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To Promote Improved
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Education in Primary Care and
General Internal Medicine

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Erratum
Please note that there was an error in the September 2012 issue of *Forum*. In the President's Column, we reported that Hill Day would be held March 5-6, 2013. It is now scheduled for March 12-13, 2013.

HEALTH POLICY CORNER: PART I

What the Affordable Care Act Means for SGIM

Mark D. Schwartz, MD

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By the time you read this, the Supreme Court decision to uphold the Affordable Care Act (ACA) will have been washed, spun, and dried by parties and pundits. The debate will rage on about the nuanced implications of the Court's curious interpretation of the individual mandate as a tax, the sobering limits it placed on Congressional authority within the commerce clause of the Constitution, and the impact on the health of the poor in mostly "red" states if they opt out of the ACA's Medicaid expansion, for which they would be responsible for only 10% of the additional cost by 2020.

The decision is an enormous win for SGIM as it preserves the core elements of the ACA in that it:

- Dramatically expands insurance coverage and transforms the insurance industry;
- Invests in the generalist workforce with payment incentives, enhanced funding for primary care training, and opportunities to align reimbursement for practice redesign with SGIM's patient-centered values; and
- Strategically funds health services, comparative effectiveness, and delivery system innovation.

The ACA survives to face its next contest in November. The grand political gamble is certain to remain a flash point regardless of the outcome of the election. The law remains unpopular with many Americans, with those at the political extremes arguing it went too far or not far enough.

I will leave longer-term predictions to the historians. My aim here is to highlight the important role of SGIM and its members in the ongoing struggle to improve health through the expanded access, quality, and value of health care envisioned in the ACA.

I had the unparalleled privilege to serve on the Ways and Means Committee as a Robert Wood Johnson Health Policy Fellow the year we passed the ACA. I followed in the footsteps of other SGIM members on that powerful House Committee—Gene Rich and Tom Tsang. I worked alongside SGIMers Andy Bindman and Steve Cha on the Energy and Commerce Committee. Congressional members and staff appreciate SGIM as a small but highly respected voice, an honest broker for the views of general internists, and a source of real world expertise in generalist practice,

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Refusing to Expand Medicaid: Truth and Consequences

William P. Moran, MD; Laura Sessums, MD; and Mark Schwartz, MD

Drs. Moran, Sessums, and Schwartz are members of the Health Policy Committee.

The Accountable Care Act (ACA) established several strategies for reducing the number of uninsured in the United States, including the expansion of eligibility for Medicaid. In contrast to Medicare, Medicaid is a federal-state partnership with individual states having the flexibility to vary eligibility and benefits beyond a core set of required federal minimums. When the Supreme Court upheld the individual mandate, it did not allow the federal government to penalize states if they refused to expand Medicaid. Several state governors have now indicated that they will not expand Medicaid benefits as initially required by the ACA, and the consequences of these decisions are monumental.

The ACA sets new minimum eligibility standards for Medicaid nationally, mandating coverage of adults with annual family income up to 133% of federal poverty level (FPL) effective in 2014. Currently, states vary widely in the percentage of FPL up to which citizens are eligible for Medicaid, averaging 72% but ranging from 11% (LA, AL) to 200% (MN, WI, ME, DC). Nationally, 22.3 million uninsured, or 47% of uninsured Americans, will become eligible for Medicaid under the ACA.[1] The cost of this expansion is significant. The ACA requires the federal government to pay 100% of costs for newly eligible Medicaid beneficiaries for the first three years (2014-2016), decreasing to 90% in 2017 and thereafter. In 2011, the federal share of states' Medicaid costs averaged 59% and ranged from 50% ($1 federal: $1 state) to 75% ($3 federal:$1 state) among states.[2] Thus, this expansion has massive economic consequences for states with large uninsured populations newly eligible for Medicaid.

Florida, for example, will receive almost $47 billion in new federal Medicaid funds over the first five years of expansion while its own Medicaid spending will increase by less than $5 billion—if the governor decides to allow expansion.[3] Five state governors (FL, TX, MS, LA, and SC), each representing states with uninsured populations of more than 20%, have announced they will not expand Medicaid. (Find your state at http://dl.ebmcdn.net/~advisoryboard/infographics/Where-the-States-Stand7/story.html.) Many states, especially those with large numbers of uninsured individuals, remain concerned that their costs beyond 2016 will further strain state budgets already decimated by recession. Yet because of the resulting increase in employment in health care, Medicaid expansion may have an overall positive economic impact.[4]

While the economic consequences of Medicaid expansion to the states are murky, it is crystal clear that states' refusal to expand Medicaid will dramatically limit the ACA reduction in the uninsured. Also alarming are the severe economic consequences for hospitals who serve the uninsured, including acade-

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Understanding Our Members

Ann B. Nattinger, MD, MPH

Many staff and member hours have gone into developing the new communications platform, which should be available to members at the time this column is published.

Earlier in 2012, the SGIM Membership Committee conducted a survey of all SGIM members to help the Society best address our needs. I want to thank DC Dugdale and his committee, including SGIM Director of Membership Chris Wojcik, for their hard work to develop, implement, and summarize the results of the survey. At the SGIM 2012 Annual Meeting in May, I also held several member listening sessions. I want to thank those randomly selected members who attended these sessions, which were very lively and thought provoking. Based on member feedback, the Council and I have developed a number of plans for moving our Society forward. While I cannot cover all of these in one column, I wanted to highlight a few.

First, let me point out a few items from the membership survey. (See also the full article on this topic by DC Dugdale in this issue of *Forum*.) Overall, 64% of respondents had high levels of job satisfaction compared to 51% in 2004. Our membership is somewhat more engaged in clinical care than previously. For example, 23% of respondents spend 50% or more time in research, 5% spend 50% or more time in education, and 26% spend 50% or more time in clinical care. Conversely, 50% of respondents spend less than 10% effort in research while only 9% spend less than 10% effort in clinical care.

The Council and I have paid particular attention to those areas for which 30% or more of respondents feel the Society is placing too little emphasis. I would summarize these as enhancing public recognition and understanding of general internal medicine, providing on-line resources for members and the public at large, and helping members to develop leadership and administrative skills. The listening sessions raised these issues as well and additionally pointed to the particular needs of hospitalists, the need for better networking resources both within and between national meetings, and the need to address the pipeline of trainees entering general internal medicine fields as a profession.

One of the ways SGIM is addressing members' needs is through our existing committees. As examples, the Program Committee has added new workshop categories of "Leadership and Administration" and "Healthcare Delivery and Redesign" to the call for workshops to encourage material in these areas. The Association of Chiefs and Leaders of General Internal Medicine (ACLGIM), our sister organization for chiefs and leaders, is planning to offer leadership material both within the SGIM meeting and at the Hess Management Institute, which occurs on the Wednesday just preceding the opening of the SGIM meeting proper. ACLGIM will also make it more clear that the Hess Institute is available to all (not just ACLGIM members) and that emerging and aspiring leaders are encouraged to attend. Additionally, our committees are encouraging hospitalist participation.

Another way we are addressing members' needs is with a major communications initiative that is overseen directly by Council. This initiative started last year due to a recognition that both our internal and external communications were in need of updating. Many staff and member hours have gone into developing the new communications platform, which should be available to members at the time this column is published. The communications upgrade has been overseen mainly by staff members Francine Jetton (Director of Communications) and Smith Bullington (Director of IT), although all staff have helped with the project to some degree.

The website remains at www.sgim.org. It includes a new design and new logos to help with branding. More importantly, the new look is accompanied by much enhanced functionality. For example, there are tabs at the top of the website to permit easy navigation between SGIM, ACLGIM, and *JGIM* pages. One of the best features of the new site is GIM Connect. This social platform is the place for SGIM/ACLGIM members to network and communicate with each other. Much like Facebook or LinkedIn, individual members will

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The 2012 SGIM Member Survey Results: Part I

DC Dugdale, MD, MS

Dr. Dugdale is chair of the Member Survey Subcommittee of the SGIM Membership Committee.

In 2011, the SGIM Membership Committee developed a survey to get information and feedback about SGIM from the entire membership. On February 14, 2012, a link to the survey was sent by e-mail to all SGIM members. The link was sent weekly, for a total of six e-mails, up until the closure of the survey on March 22, 2012. Since then, the Membership Committee has analyzed the results and is pleased to present this summary. Whenever possible, we compared the results from the 2012 survey to the 2004 and 2009 membership surveys.

In total, 3,075 people received the survey link. There were 1,043 respondents (response rate 34% vs. 50% for the 2004 survey). The survey consisted of 33 questions covering many issues, including participant demographics, satisfaction with current job, SGIM's role, critical activities that SGIM should be performing, use of organizational services, membership, finances, and overall satisfaction. Of the 33 questions, 27 were multiple choice, and the remainder were partially or completely open ended.

Composition of the Survey Respondents

The composition of survey respondents showed differences from the composition of the SGIM membership. The overall membership is 48% female (respondents 52%). The modal age range for the overall membership is 35-44 (same as respondents). Full members were over-represented among respondents (85% of respondents vs. 77% of SGIM members). Lastly, the Mid Atlantic, Midwest, Southern, and New England regions were all modestly under-represented among survey respondents compared to all SGIM members.

Selected demographic results for 2012 include:

- Gender: 52% female (vs. 47% in 2008 and 45% in 2004)
- Racial/ethnic designations (compared to the 2004 survey):
  17% Asian (vs. 15%)
  5% African American (vs. 4%)
  4% Latino/Hispanic (vs. 4%)
- Academic rank: 32% assistant professor (39% in 2004) and 43% associate or full professor (36% in 2004).

Profile of Current Job Position

Overall, the job satisfaction of SGIM members appears to be higher than it was in 2004. A significant number of SGIM members self-identify as hospitalists. Results for 2012 include:

- The three highest levels of job satisfaction (8, 9, or 10) were selected by 64% of respondents (51% in the 2004 survey).
- The three lowest levels of job satisfaction (1, 2, or 3) were selected by 4% of respondents (2% in the 2004 survey)
- 87% reported working full time (89% in 2004).
- 15% identified themselves as hospitalists. This question was not asked in the 2004 survey.

Satisfaction with SGIM

In 2012, the value of SGIM membership was rated as essential by 17%, very valuable by 38%, and valuable by 41% (total 96%) compared to 21%, 37%, and 35% (total 93%), respectively, in 2004.

- 27% reported seriously considering not renewing their membership in the past three years (22% in 2004).
- The two most common reasons for considering membership cancellation were "benefits and services do not justify expense" (54%) and "consider another society to be my professional home" (29%).

How SGIM Can Better Serve its Members

The 2012 survey asked recipients to rate the amount of emphasis SGIM puts on several activities. The areas in which more than 25% of respondents reported "not enough emphasis" are:

- Developing my skills as a leader: 38%
- Developing my skills as an administrator: 40%
- Enhancing public recognition and understanding of GIM: 42%
- Providing on-line resources for educators: 37%
- Providing on-line resources for researchers: 30%
- Fostering the sharing of clinical innovations across institutions: 28%
- Conducting a national meeting where one can learn about advancements in clinical medicine: 26%

The 2012 survey asked recipients to rate the acceptability of options to generate revenue for SGIM:

- Most acceptable: loosen restrictions on external support (33%), increase registration fees for national meetings (31%), and increase annual dues (29%)
- Least acceptable: cut services rather than increase fees (48%), increase annual dues (44%), and loosen restrictions on external support (43%)

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Next Steps

At this time, the Membership Committee is engaged in further analysis of the multiple-choice questions and is processing the several hundred responses to the open-ended questions. Once this is completed, the Committee will make recommendations to SGIM leadership about how to best address the results of the survey. A deidentified dataset of all survey responses will be available to SGIM members. Please send questions, comments, or suggestions to Chris Wojcik (wojcikc@sgim.org). *SGIM*

HEALTH POLICY CORNER: PART III

A Positive Result of the Affordable Care Act: Seize the Opportunity of the Annual Wellness Visit!

Scott Joy, MD; Bruce Peyser, MD; Kathleen Waite, MD; and Anne Phelps, MD

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The annual wellness visit (AWV) is an aspect of the Affordable Care Act (ACA) that can provide benefit to your practice of general internal medicine (GIM) and the patients you serve *right now*. Section 4103 of the ACA authorized the secretary of Health and Human Services to direct the Centers for Medicare & Medicaid Services (CMS) to define the elements of the AWV and personalized prevention plan. Nearly any medical professional can assist in delivering an AWV by obtaining and/or updating a patient's past medical and surgical history, family history, and medication allergies.[1] Lists of current medications and supplements, providers who are sharing care of the patient, and suppliers of medical services or equipment must be documented. Medical history for all AWV's must include an assessment for mood disorders either determined by review of past history or by using an accepted depression screening tool (PHQ-2). Unique to the initial AWV is the requirement to review the patient's level of functional ability and home safety, including assessment of hearing, cognitive impairment, fall risk, and performance of standard and instrumental activities of daily living. New in 2012 is a requirement to administer a Health Risk Assessment (HRA) before or during the AWV.[2] An online HRA tool that meets CMS requirements can be found at www.medicarehealthassess.org.

The AWV is an exam where patients leave their clothes on, and this paradigm change in perceived service expectations can lead to patient misunderstanding without proper advanced communication. The only AWV-required components relevant to a physical exam are blood pressure, height, weight, and BMI and/or waist circumference. The final product to result from the AWV is a personal written health plan given to the patient that includes individual health risk factors and a preventive screening schedule based on US Preventive Services Task Force grade A and B guidelines and recommendations from the Advisory Committee on Immunization Practice.

The initial AWV is coded as G0438, and subsequent AWVs are coded as G0439. Copayments are waived for the AWV, which is reimbursed once per patient per year. Certain procedures such as a diagnostic ECG or gynecological exam can be carried out and billed for with the AWV, as can separate E/M services provided during the AWV visit if the services are truly medically necessary. The 2012 total RVUs for an initial AWV are 4.99 and 3.26 for a subsequent AWV. Respective payments in 2011, not adjusted for geography, were approximately $172 for G0438 and $111 for G0439.[3]

Despite these advantages, the AWV is the benefit that nobody knows about. A survey from the John A. Hartford Foundation found that 54% had not heard of the AWV and that 72% had not had an AWV in the last 12 months.[4] The AWV is a positive aspect of the ACA for GIM, increasing RVU productivity and clinical revenue. The AWV should not become a lost opportunity for GIM, and efforts should be undertaken *now* by all clinical practices to use the AWV to illustrate how the ACA is changing clinical practice in a positive manner.

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FROM THE EDITOR

Choosing Wisely: A Great Campaign, but Will it Make a Difference?

Priya Radhakrishnan, MD

Dr. Radhakrishnan is editor for Forum *and can be reached at PRadhakri@dignityhealth.org.*

- When do you need antibiotics for sinusitis?
- When do you need a bone density test?
- When do you need a Pap test?
- When do you need imaging tests for lower back pain?
- When do you need antibiotics for sinusitis?
- When do you need an imaging test for a headache?
- How should you treat heartburn and GERD?

The American Board of Internal Medicine (ABIM) has embarked on a noble campaign to reduce health care expenditures by avoiding wasteful tests and treatments. It is a great campaign that addresses our collective pet peeves: CT scans for syncope and antibiotics for sinusitis. It is an impressive list. Not only does is give physicians food for thought before ordering tests but it also provides patients with lists of questions to ask their doctors.

But wait a minute….Let's face it. It is easier to treat patients with limited health literacy or who have no questions to ask. The explanations are detailed but easier on the physician, who can redirect time that would otherwise be used answering questions.

Why on earth, then, would we as a medical community support a campaign that asks us not only do less but invites our patients to question us? Just as we were falling into our comfort zone of algorithms and "cookbook" medicine. Just as we started ordering Pap smears by the dozens and as many A1Cs as the EHR would allow—all in the name of population health—along comes a campaign that puts the breaks on the auto-pilot systems we have grown to love and cherish. Now our nurse practitioners, medical assistants, and nurses are feeling empowered and getting comfortable ordering tests and medications for the populations we manage.

In my community, we have seen an explosion of minute clinics providing routine care from quickie physicals to sinusitis treatment all for $25 and without the hassle of a wait. The following testimonial on http://www.yelp.com/ biz/minute-clinic-chicago-2 says it all:

Developed another sinus infection. Didn't feel like dealing with a wait to get in to see my primary care physician. Walked over to the Minute Clinic and got right in. Had the exam, the consultation, and received my prescription, all in less than 20 minutes. Insurance covered it (Blue Cross), so all it cost was the regular office co-pay. Not sure why I've never done this before when I've had something so routine. Will definitely use them again in the future.

I presented the Choosing Wisely campaign information to our physicians and administrators at my hospital. Not unexpectedly, the issue of tort reform was cited as the number one reason for ordering tests, followed by patient satisfaction surveys and conflicting data about best practices, most notably the controversy surrounding prostate cancer screening. Then, the nexus of the evil insurance companies denying basic services such as DEXA scans was mentioned by some physician colleagues as the reason behind the campaign. The general sense of the medical community was a sense of fatalism—you are damned if you do and damned if you don't.

How then can we ensure that physicians who take up the cause of campaigns such as Choosing Wisely are successful in the practice of medicine and don't get penalized? I believe that it is all about the messaging and developing partnerships with all groups in health care—including patients! Drivers of health care costs are not simply physicians, hospitals, and health care systems but also patients, payers, and physician extenders who are all part of the bigger picture. We need everyone to buy in. The ABIM Foundation should consider partnering with prominent patient advocacy groups such as Society for Participatory Medicine, news media, and physicians through repeated messages within their local organizations. We learned a valuable lesson with health care reform—unless the messaging is optimal and all parties are equally invested from the beginning, the campaign will not be as successful as it deserves to be.

In my community, we have seen an explosion of minute clinics providing routine care from quickie physicals to sinusitis treatment all for $25 and without the hassle of a wait.

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Competency Rising

Chayan Chakraborti, MD

Dr. Chakraborti is a member of the Forum *editorial board and can be reached at cchakra@gmail.com.*

Today oft-used terms in medical education, at one time the words Systems Based Practice (SBP) and Practice Based Learning & Improvement (PBLI) were a source of consternation for medical educators. The terms entered our lexicon with the development of the six Accreditation Council on Graduate Medical Education (ACGME) competencies. The consternation arose from their inexplicability. The descriptions provided by the ACGME were broad and open to considerable interpretation. I recall being part of a delegation of residents cloistered in a conference room in Boston as part of a meeting called "Achieving Competency Today" (ACT)—the intended purpose of which was to help elaborate these twin mysterious competences.

Though I've been involved with quality improvement efforts, Plan-Do-Study-Act cycles, root cause analyses, and more recently team training and patient safety, the penny finally dropped recently. What it took was our hospital's migration from paper charts to an electronic medical record (EMR). "Black Sunday" occurred on July 29, 2012, and, naturally, my team was assigned the very first call cycle.

Almost at once, a sea change occurred. Much of the time on rounds inevitably became: How did you do that in the EMR? In between patients, the discussions amongst the team members involved questions about creating templates and order sets. Often, I overheard: "Hey, how did you import that lab? Did you have trouble doing this?"

Initially, I was irked with the turn that education had taken during rounds; I considered it a victory when I managed to squeeze in some chalk talks about clinical medicine. But it occurred to me that what the house staff were doing was nearly as valuable. An entirely new System (capital S) was being put into place, and the house staff were reacting to this new System and, by doing so, were inadvertently working on their SBP/PBLI competencies.

An interesting event occurred next that demonstrated real-time SBP, PBLI, patient safety, and professionalism all rolled into one unintentional activity. The day after that first call day, we found that two patients who we had "e-discharged" were never physically discharged. The housestaff identified this error when they arrived the next morning several hours prior to attending rounds. After checking on the un-discharged patients and following up with the night coverage team, they delved into the discharge process according to the EMR instructions. After double-checking with the onsite EMR help staff to see if the error lay there, they spoke to the ward clerk and the nursing staff.

On attending rounds, they somewhat sheepishly reported what happened and, through their subsequent efforts, pinpointed that the discharge order in the EMR system was being placed automatically in "Pending" rather than "Active" status. In a subsequent EMR "superuser" meeting, the hospital administration addressed this issue through a combination of user education and policy change.

On teaching rounds that day, we discussed what the housestaff had done and equated the steps they took to a mini root cause analysis, using this opportunity to discuss SBP/PBLI and tools such as failure mode effects analyses. I emphasized that while there are an increasing number of electronic failsafes to catch errors and near-misses, it takes the wherewithal of individuals to actually fix things.

Upon reflection, all the sessions I have given or attended on quality improvement or SBP/PBLI did not measure up to this one example. I believe that the housestaff demonstrated the appropriate approach by systematically interviewing stakeholders and looking for systems causes when errors occurred. Once the team provided a summary analysis of what occurred, seeing a response from the administration in short order served to validate their efforts. This validation step is difficult to emulate in classroom sessions on PBLI/SBP and may be a critical step in achieving desired competencies. Prior to the new EMR, the tendency would be to find a work-around. Since the "go-live" weekend of the new EMR, the housestaff now have greater access to systems-level issues, and they have continued to root-out areas of inefficiency. These opportunities for systems-level learning should not only be encouraged but also captured, formalized, and incorporated into the education of medical students and trainees.

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Prior to the new EMR, the tendency would be to find a work-around. Since the "go-live" weekend of the new EMR, the housestaff now have greater access to systems-level issues, and they have continued to root-out areas of inefficiency.

Remembering Elnora M. Rhodes

Ellen F.T. Yee, MD, MPH

Dr. Yee is the 2011 Elnora Rhodes Award recipient.

Many years ago when I was in Washington, DC, as a young child, I saw the White House, the president, and leaders from all across the nation. It was an impressive collective of brainpower and intelligence all gathered together in one place. I was quite awestruck, and that was just the first of many SGIM meetings that I would attend. Admittedly, I did not see the president of the United States (and maybe I wasn't that young either), but I did see the president of SGIM, and the SGIM attendees were a remarkable group. I remember very well the first time that I met Elnora Rhodes at an SGIM meeting. I was standing around looking lost, when a vision in purple came over, gave me a big hug, and said, "Welcome, Ellen. It's so nice to see you here." That vision was Elnora, then the executive director of SGIM. Elnora had a way of making you feel that you were home, that she was always glad to see you, and that you were a valued member of the SGIM family. I used to call her the heart and soul of SGIM, and when she passed away in March 2001, it left a big hole in my heart. She had touched so many lives, and it was a tremendous loss.

In 2011, I was very deeply honored, humbled, and touched to have received the Elnora Rhodes Service Award. Elnora was the first recipient of this award, established in 1997, to honor her remarkable contributions during her ten years of service as SGIM's executive director. As I reflect on this woman who had such a positive influence on SGIM, me, and numerous other members, I realize that there are now many folks in the Society who did not have the chance to meet her. So this article is written in tribute to Elnora, with the hopes that those who were fortunate to have known her will remember her with warmth and affection and that those who never met her will learn a little about the woman who led our Society to become a vibrant meaningful organization.

The following information is excerpted from a series of articles in the SGIM *Forum*. James Byrd, MD, noted that Elnora came from a close-knit family of three boys and three girls. "When she graduated from high school, Elnora faced a dilemma whether to pursue a career in music or get a degree in business. She had scholarship offers from The New England Conservatory of Music (piano) and Green Mountain College (business) in Vermont. She took her banker father's advice and chose an education that would, 'always pay the rent' with the knowledge that her love of music would persist and grow as an avocation." (Byrd J. SGIM Forum 1997; 20(11):4.) In his tribute, Stephan Fihn, MD, wrote that Elnora was a very private person with many remarkable accomplishments and that she graduated from Green Mountain College in Vermont where she was awarded the Gold Key for leadership and scholarship. She enlisted in the Peace Corps for five years, first in Lima, Peru, and then Lagos, Nigeria. In Lagos, her responsibilities included overseeing 800 volunteers stationed there; she also coordinated an evacuation of 350 Peace Corp officers during a civil war in Biafra. She then went to work for the Professional Standards Review Organization (PRSO) in Washington, DC, and worked for the American College of Physicians prior to being recruited as the administrator for the Society for Research and Education in Primary Care Internal Medicine (SCRECPIM), which would later be renamed SGIM. During her 10 years with SGIM, she built the Society from one that was $100,000 in debt to one that was solvent and had reserves for the future. During this time, "no member of the society was ever too unimportant to receive her personal attention." (Fihn S. SGIM Forum 2001; 24(5):1.)

Kurt Kroenke, MD, noted that Elnora "took an infant organization and nurtured it through childhood and adolescence…[she] infused SGIM with a sense of joy and celebration. Elnora was the consummate 'SGIMer.' The organization meant the world to her, and its mission and members were not simply her job but her calling." (Kroenke K. SGIM Forum 2001; 24(5):5.)

William Tierney, MD, who was the SGIM president when Elnora received her award, observed that she gave us "direction, purpose, and stability at a time when we were small, on shaky financial ground, and with no strategic plan." (Tierney W. SGIM Forum 1997; 20(7):2.) Even after enduring cancer and chemotherapy, Elnora "never gave up hope, never stopped being graceful and considerate of others." (Tierney W. SGIM Forum 2001; 24(5):15.)

Tom Inui, MD, noted that Elnora was so dedicated to SGIM that she put our organization and members first before herself and postponed seeking medical care for her health issues until the annual meeting she was working on concluded.

The Elnora Rhodes award has been given to individuals in recognition for "outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine." I am so grateful to have been named the recipient of this award and to follow in the footsteps of previous awardees, including Elnora Rhodes, 1997; Annie Lea Shuster, 1998; Oliver T. Fein, 1999; Shirley Meehan, 2000; Mark Linzer, 2001; Carole Warde, 2002; Jack Pierce, 2003; David Calkins, 2004; Robert Wigton, 2005; Stephan Fihn, 2006; Eric Bass, 2007; Jeffrey Jackson, 2008; James Byrd, 2009; and Laura Sessums, 2010. Congratulations to Valerie Stone, the 2012 recipient. I feel very fortunate to have had a number of opportunities to provide service to this organization.

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Practice-based Population Management: Using Your Team to Maximize Your Time

Kelli D Barnes, PharmD, and Stuart J Beatty, PharmD, BCPS

Dr. Barnes is a pharmacy practice resident and Dr. Beatty is an assistant professor of clinical pharmacy at The Ohio State University College of Pharmacy.

Improving outcomes, minimizing costs, and ensuring every patient receives recommended care are priorities in primary care practices throughout the country. Historically, primary care has centered on providing face-to-face care to patients with varying degrees of engagement in their own health. To minimize costs and improve the overall health of our patients, we must provide optimal care to every patient within our practice regardless of his/her presence or engagement. Practice-based population management (PBPM) is a valuable tool that can increase the number of patients receiving optimal care. PBPM uses proactive targeted interventions to improve clinical and financial outcomes in a population of patients.[1] PBPM is commonly completed using patient registries that can characterize patients (i.e. diagnosed with a specific disease, prescribed a high-risk medication, or targeted for preventive care interventions) to identify opportunities for improvement in care.

Legislation such as the Meaningful Use of Electronic Health Records, the Patient Protection and Affordable Care Act of 2010, and the American Recovery and Reinvestment Act have started to lay the groundwork for a system where reimbursement is based on clinical and financial accountability.[1-5] PBPM will be necessary for success in these evolving models, such as accountable care organizations (ACO) and patient-centered medical homes (PCMH). PBPM aligns with PCMH standards relating to using patient registries to monitor patients who need care management, to track and improve patient outcomes, and to support preventive care.[6] To be successful in the future, primary care offices must maximize the use of health information technology and patient care teams to conduct PBPM and other collaborative models to provide patients with optimal preventive care and chronic disease management.

Practices staffed by multidisciplinary teams have shown they can effectively incorporate PBPM into daily activities. It has been estimated that primary care physicians would need to work 18 hours per day to provide all of the care needed by patient populations. Multidisciplinary care teams can manage more patients than a physician working alone and can spend more time providing preventive health maintenance, chronic disease management, and patient education.[1] This multidisciplinary effort also aligns well with PBPM models by using the skill set of a particular team member to provide targeted interventions.

Electronic health records (EHR) also make PBPM feasible because patient data is readily accessible.[1] Many EHRs come equipped with patient registry and population management tools. These tools make pulling patient data by diagnosis, lab result, or medication usage from the EHR straightforward. In 2005, a survey of physician practices in Massachusetts indicated that 79.8% of practices could generate patient registries by diagnosis, 56.1% by laboratory result, and 55.8% by medication usage.[1] Many of these patient registries can then be exported to electronic databases for easy manipulation of the data to identify and target select areas for improvement.

Pharmacists in our PCMH are currently using the EHR and collaborating with physicians on two PBPM projects. The first project uses the EHR to identify and contact patients needing the herpes zoster vaccine. For patients interested in the vaccine, their chart is reviewed for vaccine contraindications by the pharmacist before a prescription is sent to the community pharmacy, when appropriate. The second project identifies patients with chronic kidney disease (CKD). For each patient with CKD, the EHR is reviewed for all preventive care and laboratory monitoring recommended by the National Kidney Foundation Kidney Disease Outcome Quality Initiative (KDOQI) guidelines and to ensure all medications are dosed appropriately based on the patient's renal function.[7] Any identified gaps in care are then addressed with the primary care physician. These projects are just a few examples of the many opportunities to use PBPM to improve patient care.

These two projects have improved the care of patients in our practice; however, PBPM does not come without barriers, most notably the lack of reimbursement for this type of service.[1,2,8] Already 40% of primary care is not reimbursable because it does not occur during face-to-face interaction; this leads to a considerable amount of time spent on non-reimbursable activities.[9] PBPM initiatives, such as those discussed above, increase the amount of time spent completing non-reimbursable but clinically beneficial activities. Other barriers include incomplete information in the EHR, the need to enter outside data into the EHR for it to be searchable, and limited physician time available for PBPM activities.[1] Effective use of the EHR and multidisciplinary care teams will be necessary to overcome these barriers if population management is to become a priority. At this point, grants and third-party incentives can help fund pilot projects; however, sustainable reimbursement will be a

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Bloody Diamonds

Marcia Glass, MD

Dr. Glass is associate professor of internal medicine at the University of California, San Francisco.

There are no paintings on the walls in the hospitals I have worked at in the capital of Liberia over the past five years. The bareness on the walls parallels the limited equipment I have on hand to care for patients with bacterial meningitis, pericardial tuberculosis, and malaria. Listening to some of these patients or looking at their chest films without the benefit of modern technology, I get the feeling I am seeing pathology in its most extreme form—the way people saw it when the diseases we now treat routinely in the United States were first discovered. Listening to the sandpaper sound of one man's pericardial rub, I think, "Oh! That's why we call it a 'rub!'"

Sometimes the challenges of this work, such as helping a grandmother survive a simple asthma attack, are rewarding. Other times my coworkers and I face the horror of losing a two-year-old before we have even made a diagnosis. Constantly, I struggle with the impulse to try to fix things when I know what I do may not fix anything and might even make the situation worse.

We admit many patients with septic vital signs, elevated leukocytes, and no obvious source of infection. I treat them with broad-spectrum antibiotics, and the young ones usually get better. It is frustrating not knowing what I am treating. There's a copy of *Manson's Tropical Medicine* in my office, and I have read the chapters on meningitis, malaria, tropical splenomegaly, cholera, and typhoid, but sometimes this information does not help. There is a section under splenomegaly that says: "Diagnosis of splenic disorders in the Tropics relies mainly on the astute clinical observations of a practiced internist." In spite of six years as an academic hospitalist in the United States and posts with Doctors without Borders and other non-governmental organizations in Haiti, Liberia, Uganda, Colombia, and Ghana, I encounter some patients who make me wish for help from a "practiced internist." One patient like this was a 25-year-old man admitted in a febrile delirium. Even after treating him with everything I could think of, progress was slow. He was able to talk, but it was mostly nonsensical. While staring at his chart one morning, I looked over and noticed he was drooling. "Is he foaming at the mouth?! Maybe he's got rabies!" My PA laughed at me and said, "Rabies doesn't look like that." Undeterred, I rushed to the sink to fill a kidney basin full of water. Knowing rabid patients are sometimes hydrophobic, I flicked some drops of water on him to see what would happen. Immediately, he threw his arms up and started blessing himself because he thought I was baptizing him. I smiled awkwardly. "Well, I guess he's not hydrophobic."

> Constantly, I struggle with the impulse to try to fix things when I know what I do may not fix anything and might even make the situation worse.

We do have some success stories. One 29-year-old man came in with Stevens-Johnson Syndrome after taking a sulfa drug to treat malaria. In a horrific allergic reaction, he began shedding skin from almost every surface of his body, including his lips, eyelids, and genitalia. He was in excruciating pain, and the visiting dermatologist said he would certainly die a gruesome death of infection and dehydration if he lost more and more layers of skin. In the United States, we usually sedate these patients and put them in the intensive-care unit. In Liberia, our patient was dying on a plastic mattress in a ward with five other people, one of whom had active pulmonary tuberculosis. I could not imagine how he could possibly survive. But my nurses and I tried the one thing available: Vaseline. We covered him from head to foot in it to seal the moisture in and keep the bacteria out. We told his family to feed him water and juice through a straw every hour as long as he could tolerate it, and, figuring vitamin C would help, I sent his brother to the market to bring back five oranges a day for the next week. The brother called an emergency family meeting after he thought I asked for 500 oranges a day, but, once we clarified the plan, the whole family agreed to help. We followed the same routine for seven days. Each morning, his brother arrived with the oranges and Vaseline, and my nurses and I covered his entire body with it and told him to eat the oranges after I left. We ran IV fluids and tried to keep his plastic mattress as clean as possible despite the oppressive heat. Each day, as I rubbed the Vaseline on him, chunks of skin that were as big as my hand and looked like wet rice paper sloughed off every surface of his body. His pain was almost unbearable to watch, but he said he could stand it without any narcotics. I have never seen anyone more bent on survival. Seven days after admission, I noticed new skin starting to cover up the gaping holes the old layers had left. Looking into his face, I knew he would walk out of our hospital alive.

And he did.

Thrombocytopenia in a Traveler

Mandip KC, MS (presenter), and Ingrid Lobo, MD (discussant, in italic)

Morning Report is co-edited by Michael Landry, MD, and Deepa Bhatnagar, MD. Mr. KC is a fourth-year medical student, and Dr. Lobo is a clinical assistant professor of medicine at the University of Colorado School of Medicine in Denver, Colorado.

A 33-year-old woman of Thai origin presents to urgent care for a one-day history of diarrhea and black stools. She currently lives in Denver, CO, and returned from a trip to Thailand five days prior. She was in her usual state of health until five days prior to presentation when she developed flu-like symptoms. She then noted three days of fever (up to 102°F) associated with nausea, vomiting, chills, severe abdominal pain, decreased appetite, and headache. The vomitus was blood-tinged, and the patient had an episode of epistaxis. These symptoms slowly improved but then returned one day prior to presentation with recurrence of flu-like symptoms in addition to her diarrhea and black stools. Her menstrual cycle was heavier than normal. She denied any respiratory symptoms. At urgent care, she was found to have severe thrombocytopenia and a positive stool guaiac test; she was transferred to the hospital for inpatient management. She has no significant past medical history or known bleeding issues. She denies any family history for hematologic disorders. She is not on any regular medications and denies any illicit drug use. In Thailand, she was prescribed an unknown antiemetic and antibiotic for gastroenteritis two weeks prior.

The causes of thrombocytopenia are varied and usually fit into two broad categories: decreased production or increased destruction/consumption. Decreased production includes hematologic malignancies, congenital thrombocytopenia, a drug reaction, infection, radiation, or any infiltrative bone marrow issue. Increased destruction/consumption includes broad categories of immune-mediated processes, lytic processes, and sequestration: idiopathic thrombocytopenic purpura (ITP), autoimmune disease, medications such as heparin or antibiotics, infection with subsequent disseminated intravascular coagulation (DIC) or sepsis, thrombotic thrombocytopenic purpura-hemolytic uremic syndrome (TTP-HUS), cardiac valve lysis, or sequestration into the spleen.

However, the first issue to address is the clinical stability of the patient. Without knowing her actual platelet count, she may have internal hemorrhage. With platelet counts less than 10 K/mm3, patients are at increased risk for spontaneous bleeding and may need platelet or blood transfusions for supportive care. In this patient presenting with epistaxis, hematemesis, menorrhagia, and melena, evaluating for spontaneous bleeding is a priority. This patient's physical exam should look for signs of active bleeding, signs of rash or bites, pulmonary findings, lymphadenopathy, cardiac murmurs, splenomegaly, or signs of jaundice. Once the patient is clinically assessed and stabilized, a deeper evaluation of the cause of thrombocytopenia can continue.

On presentation, her temperature is 96.4°F, blood pressure is 113/64 mm Hg, heart rate is 52 beats per minute, respiratory rate is 16 breaths per minute, and oxygen saturation is 97% on room air. Mental status is intact with no focal findings. Physical exam is notable for evidence of blood clots in the nostrils. Cardiovascular exam shows no tachycardia, regular rhythm, no murmurs, rubs, or gallops. Her pulmonary exam is clear to auscultation without any crackles or rales. Skin exam shows no rash, ecchymosis, petechiae, or bites. No lymphadenopathy is noted, and the spleen is not enlarged. Digital rectal exam shows no evidence of frank blood, and stool is scant but brown. The remainder of the exam is unremarkable.

The patient is noted to be clinically stable according to her vital signs and exam. Now I would obtain more history and more thorough exam and laboratory information to narrow down the differential, as the patient just returned from Thailand. In addition, the physical exam could be repeated to verify any insect bites or signs of jaundice. The history should include where she visited in Thailand (a rural area or large city), if she traveled to other countries, if she was exposed to any sick contacts, and what drugs were given when she had gastroenteritis. Important laboratory values should include the complete blood cell count with differential and peripheral smear, an electrolyte panel including kidney function, liver function, a urinalysis, and a DIC panel. Another consideration includes a urine pregnancy test.

In Thailand, she reports that she had an episode of food poisoning. She does not know what medications she received, but she did recover from this episode of gastroenteritis without issue. She mentions that she was mostly in Bangkok but did travel to the coast. She denies swimming in water; however, she does mention that numerous mosquitoes bit her. At that time, there were floods sweeping across Thailand, which prompted her to leave the country and travel back to Colorado. No other findings are noted on a more in-depth physical exam to suggest a cause for the thrombocytopenia.

Initial laboratory studies show platelets are 7 K/mm3 (150-400 K/mm3), her hemoglobin is 14.3 g/dL (12.1-16.3 g/dL), and white blood cell counts and differential are normal. Her sodium is 130 mEq/L (133-145 mEq/L), and creatinine is normal. Prothrombin time is 12.8 seconds (12.2-15.0 seconds), activated partial thromboplastin time is 41.9 seconds (23.4-34.8 seconds), thrombin time is 26.5 seconds (15.8-18.3 seconds),

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PRESIDENT'S COLUMN

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be able to set up their own profiles (photo, position, address and phone, prior training, interests, and many others) and decide whether each given piece of information will be available only to their contacts, to all members, to the public, or to nobody. Another nice feature is that each member can control the extent of his/her communication. For example, I belong to a number of committees. I have decided that e-mails posted by Council members should be sent to me immediately, whereas e-mails posted by most other committees will come to me in a single digest at the end of the day. Those who know me may be amazed to learn that I figured out these settings all by myself in very little time, and so I expect that others with my limited level of sophistication regarding social media will be able to do so as well.

GIM Connect will facilitate networking across the Society. Committees, task forces, and interest groups are called "communities." If your interest is not reflected in an established community, you can start a new one. You can name your group, provide a description or purpose statement, decide who can view and join the group, and have access to discussion services and to a library to hold videos, documents, and photos. You can create and view blogs and easily access Twitter, Facebook, YouTube, and LinkedIn. With these features, we hope that members will be able to find others with like interests far more easily and communicate with them. We will not need staff to set things up; rather, members can easily and flexibly communicate.

By December 2012, *JGIM* will have its own micro-site, which will allow the journal to highlight current and past articles and to host discussions about them. The new area at www.jgim.org will also host a searchable archive of *JGIM* articles and allow readers to delve into online-only supplemental material.

While I hope and expect that the new communication platform will address some of our members' unmet needs, I am aware that we have more work to do. In the area of communications, we are enhancing public (and policymaker) recognition and understanding of GIM and reaching out to the pipeline of trainees who may choose to enter the field of GIM. While these areas of external communication are not as far along, there is discussion about the possibility of partnership with trainee organizations, the use of low-cost videos targeted to trainees on YouTube, media training, and the development of op-ed pieces. I will leave more discussion of these to future columns but welcome ideas as always.

In summary, we are grateful to all the members who took time to complete the membership survey and/or member listening sessions. The Council and I are paying close attention to your feedback, and I hope we are moving in the right direction. I value hearing your thoughts, especially about internal and external communications.

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HEALTH POLICY CORNER: PART II

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mic health centers. Starting in 2014, the ACA will significantly decrease the disproportionate share hospital (DSH) payments, which are supplementary payments to facilities who serve large numbers of uninsured patients, due to Medicaid expansion and premium subsidies for state exchanges that will reduce the number of uninsured.[5] Loss of DSH payments will exacerbate the financial problems faced by safety net hospitals and providers and will be felt by many SGIM members' training programs. (More than 65% of medicine resident clinic patients have Medicaid or are uninsured.)[6] Insurers, promised dramatic reductions of uninsured, may doggedly resist efforts to indirectly subsidize care for the uninsured. Hospitals are fighting back in states resisting Medicaid expansion since they agreed to DSH and Medicare pay cuts to help pay for the expansion with the expectation of having more insured patients.

The decision to refuse to expand Medicaid may lead to a perfect storm for academic health centers—continued large numbers of uninsured, loss of DSH payments, and no new cost-shifting to the insured to make up the difference. Those are dire consequences, indeed.

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SGIM

HEALTH POLICY CORNER: PART I

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education, and research essential to the success of health reform.

SGIM's Health Policy Committee (HPC) advocates for policies that improve patient care, strengthen education and training, and promote researchers and their research in general internal medicine. The HPC provides education and opportunities for SGIM members to learn about and to engage in advocacy on the SGIM website, at national and during regional meetings, during annual Hill Day visits to Congress, and in publications, including its how-to guide "Health Care Advocacy: A Guide for Busy Clinicians."

In subsequent *Forum* articles, subcommittee chairs will expound on these key successes and advocacy agendas for SGIM:

- *Clinical Practice*: 1) improving access to care by preserving increased funding for Community Health Centers and expanded insurance coverage in the ACA, and 2) enhancing primary care physician payment by advocacy and ongoing expert consultation with the Centers for Medicare and Medicaid Services (CMS) by SGIM members
- *Education*: 1) increasing primary care training programs by ensuring funding for Title VII provisions that were reauthorized with significant input from SGIM, and 2) advocating for reform of graduate medical education funding that is aligned with society's needs for a robust generalist workforce, helped by a forthcoming SGIM position paper
- *Research*: 1) promoting NIH agendas in comparative effectiveness and community-based research by preserving funding for the Clinical and Translational Science Award program and ensuring that it supports the full spectrum of translational science, and 2) strengthening the evidence base for clinical decision-making and innovation in health care delivery by preserving funding for the CMS Innovation Center, the Patient Centered Outcomes Research Institute (PCORI), the Agency for Healthcare Research and Quality, and the VA research programs

SGIM and the HPC will build on its successful advocacy, coalition building, and valued reputation with policymakers, guided by our patient-centered values. Members intrigued to learn should explore the HPC website at http://www.sgim.org/index.cfm? pageId=245 or contact any of its leaders. *SGIM*

IN MEMORIAM

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There used to be a workshop offered at the SGIM meetings about learning to say "no." Unfortunately, I never took that workshop (though I heard it was very useful). I always felt flattered when asked to do something for SGIM and was delighted to say "yes." SGIM is my academic home, and it brings back the joy in medicine. Sometimes I think that SGIM should stand for "So Good to be In Medicine." When I was introduced as the 2011 Elnora Rhodes Award recipient, it was noted that I had chaired the Annual Meeting Program Committee not once but twice. Actually, I only chaired it once in 2010, but I was co-chair with Jeff Jackson, MD, in 2002, and if he had told me how hard he worked as chair, I might have run away from Nancy Rigotti, MD, when she approached me in Miami to see if I would consider chairing the 2010 meeting in Minneapolis! But I am very grateful to Nancy and Jeff for giving me those opportunities to work with them and learn from their incredible leadership. There is still a lot of work I have to do to live up to the honor of this award. My heartfelt thanks goes to the award selection committee; the Women's Health Task Force; Anu Paranjape, MD, who wrote the nominating letter (among Anu's many talents is that she is clearly a master of creative writing and fiction); Sarajane Garten and the SGIM staff; and to everyone who has put up with me and worked with me in SGIM. You have my deepest admiration and appreciation for all you do, and if I have not mentioned your name individually, it is in my thoughts and heart and expressions of gratitude.

In her farewell, Elnora wrote the following: "After 10 years of giving my heart and soul to the Society of General Internal Medicine, I'm moving on to other opportunities. It has been an honor to work with the creative, energetic, and brilliant individuals of our Society. We've come a long way, and I've been privileged to have played a role in our many accomplishments. We've balanced the budget (I now qualify to be president of the United States), received grants and contracts from private and federal agencies, expanded the annual meeting (our showcase), streamlined our administrative processes, and have become a mature and respected national medical organization. I got you started as an independent organization from the ACP; you're now on your own…. SGIM will always be near and dear to me. I wish you continued success. You are my family; you are my friends. Fare-thee-well!" (Rhodes E. SGIM Forum 1997; 20(3):2.)

It is hard to believe this wonderful woman has been gone for more than 11 years now. Yet I feel she will always be with us, cheering us on and encouraging us to go out and make a difference. I'll leave you with the final question that Elnora used to ask at the annual meetings: "Are we having fun yet?" And I hope your answer is "Yes, absolutely!"

Postscript: Please see the following SGIM *Forum* issues for articles and information about Elnora Rhodes: March 1997, July 1997, November 1997, May 2001. *SGIM*

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D-dimer is 2210 FEU (0-500 FEU), and her LDH is 636 U/L (98-192 U/L). Her AST is 228 U/L (0-47 U/L), her ALT is 120 U/L (0-47 U/L), and total bilirubin is 1.1 mg/dL (0-1.3 mg/dL). Urine pregnancy test is negative. Her urinalysis shows a high number of red blood cells but no signs of infection or casts. Her peripheral smear is negative for any schistocytes. Due to her low platelet count, one pack of platelets is transfused. The patient is admitted to the general medicine floor for further evaluation of her thrombocytopenia.

The history, physical exam, and laboratory values do help narrow down the differential diagnosis for her thrombocytopenia. Decreased production or an intrinsic bone marrow issue is less likely as the presentation is so acute. She has no family history for hematologic cancers, and she personally had no symptoms prior to her trip overseas. Additionally, all of her cell lines are not decreased. Some type of cardiac lytic process is also less likely as the patient has no murmur. Splenic sequestration is also less likely as she does not have any organomegaly. TTP or HUS is less likely in the absence neurological findings, renal dysfunction, or schistocytes on peripheral smear.

A drug reaction, infection, or autoimmune process is most likely. The patient was given two unknown drugs when she had food poisoning. Additionally, she was in Thailand where she could have been exposed to a viral or bacterial infection, HIV, or a vector-borne infection like malaria or dengue. She does have some evidence of DIC as her partial thromboplastin time, thrombin time, and d-dimer are elevated. She has a mild increase in her liver function testing. This could be from mild DIC or systemic inflammatory response syndrome (SIRS). An autoimmune process remains in the differential as she is a young female and could have ITP or new onset connective tissue disease.

The next step would be to continue to monitor how the patient is doing clinically, specifically looking for ongoing signs of bleeding. Additionally, serial blood counts should be monitored. If her platelets remain less than 10,000 K/mm3 or she has evidence of active bleeding, she should be further transfused. Now that the patient is stabilized, additional laboratory testing is warranted including blood cultures, acute viral hepatitis serologies, HIV testing, a smear looking for malaria, and dengue antibodies. A hematology and infectious disease consult should be considered to help determine the cause of the illness.

The patient remains clinically stable after one pack of platelets without signs of bleeding. Platelet counts are monitored twice daily. The hematology service is consulted given her clinical symptoms and profound thrombocytopenia. They find the clinical picture consistent with DIC (elevated thrombin time, d-dimer, no elevations in fibrinogen). ITP is also considered but less likely as the clinical picture does not fit and other etiologies seem more likely. The hematology service suspects an immune mediated process from a viral syndrome and recommends starting prednisone at 1mg/kg per day.

The infectious disease service is consulted. Her recent travel history to Thailand, an endemic area for many tropical diseases, is a concern. The infectious disease team suspects a possible bacterial infection with her history of gastroenteritis, vector-borne disease with her history of mosquito bites, or a viral infection. Possible etiologies include salmonella, typhoid, leptospirosis, malaria, dengue, or acute HIV. Acute hepatitis serologies, HIV, and dengue antibodies are ordered.

The patient improves clinically within two days. Acute hepatitis serologies and HIV are negative. Her platelet count trends upwards with a value of 52 K/mm3 without additional steroids. Further serological test results come back after she is dis-

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Cambridge Health Alliance Medical Director - Primary Care

Cambridge Health Alliance (CHA), an award winning public health system which is nationally recognized for innovation and community excellence, is currently recruiting for a **Medical Director** to join one of our residency clinics, the Primary Care Unit (PCU) in Cambridge, MA. CHA is a teaching affiliate of **Harvard Medical School.**

Our well respected health system is comprised of three campuses and an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston's Metro North Region. As we transition to becoming an Accountable Care Organization, this leadership role will be essential to the success of our Patient Centered Health Care Model in the ambulatory setting.

This position has both clinical and administrative responsibilities such as providing primary care to a diverse patient population, oversight for the practice medical operations, and teaching both medical students and residents. The ideal candidate will be BC, internal medicine trained, full time, have at least 4 years of progressive clinical leadership experience, as well as experience in developing and implementing quality improvement and practice management initiatives. Candidates must possess excellent clinical/communications skills, commitment towards our multicultural, underserved patient population and a strong interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

At CHA we offer a supportive and collegial environment with a strong infrastructure- including an EMR system, as well as the opportunity to work with dedicated colleagues committed to providing high quality health care to a diverse patient population. We strongly encourage both women and minorities to apply. Please send CV's to: CHA, Laura Schofield, Director of Physician Recruitment, 1493 Cambridge Street, Cambridge, MA 02139. Phone: 617-665-3555 Fax: 617-665-3553. Email: Lschofield@challiance.org; EOE. www.challiance.org

NEW PERSPECTIVES

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necessity if PBPM is to be incorporated into quality care models.

Our current model of care is not financially or reasonably designed to identify or provide preventive or disease-targeted care to patients who are not personally engaged in their own health. As we move toward ACOs and PCMH, financial reimbursement will likely be based on all patients, not just those who are proactive and engaged or those who present to their physician.[8] Primary care will need to be re-engineered to continue providing top-quality cost-effective care; physicians will become the leaders of diverse multidisciplinary teams sharing the responsibility of patient care with other team members. These teams will work to ensure that practices use PBPM and do not miss the opportunity to prevent advanced illness in entire patient populations.[6] We must take small steps in the care of our patients today if we plan to provide optimal primary care to the patient populations of the future. We must strive to provide PBPM to our patients and ensure we closely analyze the feasibility, efficiency, and sustainability of the processes we use to manage patient populations and share these experiences with other practices throughout the country. Research directed at determining the best most efficient process for PBPM activities will be essential in the next five to ten years.

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SGIM

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charged. The IgG and IgM against dengue virus are both positive with values at 19.84 IV and 14.68 IV, respectively. (Values above 2.85 IV are considered positive.)

Dengue virus is a mosquito-borne infection that is endemic in more than 100 countries with reports of more than 50 million cases yearly. Infection can range from a flu-like syndrome to a potentially lethal disease causing internal bleeding, DIC, sepsis, and even death. The World Health Organization (WHO) classifies patients with either dengue or severe dengue. The category of dengue is classified further into those with and without warning signs. Those with severe dengue must show signs of shock with respiratory distress, liver failure, heart failure, and impaired consciousness. Our patient has dengue with warning signs. Diagnosis is made clinically and with laboratory confirmation (PCR testing and serologies such as antibodies). Treatment is largely supportive (fluids, transfusions, intubation), and no antiviral therapy has been shown to be effective. Although our patient did receive steroids, this treatment has not been shown to improve survival or achieve higher platelet counts in acute infection.

Take Home Points

1. The causes of thrombocytopenia generally fit into two broad categories: decreased production or increased destruction/ consumption.
2. Dengue should be considered in the differential diagnosis for patients with thrombocytopenia if they have recently traveled to an endemic area.

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3. The severity of dengue ranges from a flu-like syndrome to a potentially lethal systemic disease. Treatment is largely supportive.

Suggested Reading

Dengue: Guidelines for treatment, prevention and control. Geneva: World Health Organization, 2009.

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