SGIM Announces the Formation of the Adults with Complex Conditions Originating in Childhood Task Force
Gregg Talente, MD, MS, and Jennifer LeComte, DO

Dr. Talente is associate professor of medicine and pediatrics at the University of South Carolina School of Medicine and chair of the Adults with Complex Conditions Originating in Childhood Task Force. Dr. LeComte is assistant medical director of the AMO at Christiana Care Health System and co-chair of the Adults with Complex Conditions Originating in Childhood Task Force.

It is very exciting to announce the formation of the Adults with Complex Conditions Originating in Childhood Task Force. The SGIM Council approved the formation of this new task force in September. The March and April issues of SGIM Forum focused on a selection of issues young adults with complex and disabling conditions originating in childhood face, some of the barriers to care, and the challenges general internists encounter when providing care to these patients. The role of the Adults with Complex Conditions Originating in Childhood Task Force will be to work within SGIM and represent SGIM nationally in promoting improvements in the care of these patients through education, research, and advocacy.

The topic of how to provide the best care for adults with complex and disabling conditions originating in childhood has been discussed for decades but has received increasing attention from national organizations as well as federal and state government in the last few years. In concordance with this increased focus, the Transitional Care for Youth with Chronic Disease Interest Group, founded in 2005, submitted a request to the SGIM leadership for the creation of this task force. We believe the time has never been better for SGIM to take a larger role in addressing the needs of this patient population and to build connections with external organizations and coalitions working in this area.
Care Coordination with Electronic Health Records
Neeraj H. Tayal, MD

In 2004, Burton and colleagues from Johns Hopkins University described how the coordination of care for people with chronic health problems was inadequate due to the limitations of the paper medical record. They argued that by transitioning to electronic health records (EHRs), coordinating care across settings would be vastly improved. They argued that EHRs should be created to facilitate the exchange of clinical information among health care workers, that a regional governance structure should be established to encourage the exchange of data, and that payments should be made to health systems and physicians who convert to EHRs.

That was 2004, almost 10 years ago. Fast forward to 2013. A majority of hospital and physician groups have replaced paper with EHRs. They have created a common health record to be shared among health care providers. Many are now collecting incentive payments for having done so through the “Meaningful Use” program. Depending on the region of the country, there may even be regional governance structures in place to facilitate the exchange of information between health systems. Now, as health systems pivot to a model of bundled payments, accountable care organizations, and population management, we need to develop an understanding of what coordinated care really looks like. We need to learn how to apply a common understanding of coordinated care, and we need effective tools to carry out these activities in a very complex work environment.

Unfortunately, many physicians remain frustrated with electronic system problems. They often voice anger over performing “clerical work” and serving as “transcriptionists.” They describe spending more time typing than caring for patients. For many, EHRs are fragmented, with multiple systems failing to properly interface. Information contained within the EHR may be difficult to find, sometimes requiring users to navigate to multiple screens. Precious time is lost, and it is difficult to impossible to focus on value-added elements such as coordinating care. We are left asking, “Can electronic systems actually hinder the coordination of care?”

It is time to get back to the basics of what coordination really means.

In 1990, Malone and Crowton published a paper defining what they called “coordination theory.” They included a description of elements needed for designing “successful cooperative work systems.” They started with the American Heritage Dictionary, which defined coordination as “the act of working together harmoniously.” From there, they developed a more refined definition: “The act of managing interdependencies between activities performed to achieve a goal.”

They describe the following components of coordination:

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As one of the “friends” of the Agency for Healthcare Research and Quality (AHRQ), SGIM is concerned about threats to the support for AHRQ. In recent years, AHRQ has struggled as Congress and others have debated how much funding the Agency should receive for its work. On September 27, I had an opportunity to meet with the new director of AHRQ, Richard Kronick, PhD, and his acting deputy director, Boyce Ginieczki, PhD. The meeting was arranged by Lyle Dennis from Cavacocchi-Ruscio-Dennis Associates, LLC, the company that supports SGIM’s advocacy efforts. I was accompanied by SGIM’s Health Policy Committee (HPC) Chair Mark Schwartz.

We requested the meeting because of the importance of AHRQ to the health services researchers among our members and concerns about the future of AHRQ. When the House of Representatives recently proposed a budget that included no support for AHRQ, we realized that we could not take for granted the support that AHRQ has provided for the types of research needed to achieve our vision for better health care in the United States. According to SGIM’s mission statement, we seek to “achieve health care delivery that is comprehensive, technologically advanced and individualized; instills trust within a culture of respect; is efficient in the use of time, people, and resources; is organized and financed to achieve optimal health outcomes; maximizes equity; and continually learns and adapts.”

We prepared for the meeting by conducting a quick survey of members of the HPC and selected members known to be very involved in health services research. Thanks to Gary Rosenthal (chair of the Research Subcommittee of the HPC) and SGIM’s office staff, we were able to design and administer the survey in less than two weeks. From that survey, we identified themes or concerns that we wanted to discuss with the new AHRQ director: 1) the importance of defining AHRQ’s unique role in supporting health care research focused on creating value for patients; 2) AHRQ’s role in developing, synthesizing, and disseminating evidence on how to translate research into practice and policy to improve health care; 3) the critical need for increased support for training and career development in health services research; 4) the need for increased support for development of methods and infrastructure for policy-relevant health services research; 5) a call for improved collaboration and coordination with other governmental agencies (e.g. National Institutes of Health (NIH), Patient-Centered Outcomes Research Institute (PCORI), Centers for Medicare and Medicaid Services (CMS), and Health Resources and Services Administration (HRSA)); and 6) a call for an expanded portfolio of innovative investigator-initiated health services research.

In preparation for the meeting, we reviewed the budget request for fiscal year (FY) 2014 that was submitted to the Congressional Appropriations Committees by Dr. Carolyn Clancy before she was succeeded by Dr. Kronick. Dr. Clancy highlighted the efforts that AHRQ had made, amid considerable economic uncertainty and fiscal constraints, to fulfill its mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. She emphasized the importance of the Agency’s programs in six areas of research: patient-centered health research and effective health care; value research; prevention and care management research; health information technology research; patient safety research; and research innovation (i.e. investigator-initiated research). The total amount requested as part of the President’s 2014 budget was $433,697,000 ($28.6 million more than in FY 2012), with $100 million for patient-centered health research (funded entirely by the Patient-Centered Outcomes Research Trust Fund), $3.3 million for value research ($0.5 million less than FY 2012); $20.7 million for prevention and care management research ($7.2 million less than FY 2012); $25.6 million for health information technology.
MORNING REPORT

A 61-year-old Man with Acute Kidney Injury and Pruritic Skin Nodules
Joan How, MS3 (presenter), and Juliette F. Spelman, MD (discussant, in italic)

Ms. How is a medical student at the Yale University School of Medicine, and Dr. Spelman is a primary care provider at the VA Connecticut Health Care System and assistant professor at the Yale University School of Medicine.

A 64-year-old African-American male presents with a two week history of tender, itchy “skin pimples” associated with fatigue, malaise, and loss of appetite. He has a significant past medical history of chronic hepatitis C, alcohol dependence with recent relapse, acute pancreatitis, and upper GI bleeding from gastric arterio-venous malformations (AVMs). He denies fever or chills. Examination shows weight loss of 10 pounds, normal blood pressure, and normal cardiac and respiratory exams. There are multiple 5 to 6 mm exoriated skin-colored papules of differing stages on the patient’s arms, back, chest, and face. He is also found to be guaiac positive. Subsequent lab values show significant acute kidney injury, with a BUN of more than 125 and a creatinine of 16.9. His last BUN and creatinine were 16 and 1.8, respectively, four months prior. In addition, the patient is severely anemic, with a hematocrit of 20.6 (decreased from 27 four months ago). He has a normal white blood cell and platelet count, a normal CPK, and normal coagulation studies.

This patient’s general malaise, fatigue, and loss of appetite are attributable to both his acute kidney injury and his anemia. It is initially thought that the multiple pruritic skin nodules are a manifestation of his kidney failure, particularly an acquired perforating dermatosis. These often present as multiple cone-shaped keratotic papules and nodules in patients with end-stage renal disease.¹

In general, the approach to acute kidney injury focuses on establishing either a pre-renal, intrinsic, or post-renal etiology. A potential cause entertained in this case is pre-renal hypo-perfusion from gastrointestinal bleed from his AVMS and subsequent acute tubular necrosis (ATN). We also consider multiple myeloma as a unifying diagnosis that may explain both his severe anemia and kidney failure (with protein deposition from light chains causing ATN). Finally, we are concerned about other causes of intrinsic renal failure given the severity of presentation, including glomerulonephritis, small vessel disease, or acute interstitial nephritis (AIN).

Upon further questioning, the patient denies any recent changes in urinary frequency or blood in urine. He denies any new or recent changes in medication, use of over-the-counter medications such as NSAIDs, or recent procedures. Renal ultrasound is negative for any evidence of obstruction. Urinalysis reveals trace blood, 7 WBC/hpf with eosinophils, and 1 granular cast and is negative for leukoestersases, nitrates, protein, and RBC casts. His urine sodium is 78, with an estimated FENA of more than 25%.

A normal clinical exam and normal fractional excretion of sodium make a pre-renal cause unlikely. Similarly, the normal ultrasound without evidence of outflow obstruction rules out post-renal sources. We are left with a potential intrinsic etiology. The urinalysis showing WBCs and eosinophils is suggestive of AIN. The lack of dysmorphic RBCs, RBC casts, or protein makes glomerulonephritis unlikely. Similarly, the paucity of granular casts makes ATN less likely as well, though it is possible that the insult happened far enough in advance of his presentation to result in a bland urinalysis.

Due to the severe renal failure and anemia, the patient is admitted and transfused with an appropriate response in hematocrit. Over the next five days, he is noted to have adequate urine output of more than 1,000 cc per day but with little improvement in BUN and creatinine. Serum total protein and calcium are normal, and subsequent SPEP testing and serum light chains come back negative.

Given the severity of presentation, lack of improvement of function over time, and evidence of inflammatory cells in his urine to suggest possible AIN, we opt to pursue renal biopsy as the next diagnostic step. Although indications for renal biopsy in the setting of acute kidney injury remain undefined, biopsy may be sought when non-invasive evaluation is unable to identify a diagnosis in the face of acute or rapidly progressive dysfunction or when there is lack of recovery in kidney function over time.² It is also important to consider biopsy when there is evidence of glomerular involvement (i.e. either nephrosis or nephritic syndrome).

We also pursue a skin biopsy to further assess the etiology of his skin eruption. Finally, upper and lower endoscopies are performed to establish cause of his anemia and hemo-positive stools.

Results of renal biopsy show significant oxalate nephropathy as the primary cause of the patient’s renal failure. On further questioning, the patient denies consumption of ethylene glycol, although he appears uncomfortable when talking.

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A new term—the learning health system (LHS)—has recently entered the vernacular of academic medicine. While advancement of knowledge has long been a central goal of academic medicine, the LHS takes this traditional perspective further to create health care systems in which “…‘science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience’” (Institute of Medicine, 2006).

Inherent in creating LHSs is the ability to test different treatments, diagnostic modalities, or strategies for organizing care using rigorous research designs that can produce the high-quality data needed to improve clinical decision-making. Such approaches are typically more rigorous than most quality improvement evaluations and often require randomizing patients to different groups in an effort to eliminate the selection bias that impacts most treatment decisions. However, our ability to conduct these types of studies in practice is hampered by the current regulatory climate, which can create tremendous obstacles if a practice-based evaluation is considered research. Thus, if the LHS is to become a reality, a new framework for regulating low-risk practice-based research is urgently needed.

This critical agenda was recently taken up in a report released last January from the Hastings Center that challenges our current approach to regulating practice-based research. The report includes two articles by Nancy Kass, Ruth Faden, and colleagues that lay out a provocative new framework that blurs the traditional distinctions between research and practice.

The first article by Kass and Faden1 systematically reviews five features currently used to distinguish research from practice—that, in contrast to practice, research: 1) involves the production of generalizable knowledge; 2) requires systematic investigation; 3) offers patients less net clinical benefit and greater risk; 4) introduces burdens or risks that are otherwise not part of patients’ clinical management; and 5) uses protocols, such as randomization, to dictate which treatments or diagnostic interventions a patient receives. In a wonderful series of examples, Kass and Faden systematically identify problems with each of the distinguishing features and conclude that the features are out of date.

For example, as health care organizations move to become integrated systems of care, the development of generalizable knowledge to benefit both current and future patients will be an explicit objective of these arrangements. Thus, the intent to produce generalizable knowledge will become an unreliable way of distinguishing research from practice.

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An observant Jew is admitted to the hospital for cardiac surgery. The night before surgery, he speaks with a friend, and the topic of medications comes up. His friend asks him if he is planning to use any medications made of pig and suggests that he can and should ask for non-pork-derived products. The patient is panicked and asks to speak with the doctor to pre-empt the possible use of pork products in his medical care. During the discussion with the doctor, the patient says that he is an observant Jew and can’t consume pork products. The doctor answers, “It’s my understanding that medications made from pig are okay for you to use.”

Two of the world’s religions, Judaism and Islam, have prohibitions on the consumption of pork. There are commonly used medical products that may be derived from pork, such as heparin, some immunizations, and gelatins used to make capsules. Does the ban on pork consumption include medications or medical products? Do we need to ask patients if they have any dietary restrictions before we prescribe medications?

Religious laws are often subject to varying interpretations. According to Rabbi Tzvi H. Weinreb, emeritus executive vice president of the Orthodox Union, “Pig derivatives are only prohibited to be ingested via normal digestive processes. There is no prohibition whatsoever against using or gaining benefit from pig or pig derivatives intravenously or as cosmetics or, for that matter, as the main component of a football.”

Even oral medications made with pork products are permitted; Rabbi Weinreb adds, “Given that the pig product is so vitally necessary to the health and well-being of the patient, it would be permissible for the patient to ingest it.” Judaic law recognizes medical necessity and the primacy of the health and well-being of the patient. This view is supported in a letter by Rabbi Abraham Adler of the Kashrus and Medicines Information service:

“It should be noted that according to Jewish laws, there is no problem with porcine or other animal derived ingredients in non-oral products. This includes vaccines, injections, suppositories, creams, and ointments.” —Rabbi Abraham Adler, MRPharmS July 31, 2003

What about Islam? In 1995, a seminar was convened by the Islamic Organization for Medical Sciences, titled “The Judicially Prohibited and Impure Substances in Foodstuff and Drugs.” The findings of more than 100 Islamic legal scholars who met to clarify Islamic purity laws became the basis for a letter written in July 2001 by the Regional Office of the World Health Organization (WHO) for the Eastern Mediterranean. Quoting from a statement issued by the scholars, the letter states:

Transformation, which means the conversion of a substance into another substance, different in characteristics, changes substances that are judicially impure... into pure substances and changes substances that are prohibited into lawful and permissible substances.

Consequently, the scholars determined that the transformation of pork products into gelatin alters them sufficiently to make it permissible for observant Muslims to receive vaccines containing pork gelatin and to take medicine packaged in gelatin capsules.

That judgment was made in 2001. A search of Islamic websites, however, found wide variation in interpretation of Islamic dietary laws and pork-derived medications.

As with any issue that involves faith and belief, there are bound to be differences in interpretation. While legal scholars in both Judaism and Islam have weighed in on the issue and declared that medications made from pork products are okay to use, it is possible that individual patients or local authorities may differ in their interpretation. Since the religious legal scholars have pronounced medications made with pork products to be acceptable, it seems unnecessary to ask patients if they have any dietary restrictions that might apply to medications.

Suggested Reading
http://www.vaccinesafety.edu/Porcine-vaccineapproval.htm

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The Midwest Leadership Board is pleased to report having completed another exciting SGIM Midwest Regional Meeting, September 12-13, 2013. Our venue was the lovely Navy Pier in Chicago. Our goal was to engage trainees, faculty, and leaders in the topic of accountable care and the role that general internists play in leading efforts addressing education, clinical care, and research.

As such, this year’s theme was “Accountable Care: Linking Research and Education to Clinical Practice.” We were fortunate to have an outstanding invited keynote speaker, Anne Pereira, MD, MPH, whose presentation was titled “Be-twixt and Between: Modeling and Teaching Care for Tomorrow, Today.” Following her presentation, we listened to outstanding talks from Drs. Elbert Huang, Elizabeth Jacobs, and Marshall Chin. These brief talks focused on the impact of accountable care on medical education, cost savings in patient-centered care, and health disparities. All four speakers then served as panelists as they engaged in discussion with the attendees.

Highlighted initiatives this year included SGIM national updates from Drs. Christopher Masi and Mark Liebow and a Choosing Wisely® presentation from Drs. Laurence McMahon, Vineet Chopra, Jeremy Sussman, and Alfred Burger. This year, medical student registration fees were waived with an accepted submission, and group mentoring sessions were dedicated to medical students, residents, and junior faculty. Institutional champions (Drs. Kurt Pfeifer, Toshi Uchida, and Cara Polland) were instrumental in planning the meeting.

We experienced record attendance with a total of 206 attendees. We received 217 submissions of which 138 were accepted, including 33 abstracts, 12 innovations, 11 workshops, and 82 vignettes.

On behalf of the Midwest SGIM Leadership Board and Planning Committee, many thanks to our committee chairs, mentors, poster judges, and all attendees.
The Evidence-Based Medicine Task Force is creating distilled, one-page summaries on high-impact research in general medicine as a tool to help doctors communicate results to patients. Each summary addresses new evidence relevant to general internal medicine, which has been covered in the media and may impact patient care. Each summary visually presents the key information about the potential benefits and harms of a test or treatment along with a clinical “bottom line” recommendation. Summaries use plain language and contain four elements: 1) brief background of the clinical question; 2) a summary of the new evidence with a quality grade and statement of primary results; 3) the clinical bottom line, with emphasis on visual presentation of results; and 4) tips for communicating the results to patients. The goal is to improve clinician communication with patients and maximize patient understanding, satisfaction, and decision-making.

Four Bottom Line summaries were created in the first year of the project regarding mammography screening among women age 40 to 49, lung cancer screening for smokers, Lorcaner for weight loss, and the Mediterranean diet for cardiovascular prevention. Upcoming summaries include vitamin D and calcium for prevention of fractures and fish oil for prevention of prostate cancer. The Task Force has completed a systematic review of methods of communicating probabilistic information to patients that will inform our Bottom Line summaries. The review is under submission.

Summaries will be posted on the JGIM website. The simplest way to view the current summaries is to go to http://www.sgim.org/web-only and check the box for the Bottom Line. (Click “download PDF” to see the full summary.) As this is a new venture that is being integrated into the existing JGIM Web format, feedback is always welcome.

The SGIM Evidence-Based Medicine Task Force is comprised of SGIM members with expertise and interest in EBM. The Task Force promotes the practice and teaching of EBM by developing, implementing, evaluating, and disseminating effective EBM resources and conducting research to advance the field. EBM Task Force members include Daniella Zipkin, MD, chair; Deborah Korenstein, MD, past chair; Koko Aung, MD, MPH; Zackery Berger, MD, PhD; Rebecca Beyth, MD, MSc; Daniel Elliott, MD, MSCE; Scott Kaatz, DO, MSc; M.E. Beth Smith, DO; Jeremy Sussman, MD, MSc; and Michael Landry, MD, SGIM Council liaison.
Dr. Fred Brancati inspired many trainees to pursue academic general internal medicine (GIM). Moreover, he motivated all of those around him to feel that our careers in GIM were worthwhile and served a greater purpose, even when the external conditions said otherwise. In response to the outpouring of inquiries regarding how to recognize his contributions to GIM, the Society of General Internal Medicine (SGIM) and the Association of Chiefs and Leaders in GIM (ACLGIM) are honored to announce the Frederick L. Brancati Mentorship and Leadership Award. SGIM President Eric Bass sees this award as “a perfect way to remember how much Fred meant to so many people as an exceptionally superb mentor and inspirational leader.”

True to his approach to leadership and mentorship, prior to his death, Dr. Brancati expressed a desire to recognize junior faculty who inspire and mentor trainees to pursue GIM—faculty who might not otherwise be recognized for their efforts. This award will recognize such junior faculty and provide support for their trainees who aspire to become leaders in the transformation of health care through innovations in research, education, and practice. Nisa Maruthur, one of Fred’s mentees, said, “This award embodies Fred’s ability to single out those intangible contributions that are valued implicitly but just not recognized.” Each award will include money for the junior faculty awardee and support for one or two of the awardee’s trainees to join SGIM and attend an ACLGIM leadership program.

The Brancati Award will complement SGIM/ACLGIM initiatives to inspire trainees to pursue GIM and to enhance their leadership training. This award is intended to help transmit Dr. Brancati’s love of GIM to the next generation of leaders in GIM. Stewart Babbott, ACLGIM president, said, “The format of this award embodies Fred’s focus on mentoring, his support of junior faculty, and his vision for developing the next generation of teachers, researchers, and clinicians.”

We are gratified to have received more than $80,000 in pledges and donations to date to establish this award and have had tremendous support from colleagues around the country whose lives were enriched by Dr. Brancati. We are pleased to offer this award for the coming year. Go to http://www.sgim.org/career-center/awards-and-grants/nomination-awards for more information on nominations and donations.
NEW PERSPECTIVES
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1. **Actors:** all persons who are carrying out activities intended to achieve a common goal;
2. **Goals:** a common end point, established cooperatively, with input from multiple actors;
3. **Activities:** physical and mental work, completed by actors, to achieve established goals; and
4. **Interdependencies:** interactions between different actors and activities.

These definitions and components of coordination apply well to the care of patients. For example, Medicare patients with more than five chronic conditions can see up to 15 different physicians and have on average sixteen home health visits per year. Each of these actors carries out activities consistent with his/her training to achieve a common goal, with each actor and activity interdependent on the other.

They go on to further define the various types of interdependencies:

1. **Prerequisite:** The output of one activity is required by the next (e.g. a nurse tells a patient not to eat after midnight on the day of surgery);
2. **Shared Resource:** The same resource is required by multiple activities (e.g. a patient requires a PET scan, but the next available appointment is not for another week); and
3. **Simultaneous Activity:** More than one activity must occur at once (e.g. a patient is scheduled for two appointments on the same day, and they are on opposite sides of town; this forces the patient to leave the first appointment early in order to make the second).

So with this model of coordination in mind, what components of an EHR are needed to improve how we coordinate care for our patients?

Let’s start with the actors who we will call care team members (CTMs). An EHR should list prominently the CTMs, including all primary and specialty care physicians involved in a patient’s care. It should also include other important actors such as nurses, social workers, pharmacists, care coordinators, home health nurses, dialysis units, and even family and friends serving as caretakers. We cannot afford to be physician-centered when considering who belongs on a care team. Simply knowing who the other actors are will go a long way in coordinating care; however, systems should go further. Listings of care team members should include thumbnail images and contact information. There should be direct links to telecommunication tools, seamlessly allowing users to call or send messages, texts, or pages. Furthermore, it should be simple to send messages to multiple recipients simultaneously. Once barriers to correspondence are removed, care team members will communicate more often and in more meaningful ways.

How can we better coordinate activities? We should develop a culture in which the flow of information is reciprocal at all levels. Primary care physicians should communicate updates on a patient’s status to specialists and other care team members just as our consultants currently do on a regular basis. It should be as much a part of our programming as it is theirs.

We must place a high priority on developing an up-to-date, well-managed problem list. It should include chronic conditions and those conditions that are not yet fully defined. Each problem should have an associated field that allows all actors to co-create a collective overview of each condition. There should be goals for each condition but also an overarching goal that reflects the overall needs and desires of the patient. The problem list should be developed in collaboration with as many actors as possible, including the patients themselves. To achieve this, we will need to develop a common understanding of coordination and a common language for managing goals and problem lists.

Medication lists are critical in providing coordinated safe health care. Our institution has had a fully integrated EHR for five years, which has provided a single, co-managed medication list. Still, we are struggling to define what medication reconciliation entails, who should perform a medication reconciliation, and how best to document dosing information. The challenges we face with the problem list are similar to those with our medication lists. Our profession would do well to develop a rubric for problem list and medication list management. This should be introduced at the earliest stages of training and continue on throughout our careers.

Making the patient part of the care team is critical to improving the coordination of care. In the past we held the paper record in a virtual quarantine. Patient were denied access unless they jumped through administrative hoops and paid exorbitant costs to obtain copies of their own records. Many EHRs have associated electronic patient portals. With electronic portals, patients and families can become more engaged members of their own care team. They can review elements of their record and communicate freely with others on their care team.

In 2011, Hysong and colleagues provided a qualitative analysis of why coordination fails between primary care physicians and specialists. Most surprising, they reported very few barriers that were specifically EHR related. Instead they concluded that the greatest contributor to poor coordination was the institution’s failure to develop a clear referral policy. In addition, they described a great deal of variation in physicians’ understanding of their roles in coordination. Physicians expressed ambiguity about their responsibilities to communicate. Physicians had individualized communication styles and mental models of what coordination meant, thus making the development of a predictable model very challenging.

As health care professionals, we must develop a common understanding of what coordination of continued on page 11
research (same as FY 2012); $62.6 million for patient safety research ($3 million less than FY 2012); and $88.9 million for research innovation ($19.4 million less than FY 2012). The requested budget also included $63.8 million for continuation of the Medical Expenditure Panel Surveys and $68.8 million for program support.

With that preparation, we entered Dr. Kronick’s office in the John M. Eisenberg Building, aptly named after the former president of SGIM who led AHRQ from 1997 until his death in 2002. Seeing John’s name on the building reminded me of his passion for excellence in research, for improving the quality of health care in the United States, and for “insisting that evidence from research should be brought to bear in answering key health policy, management, and practice questions.”

The meeting went well. Drs. Kronick and Ginieczki were genuinely interested in our thoughts and concerns. We talked candidly about how to define the unique role that AHRQ plays in the health care system, taking into consideration the size of AHRQ’s budget relative to the NIH budget as well as the challenge of differentiating AHRQ from PCORI. They emphasized that AHRQ must produce evidence for policymakers and make sure that the evidence is used to make better decisions about health care. They also emphasized the importance of measuring and demonstrating the effects of interventions on health care delivery and outcomes. They expressed a strong commitment to collaborating with other agencies within the Department of Health and Human Services and with the private sector. In that regard, they were interested in hearing my views about the value of stakeholder engagement in the work of the Evidence-based Practice Center that I direct. They acknowledged the need to support innovative investigator-initiated research as well as training and career development of health services researchers, but they could not make firm commitments because of uncertainty about their overall budget. As a professor and chief of the Division of Health Care Sciences at the University of California–San Diego, Dr. Kronick clearly appreciates the importance of investigator-initiated research. The problem he faces is that the Agency continues to be under enormous pressure to demonstrate immediate impact from the work it supports.

That brings me back to how SGIM can help its friends at AHRQ. What AHRQ needs is help in identifying and disseminating stories of how our AHRQ-funded work has had an impact on health care delivery and outcomes. We can no longer be satisfied when our work gets published in a peer-reviewed journal. We need to give attention to additional ways of sharing how our work makes a difference. We should be developing and telling stories of impact that will help policymakers and the public understand why AHRQ’s mission is so important.

I will ask SGIM’s Communications Task Force members to consider this as part of their charge in revamping SGIM’s approach to communications. I will ask the JGIM editors for their advice on how we can bring more attention to the health services research published in JGIM. I will also ask the Awards Committee to think about how we can use our national and regional awards to bring maximal attention to successful stories of research that has had a significant impact on health care delivery and outcomes.

With the permission of the SGIM Forum editor, I am now asking SGIM members to submit brief stories about the impact of AHRQ-supported work on patient and population outcomes, quality of care, patient safety, access to care, and the value of health care. I look forward to showcasing the best stories!

Right before our meeting with Dr. Kronick, Mark and I were talking about our kids and the abbreviations they use in their communications. SGIM’s relationship with AHRQ may not meet our kids’ definition of BFF (best friends forever), but it is an important friendship that I hope will continue for many more years.

**Reference**

There is a specific need for SGIM to represent the general internist in ongoing national efforts related to the longitudinal care of adults with complex childhood-onset conditions. Issues related to this patient population are increasing in visibility and importance; however, there is a gap in ongoing efforts led by pediatric groups, which focus predominantly on the transition period and less on the ongoing care needs of these patients after entering adult primary care. SGIM is optimally positioned to fill this void. The number of adults with chronic conditions and disabilities that began at birth or during childhood is rising rapidly, with an estimated 9.5 million young adults age 18 to 29 currently living in the United States. Most of these individuals are or will be managed by generalists, yet their management remains challenging due to poorly addressed clinical, educational, research, and policy needs. In 2002, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) released a consensus statement defining the steps that would provide adolescents with special health care needs the support required to transition to adult health care services. Unfortunately, there has been less work focusing on the ongoing needs of this population once they are established in adult primary care. The new task force will specifically focus its efforts in this area.

The goal of the task force is to improve the care of all adults with disabilities and complex conditions originating in childhood. To accomplish this, the task force will:

1. Increase awareness and education of SGIM membership regarding the issues related to the care of this high-risk population, which faces well-established health care disparities;
2. Collaborate within SGIM to ensure issues related to this patient population are incorporated into ongoing SGIM initiatives in practice redesign, education, health care payment reform, and health policy;
3. Promote needed research and scholarship in this area; and
4. Partner with other organizations to increase SGIM’s role in national efforts to improve care and draw attention to the needs of these patients during their adult lives.

Some interested SGIM members are already at work trying to achieve the goals of the new task force. We will be submitting a number of educational sessions for review and are hoping to offer opportunities for learning and networking at the SGIM national meeting in April. We have started collaborating with other professional and advocacy groups working in this area and plan to expand our partnerships in the coming year. We have many ideas and plans to achieve our stated goals and expect the task force to be very active from the start.

Our gratitude goes out to Dr. Bass, members of Council, and the SGIM staff for their assistance with our request for this task force. We would specifically like to express our gratitude to Michael Landry, MD, who co-founded the interest group in 2005 and whose guidance and assistance was instrumental in getting the task force approved. Moving forward, we hope to serve the membership of SGIM and invite ideas and suggestions that best meet members’ needs. We would like to invite any and all SGIM members interested in serving on the Adults with Complex Conditions Originating in Childhood Task Force to submit their CV and a brief statement of interest for review. Twelve members will be selected to serve with terms ending in 2015 or 2016. Since this is a new task force, members will have an exciting opportunity to help with the organization and planning of the task force and in setting the initial agenda of the task force. If you are interested, please submit your information by e-mail to gregg.talente@uscmed.sc.edu.

References
about the subject. He denies frequent stools or noticing his stool floating in the toilet bowl, symptoms suggestive of inflammatory bowel disorder, excess use of vitamin C, or weight-loss medication.

Oxalate nephropathy is a form of crystal-induced AKI and is caused by intra-tubular deposition of calcium oxalate crystals. More common forms of crystal-induced AKI include acute uric acid nephropathy as well as certain medications such as acyclovir, sulfonamides, methotrexate, certain protease inhibitors (indinavir), and trimeterene.3

Established causes of oxalate nephropathy include hereditary hyperoxaluria, ethylene glycol (antifreeze) poisoning, secondary hyperoxaluria due to fat or bile acid malabsorption, vitamin B6 deficiency, over ingestion of vitamin C, and excessive ingestion of foods high in oxalic acid (e.g. rhubarb, nuts, spinach).4 Conditions resulting in secondary hyperoxaluria may include inflammatory bowel disease, pancreatic insufficiency, bowel resection, jejunoileal or gastric bypass, and weight loss drugs that induce fat malabsorption (Orlistat). Normally, calcium combines with oxalate within the intestinal lumen and is then excreted in the feces as insoluble calcium oxalate complexes. In fat malabsorption, excess free fatty acids in the bowel lumen bind calcium, leaving a surplus soluble free oxalate, which is then absorbed by the colonic mucosa.5

Given this patient’s history of alcohol dependence and acute pancreatitis, we suspect that he has some degree of chronic pancreatitis and cannot rule out surreptitious ingestion of ethylene glycol.

Skin biopsies are negative for an acquired perforating disorder and instead are suggestive of folliculitis (positive Staphylococcus aureus growth on culture with many neutrophils) and pathology consistent with herpes infection (ballooning cells). Immunostain is negative, but pathology notes that the lesional tissue is not present on the immunostain, which may account for the negative test. However, at this point the patient’s lesions are resolving, so dermatology recommends a course of antibiotics and monitoring for clinical recurrence. Thus, the final diagnosis given is acute folliculitis with dermal abscess and atypical herpes infection. Upper endoscopy does not reveal signs of bleeding, but colonoscopy demonstrates a 1 cm ulcer felt to be the culprit.

It’s possible that this patient has an atypical herpes infection since patients with uremia have impaired cellular immunity. We entertain the possibility that the skin lesions represent oxalate depositions—there are some patients with primary hyperoxaluria who have oxalate depositions in their skin, but these primarily manifest as vascular lesions (e.g. livedo reticularis, acrocyanosis, ulcers, gangrene),6 which is inconsistent with this patient’s presentation.

The anemia may also have been potentiated by the patient’s degree of renal dysfunction; he may have had a greater propensity for bleeding due to platelet dysfunction resulting from uremia, as well as poor ability to compensate for bleeding due to erythropoietin deficiency.

Because the patient fails to recover from his kidney dysfunction and remains symptomatic, a permacath is placed, and inpatient dialysis is started. The patient reports resolution of fatigue and malaise and is discharged. He is currently being followed closely and undergoing regular outpatient dialysis.

Key Points
- Clinical symptoms of prolonged renal failure include weakness, fatigue, and anorexia. Other symptoms of renal failure that were not seen in this patient include edema, hypertension, and oliguria. Certain skin conditions are uncommon symptoms of end-stage renal disease but may be present in some patients.
- The approach to evaluating renal failure involves differentiating between prerenal, intrinsic, and postrenal causes.
- Multiple myeloma should be considered in patients with the combination of anemia and renal failure.
- Renal biopsy is generally indicated in cases of acute renal failure in which the diagnosis is uncertain.
- Oxalate nephropathy is seen in ethylene glycol ingestion and in patients with malabsorption, such as inflammatory bowel disease or chronic pancreatitis.

References
ety have a common interest in ensuring an affordable, high-quality health care system. Third, the LHS has a moral obligation to decrease inequalities in the evidence base for clinical decision-making (e.g., health needs of pregnant women) and to decrease disparities in health care outcomes. The article even touches on whether informed consent is needed for randomizing patients to test interventions, which represent “standard of care” treatments and for which there is clinical equipoise.

The Hastings Center Report also includes several excellent commentaries. One, co-authored by Harry Selker, highlights the importance of making regulatory oversight of research proportionate to the risk posed by the particular study, as well as the perverse regulatory disincentives clinicians and health systems face for evaluating alternative treatments in a systematic and rigorous manner.

The Hastings Center Report is a breath of fresh air that challenges our outdated framework for regulating low-risk practice-based research to evaluate standard of care interventions. While the Office of Human Research Protection (OHRP) is actively examining these issues, reform of our current regulatory system will require joint advocacy by investigators, clinicians, health care leaders, and most importantly from patients who stand to benefit from the knowledge gained from such research and from the realization of LHSs.

References
**CLINICIAN-INVESTIGATOR**

**Rhode Island Hospital, Division of General Internal Medicine**, Department of Medicine, Providence, R. I. seeks a clinician-investigator. The selected individual will have 80% protected time to develop independent research projects and collaborate on projects with other investigators at the Alpert Medical School. He/she will also participate in inpatient clinical rounds, and/or in the primary care practice at Rhode Island Hospital or Providence VA Medical Center, as well as the training of medical students and internal medicine residents. The successful candidate must qualify for a full-time medical faculty position at the rank of Assistant or Associate Professor of Medicine at the Warren Alpert School of Medicine at Brown University. Associate Professor level candidate should have a national reputation and scholarly achievements. Minimum requirements include: board eligibility or certification in internal medicine, strong clinical background in internal medicine, excellence in patient care and teaching, and a commitment to develop an independent research career. Fellowship training in general internal medicine or the equivalent is highly desirable. It is preferred that the candidate’s research interests focus on health care quality, comparative effectiveness, women’s health, cancer prevention, behavioral medicine, pain medicine, correctional health, substance abuse, or a closely related field. Rhode Island Hospital is an EEO/AA employer and encourages applications from minorities, and women. Review of applications will begin immediately and will continue until the position is filled or the search is closed. Applicants may apply by uploading a CV and letter of interest through Interfolio at https://secure.interfolio.com/apply/20647.

**Physician Investigator**

**Section of Geriatrics, Yale University School of Medicine** The Section of Geriatrics, Department of Internal Medicine, Yale University School of Medicine, is seeking a well-trained physician investigator at the Instructor or Assistant Professor level. This physician must have training in any area of clinical investigation as well as evidence of excellent potential for an outstanding career in Geriatric clinical investigation. Geriatric clinical fellowship training is preferred but not required. Yale University is an Affirmative Action/Equal Opportunity Employer.

Qualified women and members of under-represented minority groups are encouraged to apply. Interested individuals should submit a letter of interest, curriculum vitae, and the names and addresses of three external references to:

Mary E. Tinetti, M.D., Chief, Section of Geriatrics
Yale University School of Medicine,
333 Cedar Street, PO Box 208025,
New Haven, CT 06520-8025.
or e-mail enquiries to: mary.tinetti@yale.edu.
All CV’s should be submitted by January 15th, 2014.