FROM THE EDITOR

Interview with Steven Schroeder: Leading the National Commission on Physician Payment Reform

Priya Radhakrishnan, MD

I had the wonderful opportunity to sit down with Steven Schroeder, MD, chair of the National Commission on Physician Payment Reform. The brainchild of Harry Selker, SGIM past president, the Commission was charged with assessing current physician payment systems, incentives that drive physician’s care recommendations, and new payment systems to yield better results for both payers and patients. At the national meeting, which focused on innovation in health care, there was a lot of buzz about the Commission.

PR: How did you approach the work that was charged to the Commission?

SS: Harry (Selker) first approached me with his concern that bundled payments under ACOs (Accountable Care Organizations) created potentially perverse incentives for physicians to withhold needed care. He asked whether I would chair a commission on that topic. I responded that all forms of physician payment contained potentially perverse incentives, starting with fee for service. So Harry agreed to broaden the topic to physician payment reform, and we went from there. Initially, we were not sure whether we should address the SGR (sustainable growth rate) since it was so entwined with Washington politics. However, as we started doing our work, it became apparent that if we did not address the SGR, we would lack relevance.

PR: Atul Gawande recently tweeted, “Fee for service is dead.” How do you respond to this? Most practicing physicians do not believe this.

SS: I would say that the demise of fee for service has been predicted for some time now. Like Rasputin, it is very hard to kill. Many smart policy wonks think it will die soon; however, we will have to wait and see. I had the opportunity to meet Wilbur Cohen, the principal architect of Medicare, in the 1970s and ask him why Medicare incorporated the usual, customary, and reasonable fee schedule for paying physicians. He confessed that it was an attempt to gain the support of the American Medical Association, and in retrospect it was an unfortunate concession. But by then it was too late to change things.

continued on page 13
Awards from the 2013 SGIM Annual Meeting
Francine Jetton, MA

Ms. Jetton is the Director of Communications and can be reached at jettonf@sgim.org.

The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held April 24-27, 2013, at the Sheraton Downtown Hotel in Denver, CO. SGIM is proud and pleased to announce the recipients by category:

Recognition Awards
Robert J. Glaser Award was presented to David Bates, MD, MSc (Brigham and Women's Hospital), for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Elorna M. Rhodes Service Award was presented to Carol Bates, MD (Harvard Medical School), for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine.

Herbert W. Nickens Award was presented to Joanna Starrels, MD, MS (Albert Einstein College of Medicine/Montefiore). This award is presented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

Mary O’Flaherty Horn Scholarship was presented to Jessica Campbell, MD (Denver Health Hospital Medicine). This three-year grant is presented to outstanding junior medical school faculty to promote scholarship, advocacy, and creativity in the balance of work, family, and social responsibility.

Quality and Practice Innovation Award was presented to Priya Radhakrishnan, MD, and the St. Joseph’s Hospital & Medical Center, Phoenix, AZ. The award recognizes leaders of practice innovations who have improved care within the “quality” domains of the 2000 Institute of Medicine report Crossing the Quality Chasm: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equality or the patient-centered medical home goals of accessible, coordinated, patient-centered, team-based, and comprehensive care.

The ACLGIM UNLTD (Unified Leadership Training in Diversity)
When I was the director of our general internal medicine (GIM) fellowship, a colleague prepared the following advertisements for our recruitment efforts.

“The prestigious Johns Hopkins Division of Internal Medicine may design to consider applications from elite applicants. Prefer intense individuals with no outside interests from Ivy League training programs. Opportunities to work in presence of acknowledged world experts in fields of vital national importance. Opportunities also available in health promotion and clinical epidemiology. Dimly lit, poorly ventilated, cramped study carrels open 24 hours a day and on weekends. Modest salary support available for selected candidates.”

“Tired of sub-specialization? If you’re the type who likes people as much as you like science, we have just the right position for you. Nestled on Maryland’s coastal plain near the beautiful Patapsco River, our division is a happy oasis of generalism. Enjoy free-wheeling discussions about general topics having little to do with medicine and get paid for it. Linger in the café, read the classics, and bask in the warm fuzzy glow of Hopkins’ mellowest faculty. Minimal clinical duties and transcendent division director make this fellowship a complete New Age experience for the ‘90s.”

The author of those amusing advertisements was the same colleague who wrote a classic series of satirical articles in JAMA, including “The Art of Pimping,” “The Generic H & P,” and “Morning Dis-
NEW PERSPECTIVES

My First SGIM Meeting
John Anwar, MD

Dr. Anwar is a PGY-3 at St. Joseph’s Hospital in Phoenix, AZ.

This was my first SGIM meeting. I am a second-year internal medicine resident and have been involved in our practice transformation into a patient-centered medical home. Our practice was awarded the SGIM Clinical Quality and Innovation Award. Representing my residency program (St. Joseph’s Hospital, Phoenix, AZ) at the SGIM Annual Meeting was a new experience for me. After attending the meeting, I feel awe and appreciation for the rapid changes we are implementing in health care. I have gained lots of new ideas from this meeting that I will be bringing back to my institution to improve the quality of care I deliver to my patients. I met with amazing leaders, including Dr. Riley, who provided me with advice I will never forget. The medical education sessions that I had attended will improve how I teach medical students and new interns.

Leaving sunny warm Phoenix and arriving in cold Denver was a bit of a shock for me. Although the flight was short, I was unprepared to see snow on the ground. Living in Arizona has made me quite ill prepared for snow, and I had to relearn how to walk in the snow and avoid black ice from my time living on the East Coast.

April 24th, first day of the SGIM meeting. I attended the poster session and was impressed with all the ideas that were presented. Not surprisingly, there was a heavy emphasis on end of life, health care disparity, and quality of care reflecting an alignment with current health care reform. Two posters stood out for me. The first was “The Role of Cognitive Performance on the Relationship between Pain and Physical Function in Older Adult with Knee Osteoarthritis,” a poster presented by Natalia Morone. This poster opened my eyes to the importance of controlling pain in my elderly patients to slow progression of dementia. I have a fair number of older patients with osteoarthritis and chronic pain. I hope to bring awareness to this new perspective to the residents and faculty and hope to improve our treatment plans for these patients.

The second poster that I liked was “Prescription Picture.” The idea involves a pictorial display of pills and their mechanism of action, dose, and frequency in patients’ preferred language. I believe such a simple idea will facilitate patients’ understanding of their medications while empowering them to improve compliance. It will be interesting to incorporate this into a study to see its effect on patient outcomes and readmissions.

April 25th, the second day of the SGIM meeting. I went to the plenary session. Medical student Lily Munson presented an abstract on a student-run clinic titled “Remedy at UCSF: A Sustainable Student-Run Initiative.” This presentation showed how medical students can truly be an asset in reducing the amount of waste in our health care system. Each time I open a kit for a procedure, a large portion lands up in the trash unused.

The third presentation for this session was Shana Ratner’s “Creation and Evaluation of Multi-disciplinary Hospital Follow Up in an Academic General Internal Medicine Clinic.” This study takes a major step in delivering quality care and avoiding cost related to readmissions. A week prior to my arrival at the SGIM meeting, I was approached by the director of the outpatient internal medicine clinic at my residency program who is starting the same process. This approach will close the communication gap between the patient’s inpatient attending and PCP and will ensure that the patient receives appropriate post-discharge follow up within one week in case he/she cannot get to the PCP promptly. I wonder if this paradigm will lead to the birth of a new generation of physicians called “transitional internists.”

Clinician-educator careers were the focus of a mentoring panel that I attended. This session opened my eyes to the challenges that educators face, including finding protected time for research and competing for scarce research funding. Another challenge is the ability to teach and conduct research simultaneously. In several academic programs, there does not appear to be much faculty support for clinical work and education—research is the only way to attain tenure. I did not gain any insight on how to solve the challenge. I know that I eventually have to choose an institution for my practice that supports both clinical work and education of residents and students.

April 26th, the third day of the SGIM meeting. The second plenary session was by far my favorite. I was impressed by Dr. Riley’s honor lecture titled “Selma to Montgomery and Beyond: Health Disparities & Health Inequity in America.” Growing up in Egypt, I find that I am a novice in cultural competency. I stepped to the podium to ask Dr. Riley a question and get advice. “Do you think that African-Americans are still suffering from mistrust in the health care system? If yes, what piece of advice can you give me to help me in my career?” Dr. Riley looked at me and said, “John, the answer is yes about the mistrust, but you can change that. Show Mrs. Smith that you give a darn about her; sit down with Mrs. Smith and hold her hand and show her you truly care.” These words are still echoing in my mind. An audience member brought up the unconscious bias that we as physicians have but are often not aware of, and he referenced “Project Implicit.” It continued on page 15.
The National Commission on Physician Payment Reform and Health Policy Implications: Perspectives from a Hospital CEO
Scott V. Joy, MD, MBA, FACP, and Mimi Roberson, JD

Dr. Joy is medical director of High Street Primary Care, Presbyterian/St Luke’s Medical Center, in Denver, CO, and associate professor of internal medicine at the University of Colorado School of Medicine. Ms. Roberson is president and CEO of Presbyterian/St. Luke’s Medical Center and Rocky Mountain Hospital for Children in Denver, CO.

SGIM has endorsed the recommendations of the National Commission on Physician Payment Reform. For the recommendations from the report to be refined and executed, input from all key stakeholders will need to be elicited. In the spirit of administrative advocacy, I requested a meeting with Mimi Roberson, the chief executive officer of Presbyterian/St Luke’s (P/SL) Medical Center in Denver, CO, and asked her to review and provide insights regarding the report’s recommendations from the viewpoint of a hospital executive. For background, P/SL is a for-profit HCA hospital that assists in supporting a general internal medicine primary care training program and hospitalist program for the University of Colorado in collaboration with the Colorado Health Foundation. Prior to my request, she had not heard of the report but did quickly note that having Bill Frist as a co-chair of the Commission added extra value and credibility.

In regard to the specific recommendations, Ms. Roberson had a favorable reaction to the report’s effort to focus payment reform on the current disproportionate value proposition created by fee for service and to improve parity of payment for clinical services offered by primary care providers. Recommendations from the report to strengthen the outpatient management of patients with the intent to reduce unnecessary hospitalizations align well with the strategic goals of the hospital and thus are talking points to emphasize when advocating with hospital administrators.

Key recommendations of the report focus on converting from fee-for-service to value-based payment for clinical services. The complexities of multiple variables in play with chronic care management are not lost on hospital administrators. However, to make the recommendations more valuable and deliverable, it is critical to discuss with policy makers the importance of standardization of data definitions and the need to have uniform platforms to optimize sharing of clinical information across health systems to help make this recommendation a reality.

I was surprised to hear that recommendation #7, which discusses reimbursement for telemedicine services, was the one that caught her attention the most. Ms. Roberson’s viewpoint is that a robust method to enhance and encourage communication between internal and external referring providers is critical to reduce unnecessary hospital admissions and transfers. For this to happen, Ms. Roberson’s opinion is that credentialing will need to move from the current state-specific method to a process of national credentialing; thus, this could be an actionable advocacy point to discuss with policy makers.

The recommendations of the National Commission on Physician Payment Reform have the intent to fundamentally change how physicians are paid—and hospital executives interpret this statement to mean all physicians, not just primary care. For example, the report lacked commentary on income generated by physicians-owners of outpatient surgery centers. A possible unintended consequence could be that declining reimbursement for specialty services could result in cost shifting, with specialists looking to hospitals to buffer their financial losses. One mechanism to do this would be for specialists to leverage federal EMTALA rules that require hospitals to have full scope specialty call coverage. Specialists could begin asking the hospital to pay more for these professional relationships; therefore, it is reasonable to review these federal requirements with policy makers in this changing landscape of payment reform. Also not receiving comment in the report were work-life balance issues of today’s physicians and the consequences associated with income and benefits relevant to part-time providers.

So how can general internists be most effective for advocating at the hospital administrative level regarding the recommendations of the National Commission on Physician Payment Reform? In Ms. Roberson’s opinion, physicians are seen by hospital administrators as clinical partners, and it is important that hospitalists and outpatient physicians become united in patient management with hospitals and health care systems. The National Commission for Physician Payment Reform provides a vehicle to spur conversations between general internists and hospital administrators. The need for partnership and ongoing dialogue has never been stronger or more critical during this time of significant change in the systems of health care delivery.
A Case of a Young Adult with Cerebral Palsy: Addressing Medical and Non-medical Challenges During the Period of Transition

Himani Divatia, DO (presenter); Cory Allen Nourie, MSS, MLSP1; and David E. DeLaet, MD, MPH (discussants, in italic)

Morning Report is edited by Deepa Bhatnagar, MD. Dr. Divatia is a PGY-3 in the combined Internal Medicine and Pediatrics Residency Program at Christiana Health Care System; Ms. Nourie is a patient transition social work coordinator at Nemours A.I. duPont Hospital for Children; and Dr. DeLaet is an assistant professor of medicine and pediatrics at the Mount Sinai School of Medicine.

During an admission for aspiration pneumonitis, a 17-year-old female receives a consult from the Transition of Care (TOC) service for assistance in effective transition planning for her multiple medical and non-medical issues. Her past medical history is significant for cerebral palsy with spastic quadriplegia, severe neuromuscular scoliosis, delayed gastric emptying with associated gastroesophageal reflux disease, J-tube-dependent feeding, and recurrent aspiration pneumonitis. The patient is wheelchair dependent and requires total care at home, where she lives with her mother. The patient attends a special needs school for children with cerebral palsy. The team meets with the patient and her mother to discuss important aspects of transitioning from the pediatric- to the adult-oriented medical home.

YASHCN, also known as young adults with special health care needs, is a term used to describe young adults who require greater medical attention than their typical peer group and broadly includes individuals with a wide range of chronic physical and mental health conditions as well as those with developmental and mental disabilities. While moving from the pediatric world to the adult world can be stressful and unnerving for any adolescent, the transition for YASHCN is often fraught with multiple medical and non-medical challenges, as systems and eligibility for services change dramatically.

At present, the patient’s most significant medical issue is her severe neuromuscular scoliosis. She has a spinal curvature estimated to be more than 120 degrees and at least 100 degrees of pelvic obliquity, with resultant restrictive lung disease and exacerbation of her gastrointestinal symptoms. Despite the risks associated with the procedure, her orthopedic surgeon has recommended anterior and posterior spinal fusion surgery, and, in consultation with the patient’s pulmonologist, suggests that delaying surgery will only further complicate her medical picture and increase procedural risks. Her mother, however, has significant concerns about the risks of surgery and has elected not to pursue intervention at this time. The TOC team discusses identifying adult primary care and specialty providers and recommends an appropriate time frame for making a transition to adult care. It is also emphasized to the patient and her mother that pediatric orthopedic providers likely have greater experience in performing anterior and posterior spinal fusion than their counterparts who provide care for a predominantly adult patient population.

Identifying adult-oriented health care providers who are knowledgeable about pediatric-onset conditions and who are willing to accept new YASHCN into their practices has proven very challenging for pediatric providers. Information about childhood-onset conditions as well as the transition process is more likely to be reviewed in pediatric than adult care literature. Patients presenting for the first time with multiple complex medical problems at age 21 with little to no preparation for the realities of adult health care systems often prove challenging to the receiving adult provider.

The patient lives at home with her single mother and teenage siblings. Her mother would like for the patient to live at home as long as possible, although she recognizes that the patient’s ongoing care may eventually prove too challenging for the family and that the patient may ultimately require residential placement. Her mother is concerned about the quality of care she would receive out of home.

Parents’ plans to keep their young adult child living at home with them may be appropriate for a certain period of time but often become problematic as the physical care becomes challenging. Parents should be informed of residential options for their adult child and plan accordingly. Given that acceptance to a residential facility can involve potential lengthy wait times (perhaps as long as 10 years), parents should ideally register their adult child with their state’s residential service agency well before such services are needed.

The patient has outlined no specific plans for continuing education or vocational pursuits after her anticipated date of completion of high school, although she would like to work. Her mother is considering day program options. The patient does not use words to communicate, although she can express “yes” and “no” physically and appears to understand much of what is verbally communicated to her. She does have a communication device that she uses at school, but it is getting more difficult for her to use the device because of her positioning needs.

continued on page 14
1. Thoughts on pre-rounding? One debate is the utility of interns and students pre-rounding. Have any programs or institutions moved away from pre-rounding or cut it out altogether?

This was a lively discussion of new innovative approaches to eliminate redundancy and change the structure of the rounding process. We are in a new world, folks—one that exists in the matrix of our computers. The competing forces of traditionalism and modernism seem to make us pick one side over the other. There was a spirit of compromise in the cloud. In Bob Centor’s own words: “Since the goals of rounds are multiple, I believe that we must have learners pre-round and make a personal commitment in order for them to grow.”

2. The role of nurse practitioners caused a stir in the community on the heels of the New England Journal of Medicine article. There was lots of information to be gleaned about the competencies of NPs and their roles. An interesting aspect about studies on the effectiveness of NPs was presented by SGIM President Eric Bass.

3. The changes in the ABIM MOC did not offer a silver lining in this cloud for those of us who will be recertifying soon. It was, however, a good place to ask questions. Eric Green, SGIM chair of the MOC Task Force, is online, waiting to hear from you.

GIM connect is a great way to connect with colleagues, share best practices, and seek solutions. I hope that we will use this wonderful platform to share and connect, while waiting for the next national meeting. Look out for the article posts on GIM Connect.
He served as an outstanding model for anyone who aspired to be a leader in GIM. The first reason that Fred was a fabulous candidate for the award was that he was an outstanding mentor. His mentorship included people at all levels of career development—students, residents, fellows, junior faculty, and senior faculty. In their nominating letter, Jeanne Clark, Felicia Hill-Briggs, and Jessica Yeh explained that Fred “encouraged and enabled each of us to pursue new projects independent of his research program. This is one of the key qualities, we believe, of an excellent and confident mentor—the ability to allow mentees to spread their wings and fly without hindrance or insecurity.” They also noted that Fred “openly [discussed] the racial and gender-based barriers in promotion and leadership opportunities and vigorously [positioned] his mentees to overcome them.”

One faculty member, Madhav Goyal, said that “he bent over backwards to support us.” Another mentee, Sherita Hill Golden, cited eight things she learned from Fred. Number one on the list was that “in the midst of scientific discovery, the most important discoveries are what your children did at school and how your family is feeling.”

Fred also distinguished himself by the extent of his commitment to faculty development. He was bold enough to shine the light on inequities in faculty compensation by publicly displaying data on salaries. This gave the faculty the information they needed to achieve equity in support. Lenny Feldman noted, “His joie de vivre motivates us all. I don’t believe that employees are supposed to look forward to their annual reviews, but there is nothing better than meeting with Fred for that hour each year.” Fred was extremely effective in developing the infrastructure and resources that faculty needed to be successful in their work, and he did so in a consistently equitable manner. As Steve Sisson said, “Fred has a clear vision for the direction of the Division, has the ability to get the right people in place to move toward that vision, and is selfless in crediting those contributing to the greatness of the Division.”

At Hopkins, Fred was a highly visible leader. He frequently called attention to the important contributions being made by general internists in medical education, clinical research, and public health policy. As Nisa Maruthur put it, “I would never have considered a career in GIM had Dr. Brancati not been so enthusiastic in promoting academic GIM to our residency program. He helped me make a great decision, and I have never looked back.” Pat Thomas captured this aspect of Fred’s leadership very well when she said, “Way back in the days when we were not allowed to have the word ‘general’ in our divisional name, I was asked to chair the regional SGIM meeting at Johns Hopkins. Fred’s helpful suggestion was that we should title it ‘From the Belly of the Beast’… Fred has been responsible for raising and nurturing the GIM beast that now commands its own respect.”

Regarding Fred’s commitment to recruitment and retention of faculty, Zack Berger said, “His help, confidence, and advocacy have made Hopkins GIM the most supportive and congenial place I have ever worked.” Division member Gail Geller said, “He provided me with that [academic] home and has made me feel welcome ever since. I can’t think of anyone who is better at supporting faculty in times of need.” Geetanjali Chander added, “Fred is deeply committed to equity and diversity within the Division of GIM and the institution as a whole.”

Overall, Fred was amazingly successful in promoting harmony and a unified sense of pride in the Division. Division Chief David Levine, his predecessor, was proud to say that Fred took the Division to “a whole new level of scholarship, creativity, and clinical excellence.” John Flynn and Dan Brotman wrote, “In an era of increasing fragmentation of GIM divisions, Dr. Brancati’s belief that the whole is more than the sum of its parts—and his insistence that all Division members embrace this goal—has allowed for remarkable synergy.” He accomplished that by regularly looking for opportunities to connect people within the Division, by treating everyone fairly, and by celebrating the accomplishments of everyone. He allocated precious resources from his own funds to get the entire Division together every year for a celebratory party. In his own uniquely creative and humorous manner, he insisted that the Division select a dance anthem for each party. He wanted us to have fun and not take ourselves too seriously.

In recognition of Fred’s tremendous contributions to the field of GIM, going far beyond Hopkins, SGIM is creating a new national award in Fred’s honor. According to Fred’s wishes, the award will recognize a junior faculty member who has helped to inspire trainees to pursue a career in GIM. Fred thought this would be a nice way to recognize faculty who do not always get credit for their important role and who may not get recognized by the other awards SGIM has for educators, researchers, and trainees. My hope is that the Brancati Award will sustain the spirit that Fred brought to GIM with his humor, creativity, and core values, as exemplified by his insistence on having a dance anthem as part of the celebration of noble accomplishments. Maybe your group should have a dance anthem, too!

References
4. Pierach CA. And nor are we. JAMA 1992; 267:807.
FROM THE SOCIETY
continued from page 2

Award was presented to Phyllis Nsiah-Kumi, MD, MPH (University of Nebraska Medical Center); Erik A. Wallace, MD, FACP (University of Oklahoma School of Community Medicine); and Ana Palacio, MD, MPH (University of Miami Miller School of Medicine). This award recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM.

ACLGIM Leadership Award was presented to April Fitzgerald, MD (Johns Hopkins University School of Medicine). This award recognizes skills in leadership in any number of areas of academic medicine, including clinical, educational, research, or administrative efforts for faculty members within their first 10 years of appointment.

Research Awards
John M. Eisenberg National Award for Career Achievement in Research was presented to Rod Hayward, MD (Ann Arbor VA & University of Michigan), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, conduct research, or educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator was presented to Monica Peek, MD, MPH (University of Chicago), for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research and Mentorship Award was presented to Louise Walter, MD (University of California, San Francisco), in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper was presented to Alexander Smith, MD, MS, MPH (University of California, San Francisco), for his publication “Half of Older Americans Seen in Emergency Department in Last Month of Life: Most Admitted to Hospital, and Many Die There” (Alexander K. Smith, Ellen McCarthy, Ellen Weber, Irena Stijacic Cenzer, John Boscardin, Jonathan Fisher, and Kenneth Covinsky. Health Affairs 2012; 31(6):1277-85.) This award is offered to help members gain recognition for papers that have made significant contributions to generalist research.

Founders Award was presented to Melissa B. Weiner, DO, MPH (Oregon Health & Science University Department of Medicine), for her proposal titled “Evaluating a Chronic Opioid Therapy Dose Reduction Policy in Primary Care.” The SGIM Founders Award provides $10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to establish a strong research funding base.

Clinician-Educator Awards
National Award for Career Achievements in Medical Education was presented to Patricia Thomas, MD (Johns Hopkins University School of Medicine), for a lifetime of contributions to medical education.

National Award for Scholarship in Medical Education was presented to Reena Karani, MD (Mount Sinai School of Medicine), for her individual contributions to medical education in one or more of the following categories: scholarship of integration, scholarship in educational methods and teaching, and scholarship in clinical practice.

Mid-Career Mentorship in Education Award was presented to Monica Lypson, MD (University of Michigan Medical School). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician educators.

Presentation Awards
Mack Lipkin, Sr., Associate Member Awards were presented to the scientific presentations considered most outstanding by students, residents, and fellows during the SGIM 36th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zinkoff Fund for Medical Education. The award winners for 2013 are:

- Shreya Kangovi, MD (Philadelphia Veteran Affairs Medical Center), “A Randomized Control Trial of a Community Health Worker Post-Hospital Care Transitions Intervention for Low Socioeconomic Status Patients”
- Jonathan Lee, MD (University of Pittsburgh Medical Center), “National Trends in Processes and Outcomes of Care for Elderly Patients Hospitalized for Pneumonia”
- Christine Kolehmainen, MD (William Middleton Veteran’s Hospital), “Gender and Leadership in Cardiopulmonary Resuscitation”

Milton W. Hamolsky Junior Faculty Awards were presented to the scientific presentations considered most outstanding by junior faculty during the SGIM 36th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zinkoff Fund for Medical Education. The award winners for 2013 are:

- Donna Zullman, MD (Stanford University and VA Palo Alto Division of GIM), “Multimorbidity and Healthcare Utilization Among High-Cost Patients: Implications for Care Coordination”
- Jeffrey Kulgren, MD, MS, MPH (University of Michigan), “Trends in and Correlates of Awareness of a Prediabetes Diagnosis Among US Adults”
- Jacinda Nicklas, MD, MPH, MA (University of Colorado School of Medicine)
FROM THE EDITOR
continued from page 1

**PR: Is the Commission a primary care initiative? Should we not align with the other primary care organizations? So far the ACP (American College of Physicians) is the only organization that has, sort of, supported it.**

SS: I believe that this is not a primary care only issue. It’s an issue that affects the neurologists, cardiologists, pediatricians, and family docs—everyone. How you pay physicians affects everyone. It is also important to note that we did have representation from other fields in the Commission—we had a cardiologist and a pulmonologist and a cardiac surgeon. Rather than posing this as primary care against everyone else, the Commission decided to make common cause with all physicians who use evaluation and management (E & M) services.

**PR: With health reform, ACA, do you worry that rather than cost savings, we are only moving toward cost shifting?**

SS: The ACA was really charged with expanding coverage rather than actual cost containment. It did contain some cost containment features, but they are much less robust than the coverage expansion features.

**PR: Did the Commission address student debt? A couple out of medical school easily can start out with a combined debt burden of around $600K. We have seen that it does have some effect on the choice of specialities, particularly those who are more open in career choices.**

SS: The Commission did spend some time talking about student debt, but addressing it fell outside the charge of the Commission. My (personal) opinion is that medical education is much too expensive and that graduating with large debt exerts unfortunate influences on subsequent career choices. However, I don’t believe that the debt burden is the only thing influencing student career choice. Lifestyle issues, including the ability to do shift work, are important for this generation—exemplified by the ROAD (radiology, ophthalmology, anesthesiology, and dermatology) specialties. Also I think primary care is not for the faint hearted—many students want to be masters of their domain, and it is harder to fully master the myriad conditions that present to the primary care physician.

**PR: As we look at value in the context of physician payment reform, can you comment on supply? It is estimated that we will be adding about 15 to 20 million more patients to a system that is already stretched. There appears to be a looming shortage in primary care.**

SS: It is time for the development of teams and leadership. States won’t pay a lot for Medicaid services, and it is likely that access may be restricted. Many doctors won’t accept Medicaid, and it is conceivable that federally qualified health centers and county hospitals and clinics will see the bulk of these newly insured patients. The Massachusetts experience worked relatively well but started from a high level of population insurance coverage to begin with. Each state will probably contrive a different solution, and there will be no magic bullets. NPs and PAs will surely play an important role, but in some states, like California, we are seeing that they are quite expensive and that they too have a problem with numbers choosing primary care. The emergence of concierge primary care is a fascinating new market place phenomenon. On the one hand, it clearly represents a protest against the pace and reimbursement of ordinary primary care. It seems to be flourishing in high-income areas where wealthier people are willing to pay the concierge fee in order to get the kinds of service they want. As such, concierge care is clearly in conflict with the egalitarian impulses of most SGIM members. On the other hand, to the extent that it sends a message to influencers, who find it hard to locate a primary care physician, that might generate more favorable reimbursement and other policies to help strengthen primary care.

**PR: How will you operationalize this report?**

SS: The next step is for the public, CMS (Centers for Medicare & Medicaid Services), and Congress to comment. I believe that there is bipartisan support for the 12 recommendations of the Commission. Medical costs are out of control, and now is the time to act. I have more confidence than before that we may see some action, although clearly the climate in Washington makes it very hard to pass reform legislation of any type. The private payers understand as well that we need to act, but will they do the right thing? All the lobbies are hard at work and powerful; primary care needs to make allies with other medical specialties in order to achieve physician payment reform.

**PR: What can the primary care doctor do to support the work of the Commission?**

SS: Write to your Congress representatives and senators—find influencers and support candidates who will help us. Write Op-Eds for newspapers, radio. It is interesting how primary care doctors are so persuasive when it comes to their patients and are such strong advocates; yet when it comes to our field, we are not. Also, the extent to which primary care physicians have access to health insurance executives is another route to payment reform. Remember that “the moral arc of the universe is long but it bends towards justice.” I am reassured and impressed that medical students continue to go into medicine for the right reasons—nourish and nurture them. While primary care practice can be challenging, it is a rewarding field.
There is a continuum of vocational programs available for adults with disabilities. A day program focuses on social and recreational life for participants but not usually job skills. However, certain medical needs (such as the presence of a feeding tube) might limit which day programs a young adult can attend, as local policy may dictate that a nurse must be on staff to manage these needs. Young adults with disabilities who are interested in working should contact their state Office/Division of Vocational Rehabilitation (VR) for assessments, guidance, and support. VR services can range from supported employment with a job coach to helping pay for modifications to one’s car to assist with transportation to work. Those YASHCN wishing to pursue post-secondary education should be made familiar with provisions in the 1990 Americans with Disabilities Act that support their admission to schools and mandate the provision of academic adjustments that assist their learning.

The TOC team also discusses the legal status change that will occur on her 18th birthday, offering resources for health care power of attorney and guardianship for the patient and mother to consider.

Becoming an adult, legally, occurs in most states on one’s 18th birthday. This means that medical decision making and consent for evaluation and treatment falls to the young adult. When a person is believed to have such significant intellectual disabilities that he/she cannot make a legally binding decision for himself/herself, a parent may decide to file for guardianship. The decision to appoint a guardian means that the young person is determined to be incompetent to make decisions. Alternatives to guardianship like health care power of attorney allow young adults to maintain their autonomy but authorize parents (or another chosen adult) to access medical information and assist in decision making.

The TOC team was again consulted when the patient was admitted at age 18 for a five-month hospitalization due to complications of aspiration pneumonitis. Her mother has been appointed legal guardian. Her mother continues to refuse surgical intervention due to the perceived risks, although she recognizes that her daughter’s condition will likely continue to deteriorate. The palliative and supportive care team is consulted to help support the patient and her mother with comfort care. Upon hospital discharge, the patient is approved for eight hours of nursing per evening to help relieve the mother’s caregiving stress. A short time later, the mother contacts the TOC team social workers. She is distraught because she has been notified that her daughter, now age 19, will lose her nursing services in two days. After multiple phone calls by the social workers, Medicaid office, and home health care agency, it is determined that the patient’s mother overlooked several letters informing her of the need to choose a long-term Medicaid option upon her daughter turning 19 to maintain home nursing. An exception was granted, and the family elected for long-term care coverage that afternoon, ensuring that the patient would be able to keep her home nursing supports in place.

Insurance changes happen at specific ages. A child ages out of the state’s Children’s Health Insurance Program (CHIP) on his/her 19th birthday. Many YASHCN are eligible to apply for their state’s Medicaid on their 18th birthday. Some states link Supplemental Security Income (SSI) eligibility to Medicaid; thus, if the individual qualifies for and receives SSI, he/she is automatically enrolled in Medicaid as well. Some YASHCN are able to receive Medicare if a parent who has paid into Social Security becomes disabled. The Affordable Care Act extended coverage for young adults on a parent’s private health insurance until age 26, which helps some YASHCN make the transition to adult-centered care more smoothly. However, many YASHCN may again need to change providers after age 26, when they are no longer eligible to remain on their parents’ insurance plans.

At present, the patient is receiving nursing services in school as well as home nursing in the evenings and weekends so that her mother can continue to work to support the family. She has been given information on job programs as well as day programs, group homes, and nursing homes. The TOC team is working with the family to identify a primary care provider who will be comfortable managing the patient’s multiple complex medical issues in collaboration with adult-oriented subspecialty providers while continuing to focus on general well-being and preventive health concerns. The TOC team will continue to offer support until the patient turns 21.

Key Learning Points
1. Some YASHCN benefit from a well-coordinated transition plan with multi-disciplinary support as they move from pediatric to adult-oriented care systems.
2. YASHCN face many non-medical as well medical challenges as they navigate this transition period.
3. Health care practitioners providing care to YASHCN should be familiar with available resources that might ease the burden of transition.

References
2. Pacer Center. ADA Q & A: continued on page 15
FROM THE SOCIETY

continued from page 12


SGIM Clinical Vignette Oral Presentation Award was presented to Kavel Visrodia, MD (Mayo Clinic Rochester), for his presentation “A Puzzling Case of Nausea ad Nauseum.” This award recognizes the best presented clinical case by a medical student, internal medicine resident, or GIM fellow (not faculty) at the SGIM annual meeting.

Best Cancer Research Oral Presentation Award was presented to Nancy Rigotti, MD (Massachusetts General Hospital), for her presentation “Promoting Smoking Cessation after Hospital Discharge: The Helping HAND Randomized Controlled Comparative Effectiveness Trial.” This award recognizes the top-ranked and reviewed abstract presentation in the cancer research track at the annual meeting.

Best Cancer Research Poster was presented to Richard Hoffman, MD, MPH (New Mexico VA Health Care System), for his poster “Poorly Informed Decision Making for Cancer Screening: Results from a National Survey.”

Outstanding Quality/Patient Safety Oral Presentation Award was presented to Gina Kruse, MD, MS, MPH (Massachusetts General Hospital), for her presentation “Overuse, Underuse, and Misuse of Colorectal Cancer Screening Tests.” This award recognizes those who present the most outstanding oral abstract presentation related to quality assessment, gaps in quality of care, medical errors, quality improvement, or patient safety in the inpatient or outpatient setting at the SGIM annual meeting.

Best Geriatrics Abstract Award was presented to Rebecca Sudore, MD (University of California, San Francisco), for her abstract “A Novel Website to Prepare Diverse Older Adults for Decision Making and Advance Care Planning: A Pilot Study.”

Best Geriatrics Poster was presented to Rebecca Eskin (Columbia University College of Physicians and Surgeons) for her poster “Status of Advance Directive and Goals-of-Care Discussions in a University-Affiliated Community Hospital.”

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NEW PERSPECTIVES

continued from page 4

is a cognitive test by Harvard that tests unconscious bias. I went home and took the test (Race IAT), finding the results quite interesting: I too had biases. I will bring this test to my residency program and ask all doctors and nurses to take it to help them recognize their biases.

Another great idea that was discussed in the same plenary session was the use of the Internet in patient care. Jacinda Nicklas presented “A Web-based Lifestyle Intervention to Decrease Postpartum Weight Retention in Women with Recent Gestational Diabetes Mellitus: the Balance after Baby Pilot RCT.” This is a great tool that can be utilized to promote better health in a support group format. I may use the same concept for my diabetic patients, as it will help build community among patients who are taking control of their lives. I am not sure yet about the legality or privacy issues, but it is an idea to consider.

A session that I benefited from was Robert Smith’s workshop titled “Improving Efficiency, Effectiveness, Patient Satisfaction, and Health Outcomes and Reducing Disparity Through Evidence-based, Patient-centered Interviewing.” He described a new stepwise strategy in patient interviewing that empowers patient and improves the quality of care by tapping the patient’s psychosocial characteristics. I find that patient interviews are challenging to manage time wise and think that all residents will benefit from learning these strategies, irrespective of their career choices.

I was very satisfied with the meeting content and intrigued by the vast array of ideas and research that was presented. I return to sunny Phoenix enriched. SGIM will become my professional home. I will make sure to try to attend all the national meetings and will never forget the warm friendly feeling that I experienced in Denver.

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MORNING REPORT

continued from page 14


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