

FROM THE SOCIETY

The Impact of Health Care Reform on Medical Education and the Primary Care Workforce

Mark D. Schwartz, MD, and Angela Jackson, MD

Dr. Schwartz is past chair and Dr. Jackson current chair of the SGIM Health Policy Education Subcommittee.

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S GIM members will find many important provisions that have the potential to reshape medical education and primary care (PC) work-force policy in the Patient Protection and Affordable Care Act (PPACA), which was amended by the Health Care and Education Reconciliation Act of 2010. We briefly describe the major changes here in three categories: planning, pipeline, and payment and practice.

Planning

For the first time in our history, Congress has enacted a coordinated and national effort to plan for our local and national health care needs, investing unprecedented resources for data collection, analysis, and planning. PPACA authorizes the Secretary of the Department of Health and Human Services (HHS) to establish a National Healthcare Workforce Commission to provide comprehensive, unbiased information to Congress and the Administration about how to align federal health care workforce resources with national needs. A focus of the Commission will be to examine the barriers of entering and remaining in PC careers. HHS will also provide grants for State Workforce Development (\$8 million per year) and regional Centers for Workforce Analysis (\$12 million per year) to collect, analyze, and report data related to Title VII (of the Public Health Service Act) primary care workforce programs.

Pipeline

Many SGIM members are products or leaders of educational programs funded via Title VII. Since its authorization expired almost 10 years ago, the nation's only federal program supporting PC training has been subject to the political winds of the annual appropriation process—not infrequently nearly eliminated only to have some funding restored in the 11th hour. Title VII

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Three Resolutions for Effective Balance

Kim Pham, MD, MPH

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Another patient inquired after my children today. I have various items scattered throughout my office: photos of my children, spouse, and dogs; my Firefighter I certification; and batik prints and hand-painted roof tiles collected from travels. They are all there to soothe the unease so often associated with a visit to the doctor, to serve as a starting point for conversation. Today, the conversation started with a question: "How much time do you allow your kids to spend playing video games?"

I attend in the primary care clinic of a VA medical center. Because most veteran women opt to enroll in the Women's Clinic downstairs, all but three of my 600 patients are men. Most are veterans from the Korean or Viet Nam War eras, although more young veterans are enrolling from recent deployments and a handful hark back to World War II. Despite the diversity of their ages and backgrounds, they share much in common. For one thing, many of them express initial discomfort with having been assigned a woman provider; all have overcome this by

the end of our first encounter. I often thank them for sharing their combat or life experiences with me. So, it is not surprising that many feel comfortable offering me advice.

Often the advice goes something like this: "You work so hard here... make sure you spend enough time with those kids; they grow up fast!". I can't help wondering whether these patients would offer the same advice to a male provider. Still, they voice a concern shared by patients and colleagues alike—that is, just how does one balance career, family, community?

In search of balance, I left clinical medicine altogether for several years. First, I ventured into public health academia. Eventually, the grant writing, lecture planning, and thesis grading felt too isolating and just as easily spilled into family time. Then, the opportunity arose to oversee medical programs for a humanitarian not-for-profit organization—a chance to apply both my clinical and public health training. Rewarding as it was to collaborate with partner agencies in developing countries, something was still missing: those conversations with individual patients and their families. The deciding point came in the form of an ABIM recertification deadline. I could either forego recertification and continue as I was or recertify and return to clinical practice.

I chose the latter. Why? I had learned that patient care was what I found most gratifying. Perhaps the better question is: "How?". I made a few resolutions.

Resolution #1. Actively manage time. The shift from full time to part time was a major step toward sanity. Although a night owl by nature, I adopted very early morning office

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Managing the Primary Care-Hospital Interface: SGIM and a Need for New Models

Gary Rosenthal, MD

“What we’ve got here is...failure to communicate.”

—The Captain (played by Strother Martin) to Luke (Paul Newman) in the 1967 film *Cool Hand Luke*



The past year has been a whirlwind of transitions for me. As President-elect, I spent a good bit of time trying to get up to speed with all things SGIM and figuring out how to act presidential. Transitions were also prevalent in my personal life, as my wife and I watched our older daughter, Allison, graduate from college and begin a new semi-independent (i.e. art history major in the midst of a recession) life in Chicago and our younger daughter, Jaime, graduate from high school and began her freshman year in college in St. Louis. While our new found freedom as empty nesters has been welcome in many ways, the transitions have also spawned other anxieties and challenges, particularly with regard to figuring out new ways of communicating with our kids and remaining a part of their lives.

During a recent weekend, my nest became a little more empty when my wife traveled to a professional meeting. I decided to take advantage of the solitude and review the ever-growing stack of journals on my desk. An opinion piece¹ in the *Annals of Internal Medicine* by Howard Beckman caught my eye. In the article, Dr. Beckman described the changes he had experienced over the past 15 years in his GIM practice in caring for his patients who required hospitalization. Previously, Dr. Beckman made rounds on his patients multiple times during the day. However, after moving his office practice off-site from the hospital, he somewhat reluctantly agreed to have his patients managed by hospitalists. He described his initial trepidation at “abandoning” his patients when they

were most vulnerable, but he clearly recognized the increasing challenges in caring for hospitalized patients (e.g. the need to be current with practice guidelines, developing fluency with his hospital’s EMR), as well as the benefits of hospitalists in making his on-call nights more manageable.

However, Dr. Beckman soon encountered a number of frustrations in working with hospitalists, stemming largely from what he perceived as their limited knowledge of his patient’s medical histories and life circumstances and, perhaps most importantly, from the poor channels of communication between hospitalists and primary care practitioners. He went on to note how “we have lost continuity of care and the core element of effective cross-coverage: skilled explicit transitions of responsibility from one clinician to another” and expressed his doubt that many patients, if asked, would choose the current model.

Dr. Beckman’s piece elicited a follow-up editorial and large number of letters to the editor. Of those published, several echoed the concerns that Dr. Beckman raised, particularly the “voltage drop” in information that occurs in the transitions between primary care and hospital care. Others noted the positive impact of hospitalists on outcomes of acute care and the critical need to improve channels of communication and coordination across settings.

The issues raised in this series of perspectives represent some of the most fundamental challenges within generalism and demand our urgent attention. While the picture painted

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by Dr. Beckman and others might lead some to pine for the “good old days,” it’s important to recognize that the emergence of hospitalist models has been driven by potent economic, social, and regulatory forces and the increasing complexity of inpatient medicine. (And by the way, the good old days weren’t all that good). Thus, the hospitalist model is here to stay. Moreover, the available data suggests that hospitalist care is likely associated with improved efficiency and may be associated with better clinical outcomes and higher teaching evaluations by trainees.

Thus, our task is not to recreate Marcus Welby but to come up with effective ways to facilitate communication between ambulatory and hospital-based practitioners and between the multiple hospitalists who might care for a patient

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Appreciating the Importance of Leadership

Steven A. Wartman, MD, PhD, MACP

Dr. Wartman is President and CEO of the Association of Academic Health Centers.



Steven Wartman

Leaders must be guided less by the trajectory suggested by their CV and more by looking at “what is right” for the organization.

It was my privilege to serve as SGIM President from 1988 to 1989 as I had “grown up” professionally in the Society. It was then known as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM)—a rather descriptive but cumbersome name. I remember my younger brother spending a summer with us and referring to my academic society as “Schwepcim.” Obviously, a name change was a good idea.

In the late ‘70s and early ‘80s, general internal medicine struggled intensely to gain credibility in academic medicine, and SGIM was of profound help and inspiration. An important step occurred at the 1984 national meeting, which was extended from its usual one-day format to two full days. The rationale for this

change was the compelling need to separate the Society from the American Federation for Clinical Research (now known as the American Federation for Medical Research) to which its meeting was attached. As the meeting chair, I was anxious about the outcome; yet today, one would be hard pressed to find a more vibrant meeting than the SGIM annual meeting. I am grateful for the opportunities the organization has provided and its contributions over the years.

My most active period with SGIM occurred during my 13-year stint as founding division and residency program director at Brown/Rhode Island Hospital. Subsequently, I gained new perspectives by chairing two departments of internal medicine and serving as Executive Vice President for Academic and Health Affairs and

Dean of Medicine at the University of Texas Health Science Center at San Antonio. For the past five years, I have been privileged to lead the Washington, DC-based Association of Academic Health Centers—an organization that provides advocacy, member services, and thought leadership to academic health centers in the United States and around the world.

Based on these experiences, I believe that the hard-fought battle for the academic legitimacy of general internal medicine appears to have been won. In this regard, SGIM has largely taken the path of other established specialty societies in being a leader and fostering development of the field as an important proving ground for career development and advancement. Are there other roles for SGIM? Might this be found in health reform? 0

Clearly, the ups and downs regarding health reform over the past year have highlighted deep divisions among the American people and their government representatives. The fundamental divide, it seems to me, is over the issue of health care as a right or privilege. Unlike our counterparts in Canada, the United Kingdom, and other countries that have established a framework for universal health care, the United States is not unified in accepting this precept. After all, we’re a nation with more than 200 years of rugged individualism—we like to pull ourselves up by our bootstraps, and we don’t like handouts or taxes. For example, we’re divided over the role of the market in health care. Some believe it is the path to a more effective, efficient system; others hold that the market cannot solve social problems

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Billing for Inpatient Admissions in a Teaching Environment: Did the Guidelines Change?

Yvette M. Cua, MD

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Many of you may have seen the FAQ posted on the National Government Services (NGS) website. NGS is the Part A/Part B Jurisdiction 13 Medicare Administrative Contractor (A/B J13 MAC). The question was:

If the resident admits a patient at 10:00 p.m., how long does the teaching physician have to see the patient and link to the resident's note?"

If their answer caused you worry, anger, confusion, or fear, then you are not alone. To summarize the full-page reply, the Newby Consulting Firm's analysis stated that since the resident performed the admission work on Day 1, and the teaching physician (TP) saw the admitted patient on Day 2, the TP could only bill for a subsequent visit. Furthermore, the TP could not link to the previous evening's resident note in lieu of rewriting the same information themselves. This was the first time this interpretation of the TP guidelines with respect to this scenario had ever been put in writing, and although NGS is the local Medicare fee-for-service claims processor for New York and Connecticut, the FAQ commented that "this was confirmed by CMS national."

Fast forwarding to last week, I had the wonderful opportunity to speak with the Association of American Medical Colleges (AAMC) and the Center for Medicare & Medicaid Services (CMS) Department of Practitioner Services to review and discuss the current "understanding," "interpretation," and "clarification" of the TP documentation guidelines in light of this posting. The open lines of communication and unanimously sincere interest in doing the right and fair thing for all involved parties was unquestionably evident and welcomed. The final results of our conference call were that all parties

agreed: 1) the TP may bill an initial inpatient visit on the calendar date of their first face-to-face visit with the patient, even if that visit takes place on the calendar date after the resident's initial assessment and documentation, and 2) the TP may link to the resident's documentation, even if dated the previous calendar date, provided that the time interval between resident and physician visits are within "ethical and medical standards of care." CMS made the additional comment that NGS's FAQ is officially rescinded. Plans are in place to amend the Medicare manuals to reflect these clarifications.

Wow! As relieving as it is to hear this given the work I do in a teaching environment, various aspects do require clarification to ensure we all understand exactly what is expected and underlying those statements. In getting through our day, we have a responsibility to CMS to ensure that physician education on documentation guidelines is clear, up-to-date, and accurate. Since there are several expectations of us as TPs in this scenario as well as in all patient care encounters involving resident participation, I thought this was a great opportunity to review them. It is because of variable understanding of these underlying key concepts that much stricter and limiting interpretations are sometimes adopted.

For many practitioners struggling to keep up with medical literature, the term "documentation guidelines" means memorizing tables with entries like "10 ROS (review of systems)" or "3 PFSH (past medical history, family history social history)" because that's how we survive—what's the least amount of information we need to know to get through the day—and often we do not fully understand the principles underlying these criteria. There are very few numbers "set in stone" when examining the published guidelines. The

guidelines are all prose descriptions of what CMS considers the amount of work done to achieve a certain level of service and reimbursement rate. So like any set of guidelines that we read, they are subject to differences in interpretation and implementation by the various A/B Medicare administrative contractors.

Many of the documentation and coding guidelines are worded in a way that leaves them open to interpretation. As frustrating as that may be to compliance offices, it was actually done with our best interests in mind. Knowing that no Medicare manual can trump clinical judgment, often the vague passages allow for case-by-case variability in documentation that does not fit into the "usual visit."

Separate from the 1995 and 1997 Evaluation and Management Guidelines that most of you are familiar with, there is what I call the "Documentation and Coding Bible," also known as Chapter 12 of the Medicare Processing Manual (<http://www.cms.gov/manuals/Downloads/clm104c12.pdf>). Section 100.1.1A discusses TP documentation guidelines and is where you'll find the often-quoted statement, "When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician..." We need to understand that combining resident plus TP documentation is not synonymous with combining resident plus TP work to achieve the optimal level of billing. Medicare has already paid for the resident's work through Part A contributions to graduate medical education (GME), thus we can only bill for the work we personally do toward each visit. Another way to put it is that the TP guidelines "cut us a break"—they allow us to use the resident's documentation as proxy to

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Make Eye Contact and Smile

Damian Frackowiak, MD, and Allan S. Detsky, MD, PhD

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Several years ago, one of us (AD) entered an elevator in a teaching hospital where he did not normally work, wearing his winter coat. The other people in the elevator included four medical residents dressed in white coats and three other “civilians” also dressed in their winter jackets. The four residents chatted among themselves and made no eye contact with the others. The faculty member knew all four residents well, but they did not acknowledge his presence—perhaps because he was both out of place and out of uniform. One by one, the other winter-coated people left the elevator leaving the faculty member alone with the four residents. He stared at each of their faces sequentially, but none made eye contact. He tried to get an acknowledgement from them by gradually moving closer to one and peering over her shoulder at her reading material. The resident perceived his presence and slowly moved away but still made no eye contact. Finally, the faculty member nudged the resident’s shoulder, which startled her. She looked up and shouted, “Dr. Detsky!”. The other three residents immediately looked over, were surprised, and said hello.

This vignette illustrates a common phenomenon in hospitals. The staff frequently interact with each other completely ignoring those who are not members of their “tribe.” It is almost as if the “clients” are not there, often overlooked because they are dressed differently. These strangers are not part of the clique or social circle worthy of acknowledgement. This can be contrasted to other service organizations such as fine hotels where the staff are trained to make eye contact with every customer, to smile, to say hello, or to offer some other greeting.

What makes humans different from other animals is the development of physical functions such as

the use of the thumb, pharyngeal muscles that permit variation in vocalization, and muscles that determine facial expression. Eye contact and an ability to smile are definitely human functions that allow us to interact with complexity. Many experts have noted that a significant proportion of communication between individuals is non-verbal.

We both enjoy live theatre and share a preference for sitting as close to the stage as possible in order to view the facial expressions of the actors. One of us (DF) recalls a play that lasted three hours with not one word being spoken—a mute play. There is an obvious feeling of uneasiness attending such an event, wondering how it can be understood without knowledge of sign language. However, the actors communicated through gestures, facial expressions, eye contact, and smiles, and after a while, it seemed that the spoken word would only distract from what seemed to be a flawless mode of communication.

One of the clues that a child may be autistic is his/her inability to smile, which is expected to be seen by age 18 months. Indeed, most parents carefully watch for their child’s first smile as an important milestone and often think that they achieve it early on only to be disappointed when a more experienced parent declares, “It’s only gas.” Kramer¹ notes that children of depressed parents have exceptional abilities to judge character perhaps by picking up cues from subtle facial expressions, which are primarily withdrawn or indifferent.

We all know people whose natural facial expression appears to be a scowl or frown. Their mouths curl down at the ends and foreheads are constantly wrinkled even when they are content or happy. Imagine what it must be like for these people to go

through life with everyone thinking they are distressed or overly serious. There is a Yiddish expression for this kind of person: a verbissina punum (grim face).

As part of what is likely a skill that was developed during evolution, young men know that one of the key elements of a successful social confrontation in locations like bars is to assume a confident and well-balanced posture, minimize the body area exposed to a potential blow, and finally look your opponent straight in his eyes to let him know you will not back down. This leads us back to our own setting, as neither of us frequently gets in bar fights. We do, however, walk down the halls of our institutions on a daily basis. We feel that we are different than many people in that we are willing to look others in the eye and even offer a smile. When we have been on the other end of the interaction (i.e. as patients), we enjoyed that recognition. Eye contact and a smile from anyone on the hospital staff made us feel better and reassured. We also recall hospital receptionists greeting us at their desks by speaking with their heads down, saying “How can I help you?” with their words while displaying body language to mean otherwise.

Why do most people not make eye contact or smile? Could it be because they are afraid the other person will engage them in a conversation they do not want to have? Are they trying to avoid being drawn into an activity that will take up time? Are they worried that the interaction will involve an emotionally fragile patient or family member who will make them uncomfortable? Do they wonder what will happen if the person smiles back?

So, colleagues, consider this the next time you are walking down the hall and notice that patients are looking
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The Hits Keep Coming: American Hospitalist Academy Creates “Aha!” Moments

Harry L. Hoar, MD

Dr. Hoar is assistant professor of medicine and pediatrics at Tufts University School of Medicine.

“Aha!” Moment (def.) A sudden understanding, recognition, or resolution.¹

Synonyms: “lightbulb” moment, “eureka” moment, epiphany

When I returned from the Academic Hospitalist Academy (AHA) in November 2009, I was exhausted from the intense four-day meeting. Yet, at the same time, I was filled with energy and optimism about my academic future. I gushed about the AHA with my fiancée so much over the following days that a verbal shorthand necessarily developed between us when referring to the Academy: “Academic Hospitalist Academy” was shortened to “The Academy,” which became “A-H-A,” which soon became “The Aha!” or simply “Aha!”. Since that time, I have had several AHA “Aha!” moments, as the lessons I learned at the Academy have started to pay off in my academic career. The following is a review of “Aha!” moments from a historical and scientific perspective and a description of the “Aha!” moments I have had as a result of applying the lessons I learned at the AHA.

October 1986. The Norwegian synth-pop band *a-ha* reached #1 on the Billboard charts with their catchy tune “Take On Me.” *a-ha* (note the traditional use of the lower-case and italicized a’s) went on to be nominated for the Best New Artist Grammy. The group regrettably did not win the Grammy, but they did win seven MTV Video Music Awards and eight Spellemannprisen Awards (the Norwegian equivalent of the Grammys).² Unfortunately, this *a-ha* moment did not last long; the band had no more hits, and they are now listed third on the VH-1 list of all-time ‘80s “one-hit wonders.”

May 11, 2006. The *Observer* online published an article titled “That ‘Aha!’ Moment Takes Preparation.” The article reports on a new study using EEG and fMRI techniques that

“reveals that the distinct patterns of brain activity leading to ‘Aha!’ moments of insight begin much earlier than the time a problem is solved.”³

November 8-11, 2009. The faculty at the Academic Hospitalist Academy (AHA) delivered a string of catchy “tunes” with titles such as: “Peer Networking to Build a National Reputation” and “How to Develop a Clinical Vignette” by Dr. Jeffrey Wiese, “Didactic Teaching” by Dr. Robert Centor, “Curriculum Development: The Basics” by Dr. Shobhina Chheda, “Pearls to Hospitalist Success” by Dr. Andrew Auerbach, and many others. At the conclusion of the meeting, in a truly “Aha!” moment, the participants gave the AHA faculty a long and heartfelt standing ovation for putting together such a well-conceived and well-delivered conference, much like the standing ovation the audience at the 1986 MTV awards must have given the band *a-ha*. Wisely, in his closing comments, Dr. Jeff Glasheen reminded us not to let the AHA “Aha!” moment pass when we returned to our busy professional and personal lives. In other words, he urged us not to let the AHA fade into the one-hit wonder obscurity of the band of nearly the same name.

January 18, 2010. The clinical vignette abstract I started working on at the Academy for the “How to Develop a Great Clinical Vignette” session was accepted as a poster at the upcoming Society of Hospital Medicine Annual Meeting. Aha! What’s more, I was invited to present my poster at the Academic Hospital Medicine Summit, which “offers a unique opportunity for junior faculty to engage and network with nation-

For those readers whose academic hospitalist careers could use a few “Aha!” moments of “understanding, recognition, or resolution,” plan on attending the next AHA.

ally prominent senior faculty and to present their work for feedback.” Aha! Talk about “Peer Networking to Build a National Reputation”!

February 22, 2010. I received word that I had won a \$15,000 educational innovations grant for a curriculum to teach diagnostic reasoning to third-year medical students. Aha! The lessons from “Curriculum Development: The Basics” have paid off!

March 2, 2010. Using an approach modeled after the many great faculty speakers at the AHA and applying the principles I learned in the “Didactic Teaching” session, I delivered grand rounds at my home institution. Comments on the feedback forms for my presentation included the following:

“Excellent, interactive presentation.”

“I loved your grand rounds. You are an excellent speaker.”

“This was one of the best grand rounds ever done about a crucial topic! I’d like to hear more from Dr. Hoar....”

Aha! Aha! And Aha!

March 3, 2010. During a casual conversation about nothing in particular, my division chief happened to mention that I would be given 20%

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The Halls of Congress: A Doctor's Perspective of the Hill

Tara F. Bishop, MD

Dr. Bishop is a fellow in general internal medicine at the Mount Sinai School of Medicine.

The Hart Senate Office Building is a light-filled, modern edifice with a big atrium so that if you are standing on the ground level you can see rows of Senators' offices above. It is strikingly modern compared with the Russell and Dirksen buildings, its older counterparts. The Hart Building lacks their marble floors and a dark wooden molding but appears more abuzz with activity. Within minutes of walking its halls, one knows that the world of Washington politics is alive and well.

It is SGIM's annual Hill Day, and I am in the Hart Building awaiting a meeting with an aide to Senator Chuck Schumer of New York. I have been thoroughly briefed on health care issues that are important for general internists and the nuts and bolts of lobbying. I feel quite prepared to speak with Senator Schumer's staff—perhaps I am too prepared.

The legislative correspondent that my colleague and I meet is fresh out of college, having graduated from the University of Chicago eight months prior. She seems eager to impress upon us that she understands health care and the issues concerning general internists. We discuss payment reform, the need for comparative effectiveness research, and the dwindling primary care workforce. She nods her head in agreement. "The Senator completely agrees," she says.

We have two similar meetings with aides for New York's junior Senator Kirsten Gillibrand and long-standing

Representative Jerold Nadler. All the congressional aides appear to be in full agreement with our viewpoint. As I walk across Capitol Hill, with its hustle and bustle of legislators, staff, lobbyists, and visitors, I wonder, "Have I actually made any difference today?"

Advocacy is the act of arguing in favor of an idea or a cause. The term conjures up images of protests and sit-ins, letter writing campaigns, and e-mail blitzes. I wouldn't normally equate advocacy with lobbying. Lobbying seems much more crooked, invoking pictures of politicians being wined and dined and lobbyists buying their way into legislation. But on Hill Day, I realized that lobbying is one part of the spectrum of advocacy, and if I want to be an effective advocate for my patients and my profession, then I'd better get good at it.

Despite the fact that my legislators are in agreement with the majority of SGIM's policy positions, I realized on Hill Day that most representatives and senators lack the hands on experience to understand why SGIM's positions are important. None of my legislators has seen a patient with diabetes, hypertension, and congestive heart failure in his/her office and then spent hours of unpaid time coordinating care for that patient. None of my legislators has been baffled trying to decide between two tests for a patient with low back pain because there are conflicting studies and guidelines. None of my legislators has witnessed swarms of intelligent young doctors shying away from pri-

mary care because the work is hard and the pay is low.

But I have seen all these things, and my stories and my experience provide ammunition for my representative and senators who are fighting a hard battle in Washington. If they don't know what's happening on the ground, how can they convince their opponents otherwise?

The halls of the Congressional Office Buildings are teeming with special interest lobbyists. Seeing the activity in Washington and during one particular meeting, I grasped the importance of my voice. If I don't advocate for my patients and my profession, no one will.

The meeting is with an aide to Senator Gillibrand. As my colleague and I are about to leave, she asks if we had heard of the 360 degree colonoscopy. "Is it more effective at detecting cancer?" she asks.

Why did she ask us this question? She asked because the company that makes the device met with her the day before. They were trying to convince her and the senator that Medicare should pay for this procedure.

"I'm not sure about the 360 degree colonoscopy," I say. "But I think it speaks to why comparative effectiveness research is so important. We need to figure out if new technologies are in fact better than old technologies."

In that one-minute conversation, my lesson from Hill Day is learned. The lesson is that many other people are promoting their interest in health care. Sometimes they advocate for good things; sometimes they advocate for bad things. I believe that I am advocating for the benefit of patients and that my voice on behalf of physicians and patients is crucial. I hope others realize the strength of their experience and will join me in the halls of Congress next year.

"I'm not sure about the 360 degree colonoscopy," I say. "But I think it speaks to why comparative effectiveness research is so important. We need to figure out if new technologies are in fact better than old technologies."

Mesenteric Ischemia

Robert Boxer, MD, PhD; Dheeraj Kumar, MD; and Douglas Wright, MD, PhD

Dr. Boxer is an instructor in medicine at Brigham and Women's Hospital in Boston, MA; Dr. Kumar is clinical assistant professor in medicine at the University of Florida College of Medicine in Gainesville, FL; and Dr. Wright is an instructor in medicine at Harvard Medical School in Boston, MA.

Objective: To enable learners to distinguish among the various forms of mesenteric ischemia.

Case: A 74-year-old woman who is a former heavy smoker and has a history of atrial fibrillation, hypertension, hyperlipidemia, coronary artery disease, and heart failure presents to the emergency room with several hours of nausea, vomiting, and severe abdominal pain. Although she occasionally has abdominal pain following large fatty meals, she states that the pain today is more severe and longer lasting. She reports being in her usual state of health and ambulating without difficulty in her home until three days prior to her presentation, when she began to have symptoms of an upper respiratory infection. While feeling bad, she decreased oral intake but continued to take all of her regular medications, including her antihypertensive medications and diuretic. On exam, she is tachycardic and hypotensive, with dry mucous membranes and a benign abdominal exam. Laboratory analysis reveals an elevated white blood cell count and a lactate level of 5 mmol/L (0.5-2.2 mmol/L).

Teaching Logic: Many learners have a better understanding of the different types of cardiac ischemia than they do the different types of intestinal ischemia. Drawing an analogy to angina pectoris, demand ischemia, and ST elevation myocardial infarction (STEMI) is a useful way to help learners distinguish chronic mesenteric ischemia, acute non-occlusive mesenteric ischemia, and acute occlusive mesenteric ischemia.

Chronic Mesenteric Ischemia

Similar to angina pectoris, chronic

mesenteric ischemia or “intestinal angina” occurs in patients with atherosclerotic vascular disease when oxygen demand exceeds supply. In chronic mesenteric ischemia, fixed stenotic lesions of the splanchnic vasculature result in limitations to blood flow at times of increased intestinal activity. Patients are typically elderly individuals and report dull, crampy abdominal pain occurring shortly after eating.¹ Food aversion related to the anticipation of postprandial pain may result in weight loss. CT or MR angiography can be used to establish the diagnosis. In addition to measures aimed at halting the progression of atherosclerotic disease, definitive treatment requires either surgical reconstruction or endovascular intervention such as percutaneous transluminal angioplasty with or without stent placement.²

Acute Non-occlusive Mesenteric Ischemia

Similar to demand ischemia (i.e. type II myocardial infarction³), in which limitations in oxygen supply are severe enough to result in cardiac myocyte injury, limitations in oxygen delivery secondary to splanchnic hypoperfusion and vasoconstriction lead to intestinal injury in acute non-occlusive mesenteric ischemia. The typical patient has underlying atherosclerotic vascular disease, may suffer from chronic mesenteric ischemia, and experiences an additional insult that reduces intestinal blood flow, such as a myocardial infarction with heart failure, heart failure from other causes, sepsis, or severe intravascular volume depletion.⁴ However, similar to demand ischemia, acute non-occlusive mesenteric ischemia can also occur in patients without

atherosclerotic vascular disease if an acute cause of hypotension, such as sepsis, results in impaired oxygen delivery. Mesenteric vasospasm in these settings maintains cerebral and cardiac perfusion at the expense of intestinal perfusion and, when severe, can result in intestinal ischemia. Patients with non-occlusive mesenteric ischemia may exhibit abdominal pain; however, the presence of abdominal symptoms is more variable than that seen with acute occlusive mesenteric ischemia, and the presentation is often predominated by the precipitating process.⁴

Acute non-occlusive mesenteric ischemia has a high mortality and requires rapid diagnosis. CT findings consistent with acute non-occlusive mesenteric ischemia include bowel wall thickening and intestinal pneumatosis. However, CT and MR angiography can give more information regarding the mesenteric vasculature. Angiography remains the gold standard for diagnosing acute mesenteric ischemia and is particularly important as papaverine, a potent vasodilator, can be infused to reverse mesenteric vasoconstriction. In acute non-occlusive mesenteric ischemia, initial management is focused on restoring blood flow by treating the precipitating condition, though bowel infarction may necessitate surgical intervention.

Acute Occlusive Mesenteric Ischemia

Occlusion of the mesenteric arteries can result from either thrombosis or embolization. Similar to the heart where STEMI often occurs in patients with chronic exertional angina, acute mesenteric arterial thrombosis usually occurs in patients with chronic mesenteric ischemia and is

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CHALK TALK

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responsible for approximately 30% of acute occlusive mesenteric ischemia. Unlike the coronary arteries where thrombosis of unstable atherosclerotic plaques is responsible for the majority of STEMI, approximately 60% of cases of mesenteric artery occlusion are due to embolization from other sites.⁴ Dislodged thrombus arising from the left atrium, left ventricle, or mitral or aortic valves can embolize to the mesenteric arteries, with the superior mesenteric artery being the most common site for embolism due to its relatively large caliber and narrow angle at which it comes off the aorta. Mesenteric venous thrombosis, in the setting of hypercoagulable states, portal hypertension, abdominal infections, abdominal trauma, or pancreatitis, results in increased resistance to arterial and venous blood flow and is the cause in approximately 5% of acute occlusive mesenteric ischemia.⁴

Patients with acute occlusive mesenteric ischemia classically present with acute abdominal pain that is out of proportion to physical exam findings (i.e. the patient may have significant abdominal pain, but there is minimal or no tenderness to pal-

pation of the abdomen) and is often accompanied by nausea, vomiting, and forceful bowel evacuation.⁴ Like non-occlusive mesenteric ischemia, CT and MR angiography or invasive angiography can be used to diagnose acute occlusive mesenteric ischemia. However, acute mesenteric arterial occlusion in the absence of adequate collateral blood flow will rapidly result in bowel infarction and requires emergent laparotomy for resection of non-viable intestine and restoration of blood flow to salvageable intestine through embolectomy or thrombectomy in conjunction with other revascularization approaches, such as endovascular stenting.²

Summary and Discussion of Case:

The different forms of mesenteric ischemia, including chronic mesenteric ischemia, acute non-occlusive mesenteric ischemia, and acute occlusive mesenteric ischemia, can be remembered by thinking of their cardiac correlates—angina pectoris, demand ischemia, and STEMI, respectively. The patient from our case has known coronary artery disease and multiple risk factors for atherosclerosis. In addition to her

baseline symptoms suggestive of chronic mesenteric ischemia, she is now presenting with symptoms concerning for acute mesenteric ischemia. The overall clinical scenario suggestive of mesenteric hypoperfusion resulting from dehydration while continuing to take her cardiac medications points toward non-occlusive mesenteric ischemia. However, occlusive mesenteric ischemia is also a possibility, and her history of atrial fibrillation puts her at additional risk for arterial embolization.

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SGIM

NEW PERSPECTIVES

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protected time for academic and educational pursuits at the start of the next budget cycle. Aha! Those “Pearls to Hospitalist Success” are paying off!

As suggested in the article, “That ‘Aha’ Moment Takes Preparation!”, the “Aha!” moments we experienced at the first AHA took a lot of preparation. The quality of the final product at the AHA reflects the immense amount of time, thought, and energy the faculty put into preparing the conference. Fittingly, they also expected participants to come prepared and be actively en-

gaged in this highly interactive conference. For those readers whose academic hospitalist careers could use a few “Aha!” moments of “understanding, recognition, or resolution,” plan on attending the next AHA. It will provide you with the “distinct patterns of brain activity leading to ‘Aha!’ moments of insight” that you are looking for in your academic career. Unlike *a-ha*, the AHA ‘Aha!’ moments keep coming for this attendee.

Editor’s Note: April 9, 2010. Dr. Hoar’s clinical vignette won first place in the

pediatric clinical vignettes category at the SHM annual meeting. Aha!

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SGIM

REFLECTIONS

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and that health care, like police and fire protection, is the responsibility of society. I think the problem with health reform lies largely in the American psyche—and that, indeed, is hard to change. And so, I believe health reform will be largely incremental in scope, driven by politics, ideology, and economics. SGIM in this context can play an important role by innovating and supporting strategies for new models of primary care and clinical research. Paradoxically, this strategy might even involve the morphing of the organization into something larger, more inclusive, and less discipline specific—a topic, perhaps, for another discussion.

But, I think there is also another significant role for SGIM. Because my current position involves the opportunity to interact with leaders of academic health centers, I have gained a new appreciation of the importance of leadership. These leaders, largely with the title of Vice President for Health Affairs or the equivalent (sometimes they are chancellors, presidents, or VPs with dean titles), have enormous responsibilities for educating the next generation of health professionals, producing high-quality research, and delivering a broad spectrum of patient care (and often serving as their community's health safety net). As I delve more deeply into their issues, I realize more fully the importance of leadership.

To a certain extent, leadership has been underrated in academic medicine. Often seen as “crossing over to the other side,” it has been viewed as bureaucratic and inhibiting. At times, the impression among some faculty is that the academic leader is “sitting on a pile of money and not giving me any of it.” But in this new era for academic health centers, leadership *really* matters. Leaders must be guided less by the trajectory suggested by their CV and more by figuring out “what is right” for the organization and charting a path to get there. Beyond a certain level of demonstrated competence, new leaders must have a broad—not narrow—vision and, most importantly, have a personality that works well with others.

The leadership challenges in academic medicine are extraordinary, especially when one considers that the enterprise, although responsible for a bottom line, cannot be run as a traditional business. For example, many “product lines” (such as education and charity care) may not be profitable yet cannot be discontinued. The research enterprise is crucial to create new knowledge, to develop and sustain a reputation, and to provide motivation and energy for the faculty; yet, it is generally not a net winner in terms of generating a clear profit and requires subsidization. And the faculty, many of whom are tenured, often view themselves as

independent professionals who do not have to take orders and can pursue whatever they choose.

I believe that many of the components of effective leadership in this complex environment are second nature to academic generalists, including being able to climb out of a discipline-specific or silo mentality to look across the broad scope of an institution; to have a tolerance for ambiguity, uncertainty, and frustration; and to demonstrate superb communication skills. Of course these must be combined with highly personal characteristics, including a strong sense of self, reflected by a deep understanding of one's own strengths and weaknesses; a perspective honed by both good and bad life experiences; and the ability to maintain the highest ethical standards—through good times and bad.

SGIM, I believe, has the opportunity to play an important role in promoting and enabling leadership at the highest levels in academic medicine. Through the establishment of a major leadership initiative, SGIM can create an exciting, positive image of the value and importance of leadership. This “leadership academy” can serve as a training ground for a new generation of leaders in academic medicine. As academic health centers evolve to meet substantive future challenges, SGIM can help develop a cadre of leaders to meet them.

SGIM

COMMENTARY

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us rewriting the exact same thing, which CMS recognized in November 2002 didn't add to patient care and actually took the TP away from more important patient care activities. The TP guidelines by no means allow us to do any less *work* toward the patient encounter while getting paid the same amount. If we do less *work* toward that visit, we are then

limiting our level of billing regardless of how detailed the resident's *documentation* is.

Let's use the level 3 initial inpatient visit as an example. To bill a 99223, I need to perform and document at least 10 ROS and at least eight organ systems on physical, among other things. This implies that I personally performed or was present

when my resident performed those 10 ROS and the eight-organ system physical. That's what I'm attesting to in my linkage statement. If I didn't review all 10 systems or examine all eight organ systems on physical, and only my resident did, then I did not perform all of the “key components” to allow me to bill the level 3 visit,

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PROFESSIONAL-PERSONAL BALANCE

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hours. I found that patients appreciated the availability of appointments that they could attend without missing work (as well as the availability of parking then). This also allows me be home in time to engage my children in after-school debriefing while the day is still fresh in their minds. The electronic medical record allows me to leave the office when I need to and complete work at home, a mixed blessing to be sure. A recently implemented regional call center system has eliminated evening and weekend call assignments, yet I remain “in the loop” through updates on the EMR.

Resolution #2. Share the responsibility. I am fortunate to have found

a work environment that focuses on planned care and team support. The practice infrastructure enables me to enlist the capable assistance of my team health technician, nurse, or the firm’s pharmacist, case manager, or nutritionist before or between visits. The patients benefit from their expertise, and my time can be more focused. I am also fortunate to have a very supportive spouse—an academic emergency physician who, despite an erratic clinical and speaking schedule, had assumed many of the household chores when my previous work entailed long commutes and frequent international travel. Now, despite my more palatable schedule,

he continues to be very involved in household activities.

Resolution #3. Stop nagging. With patients, I work hard to avoid paternalism. I have learned to educate more while nagging less. It is the nagging that is so time consuming, after all. On the home front, my family applauds this last goal in particular, though they recognize it is the one that I struggle with most. My adolescents crave their independence, and yet...

Which leads me to answer my patient’s question of the day: My children will regain their video game privileges when they remember to finish their homework on time. **SGIM**

COMMENTARY

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even if medical necessity deemed a level 3 was appropriate. I would then only bill for the amount of work that I personally did, regardless of the larger amount of documentation and work that the resident did, and attest to that in my linkage statement.

Now you can see why there is no specified time frame during which we can link to a resident’s note. It makes sense that this benefit of “linking” and saving time and energy on an administrative task is lost the longer the time interval between resident and TP documentation. There is a greater likelihood that the history, physical, assessment, and plan will have changed, thus mandating that we document those additions or discrepancies in our TP note and making it easier to write our own free-standing note than trying to link to fragments in the resident’s already outdated information.

The linkage statement needs to state our personal involvement in the service that we performed or were present for when the resident performed the “key components” of the visit, including how we participated in the management of the patient. “Key components” is left vague to allow the TP to decide what is “key” per visit. Again, remember

that if the patient is sick enough to warrant the higher-level visit, like the level 3 admission, then he/she is sick enough to require the extra work of gathering or confirming the supporting documentation, like ROS, PMH, FH, and physical exam. If we do not do or witness the performance of these components of the visit, our billing will be limited to what we personally did and/or what the documentation supports.

One other related concept I need to mention is the “24-hour rule” that many of you may have heard talked about and even quote yourself. It doesn’t exist. By *convention*, many compliance offices have allowed TPs 24 hours to link to a resident’s note, but that is *not* a CMS guideline published or promoted anywhere. Some may confuse the need to have the H&P on the chart with the ability to link to it. From CMS’s standpoint, an H&P is an administrative task, thus they do not call the code set 99221-3 “H&Ps” but rather “initial inpatient visits.” One of the Medicare terms of participation requires that an H&P be on the chart from 30 days prior to an admission to up to 24 hours after the patient is admitted. CMS will *not* pay for an H&P to be written—again, that is administrative work. Remember,

they are paying for the medically necessary work: history, exam, and thought process that went into the visit. We by convention write all of this on an H&P form, but it’s key to remember that we are not getting paid for completion of that form. We are getting paid for the work done, leading to that documentation. Thus, keep in mind that if you are called to put an H&P on that chart for a surgical patient and they are not asking for your opinion, as lousy as it sounds, you cannot bill for that work—there was no medical necessity for you to evaluate and manage anything. The surgeon is politely asking you to do their administrative work so that the hospital doesn’t come after him/her (not knocking surgeons).

All of the above comments are in relation to initial inpatient visits. This discussion does *not* apply to observation admissions, as they are governed by different rules, so talking about linking to a previous night’s note does not make sense.

I am open to and welcome your questions and hope that this outlet will become a useful one with regard to documentation and billing nuances that commonly arise. I thank Bob Centor and SGIM for this opportunity to help the medical community. **SGIM**

SIGN OF THE TIMES

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ing at you. Look back and offer a smile. This simple action may go a long way toward putting these frightened and anxious people at ease in a hospital setting where much is at stake for them. There are many days when we doctors are discouraged because, despite our considerable efforts on behalf of patients, we feel

that we are accomplishing very little to help them. Perhaps on those days the reassurance we give patients by looking them in the eye, smiling, and having them smile back will make us feel we are helping someone.

Acknowledgements: We wish to thank Maureen Shandling, MD

(Mount Sinai Hospital, Toronto), and Ciaran Dickson (Toronto) for the comments on an earlier draft.

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SGIM

PRESIDENT'S COLUMN

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during a single admission. Let me suggest three possible avenues for addressing the communications hurdles and roles that SGIM can play in these scenarios.

First, hospitalists need to be integrated into the patient centered medical home (PCMH) and other advanced models of primary care being promoted. The ultimate success of the PCMH (and the long-term viability of ambulatory GIM) will depend on its impact on controlling the costs of chronic disease care. While it is hoped that more comprehensive and proactive primary care will impact costs through fewer hospitalizations, more effectively managing transitions in care and decreasing post transition adverse events can also have a major impact on costs. Our failure to incorporate hospitalists into the PCMH "medical neighborhood" would represent a major missed opportunity for SGIM and other organizations actively promoting PCMHs.

Second, financial incentives should be aligned to reward high-quality communication and care transitions. As noted by Dr. Beckman, current models do not reimburse primary care physicians for sending records, speaking by phone to inpatient providers, or visiting patients. Furthermore, current models do not explicitly reimburse hospitalists for reviewing lengthy outpatient records or spending the time to understand patients' acute illnesses in the broader context of their prior medical and social histories and their personal lives.

Advancing payment models that explicitly reward such tasks (in lieu of excessive consultations and testing) could be a focus of SGIM's advocacy and research efforts.

Nonetheless, in the absence of meaningful payment reform, each of us as generalists must recognize the duality (i.e. both inpatient and outpatient) of our responsibilities to patients. As primary care providers, we have an obligation to actively participate at least by phone in the care of our patients who are hospitalized. As hospitalists, we have an obligation to actively seek information from primary care providers and recognize the value of primary care providers' broader perspective of the patient. Anything less is unacceptable.

Third, we need to develop more effective ways of communicating vital pieces of information across care settings. Importantly, these communications should begin before or soon after patients are admitted and capture the patient's story (not merely the results of prior tests) so that hospital care is personalized to meet the needs of individual patients. In the example provided by Dr. Beckman, this would mean that the hospitalist caring for his patient with a COPD exacerbation understood that the patient was receiving alprazolam because of an underlying panic disorder. In this regard, EMRs can be an important conduit for transmitting such information. However, because the volume of data in EMRs is huge, effective communication will require that only the most

salient information pieces of data be transmitted. Perhaps EMRs can be engineered so that key pieces of information relevant to transitions across settings, such as advance directives, chronic medical conditions, or adverse events associated with prior medications (i.e. the "10 most important things to know about Mrs. Jones") are seamlessly transferred. Perhaps, in the absence of universal EMRs, patients and their families can be activated to reliably convey information across settings and trained to be more effective advocates for their own hospital care. These are all areas and issues in which SGIM members have fluency and that could be a focus of our committees and task forces.

As an organization that embraces the ambulatory and hospital aspects of generalist practice and that is committed to comprehensive patient-centered care, SGIM is ideally positioned to play a formative role in developing strategies to improve communication between hospitalists and primary care physicians. I believe the effective navigation of transitions in care will be central to the ultimate success of the PCMH and improving the value of health care. I encourage you to read Dr. Beckman's thought-provoking perspective, review the subsequent letters, and send me your thoughts on this topic.

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SGIM

FROM THE SOCIETY

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programs include the full spectrum of education and training, from pipeline programs preparing underrepresented and disadvantaged minorities for health careers to student loans and scholarships; medical school “pre-doc” PC curricula; and PC residency, fellowship, and faculty development training programs. While it is important to remember that the newly reauthorized Title VII programs remain reliant on the appropriations process, PPACA more than doubled Title VII funding to \$125 million per year. Importantly, the law further stabilizes funding by expanding the grant cycle from three to five years and repeals the “ratable reduction” provision that for years has carved out about two thirds of the appropriated funds for family medicine programs. Thus, the playing field is now level in statute, and GIM applicants can compete for the full appropriated amounts. Funding decisions will continue to favor programs with an established or improving track record of graduates who select and remain in PC and that care for underserved and vulnerable populations. Now, programs addressing the interdisciplinary skills needed for patient-centered medical homes (PCMHs) will also be favored.

The new law increases and extends the authorization of appropriations for the National Health Service Corps (NHSC) scholarship and loan repayment program. Authorized funding is \$320 million for 2010 and rises to \$1.2 billion by 2015.

PPACA will expand graduate medical education (GME) coverage for resident activities, counting didactic non-patient care time and clinical training time outside the hospital toward calculations. Each year, several hundred residency slots go unfilled. The new law will redistribute these as PC positions, mainly to programs in rural states with track records of training PC physicians. HHS will also expand PC teaching capacity with new grants to support new residency training programs in community-based Teaching Health Centers (\$50 million per year). PPACA also authorizes \$230 million in annual GME funding to cover the indirect and direct expenses of training PC residents in these new or expanded teaching health centers.

Payment and Practice

PPACA has several payment and practice provisions aimed to promote and improve PC. PC physicians will

receive a 10% increase in Medicare payment through 2015. The law will also increase Medicaid payment rates to 100% of Medicare rates for PC services provided by PC physicians in 2013 and 2014. PPACA authorizes \$10 billion to establish a new Center for Medicare and Medicaid Innovation (CMI) that will test innovative payment and service delivery models, including PCMHs, community-based health teams, patient decision-support tools, various bundling strategies, and health care innovation zones. The new law also dramatically increases support for Community Health Centers (CHC) to \$11 billion through 2015 for capital investment and services.

The new law has begun to send multiple loud signals that PC training and practice are increasingly valued and needed and that primary care will serve as the foundation of our health care system and the key to our nation’s health. Much work remains to be done, and SGIM members need to be vigilant and persistent in our advocacy efforts, especially for full appropriation of these newly authorized funds.

SGIM

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Join Our Faculty

At Franklin Square Hospital, an award-winning, 350-bed facility and member of the MedStar Health System, we strongly support graduate medical education and offer several ACGME accredited residencies. Our Internal Medicine Residency Program has 35 residents and a major affiliation with the University of Maryland School of Medicine. Full-time generalist and specialty core faculty, as well as full-time chief residents, are dedicated to our teaching program and have academic appointments at the medical school.

CORE FACULTY General Internal Medicine Internal Medicine Residency Program

The faculty member will work closely with the Program Director and Chair of the Department of Medicine to support all facets of the residency training program, including teaching clinical medicine, both in the inpatient and outpatient setting; didactic teaching; mentoring and provision of feedback; and mentoring of scholarly activity. The faculty member will have the opportunity and protected time to pursue specific educational and scholarly interests.

Our ideal candidate has experience in Internal Medicine graduate education as a faculty member and is eligible for Maryland licensure.

We offer an attractive salary/benefits package that includes medical, dental, vision, life, STD/LTD, pre-tax retirement savings plan, tuition reimbursement and more. For consideration, please forward a letter of intent and CV to Phillip F. Panzarella, M.D., M.P.H., Chair, Department of Medicine, 9000 Square Drive, Baltimore, MD 21237; or email Patti.Bruno@medstar.net.

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SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037
www.sgim.org



Academic General Internal Medicine

West Virginia University, Department of Medicine, Section of General Internal Medicine and Geriatrics is seeking an internist at the Robert C. Byrd Health Sciences Center.

This is an exceptional opportunity to join a twenty-member GIM section as a full time faculty in the clinical-emphasis track of the School of Medicine. Applicants must be board-certified / board-eligible in Internal Medicine and interested in providing outstanding clinical care in the inpatient and outpatient setting, concurrent with teaching residents and students. Scholarly activity is highly encouraged. Initial rank will be commensurate with experience.

The Health Sciences Center of West Virginia University has the full range of specialties and residencies/fellowships and has seen substantial expansion of the teaching hospital, outpatient clinics, cancer center, and medical school. These outstanding facilities are within a five-minute walking radius on the HSC campus. Morgantown, WV, has been recognized as one of the best small cities in the country. It is the home of West Virginia University. The main downtown campus of WVU is connected to the HSC campus by Morgantown's unique personal rapid transit system. Morgantown is a one-hour drive from Pittsburgh, PA, and three-and-one-half hours from Washington, D.C.

The successful applicant will join colleagues in the Section of General Internal Medicine and Geriatrics where faculty members provide extensive teaching, clinical care, and administrative service to the Health Sciences Center. Faculty members rotate responsibilities for inpatient services, provide outpatient faculty clinics and precept the residents' continuity clinics. Scholarly activities of Section members are closely aligned with teaching and service roles that include ambulatory, consultative, geriatric, and hospital medicine, as well as women's health.

The position will remain open until filled. Qualified applicants should submit a curriculum vita and the names and addresses of three references to blakel@wvuh.com (preferably) or by mail to:

Shanthi Manivannan, M.D.
Section Chief and Search Chair
Attn: Laura Blake
WVU School of Medicine
PO Box 9897, Rm 2244 HSC
Morgantown, WV 26506

WVU is an equal opportunity/affirmative action employer.
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