenomenon of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." Osler reminds us that evidence is critical to delivering patient-centered effective care and that the field of medicine is sometimes calm and sometimes stormy. To guarantee "smooth sailing," we need everyone. Here we provide the top 10 reasons to attend this year's Annual Meeting.

1. *Hear from visionary plenary speakers*.
   - Robert Brook, MD, ScD, award winning scholar on quality of care and a futurist regarding the role of general internal medicine, will give the Malcolm Peterson address.
   - Daniel D. Federman, MD, renowned leader in medical education and past recipient of the Abraham Flexner Award, will focus on the generalist's teaching of medical students and ways to attract future trainees to general internal medicine.
2. *Participate in a rousing plenary debate on financing health care reform*. Hear both Steffie Woolhandler, MD, MPH, a founder of the Physicians for a National Health Program, and Richard Epstein, James Parker Hall Distinguished Service Professor of Law University of Chicago, known for conservative views on the subject.
3. *See old friends and make new ones*. Need we say more?
4. *Get invaluable feedback and ideas about your work*. How many times have you modified an analysis for a study after receiving feedback? Or how often have you been able to address issues that reviewers might ask before your work has been submitted?
5. *Seek advice from the comfort of your seat*. Meet the Professor Panel Sessions are new this year! Advanced sign up not needed. Join us to pose those important advancement questions to a prestigious panel of clinician-educators, clinician-researchers, or clinician-administrators.
6. *Collaborate with individuals from other institutions*. The national meeting is the place to network and to set the stage for collaboration. Join an interest group and promote what you care about the most. Make your workshop or short-course count twice. Need tips and suggestions on how to do this? Read the September 2008 *SGIM Forum*—a great way to document scholarship in your teaching portfolio. Many peer-reviewed publications were conceived or shaped after attending the national meeting.
7. *Visit the simulation center at the University of Miami, one of few in the world*. Did you know that HARVEY (the cardiopulmonary simulator) was developed there (http://www.gcrme.miami.edu)? Over 1,200 centers worldwide use the educational programs developed at the center. Transportation will be provided after the Simulation in Medicine Special Symposia on Friday. Register early. This session is limited to 30 participants!
8. *Learn how to support your passion in a part-time academic career*. Hear from previous Mary O'Flaherty Horn Scholars in a session that is new to the annual meeting program this year! Bring your division director to learn about the program. Primary care needs new role models for young people starting their careers.
9. *Obtain credit toward your ABIM Maintenance of Certification*. The modules have been highly popular at the national meetings—obtain 10 points for each of the two 25-question office-based modules.
10. *See Miami and bring your family*. Last, but not least, the Fontainebleau Hotel, as our kids would say, is just amazing! The recently renovated facility has been featured in the *New York Times, USA Today,* and the *Birmingham News*. The beautiful beach and the incredible rates obtained for the SGIM meeting makes a perfect venue to bring your family.

Step back and re-energize yourself! Learn from experts in the field. Learn new skills. Teach others, and give feedback. Generate new ideas. Challenge your peers and trainees to improve their work. Help shape the future of general internal medicine.

The Miami Annual Meeting will showcase the stimulating work of SGIM members. To deliver the best possible care, we need outstanding clinicians, researchers, educators, systems of care, and an effective health policy framework. See you there!

References

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Primary Care to Hospitalist and Back

Eric Chanko, MD

Dr. Chanko is Associate Professor in the Department of Medicine at Yale University, VA Connecticut Health Care.

"Would you like some fries with that antibiotic?"

How often I have been tempted to utter these words, but somehow my better nature always prevails. It may seem cynical, but now that medicine has become a volume-driven and not quality-based business, are we really that different from McDonalds? When I entered medical school at the ripe old age of 32, I dreamed of becoming a younger version of Marcus Welby. I would get to spend time with my patients, develop life-long relationships with them, and be there for them at life's most crucial times. Furthermore, I would be involved in all aspects of their care. Granted, this may have been naïve; however, a close facsimile would not have been unreasonable. In fact, I still remember a specific made-for-TV moment early in my career that at the time seemed to make all of my earlier sacrifices worthwhile. I was racing from one patient's room to another on a particularly hectic day when a woman in the hallway yelled, "I've been looking for you!" I was unnerved, as I didn't remember her, and she appeared very emotional. When she was close enough to touch, she threw open her arms and hugged me saying, "Thank you, thank you!" I had seen her husband two weeks earlier and had informed him that I thought his recent fatigue and mild shortness of breath were due to coronary artery disease. His presentation was atypical, but I had arranged an immediate stress test, resulting in an emergent bypass. His cardiologist had told her to thank me when she saw me because his vascular disease was so extensive; he was a "walking time bomb." Her hug was so tight and genuine that it literally made not just my day but my whole year. It reminded me why I had become a physician.

Unfortunately, with reimbursements on the decline and costs on the rise, seeing more patients and spending less time with each one has become a necessity. Managed care dictates the patient will follow the physician that their insurer selects and not necessarily the doctor of his/her choice, resulting in the extinction of loyalty, the deterioration of bonds, and a revolving door of patients. Inevitably, quality and job satisfaction suffer. Furthermore, we live in an attention deficit world where few have the luxury to tolerate even the most minimal of waiting times; speed and access have trumped quality. If there is any doubt, just check the number of minute clinics that have popped up all over the United States. If this isn't the medical equivalent of fast food, then I don't know what is.

Then there is the paperwork. Ah yes, the paperwork. In addition to the labs, radiological exams, miscellaneous tests, disability benefit forms, non-formulary requests, etc., there is the follow up on studies ordered by the sub-specialists. If they order a test and copy you on it, you have a responsibility for making sure the patient is aware of the results. In our ever-growing litigious society, one can ill afford to miss just one abnormal lab. Since personal responsibility is a foreign concept in the American judicial system, you are also responsible if patients miss their own appointments for screening tests, such as colonoscopies.

This accumulates to hours greater than your original patient contact hours. You have essentially become a clerk who dabbles in medicine. Your family life suffers, and you are sent down the path of even greater job dissatisfaction.

But all hope is not lost. There is a new option for the general internist—hospitalist medicine. I switched tracks after many years as a primary care physician. Yes, it lacks the continuity of patient care that primary care once provided, but it does eliminate many of the non medical headaches that now overburden the woeful primary care practitioner. Gone are the paperwork and forms that overwhelm even the slowest practice. Gone are the complaints from patients waiting more than 15 minutes to be seen by the clinician. Gone is the time crunch where you have to evaluate, diagnose, and document a patient visit all in a 15-minute slot.

Yes, there are times you feel like a glorified resident as your beeper chirps incessantly, but when your day is done, it is done. There are none of the clerical duties that keep primary care physicians' lights burning to the wee hours of the morning. And although no physician in his or her right mind ever went into medicine for the money, compensation is higher for what really amounts to fewer hours of work.

Inevitably, what any individual wants from a job is some degree of appreciation. Obviously, improved remuneration for the primary care practitioner is essential, but gratitude from their patients and respect from their colleagues would go a long way to making up the difference. As a hospitalist, I felt valued not just by the primary care physicians I represented but by the subspecialists and, most importantly, the patients. Perhaps it is because you are there when they are most vulnerable and ill that makes them more grateful, but I received more "thank yous" as a hospitalist than as a primary care physician.

And yet despite the acknowledgement, higher remuneration, and decreased workload, I still longed for that intimate bond with my patients that one can only have as a primary care physician. At the VA,

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Middle-Aged Man with Hepatitis

Robert Centor, MD (presenter); Chad Miller, MD (discussant, in italic)

Dr. Miller is Associate Program Director, Tulane University Internal Medicine Residency Program.

A 62-year-old white man presented to the VA with one month of malaise, vague abdominal pain, and one week of jaundice. He also reported decreased appetite and a 10-lb weight loss over the previous month. For three weeks, he had of four to five loose stools daily and had dark urine over the prior two weeks. He stopped alcohol intake 10 days prior to admission but had drunk an average of 12 beers/day for 30 years. He reported taking as much as 5 grams of acetaminophen daily for the past year as self-treatment for shoulder pain.

Past medical history was unremarkable. He was taking no other medications. He had no recent travel and was presently unemployed.

His laboratory data revealed a normal CBC and electrolyte panel: T Bili 12.7; Dir Bili 11.9; alk phos 432; AST 1185; ALT 684. He was admitted to the hospital.

This man has significant hepatocellular damage. When faced with a patient with liver injury, it is important to identify the pattern as either hepatocellular, cholestatic, or mixed. This is easiest by comparing the ALT to the alkaline phosphatase. A rise in ALT out of proportion to the alkaline phosphatase suggests hepatocellular injury while a rise in alkaline phosphatase out of proportion to the ALT suggests cholestatic disease. This patient's ALT is more than ten times greater than normal, while his alkaline phosphatase is around three times greater than normal. Therefore, the etiology of this man's liver disease is from direct injury to hepatocytes.

The most common causes of acute hepatocellular injury are toxin-mediated, infectious, or ischemic. This patient has two significant risks for toxin-mediated liver disease: alcohol and acetaminophen use. It is unusual for alcoholic hepatitis to result in the rise of the transaminases above 400 unless there is an additional insult, such as acetaminophen toxicity. The combination of alcohol and acetaminophen is particularly concerning because alcohol induces the cytochrome p450 system, resulting in greater production of the toxic metabolite of acetaminophen. Heavy chronic alcohol use (> 60 grams/day) also severely depletes glutathione, one of the few defenses the liver has against acetaminophen toxicity.

The nearly 2:1 ratio of AST:ALT is consistent with chronic alcohol use. A deficiency in vitamin B6 (pyroxidal phosphate) leads to a decrease in the amount of ALT that hepatocytes can produce. It is interesting to note that this pattern is due to a deficiency in ALT, not an abundance of AST. Although there are a number of other cells that contain AST (cardiac, musculoskeletal, pancreatic, kidney), there is no current evidence to suggest injury to another organ besides the liver.

The primary diagnosis at this point is acetaminophen toxicity in the setting of alcoholic hepatitis. Nevertheless, potential infectious causes such as hepatitis A, B, and C should be evaluated. A careful history of all medications or potential exposures, especially herbal supplements, should be taken to evaluate other causes of toxin-mediated liver injury. Besides acetaminophen, ecstasy is a common potential hepatotoxin in high doses, although this seems unlikely in this patient. Autoimmune hepatitis can present similar to viral hepatitis but is frequently associated with other signs of autoimmune disease and tends to occur in young to middle-aged women. Ischemic liver damage (shock liver), congestive hepatopathy (right heart failure), and Budd-Chiari syndrome may cause this degree of liver damage, but there are no signs or symptoms to suggest that any one of these causes is likely.

Finally, one last possibility to consider is an acute insult upon an underlying chronic liver disease (besides alcohol). It would be very unusual for Wilson's disease to present in a man greater than age of 40. He has no family history to suggest alpha-1 antitrypsin deficiency. Hemochromatosis or chronic hepatitis B or C infection would be the most likely alternative causes of chronic liver disease in this man. He has no other signs or symptoms to suggest hemochromatosis, such as increased skin pigmentation, arthralgias, pancreatic disease, or cardiac disease, but this could be early in onset. Alcohol use in a patient with hemochromatosis is very concerning because this would accelerate the deposition of iron in the liver.

The primary diagnosis at this point is acetaminophen toxicity in the setting of alcoholic hepatitis. Nevertheless, potential infectious causes such as hepatitis A, B, and C should be evaluated.

Further tests should include an acetaminophen level; coagulation studies (PT, PTT); and Hepatitis A, B, and C serologies. Screening for hemochromatosis by measuring transferrin and iron saturation are appropriate, but it should be noted that alcoholic liver disease may cause both to be elevated from acquired iron overload. A right upper quadrant ultrasound may not be particularly helpful in hepatocellular disease but could contain potentially valuable information about liver size, masses, abscesses, the biliary tree, and portal flow.

The patient had an acetaminophen level *less than* 10 microgram/ml. Other tests included ferritin *greater than* 1000 and ANA + (1:320); Hep A, B, and C were all negative. RUQ ultra-

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ESSAY

Meeting in the Middle: Lessons learned from Community-Based Participatory Research

Charmaine Smith Wright, MD

Dr. Wright is a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania.

During my first year of fellowship, I decided on a community-based participatory approach as a way to unravel some of the complex nutritional challenges facing low-income postpartum women in the Philadelphia area. After finding a community agency with goals similar to mine, I arrived with written survey in hand, ready to find out all the answers and "make a difference." However, I hadn't learned that the humbling and painstaking collaborative process of designing the study would be so intense and so integral to the research. In fact, it was the research.

Community-based participatory research (CBPR) can be a powerful tool to bring about social change—from improving individual healthy behaviors to enacting broad-scale public policy. Health and health care are increasingly recognized as complex and dependent on local forces, and both communities and funders are demanding community-relevant research and collaboration. Naturally, there are challenges as well.

Defining the Community and Their Concerns

CBPR takes time, trust, and mutual goals. Research protocols cannot come from the academician; instead, the initial concern and call to action must arise from the community itself. In my case, after meeting with the executive director and research director of a community agency, it was apparent that our intervention's success hinged on the client's buy-in that a problem existed and needed to be addressed. Despite knowledge that obesity was a concern, we were at a loss regarding who we should teach, what we should teach, and how. Who was our target community—the staff of the community agency, the potential teachers of nutrition education, the neighborhood mothers, the children? For CBPR to be successful, the community partner must be willing to be interactive and involved in the study from creation to execution to evaluation, and their role in educating the academic partner must not be underestimated. Accordingly, a shared appreciation of each partner's knowledge must be maintained at each stage of the research.

After deliberation, I worked with an agency serving a multi-ethnic community of low-income women during and after delivery. However, the agency operated through eight small satellite offices from which emanated an army of family advocates who were most often peers of the very clients they served. These family advocates had the most contact with the clients and provided direct home care every day of the week. It was quickly clear that our best way to approach the clients was through these fiercely protective and outspoken family advocates.

Navigating the Institutional Review Board

CBPR requires doing research "with" the community, and not "to" the community. But in its efforts to protect the individual, sometimes the IRB decides "for" the community how its individuals need to be protected. Our study design took place in intense collaboration with a community of family advocates, sometimes calling into question routine IRB protocol. For example, our IRB was understandably concerned about the family advocates' research training and requested that anyone involved with the survey take a course in patient-oriented research. The research director at the community agency was overwhelmed and dismayed at the thought of this administrative burden, which would have had to include eight agency sites with staff scattered over four counties who largely operated "in the field" as direct in-home care providers.

IRBs have traditionally been focused on "individual ethics"[1] and not community ethics. Accordingly, they have been slow to adopt policies and procedures that would equip them to properly assess CBPR submissions and unwittingly may be leading to the exclusion and silencing of some members of the community. In fact, the IRB seemed ill equipped to evaluate community risk when the community of family advocates had their own elaborate training procedures and well-established protocol to protect their clients. As most family advocates were actually peer advocates—from the same class, ethnicity, and even the same block—as the very clients they served, weren't the family advocates better positioned to evaluate individual risk? Some have suggested having separate review boards for different types of research as suggested by some researchers, though this suggestion has serious shortcomings as well.[2]

We ultimately compromised with the IRB to conduct a practical yet ethical investigation by having clients, rather than family advocates, self-administer the survey. We ensured that the research director at the agency had an up-to-date certification in patient-oriented research, and both of us worked directly with the staff to maximize their familiarity with the ethical conduct of research.

Enjoying the Journey

The survey for the observational study is now in the field, and we are working on a curriculum for a weight loss intervention to battle maternal obesity. As we look forward to defining solutions to help address this epidemic, the CBPR process becomes even more important. Practicality, evaluation, evolution, and sustainability of the intervention all depend on the input of community

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INPATIENT MORNING REPORT

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sound showed an echogenic liver with a normal biliary tree.

If he has used any acetaminophen within the last 36 hours, N-acetylcysteine should be used despite the low acetaminophen level. Otherwise, the damage from acetaminophen has already been done. It is important to note that it may take up to three months for routine hepatitis C assays to be positive. Hepatitis C PCR would be definitive. He has no travel history to suggest that Hepatitis E might be a risk. Epstein-Barr virus and cytomegalovirus can also cause viral hepatitis but tend to occur in immunocompromised individuals. An HIV test should be performed.

The high-titer positive ANA is interesting. Autoimmune hepatitis, particularly type I, is associated with a positive ANA. Antibodies to smooth muscle (actin) should be ordered. Type II autoimmune hepatitis has anti-LKM1 antibodies, and type III has antibodies to soluble liver antigen, but neither is associated with a positive ANA. Another liver disease commonly associated with ANA is primary biliary cirrhosis (PBC). The normal biliary tree by ultrasound and hepatocellular pattern of injury are not consistent with classic PBC, but there is a variant of PBC that overlaps with autoimmune hepatitis. Anti-mitochondrial antibodies should be ordered. Although this seems unlikely in this patient, sarcoid only involving the liver may be associated with a positive ANA.

Ferritin is an acute phase reactant and may rise out of proportion to body iron stores in the setting of inflammation and hepatocellular necrosis due to increased release from tissues. Transferrin better reflects body iron stores, has a higher positive predictive value for hemochromatosis than ferritin, and should be ordered. Normal levels of transferrin make hemochromatosis unlikely. If transferrin is elevated, genetic testing for an HFE gene mutation is appropriate.

The patient was empirically treated with N-acetylcystine, despite the low acetaminophen level. Discharge labs were very similar to admission labs. He was discharged with a diagnosis of alcoholic hepatitis.

He returned one month later for follow-up. Since discharge, he gained 5 lbs., and his diarrhea resolved. He remained jaundiced and had the following labs which prompted readmission:

- CBC: WBC 10.8; Hgb 12.0; plt 227
- BMP: Na 140; K 3.9; Cl 104; HCO3 22; BUN 9; creat 0,8; glu 106
- Liver tests: T Bili 14.9; D Bili 13.4 Alk phs 386; AST 558; ALT 490.

A diagnostic test was performed.

Assuming he has refrained from acetaminophen use and alcohol, he has a persistent hepatocellular pattern of injury. At the top of my differential remains autoimmune hepatitis (type I) followed by hemochromatosis. Autoimmune hepatitis appears most likely because it explains all of this patient's lab abnormalities. Hemochromatosis does not explain the positive ANA, and I would expect more signs of iron overload. Smooth muscle antibodies, anti-mitochondrial antibodies, and a transferrin level should be pursued. If the antibody tests are negative and the transferrin is normal, then liver biopsy is necessary for diagnosis.

The patient underwent a liver biopsy, which showed classic findings of autoimmune hepatitis. This case pre-dates the availability of genetic testing for hemochromatosis, so those results are not available. He was treated with steroids with improvement in his hepatitis.

Key Points

- AST and ALT elevation above 400 in a heavy alcohol user should prompt exploration for an additional cause of liver injury.
- Transferrin is a better screening test than ferritin for hemochromatosis, especially in the setting of known inflammation or hepatocellular necrosis.
- Autoimmune hepatitis may mimic the presentation of viral hepatitis.
- Acute autoimmune hepatitis responds well to corticosteroids.

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ESSAY

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partners. We have focused on capacity-building during the process. As a fledgling researcher, I am learning to walk with one foot in the halls and one in the 'hood—somewhere right in the middle.

Thus, core elements of any successful CPBR project include:

- Listening to the needs of the community and do not advance your objectives ahead of theirs
- Taking some time to understand the different types of communities with which you may be collaborating
- Being patient!
- Not being afraid to educate the IRB in CBPR practice
- Making sure your CBPR project documents the research process and focuses on building capacity in the community
- Being patient!

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PRESIDENT'S COLUMN

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to promote collegiality, while standing firm on principles. Our environment seemingly aims to pit specialists against generalists, general medicine against family medicine, both against emergency physicians, hospitalists against primary care, and MD primary care clinicians against nurses, who are gearing up to fill the primary care gaps. Yet it will take all hands on deck to even begin to solve the crises that confront us. As we flesh out the PCMH, we can respond to the criticisms from people like Dr. Glauser by building appropriate goals, methods, and accountability into the PCMH concept. As an illustration, the following is an excerpt from my response, on SGIM's behalf, to Dr. Glauser's article:

As an active general internist and primary care clinician and President of the Society of General Internal Medicine, I was very interested in your recently published article on the disgraceful state of primary care by Dr. Jonathan Glauser. His distress about the functioning of the US medical care system resonates with me. His passion, however, should be redirected toward joining with other committed physician and non-physician groups in reform efforts...The patient centered medical home (PCMH) in particular is a reform effort that should be shaped by all of the groups impacted by the primary care system... It is essential to integrate emergency department perspectives into the patient centered medical home design, and we hope Dr. Glauser and other passionate emergency physicians will become participants in the design process.

We could respond to concerns related to emergency medicine through our work with the American College of Emergency Physicians and will do so. Engaging in broader dialogue, however, achieves different goals. By responding in public as we have, we promote dialogue. By proactively seeking opportunities to dialogue with our colleagues and the public—by attending one of President Obama's community forums on health care reform; by organizing a forum discussion for your school or department (http://change.gov/page/s/hcdiscussreport); by writing an article for a newsletter or newspaper; by speaking to a community group, a policy maker, or a reporter; or by participating in SGIM's Hill Day or Off the Hill Day—all SGIM members can help to direct attention to solving health care problems instead of wasting energy placing blame.

To provide comments or feedback about President's Column, please contact Lisa Rubenstein at Rubenstein.Lisa@gmail.com

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ANNUAL MEETING UPDATE

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large, unwieldy government entity—the sort of thing often paired with words like "bloated" or "inefficient." Tasks that might seem simple in another setting, like ordering supplies, hiring a new employee, or making a change in a policy, were no longer so easy to accomplish. Forms, committees, and approvals of all sorts were required for even the smallest of changes. Bureaucratic delays and impediments were commonplace. Meetings were long, frequent, and often unproductive. The heavy burden of bureaucratic impediment was evident in the oft repeated phrases "it can't be done" and "it's not done that way here."

After this dizzying array of first impressions, I was left in a state of cognitive dissonance as I reflected on these new sites, sounds, and experiences. What had I done? Was I now just another cog in a byzantine, monolithic, inefficient health care system in need of a paint job? But looks and first impressions can be deceiving. I soon came to discover that while the walls may have needed paint, they contained within them some intriguing lessons in health care reform. By digging a bit deeper, it soon became apparent that the care was indeed special, of very high quality, and in many cases more efficient then that being delivered elsewhere.

My first hint of this came as I got to know the VA staff. I began to notice even in the most mundane of day-to-day encounters that VA staff that truly cared about the veterans and demonstrated that caring in myriad ways. A strong sense of mission and dedication to patients seemed to have been inculcated in all levels of staff. There was a remarkable preponderance of talented, smart people doing amazing things in their jobs each day. In addition, I became increasingly aware that there was something different in the VA culture. I was impressed with the relentless emphasis and focus on quality. Using a "Balanced Scorecard" approach, staff at all levels, from the hospital director to the front line clinicians, were held accountable for outcomes in clinical quality, access, and patient satisfaction. Quality reports were ever-present at meetings and were carefully scrutinized. All levels of staff were aware of the metrics with which they were being assessed. Outcomes data and quality metrics were used to drive innovation and improvement.

My first patient was a delightful former Air Force colonel from the Vietnam era. When I entered the room, I had in front of me his complete record on a computer screen. I ordered medications from the VA pharmacy, consults to GI, and arranged for follow up—all using a desktop computer. Lab results going back years were readily available. Even his recent inpatient admission was fully available in the same record. There was no scrambling for outside records, no struggle to read illegible handwriting, and no leafing through piles of results to find the ECHO or the CT scan.

As I worked through the visit, computerized alerts reminded me that he was due for tobacco screening and a diabetic foot exam and suggested that he should be considered for a thiazide diuretic for his hypertension. A click on the alerts led me to a screen that walked me through the process of screening, ordering needed tests, and prescribing appropriate medications. Many medications that I was used to prescribing were not on the VA formulary and, therefore, off limits. But for the most part, I was surprised how quickly I adjusted to using lower cost medications. In a way it was liberating. No longer did I have the option of prescribing many higher-priced medications. Someone else was making the decision about the relative costs and benefits of various treatments.

There were other significant aspects of this encounter representing a fundamental shift in the way I practiced. My workload was governed by a panel size and determined by a number of factors, including my clinical hours, staffing ratios, and the overall risk adjustment for our facility. I had more time to spend with this patient but more things to accomplish in one visit. There were no incentives to see him more frequently or order more tests or procedures. To the contrary, the incentives were to provide high-quality care, keep him healthy, and avoid future visits to the hospital and clinic. The VA represents a true capitated system, with lifetime patient enrollment.

Gradually my musty, chaotic first impression gave way, and in its place I began to perceive the elements of a system, mundane at first pass, that was translating evidence into practice on a large scale and doing it quicker and better than anywhere else. Behind the computer screen, the evidence for tobacco screening and nicotine replacement, as well as ACE inhibitors, statins, aspirin, and many other evidence-based care items, was being operationalized on a large scale.

The primary care encounter is a complex blend of art and science. The provider balances patients' goals and objectives with science, evidence, population-level guidelines, and recommendations. The balance that is struck between the science and the art is unique to each patient. The VA has demonstrated how to create a "culture of quality" and achieve impressive outcomes in primary care through integration, thoughtful application of technology, and parsimonious allocation of resources, along with a singular dedication to its mission.

As state governments and a new presidential administration apply themselves to the task of reforming health care, they should look to the VA for ideas. Comparisons of metrics from the Health care Effectiveness Data and Information Set (HEDIS) show that the VA achieves higher quality scores than Medicare, Medicaid, or commercial insurance.[4] How remarkable to think that a government system, caring for a highly complex and vulnerable patient population, has produced such exceptional results. Now as I wend my way through the numbered buildings I don't notice the must or the paint because my eyes are looking forward, planning ways to continue serving veterans and ensuring that the care they receive remains the best and keeps getting better.

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CURBSIDE CONSULT

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to mind.) It would be helpful to think through and prepare a business plan before seeing university leaders and requesting funds. What's the return on their investment going to be? Is it something that they value? Can they provide in—kind funding instead of financial support if dollars are tight? What do you have to give to them-what's the quid pro quo?

Do the costs of a "program" or "center" have to be based on "soft money"? How is it possible to have the security of a stable program when you live from grant to grant?

Ashton: Even center grants have a reapplication and competition cycle, so yes, even centers are based in large part on soft money. The stability factor has to result from factors such as fidelity to the program/center's mission, organizational goals, and leadership. That said, it is critical for a program/center to have a source of funds that can support the infrastructure needed to run an organization. Center grants from federal agencies or associations provide that. In some cases, private philanthropy funds might be garnered, so it is worth a visit to the university's development office. The university may be willing under some circumstances to make a time-limited investment of funds or in-kind support. Generally, the goal is for a program or center to mature toward self-sufficiency.

What are some key steps that a late junior faculty member can take in expanding her research portfolio and programmatic reach?

Lurie: Talk with others outside of their research sphere, either in their institution or in their community. Branch out and develop new ideas and new partners.

A late Assistant Professor is considering a move to a new medical center, where he perceives a greater institutional commitment to helping him broaden his research agenda. What more do you need to know in helping to counsel him?

Lurie: Think hard about whether the issue that is driving you to consider a move is really institutional commitment and ensure that you have really exhausted the avenues for getting support in your own institution. Remember that moving can be both exciting and disruptive, and recognize that it will take time to establish yourself in a new institution.

A mid-level faculty member is invited to serve on the institution's Institutional Review Board, a search committee for a new department chair, and also to lead a weekly workshop series. What are the key things she should think about as she considers whether or not these are wise to agree to?

Ashton: It is helpful to have an explicit personal mission statement and a set of professional priorities for oneself and to return to them often. It is also helpful to write down some decision-making guidelines to use when you are presented with a new request or new opportunity. For example: Take time to think and discern. How will this activity or contribution help you achieve your strategic goals and priorities? Which goal/priority does it advance? If you engage in this activity, will it impair your ability to fulfill another of your goals/priorities? What are the expected benefits of participating in this activity relative to its costs in terms of time, energy, and things foregone? What role is self-indulgence playing? How many steps away from the "revenue line" is this activity?

Lurie: Think about what you want to do, what you'll learn and grow from, and where you can best contribute given your skills. Don't necessarily agree to too many things that will spread you too thin and leave little time for the things you enjoy, whether at work or in your personal life.

Are there any considerations for mid-level faculty who are women that are distinct from those for men?

Ashton: Not that I know of. Perhaps the distinctions should be drawn between professionals with kids and those without. Children increase the complexity of planning for sabbaticals and career moves (they may also increase the joy of such experiences) and have to be part of the planning process.

Lurie: There are lots of considerations for both. But for both, many involve decisions about new responsibilities, commitments, or even new jobs. All of these involve considerations for family and partners who also have fulfilling jobs and the ways in which different people work out their relationships at work or at home. I don't think they are generally issues for men or for women alone.

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NEW PERSPECTIVES

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EDITORAL: PRIMARY CARE TO HOSPITALIST AND BACK

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there is no concern about your patient leaving because his insurance carrier has changed. Furthermore, loyalty and respect are second nature to those who serve. Therefore, I came back to primary care to once again try to forge those relationships that could not be developed either as a primary care physician outside the VA or as a hospitalist.

However, for those outside the VA, the fact remains that primary care is significantly underappreciated for all it brings to the table. Primary Care physicians cannot expect to pay back their school loans, carry a mortgage, and send their children to college on dwindling reimbursements. Furthermore, they need more time to dedicate to their patients and their needs. Most of the patient care starts after they leave the exam room in the form of medications, arranging follow up exams, labs, phone calls, etc. None of this is reimbursed. Most patients say they want a physician and not a paraprofessional as their primary care provider. Unless the entire system is overhauled and primary care physicians get their due, this will become the exception, not the rule. More and more internists will be drawn to hospitalist medicine for lifestyle, reimbursement, and respect. It's really a shame. What do they ask for? Time with their patients and financial (as well as professional) recognition for what they do. Oh yeah, and once and a while a hug would be nice, too

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EDITORIAL: THE BUNDLING NEMESIS

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components: a detailed history; a detailed examination; medical decision making of moderate complexity." The CPT also stipulates that on average I spend 25 minutes in "intra-visit" (face-to-face) time, 5 minutes in pre-visit time, and 10 minutes in post-visit time. These are the current "bundling" assumptions for the 99214 service code.

So there it is. I worked my 52 hours and got paid for 40 (60 visits @ 40 minutes a visit).

Virtually all the CPT service codes used by physicians have pre-, intra-, and post-visit times that are similarly bundled. For the radiologist, the total "visit" time with a single view chest x-ray is five minutes (for a minute's work); for a colonoscopist, it is 75 minutes (for maybe 30 minutes of work). For a surgeon doing an open splenectomy, it is 15 minutes for "dress, scrub and wait," 120 minutes of skin-to-skin time, and 193 minutes of post-op hospital time after the day of surgery—a whopping 7 hours and 22 minutes. These official CPT times are based on suspect and unsound data that have been sequestered by the AMA. The AMA's Resource-based Relative Value Update Committee (the RUC) is the invisible force that has sustained this system. CMS, the government agency with ultimate responsibility for monitoring the rules of physician compensation, has been complicit.

We generalists are at a profound disadvantage. Most if not all of our specialty colleagues have learned or chosen to reduce the time spent in all the separate activities bundled with each CPT service code. We have chosen (or been chosen) to struggle with the formulary prior approvals, phone messages, organizing and reviewing multiple sets of data, managing consultation notes, and more. As a consequence, our service times have grown.

We are plagued by the biases built into the current RBRVS system. We are forever confined by absolutely absurd bundling assumptions for our E/M service codes.

We need a compensation formula the reflects the current reality: There is more work associated with each visit (the tests and consults that come from our medically necessary efforts to closely manage many concurrent active problems), and there is more work associated with the management of each patient over time (the availability to answer non-visit-related care needs, manage formularies, ensure that the patient's electronic record is accurate, and more).

As generalists, we are compelled to act. We must demand a more equitable system of MD compensation. First, the value of the current CPT E/M codes used in outpatient primary care practice by primary care doctors needs to increase by around 50% to cover the increased post-visit "bundled" responsibilities of generalists. Second, a care management fee needs to be created in order to cover not only the professional work required to maintain useful and reliable medical information, manage medications, provide emergency care, and pay for office infrastructure, including personnel and hardware.

For general internal medicine to survive, we must have income parity with our specialty colleagues. Roughly 75% of total compensation should be based on face-to-face care and 25% on care management. Both are necessary due to the episodic care needs that emerge from each encounter and care management needs that are implied by each patient in our "village," regardless of how often they require face-to-face care.

Political forces to reform health care will be building over the months ahead. We within SGIM must consistently and strongly support a hybrid model for Medicare reimbursement that includes an enhanced RBRVS payment and a new and substantial care management payment adjusted according to clinically relevant patient characteristics.

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