HEALTH POLICY CORNER

Shaping our Physician Workforce Through GME
Christopher Goodman, MD

Dr. Goodman is a PGY3 in the J. Willis Hurst Internal Medicine Residency Program at Emory University School of Medicine.

“The medical schools, hospitals, and government... appear as if in a conversation piece, discussing with themselves issues which have been apparent for years.”

—Rosemary Stevens (1978)

One consistent message amidst all of the talk about health care reform has been that primary care is in dire need of an influx of manpower. With the recent passage of the Affordable Care Act and the expected increased demand on primary care, we are likely to hear more regarding strategies to promote primary care; however, the challenge in promoting primary care among physician graduates has essentially been an unresolved problem for years. In 1931, 87% of physicians were generalists, but this rate dropped to 50% in 1960 and 32% in 1994. Much has been written on the factors that have influenced this trend (e.g. preferential reimbursement, greater prestige, better work hours, etc.), and in general most of these issues are somewhat self-evident among physicians. Perhaps less well-known among physicians is the history behind the trends, especially in graduate medical education (GME)—policies that have shaped the physician workforce and at times attempted to shift the balance in favor of primary care.

GME, the final step before licensure and direct function of the physician workforce, is a primary target for physician supply policy. To be licensed to work as a physician in any given state requires either one or two years of residency training, which means that the number and type of residency positions essentially determine the number and type of physicians. The first one-year post-graduate training program began at Harvard in the mid-19th century to the chagrin of medical faculty, but such programs would not become commonplace until the rise of the hospital. Historically, the hospital was a place of care more than cure, so few were built; however, at the end of the 19th century, the hospital, for a variety of reasons, was becoming an acceptable place for the treatment of disease. American Medical Association (AMA) records from 1875 show there were 661 hospitals in the United States. By 1900, that number increased to 2,070, and in 1909 the number had more than doubled.

continued on page 12
FROM THE SOCIETY

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS
President
Ann B. Nattinger, MD, MPH
anatting@mcv.edu
Milwaukee, WI
(414) 805-0840

President-Elect
Eric B. Bass, MD, MPH
ebass@jhmi.edu
Baltimore, MD
(410) 955-9871

Immediate Past-President
Harry P. Selker, MD, MSPH
hseinker@tuftsmedicalcenter.org
Boston, MA
(617) 636-5009

Treasurer
Katarina Armstrong, MD, MSCE
karmstro@mail.med.upenn.edu
Philadelphia, PA
(215) 898-0957

Secretary
Jean S. Kutner, MD, MSPH
jean.kutner@ucdenver.edu
Denver, CO
(303) 724-2240

Secretary-Elect
Gisselle Corbie-Smith, MD, MSc
gcorbie@med.unc.edu
Chapel Hill, NC
(919) 962-1136

COUNCIL
Clarence H. Braddock III, MD, MPH
cbrad@stanford.edu
Stanford, CA
(650) 498-5923

Shobhina G. Chheda, MD, MPH
sgc@medicine.wisc.edu
Madison, WI
(608) 263-2788

Thomas H. Gallagher, MD
thomas@uw.edu
Seattle, WA
(206) 617-7158

Michael D. Landry, MD, MS
mlandry@tulane.edu
New Orleans, LA
(504) 988-5473

LeRoi S. Hicks, MD, MPH
leroi.hicks@ummassmemorial.org
Worcester, MA
(508) 334-6440

Somnath Saha, MD, MPH
sahas@ohsu.edu
Portland, OR
(503) 220-8262

EX OFFICIO COUNCIL MEMBERS
Chair of the Board of Regional Leaders
Christopher Masi, MD, PhD
cmasi@northshore.org
Evanston, IL
(847) 250-1277

ACLGIM President
Deborah Burnet, MD, MA
daurnet@medicine.bsd.uchicago.edu
Chicago, IL
(773) 702-4582

Co-Editors, Journal of General Internal Medicine
Mitchell D. Feldman, MD, MPH
mfieldman@medicine.ucsf.edu
San Francisco, CA
(415) 476-5887

Richard Kravitz, MD, MSPH
rkravitz@ucdavis.edu
Sacramento, CA
(916) 734-1124

Editor, SGIM Forum
Priya Radhakrishnan, MD
pradhakr@chw.edu
Phoenix, AZ
(802) 406-7298

Associate Member Representative
Bradley H. Crotty, MD
crotty@post.harvard.edu
Boston, MA
(617) 575-9304

Health Policy Consultant
Lyle Dennis
Washington, DC
ldennis@dc-crd.com

Executive Director
David Karlson, PhD
1500 King St., Suite 303
Alexandria, VA 22314
KarlsonD@sgim.org
(800) 822-3060;
(202) 887-5150, 887-5405 Fax

Director of Communications and Publications
Francine Jetton, MA
Alexandria, VA
jettonf@sgim.org
(202) 887-5150

News from the Women and Medicine Task Force
Anuradha Paranjape, MD, MPH; Jennifer McCall-Hosenfeld, MD, MSc; Wendy L. Bennett, MD, MPH; and Amy S. Gottlieb, MD

Dr. Paranjape is chair, Dr. McCall-Hosenfeld is co-chair, Dr. Bennett is abstract chair, and Dr. Gottlieb is Career Advising Program chair for the SGIM Women and Medicine Task Force.

In 2007, SGIM Council created the Women’s Health Task Force (WHTF) to support research, education, and clinical practice in women’s health. In 2012, members of the WHTF voted to change the name of the group to the Women and Medicine Task Force (WAMTF) in order to reflect the expanded scope of its mission and activities. In addition to promoting women’s health endeavors, the Task Force has taken a leadership role in fostering the academic advancement of female physicians. The name change was recently approved by SGIM Council.

During the 2012 annual meeting in Orlando, FL, the Task Force hosted its sixth Distinguished Professor in Women’s Health lecture. The speaker was Carol Weisman, PhD, distinguished professor of public health sciences and obstetrics and gynecology at the Pennsylvania State University College of Medicine and a member of the Institute of Medicine’s Preventive Services for Women Committee. Dr. Weisman presented a keynote lecture titled “The Affordable Care Act and Women’s Preventive Services: The 2011 IOM Report” to a standing-room-only audience. Following her presentation, Dr. Weisman also served as the discussant for the women’s health oral abstract and poster sessions.

The Task Force would like to thank everyone who presented women’s health workshops, oral abstracts, posters, and the 2012 Update in Women’s Health. Additionally, we would like to announce and congratulate the 2012 winners of the Best Women’s Health Oral Abstract and Best Women’s Health Poster Presentation. These submissions received the highest ratings by peer reviewers.

Best Women’s Health Oral Abstract
Eleanor Bimla Schwarz, MD, MS, associate professor of medicine, epidemiology, and obstetrics, Department of Obstetrics, Gynecology & Reproductive Sciences, University of Pittsburgh

“ Asking for What She Needs? Pregnancy Testing or Emergency Contraception”

Best Women’s Health Poster
Jacinda M. Nicklas, MD, MPH, MA, GIM research fellow, Beth Israel Deaconess Medical Center and Harvard Medical School

“Factors Associated with Depressive Symptoms at Six Weeks Postpartum Among Women with Recent Gestational Diabetes Mellitus”

The WAMTF will continue to advance women’s health research, education, mentoring, and clinical...
Although February may be a down month in some ways, I think it is an exciting time for academic general internal medicine (GIM) divisions. One reason is that winter is a common time for candidates and divisions to negotiate positions and make decisions about the future.

The recruitment process can be stressful for both candidates and those responsible for hiring them. However, it is exhilarating as well, as one gets to know many new people through the process and compare how things are done at different places. I think the interviewing process is particularly helpful for candidates because the process of interviewing typically helps them to clarify what they really want in a position.

Over the years I have spoken with many individuals seeking new positions. Sometimes I am hoping to hire an individual into our division, and sometimes I give advice to a candidate as an outside advisor. One item that frequently needs more discussion is mentorship of the candidate in the new position. I have come to believe that having engaged mentorship is one of the most important predictors of success and happiness in a new position. If I cannot see who would mentor an individual, then I am much less enthusiastic about the recruitment, no matter how well qualified the candidate is.

If I cannot see who would mentor an individual, then I am much less enthusiastic about the recruitment, no matter how well qualified the candidate is.

A junior faculty member’s mentoring needs with a single individual. Having two to three faculty members named as mentors in the letter increases the number of individuals (in addition to the chief) who feel especially vested in the success of the new faculty member.

I am sometimes asked what other resources prospective faculty members should consider requesting during negotiations. Of course, this depends greatly on the responsibilities of the particular position. Many GIM faculty are appointed as clinician-educators. Faculty holding these positions will often have clinical responsibilities (outpatient and/or inpatient) for 50% to 80% of their effort, with the remaining effort allocated to specific educational responsibilities. It is important that the allocation of time/effort be specified in the offer letter to avoid confusion later. I advise clinician-educator faculty also to inquire about support for any educational roles. For example, if you are to become the director of a particular course, you need to know about administrative support for the course. You do not want to be the one personally e-mailing dozens of trainees about their schedules. In addition, clinician-educator faculty may wish to negotiate for additional development opportunities as a faculty member, depending on one’s background. These opportunities might include learning about the principles of curriculum development and implementation, assessment of learners, and giving feedback. The institution may offer such opportunities or one could ask for an external opportunity to be included in the offer, such as the SGIM TEACH program. (See more information at www.sgim.org/go/TEACH.)

Prospective faculty who expect to develop externally funded research programs should also receive resources to support their start-up phase. One resource will be substantial protected time, which is often 75% to 80% for those who expect to secure federal funding for their research. The other resources needed would be customized to the specific research planned but should include enough support to gather and analyze pilot data and develop relationships to facilitate the research to be undertaken. These days, NIH support is challenging to obtain, so it is better if the support is sufficient for what may be several rounds of applications. I also think it is good if the offer letter specifies whether the support can be held over for future years if not spent in the initial year or two. Research-intensive prospective
FROM THE EDITOR

Advice to Graduating Residents
Priya Radhakrishnan, MD

I want to become a doctor to serve those in need.
I want to become a doctor to help those like my grandfather who had heart failure and suffered a lot.
I want to become a doctor to serve those in need.
I want to practice geriatric medicine because I want to help patients like my grandmother who had a stroke.
I worked in a city hospital in Beirut amidst bombs, and I want to make sure I get a chance to serve the poor.

I love reading residency personal statements. I am awed and energized by the fresh young perspectives. As we roll into this year, residency interviews behind us, our graduating residents start looking for jobs, and I start interviewing for new faculty. I also start advising our residents on contracts, job offers, and tail insurance. This is the advice that I will be giving my residents.

As you look at job interviews and offers, here are some basic things that should be considered:

1. Location. Where you practice is important. Inner city or downtown hospital-based practices have a higher load of un- and under-insured patients. Suburban practices, on the other hand, tend to have more commercial payers. Understand the role of the location of the practice and the effect that it has on your longevity in the practice.

2. Value. As the reimbursement structure changes, find out about pay for performance (P4P), meaningful use, and patient-centered medical home (PCMH) incentives and how they affect your pay. The reimbursement structure is sure to change. Ask about the incentives based on care. Ask about how the practice fares in the value-based metrics and its patient satisfaction scores, including how patients are surveyed, what tools are used, and what their scores are. On the other hand, practices in underserved areas, particularly hospital-based practices, tend to have patients with complex medical issues. Ask about care coordination pathways, PCMH, and P4P in the context of care coordination.

3. Connectivity. You are the iGeneration. Ask about connectivity and plans for e-communication. In this day and age, I would not join a practice that does not have an electronic health record (EHR) or plans to transition to one. If the practice has more educated patients, ask about the use of electronic communication, including patient portals. Ask about the reporting function of the EHR and how it supports population-based health.

4. Reimbursement. Find out what the prevailing wages are in your area. (You can get this information from MGMA/recruitment company websites.) Understand the difference between base pay and total compensation (base pay + benefits). If you are considering joining a private practice, the medical insurance, 401K, and other benefits may lead to more out-of-pocket expenses when compared to a larger corporation or hospital-based practice. This is particularly important if you or one of your dependents has a health issue. Copays for medical and hospital visits are ever increasing. Do not pick a plan with a high deductible unless you also plan to start a health savings account (HSA). It is not unusual for many smaller private practices to offer larger base salaries, particularly in large metropolitan areas for a defined period (one to two years). Ask for a sign-on bonus and relocation expenses. Beware of a larger-than-normal base salary for one year followed by a productivity-based salary for the next. If that is the case, ask about sharing in HMO capitation, buy in (particularly if the practice owns equity), land, surgery centers, and part ownership in joint ventures. My close friend got a "great" job offer in Chicago—about $20,000 more than the rest of us—only to have her salary slashed by 50% the following year since it was based on "eat what you kill." Her employer assigned all the HMO patients without sharing the capitation profits. If it looks too good to be true, it probably is.

5. Finances. Understand your debt and revenue need. Speak with a financial planner and tax consultant to understand what your take home pay will be after student loans and debt payment are done. If you have additional personal debt, consolidate it. In single-earner households, particularly if you have a family and small children/dependents, this is crucial. You may be better off paying off the debt by working in a medically underserved area. Make sure that you have looked at loan repayment opportunities. There are several in both urban and rural areas with good base pay and benefits. Look into medical directorships and moonlighting, particularly in urgent care, emergency rooms, or long term-care facilities. The advantage of moonlighting is that you can build your practice with new patients. Research what your medical malpractice costs for moonlighting will be and what tax benefits you will be able to take advantage of.

continued on page 14
The implementation of electronic medical records (EMRs) certainly holds great promise for improving quality and efficiency of health care delivery. It may even allow us to bend the cost curve. To date, though, this last assumption has not been demonstrated, and many in fact worry it may increase health care costs. One way in which EMRs may be increasing health care expenditures is by increasing professional billing costs. A recent New York Times (NYT) article shined a light on this possibility and raises questions about physician overbilling and fraud.¹

The publication from September 2012 detailed the changing professional billing patterns documented over the past 10 years by the Office of Inspector General (OIG) and the Department of Health and Human Services (DHHS). The report analyzed Evaluation and Management (E/M) coding patterns for 442,000 providers from 2001 and 2010. The report describes a steady increase in billing higher, more expensive codes and a corresponding drop in the lower, less expensive codes. As an example they report that for the visit type Office Visit Subsequent, the selection of the two highest codes collectively increased by 17% (15% for level four 99214 and 2% for level five 99215; see Figure 1). These services were reimbursed at approximately $97 and $132, respectively, in 2010. The same pattern was described for the visit type Inpatient Subsequent. For this visit type, there has been a 16% drop in the lowest level 99231 code with a corresponding increase in the higher level 99232 and 99233 codes of 6% and 9%, respectively. The most dramatic increase has been with emergency room visits with all four of the lowest billing levels (99281, 99282, 99283, 99284) dropping with a corresponding increase of 21% in the highest code (99285). The report goes on to say that approximately 1,700 physicians were identified to bill the two highest codes 95% of the time. The OIG singled these individuals out from the rest as “high billers” and recommended further action targeting these individuals.²

The OIG report focused on changing billing patterns, but the NYT investigators have rightfully asked the next logical question: Why have physicians steadily increased the selection of more expensive, higher level services? Many critics point to EMRs as a potential contributor. Certainly there is anecdotal evidence that EMRs may contribute to higher billing selection. The NYT article lists a number of hospitals that tallied 40% to 50% increases in billing the highest-level professional codes after EMR implementation. They even quote an EMR vendor bragging that their systems will facilitate higher billing levels. This vendor is quoted as saying it “plays the level-of-service game on your behalf and beats them at their own game using their own rules.”³ One might also consider the many documentation tools in an EMR intended to improve efficiency.

Systems allow users to copy forward previous notes and use functions such as “make me the author.” We now have a lexicon of terms to describe these tools, such as record cloning, default notes, single-click templates, and E/M optimizers.³ These tools allow physicians to create lengthy progress notes with elaborate reviews of systems and physical exams. They also allow users to pull in large amounts of discrete data into notes. The resulting notes, sometimes five pages long, might lead one to conclude that more work has been done and thus justifies a higher billing level. Some are concerned that these tools create a situation in which a physician might cross the line into improper and possibly even fraudulent documentation. The OIG certainly thinks EMRs may be a culprit. In their work plan for 2012, they state: “We will assess the extent to which CMS made potentially inappropriate payments.... We will also review multiple E/M services for the same providers and beneficiaries to identify EMR documentation practices associated with potentially improper payments.... We continued on page 13
**SGIM LEADER OF THE MONTH**

**Jen Smith: Finding Opportunity**

Deborah Burnet, MD, MA

*Dr. Burnet is professor of medicine and pediatrics and chief of general internal medicine at the University of Chicago.*

**“Out of crisis and in the midst of chaos comes the birth of fantastic opportunity.”**

So said Jen Smith, chief of general medicine at Stroger-Cook County Hospital, a large public safety-net hospital in Chicago, at the recent ACLGIM Summit in Phoenix, which focused on resilient leadership in times of stress. She was speaking of the time in 2009 when the County budget was cut 20% across the board and the division of general internal medicine (DGIM) leadership left the institution. In the midst of that crisis, she was asked to step up to take on the role of DGIM chief.

Sensing opportunity even in the midst of chaos, Jen resolved to take on the role of division chief. She knew she needed to get others rapidly on board, as many colleagues were departing. The DGIM provided a great deal of teaching and clinical service but was losing stature and recognition in the hospital. Faculty members did not share a common vision of what it meant to be clinician-educators; individuals did their work but did not always step up for teaching and other roles. Jen called together a leadership group from within DGIM, which numbered about 45 faculty overall. They went back to basics—who they were, why they were at the County, what they stood for, and what they wanted others to know about them. They developed a draft of these principles and brought them to the whole division for discussion and modification. As a result of this process, all members of the DGIM could say they knew what the division stood for and what each member contributed to the effort.

To maintain a high level of investment, Jen empowered section chiefs in areas such as preventive medicine, medical education, women’s health, palliative medicine, geriatric medicine, and consult medicine. Every member of the division was asked to join a section. Most sections meet twice a month—one for a business meeting and once for didactics and faculty development. The result has been the development of a cadre of effective section leaders, an effective mechanism for mentorship and accountability, and productive academic work coming out of each section.

“Chaos” comes from the Greek word for “gaping wide open.” In Greek, *krisis* refers to the turning point in a disease, with roots meaning “to sift, to separate.” Jen stepped into leadership during a time of enormous stress. She saw possibilities gaping wide open. She challenged faculty to sift through the meaning of their work and to come up with a vision they could embrace, articulate to others, and implement. She empowered others to become leaders and implemented a system of accountability and mutual support. The result has been a healthy, more productive, and resilient work force.

**Update from the ACLGIM Seventh Annual Winter Summit**

ACLGIM develops leadership skills for division chiefs, hospitalist directors, associate chiefs, section heads, administrators, and other emerging and aspiring leaders in academic general internal medicine (GIM). ACLGIM met in Phoenix in December for our Seventh Annual Winter Summit to consider current issues in health care and strengthen leadership skills. The meeting theme was “The Post-Election Affordable Care Act Era: Leading Sustainable Change,” and the meeting presentations are available at http://www.sgim.org/aclgim-meetings/past-summits.

Tim Ferris, Partners HealthCare vice president for Population Health Management and medical director of the Massachusetts General Physicians Organization, sparked discussion on “Population Health Management” in light of new policies and incentives under health care reform, reviewing evidence from demonstration programs. Coleen Kivlahan, senior director of Health Systems Policy and Innovation at the Association of American Medical Colleges, gave us timely insights on the implementation of health care reform and its implications for academic medicine. Chiefs and other leaders shared relevant experience from their own institutions.

Participants organized into learning teams focused on topics such as medical education, research, health care policy, administration, and faculty development, as we worked with facilitator Dorie Blessoff, adjunct instructor of learning and organizational change at Northwestern University, to identify opportunities for resilience in times of change and fiscal constraint. She used “scenario planning” as a method for envisioning potential environmental trends and planning strategically for various outcomes.

A highlight of the program was a case study presented by Jen Smith, DGIM chief at Stroger-Cook County Hospital in Chicago. Participants explored with their learning team members how they would apply principles of resilience and scenario planning at their home institutions, and some groups planned to continue conversations and follow-up beyond the meeting.

For more information or meeting materials, visit our website. The continued on page 8
Reinventing House Calls: A Simple Solution for Complex Patients?
Andrew Schamess, MD, and Neeraj Tayal, MD

Dr. Schamess is assistant clinical professor at The Ohio State University Wexner Medical Center, and Dr. Tayal is a member of the Forum editorial board. Dr. Tayal can be reached at Neeraj.Tayal@osumc.edu.

When one of the authors was practicing in rural western Massachusetts, he asked an elderly patient—an African-American and a New Englander of many generations—how his family first settled in the area. The patient related the following story:

**After the Civil War, my great grandfather attended medical school in the South. Small proprietary medical schools were common in those days, some of them accepting “negro” students.** Upon completing his training, he came up North and settled in Berkshire County, Massachusetts, because he’d heard there was no doctor there.

The first day he hung out his shingle, a boy came to summon him to a difficult delivery. He ran a mile, following the boy, to a neighboring farmhouse—only to discover that the “patient” was not a person but a cow. After contemplating the comparative anatomy, he decided to take the case and successfully delivered the calf. Thenceforth, he was the town veterinarian as well as doctor. He eventually bought some land for a farm, raised a family, and practiced contentedly there for the rest of his life.

The story is, among other things, a reminder that in the 19th century most doctor visits (medical and veterinary) were house calls. The patient’s home functioned as the modern hospital, with the family serving as caregivers. Doctors came to know the details of their patients’ lives quite intimately. Regardless of their provenance or how they were trained, doctors fit quite integrally into the communities in which they lived and practiced.

The story also provides an example of some traditional virtues that may be undervalued by today’s physicians: resourcefulness, adaptability, and the willingness to go beyond the comfortable boundaries of standard practice if necessary to help an ailing patient.

The Flexner Report, published in 1910, put an end to proprietary medical schools. It set the current standard for medical education: two years of didactic teaching followed by two years of clinical training under the supervision of qualified faculty. It laid the groundwork for the growth of American medicine as a scientific discipline and paved the way for many developments that followed: the embrace of scientific research by universities, the accumulation of biomedical knowledge and its application to advanced therapeutics, and the growth of medical specialties and the highly technological medicine practiced today.

In the 20th century, the use of telephones and automobiles, the concentration of population in urban areas, the shrinkage of household size, and the construction of modern hospitals rendered the house call obsolete. By mid-century, many physicians were purchasing space in new buildings near hospitals. They made inpatient rounds in the morning and kept office hours in the afternoon. Home visits seemed inefficient, almost primitive. An x-ray machine and a clinical laboratory—the new tools of the trade—did not fit into a black bag. By the 1970s, home visits comprised less than 1% of all patient visits.

Indeed, even those of us in practice today are sometimes disturbed by the pace and nature of change in the social, economic, and policy climate of medical practice. Our patients feel it, too. Some benefit from the advances in knowledge and technology, but just as many have harrowing stories of fragmented care, insensitive providers, and treatments that seemed worse than the disease. Some older patients still remember the friendly reassuring family doctor who made house calls and wonder where he/she went.

In fact, those who have the most difficulty navigating the modern medical system are also those who have been marginalized by the service- and technology-driven economic expansion of the past half-century: ethnic minorities, immigrants, the under-educated, and the poor. A large body of evidence points to lower quality of care and worse health outcomes for these groups.

These demographic factors, combined with age and chronic illness, define a population that has become increasingly problematic for hospitals and health care providers: high recidivists for whom the failure of chronic disease management has resulted in frequent repeat hospitalizations, heavy use of emergency medical services, and exceedingly high cost of care.

This population has come into focus recently as health care systems try to respond to cost reduction measures imposed by payers. Of particular concern to providers is the new Medicare rule eliminating payments to hospitals for 30-day readmission of patients discharged with pneumonia, acute myocardial infarction, or congestive heart failure.

Work in the field of complexity science provides useful insights that allow us to model the impact of health system interventions on chronically ill patients. Cumulative complexity, as experienced by the patient, consists of the sum of the challenges involved in daily life, including those imposed by illness.

continued on page 11
This year, the 2013 New England Regional SGIM Meeting will take place on Friday, March 8, 2013, at the historic Yale University School of Medicine campus. We are thrilled to bring the meeting back to Yale for the first time in many years and to offer our colleagues an event that highlights the collaborative efforts of thought leaders throughout the region.

These cooperative efforts will be clearly reflected in the content of the meeting. For example, regional program directors, the Connecticut American College of Physicians, and the New England Region have collaboratively developed a special faculty workshop series designed to help educators understand and implement new programmatic requirements for the competency-based evaluation of residents. These sessions will train attendees to effectively utilize milestones, entrustable professional activities, and narrative reports as required by the Accreditation Council for Graduate Medical Education (ACGME) Next Accreditation System.

Similarly, SGIM’s sister organization ACLGIM has partnered with us to host a career panel targeted at junior faculty looking for guidance on the appointment and promotion process. Trainees can look forward to a similar interdisciplinary panel that can offer guidance on selecting a career within general internal medicine.

New this year, the content of the regional meeting will also reflect a theme, similar to the national meeting. This year the meeting theme will be “The Art of Medicine,” defined both as 1) the artful implementation of the science of medicine and/or medical education and 2) the role that medical journalism, creative writing, and other written, visual, and musical arts play in health care, healing, and medical education.

We intend to make the meeting theme a palpable presence throughout the day; there will be chamber music during lunch, sessions dedicated to creative writing and medical journalism, a guided tour of the historic Yale Cushing/Whitney Medical Library and the famous Yale Cushing Center (aka “Brain Lab”), and a recurring focus on the art of diagnosis. Our plenary speaker this year, H. Gilbert Welch, MD, will echo this theme in his presentation regarding the phenomenon of overdiagnosis and unnecessary testing as we continue “making people sick in pursuit of health.” As always, the meeting will also feature peer-reviewed oral and poster presentations as well as workshops and symposia addressing a variety of topics relevant to the practice and teaching of general internal medicine.

If you live in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, or Vermont but have never attended a regional meeting before, we guarantee this will be a high-yield complement to the national meeting that will be well worth your time. If you live outside of the New England region, consider joining us anyway! We look forward to seeing you this March in New Haven for this much-anticipated event!
How to Get to Yes! A Strategy of Negotiation for Physicians
Eric Linson, MBA

Mr. Linson is the practice manager of the adult hospitalist service in the Division of General Internal Medicine at the University of Iowa Hospitals and Clinics. He can be reached at eric-linson@uiowa.edu.

Physicians use the constructs of negotiation every day. This includes cooperation, compromise, discussion, intervention, conversation, and exchange of information with colleagues, support staff, patients, and caregivers. Just the other day, a junior physician walked in my office and asked if “she should take it personally” following a meeting in which her more senior physician colleague asserted support for his agenda. Why do so many physicians react negatively to the process of negotiation?

Physicians and other leaders often “take negotiation personally” because they don’t know how to negotiate successfully. They primarily focus on the perceived power of the other party compared to their own effort to obtain a dominant position to achieve a desired outcome. The result frequently enhances one’s self-confidence in the short-term but risks losing mutual respect and threatening the desired outcome in the long run.

Fisher, Ury, and Patton in their bestseller Getting to Yes (1991) explain the method of principled negotiation. The technique seeks to identify principles from both sides that are and are not up for negotiation rather than on positions or the people involved.

The technique is built around the following four paradigms:

- Separate the people from the problem;
- Focus on interests, not positions;
- Invent options for mutual gains; and
- Insist on using objective criteria.

The method of principled negotiation can be used by general internal medicine physicians to effectively reach compromise.

One example of negotiation is a general internist’s first job offer and contract. Some board-eligible graduates from residency might be apprehensive in negotiating up front their respective salary and benefits with prospective employers or group practices. They may fear that negotiation will reflect badly on them before they start or result in not being offered a desired position at all. The reality is that general internists are in demand and will be in demand in the foreseeable future as prospective employers seek to adequately resource their missions. Prospective employers will not only negotiate but will welcome creative and innovative solutions from them to cultivate and retain talent. This might include the prospective employer’s desire for you to work five full days when you only want to work four. Instead of taking a strong position, consider determining the number of patients the prospective employer would like you to see and evaluate whether you can accommodate this number of patients in four full days.

A second example of negotiation is getting more resources or maintaining resources for your program in an environment of decreasing profits, increasing regulations, and increasing accountability. In simple terms, everyone at the top, including the C-suite, will attempt to squeeze all that they can from every resource available. This includes those closest to patients—general internists. Instead of getting angry or distressed about the current state of affairs, find new and creative solutions to the problem. For instance, if the C-suite or department chair says “No” to your request for more FTEs, try to reframe the proposition to focus on what is important to the C-suite, such as the increased profits, improved quality, or greater patient satisfaction the additional physician will bring. In this way, the gain will accrue not only to the patient and hospital but also to the group practice, which will have greater physician job satisfaction and decreased turnover.

Now general internists or general internal medicine groups can and do employ a couple of strategies to improve their respective positions of influence. One is they may hire a competent and trustworthy administrator or practice manager to broker such negotiations. Another technique is for physicians to cultivate and retain talent. This includes those closest to patients—general internists. Instead of getting angry or distressed about the current state of affairs, find new and creative solutions to the problem. For instance, if the C-suite or department chair says “No” to your request for more FTEs, try to reframe the proposition to focus on what is important to the C-suite, such as the increased profits, improved quality, or greater patient satisfaction the additional physician will bring. In this way, the gain will accrue not only to the patient and hospital but also to the group practice, which will have greater physician job satisfaction and decreased turnover.
The Official Launch of PREPARE
Rebecca Sudore, MD

Dr. Sudore is a staff physician at the San Francisco VA Medical Center and associate professor of medicine at the University of California, San Francisco. PREPARE can be accessed at http://www.prepareforyourcare.org.

How can people prepare to have the conversation about what matters most in life and how can they prepare for medical decision making?

A new interactive, easy-to-use advance care planning website called PREPARE can help. PREPARE shows people, through videos and a step-by-step process, how to have the conversation and make informed medical decisions.

I have been profoundly struck by examples in my own family and from my geriatrics and palliative care patients that most people lack a framework to face complex medical decisions when they arise. We, the health care establishment, admonish people to do advance care planning, which usually means filling out advance directive forms focused on hypothetical scenarios and preferences for life-sustaining treatments such as CPR. Because no one can predict all unforeseen medical and personal circumstances, this approach to advance care planning does not always help during a medical crisis.

What we often don’t do well is to teach people how to identify what is important to them in life and how they want to live; how to communicate their wishes to their family and doctors in a meaningful way that can affect their medical care; and how to face complex and often scary, in-the-moment medical decisions in the context of their deeply held beliefs and values.

We set out to change that. We have created an interactive website called PREPARE that is focused on teaching people the skills they need to identify what is important in life and the language they need to communicate this information. PREPARE focuses on the “how” and not just on the “what.”

There are many helpful advance care planning tools. However, based on a series of 13 focus groups of patients and surrogates from diverse backgrounds and our prior research, we developed PREPARE to fill in what we saw as fundamental content and functionality gaps in currently available tools, especially for older adults from culturally diverse backgrounds. (See links to research references below.) PREPARE is innovative in the following ways:

1. PREPARE walks people through an easy-to-follow five-step process. We recognize that advance care planning comprises not just one but several steps, such as choosing a medical decision maker and asking him/her to play that role, deciding what matters most in life, discussing leeway in surrogate decision making, learning how to tell others about one’s wishes, and practicing how to ask clinicians questions to make informed medical decisions. We developed PREPARE to help people engage in each of these steps in a systematic way.

2. PREPARE is focused on preparation for decision making and communication skill-building. We developed PREPARE to give people the tools to identify what is most important in life, the concrete skills to communicate these wishes, and the framework to prepare people for informed medical decision making. PREPARE is appropriate for any stage in life or illness.

3. PREPARE is focused on empowering the individual and not just the medical establishment. We designed PREPARE to be completed outside the clinician environment. It is not as a substitute for a conversation with a clinical provider, but it does prepare people for these conversations before they are necessary. This empowers the individual and may save the clinician time.

4. PREPARE is easy to use. We targeted PREPARE to a fifth-grade reading level, presented in a large font with large intuitive buttons. We also included voice-over of all text for individuals who have poor vision or difficulty reading and closed-captioning of all video content for those who are hard of hearing. People with deficits in reading, vision, and/or hearing are vulnerable to making uninformed medical decisions because of a lack of understanding. PREPARE aims to change that.

5. PREPARE includes concrete video demonstrations. We developed videos that show people how to perform each of the five steps, including how to identify good surrogate decision makers and how to ask them to serve in that role.

6. PREPARE is culturally appropriate. The content of PREPARE is the result of extensive research, including 13 focus groups with patients and surrogate decision makers and input from older adults from culturally diverse backgrounds. We attempted to provide culturally balanced content and

continued on page 11
treatment regimen, and barriers to care, counterbalanced by the personal, social, and financial resources available to the patient to cope with these challenges.  

As cumulative complexity rises, the likelihood of successful illness management falls. This suggests that one way to improve patient adherence to chronic disease management is to simplify care. For some patients, the challenges of making and keeping appointments, leaving the house and getting to the doctor’s office, and overcoming the linguistic and cultural differences they may encounter there must be overcome to achieve stable management of chronic conditions.

At our institution, we are piloting a home visiting program targeting chronically ill patients at high risk of readmission. With a team that includes a physician, an advanced practice nurse, a social worker, and a pharmacist, we will provide ongoing continuity care in the home setting to patients facing physical, transportation, or social barriers to office-based care. Our aims are to improve access, coordinate care, and help to address complicating life factors, such as financial and housing instability, caregiver stress, and physical disability, that interfere with effective chronic disease management. We will measure the impact of our intervention on utilization and health-related quality of life.

Home visiting has come back into focus as a promising approach to care delivery, especially in hard-hit ethnically diverse urban communities. The Veterans’ Administration has reduced costs with a home-based primary care initiative. Academic medical centers in many areas have reported promising outcomes from home visiting programs. More data are needed, but in the current economic climate, home- and community-based programs may move from a peripheral place in medical centers to the cutting edge of health care redesign.

By leaving the comfort of their offices and the convenience of scheduled and routine, health care providers are re-learning some old lessons: how to navigate social and economic differences, build trust, and address the perceived (and not always strictly medical) needs of patients and families. They are stepping back into a traditional role as vital now as it was a century ago.

References
to 4,359. (Today, the number of hospitals stands at 5,815.)

As hospitals grew, so did the availability of internships. Physician graduates were desperate for the status as well as the experience of internships, and hospitals were eager for the cheap labor. By 1932, 95% of graduates were obtaining internships, the majority of which were in hospitals. This was a dramatic change for a generalist workforce that had previously been entirely community trained. This market-driven marriage of the hospital and physician graduate training had a significant impact on the workforce since it led to the placement of GME in the increasingly specialized realm of burgeoning academic medical centers.

In 1965, Congress, recognizing the extra burden hospitals took in supporting the educational activities of future physicians, created the direct graduate medical education (DGME) payment as part of the Medicare legislation. The DGME payment provides funding to cover hospital costs for resident salary and benefits. Meant to be a temporary aid, the DGME along with the associated indirect medical education (IME) payment became indispensable sources of income for hospitals. From the 1960s to the mid-1980s, DGME payments were essentially blank checks; hospitals were paid loosely depending on the number of residents they hired. The result was rapid growth in massive academic medical centers as well as a steady increase in the physician per capita ratio predominantly driven by growth in the subspecialties.

Legislation was passed in the 1980s that put in place new strategies to limit the growth of DGME costs and to influence the number and types of GME positions. The COBRA Act of 1986 created what are known as the “per resident amount” (PRA) and “initial training period,” essentially refinements of the DGME payment. The PRA defines how much money a hospital will receive for a given resident. Later, additions to the PRA would allow residents to work in non-traditional areas such as nursing homes, free clinics, and prisons during their training and also reimburse GME programs slightly more for residents in primary care. The “initial training period” is the amount of time required to finish the residency of choice. Anything beyond this initial training period, including fellowship, is only supported at half the standard calculated amount—a clear attempt to incentivize support of primary care in GME administration.

Beyond these specific changes to the DGME there are a variety of other notable pieces of legislation from the 1970s through the 1990s that attempted to promote primary care—examples include Title VII funding for academic general medicine programs, National Health Service Corps funding to promote primary care in underserved areas, and various rural rotation funds across the country that expose medical students and residents to work in rural areas. Despite these resources, the trend among physician graduates to prefer subspecialized care continued, and one major piece of legislation essentially closed the door on any possibility for change.

The Balanced Budget Act (BBA) of 1997 was written and passed at a time when managed care was being actively implemented with the hopes that it would lead to decreased use of medical services, better quality care, and the need for fewer physicians. The legislation “froze” the number of residency positions funded by the federal government at each hospital. Some nuances were allowed based on regional changes in the GME positions, but on the whole the legislation initially accomplished its goal. For the first five years after its passage there was a temporary plateau in the number of trainees, but around 2002 the number again began to rise with the greatest proportion of growth in the subspecialties and a decrease in residents entering primary care from 28% to 24% over the ten years from the start of the legislation.

In considering the continued clamor to promote primary care in our aging society with values shifting toward equitable access to care, it is important to understand some history. The challenge for policymakers over the years has been promoting primary care as a career choice among physician graduates, but how can we expect progress when federal policy limits the number of GME positions? Re-incentivizing primary care through dramatic changes in health care delivery or reimbursement may be necessary as health care reform continues, but still the number and type of practicing physicians have to be managed. No consensus exists on how to reverse the cap on GME and at the same time promote primary care. For now we are left with an agreed-upon deficit of primary care physicians and a set of legislative handcuffs on GME growth that not only hinders our ability to promote primary care but also limits whatever small cumulative effect that millions of dollars and a variety of legislative policies could potentially have on the primary care pipeline.

References
4. A half-century in retrospect: hospitals, medicine, manners and customs as the association was growing to maturity. Hospitals 1948; 22:56-66.
5. Grumbach K. Fighting hand to hand. continued on page 13
SIGN OF THE TIMES: PART I
continued from page 5

will identify fraud and abuse vulnerabilities in electronic health record (EHR) systems.”

On the other side of the argument, physicians—especially in primary care—may have historically under-billed and are now simply coding more accurately. The old adage has been: If you don’t know the answer, pick “C.” Perhaps for physicians, the adage has been: If you don’t know the answer pick “3” as in “99213.” They are both in the middle and are “safe.” Certainly, the complexity of the documentation guidelines has befuddled many of us and perhaps resulted in this middle-of-the-road behavior. It remains difficult to believe that a majority of patients seen by internal medicine physicians should ever have been billed as “low complexity.” Perhaps the 54% of established office visits billed at a level 3 in 2001 should not be the baseline for comparison. The higher billing trend documented by CMS has been gradual and might better be explained by a decade-long effort to teach coding and documentation guidelines to physicians. These efforts may have gradually given physicians the confidence to bill more appropriately for the correct level of service. These new electronic documentation tools of the EMR may simply be facilitating the application of this improved understanding.

Another possibility might be that EMRs allows physicians to accomplish more during each office visit. In well-designed EMRs, physicians might be able to process more information and as a result make more medical decisions. One could also argue that the complexity of patient management has likely increased. There would certainly be evidence to support this position. The last decade has brought additional diagnostic tests and medication combinations for diseases that were previously not treatable. Our aging population and obesity epidemic are increasing the number of patients with multiple chronic conditions. The number of practice guidelines has certainly ballooned over the past decade. Another factor that might warrant consideration is that with a higher shift of medical expenses to patients, patients are apt to handle more complaints in a single visit as opposed to paying multiple co-pays over several visits.

All of these are possible counter arguments to the claim that physicians are simply billing the system by selecting higher billing levels for the same amount of work. As of 2012, we simply do not know the contribution of each of these factors to changes in billing patterns over the past decade. There are no studies analyzing the factors described above, but this area would likely be of high interest to payers. Certainly, there are blatant fraudsters who should be identified and rooted out as always. The bigger concern though remains the “others” who must answer to an increasingly suspicious population of regulators, policy makers, auditors, and even patients.

Physicians are wise to pay attention to the OIGs efforts to address improper documentation of E/M services. Previous OIG efforts have resulted in significant financial impacts to physicians. In 2006, the OIG reported that 75% of consultations did not meet Medicare coverage requirements and that 95% of consultations billed at the highest level were mis-coded. As a result of this analysis, Medicare discontinued payments for consultations in 2010. With attention now being focused on new and established office codes, let’s hope the outcome is not more audits and denials of payment. Rather, let’s hope for a completely revamped system of documenting physician work. The current system is an expensive distraction from patient care. This is a waste that cannot be afforded in an economy where the demand for physicians is outstripped by supply. Our current documentation and billing system was formulated 17 years ago. A large majority of physicians will be working on EMRs within the next couple of years. We need a documentation and billing system that leverages the EMR to maximize time for clinical work rather than for generating invoices.

It’s time for an “upgrade” in technology and in policy!

References
1. Simborg D. There is no neutral position on fraud! J Am Med Inform Assoc 2011;18:675e677. doi:10.1136/amiajnl-2011-000206
President’s Column

continued from page 3

Faculty should seek specific advice from their mentors about the type and amount of support. Let me offer here a word of hope. Despite the tight funding environment, it is still possible to secure federal and/or foundation support as a new investigator. It takes hard work, committed mentorship, and some start-up resources, but it can be done. I hope that those who pursue a research-intensive pathway do not become discouraged.

Some institutions, my own included, have a specific faculty track for more clinically oriented individuals. These individuals may not be engaged primarily in medical education work, although they usually teach for a part of their effort. Given their high degree of clinical effort, they sometimes proceed along an administrative pathway, conducting quality improvement work and eventually becoming medical directors for various clinical operations. If you are considering such a position, it is worthwhile to understand in advance whether promotion can occur with that job description and what the criteria are. Having advanced knowledge of the SGIM Quality Portfolio components (http://www.sgim.org/file%20library/aclgim/tools%20and%20resources/qualityportfoliotemplate.pdf) may be useful. Since all faculty require mentorship, a mentor should still ideally be identified prior to accepting the position. Individuals who embark on this career pathway may wish to negotiate for resources to assist with quality improvement work and may wish to consider training in this area. Individuals embarking on this career pathway may wish to negotiate for attendance at courses offered by SGIM or ACLGIM, such as the Academic Hospitalist Academy (co-sponsored by SGIM/ACLGIM and the Society of Hospital Medicine) or others. I suggest having specific language in the offer letter to provide support for attendance at one or more such courses within the first couple years of being on the faculty.

In the end, one of the most important things that I seek in a prospective faculty member is fit within our division. I look for whether they will fit with our culture and potentially cultivate productive relationships with our existing faculty. This is the kind of thing that is assessed at dinner or other informal recruitment activities. One of the most gratifying parts of my time as division chief has been to pull together a group of faculty who support each other and who celebrate the successes of their peers. This benefits the institution as well as the faculty members by helping to lead to a positive sense of engagement. Getting a sense of the milieu of the division you are considering can be just as important as having all the details covered in the offer letter.

From the Editor

continued from page 4

6. Insurance. Get death and disability insurance—often it is cheaper to get these while in residency and increase the value after you get a job. (It varies based on state, age, etc.) I cannot overstate the value of disability insurance, particularly if you have dependents. Negotiate tail insurance if you can. (Most practices will not pay for tail insurance.) If you do not have a confirmed long-term plan to stay in the same practice due to family, it may be better to join a hospital- or corporation-based practice that is self-insured. I joined a practice while my husband was in fellowship training only to relocate two years later. When I left my first practice in Chicago to move to Phoenix after my husband finished his training, I had to pay $30,000 for tail insurance. Needless to say, we had to take out another loan to pay for the tail, which was about a fourth of what I had earned pre-tax. It took me years to pay it back.

7. COLA. No not Coke or Pepsi but cost of living adjustments.

8. Work Load. Your generation has been blessed and cursed with duty hours. Understand that there are no duty hours post residency—if you adopt an attitude of clock watching, you will be miserable. While planning for the transition, make sure that you work on improving efficiency. Use the last few months of training to finish your work quickly and efficiently. Use your mobile devices to your benefit. Try to finish your patient visits more efficiently and manage your work schedule.

9. Practice Management. Attend a coding and billing seminar to understand the process. There are several online courses available.

10. Wellness. Develop your personal plan for ensuring wellness. Do not ignore your physical and mental health. Spend time with your friends and family. Find time to spend on what makes you happy. Remember, work can expand to fill time. While it is important not to be a shift worker with an eye on the clock, plan for time off and vacations.

11. Manage Change. Do not become like several of your peers. Ignoring current affairs will only put you in a disadvantaged position. Along with developing a schedule for learning new clinical information, ensure that you are up to date on current health affairs. The next few years will be marked by constant change in medicine. Learn, adapt, and understand before reacting.

Plan your career as you would research a clinical plan of action for a complex patient. There are many variables that need to be considered. Good luck.
content at the SGIM 2013 Annual Meeting in Denver, CO, and is looking forward to hosting the following events.

**Distinguished Professor in Women’s Health.** We are very pleased to announce that the 2013 Distinguished Professor in Women’s Health will be Karen Freund, MD, MPH. Dr. Freund has been an SGIM member, leader, and mentor in women’s health for many years. She is currently the associate director for research collaborations within the Tufts Clinical and Translation Science Institute. Her many research interests include health system interventions like patient navigation to reduce health disparities, especially in women’s cancers. Dr. Freund also is a nationally recognized expert in faculty development. She has previously served as the principal investigator of the BIRCHW (Building Interdisciplinary Research Careers in Women’s Health) K-12 Program at Boston University and currently serves as the principal investigator on the longitudinal follow-up to the National Faculty Survey looking at predictors of academic success among junior faculty. She is committed to developing programs to mentor the next generation of clinical and translational investigators. We are very excited to kick off our women’s health programming this year with such an accomplished investigator and committed mentor.

**The Career Advising Program (CAP).** The WAMTF would like to announce the creation of CAP, a collaborative initiative with the Women’s Caucus. CAP aims to help female junior faculty successfully navigate the academic medicine promotion process. By connecting these SGIM members with senior “career advisors” throughout the organization (i.e. associate or full professors), the WAMTF and Women’s Caucus hope to foster academic advancement of women in medicine. Advising will complement existing SGIM mentorship programs by focusing specifically on academic promotion. Guidance will center on effective CV preparation, targeted committee membership, and strategies for relationship building with external letter writers. We plan to launch CAP with an inaugural networking reception during the 2013 annual meeting. Stay tuned for details in the final program. We look forward to another successful year and hope you can join us in Denver!

**SIGN OF THE TIMES: PART II**

they have family and friends involved in their life, and whether or not they want to be involved in their own medical decision making. People can choose the content that is most appropriate to their situation.

8. **PREPARE is actionable.** We developed questions that are asked throughout PREPARE, such as who may be able to play the role of a surrogate decision maker, whether or not this person has been formally asked to play that role, and what is most important in that person's life. PREPARE then collects this information into a summary that allows the individual to review the preparation steps that have or have not been completed. The user is then asked to make an action plan to complete one of the steps in the PREPARE program. Participants are encouraged to share the summary and their action plan with their clinicians, family, and friends.

9. **PREPARE is free to the public.** We decided early on to make PREPARE available to anyone who was interested. We depend on grants and donations to keep it going.

We have conducted preliminary studies, currently awaiting publication, that demonstrate that PREPARE is easy-to-use by both younger and older adults, that people like the website and are willing to use it, and that PREPARE results in significant improvements in confidence and readiness to engage in advance care planning and communicate one's wishes.

I believe the tide is turning in America and that people and their families are more open to talking about what is most important in life and for their medical care. They just need a road map. We hope that PREPARE, along with other excellent advance care planning tools, can help be the road map that empowers people and their families with concrete skills to identify and communicate their wishes and to make informed medical decisions.

**Acknowledgments:** The PREPARE website was created in partnership with People Designs, Inc. (http://www.peopledesigns.com), and with financial support provided by the Department of Veterans’ Affairs, the National Palliative Care Research Center, the Steven T. Bechtel Foundation, and the Hellman Family Foundation. PREPARE would not be possible without the blood, sweat, and tears of the project team and a great deal of support from colleagues, friends, and family.

**Suggested Reading**


GENERAL INTERNAL MEDICINE FELLOWSHIP
HARVARD MEDICAL SCHOOL

A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 7/1/14. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. Research areas of special interest include primary care, preventive medicine, vulnerable populations and healthcare disparities, and patient safety and quality of care. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year. For information, contact:

Rachel Quaden
HMS Fellowship in General Medicine and Primary Care
Beth Israel Deaconess Medical Center
1309 Beacon Street, Brookline, MA 02446
617-754-1434, rquaden@bidmc.harvard.edu, www.hms.harvard.edu/hfdfp.

The 2014 application deadline is 3/1/13. The participating institutions are equal opportunity employers. We encourage underrepresented minorities to apply.