HEALTH POLICY CORNER

Health Insurance Exchanges: Are We Ready?
Patricia Harris, MD, MS

In January 2014, all legal residents of the United States will be eligible for health insurance coverage. Health insurance exchanges have been set up that will allow purchasers to choose individual nongroup plans. The Patient Protection and Affordable Care Act (ACA) has provided for subsidies to ensure that the coverage is transparent and accessible. Tax credits and low-cost insurance plans promise to make coverage affordable for everyone, especially those lower-income non-poor residents who previously were ineligible for government-sponsored (or private) insurance. Enrollment was set to begin in October 2013.

Alas, Americans do not understand the plan. A Gallup poll found that just under half of uninsured Americans are unaware that they have to purchase a plan or face a penalty in 2014. (Overall, 19% of Americans were unaware of the penalty, suggesting that those who have insurance understand the ACA better than the uninsured.) Additionally, studies show that only 14% of recent poll respondents understood basic insurance terms such as co-pay, deductible, co-insurance, and out-of-pocket maximum.

The outcry against the ACA continues, with naysayers concerned about a variety of issues ranging from budgetary matters to the loss of physician autonomy to crowding in overworked primary care offices to invasion of privacy. It confounds the opposition that the plan is essentially a reworking of the conservative Heritage Foundation’s 1989 essay by Stuart Butler, titled “Assuring Affordable Health Care of All Americans.” The Obama Administration has allowed for confusion by not mounting either a defense or a strong public service message that tells us what the ACA actually provides.

The focus on states’ rights has, of course, confounded the issue. In a very real sense, we are grappling to understand how the 50 states, Washington D.C., and various territories fit into the federal scheme. The Obama Administration had anticipated that most states would create their own health insurance exchanges, but in fact 33 have chosen to let the federal government operate them. Furthermore, the ACA had anticipated (almost 100%) federal funding of Medicaid expansion as a fundamental component of ensuring coverage for all. Since the Supreme Court struck down state requirement for expansion, 21 states have refused to participate, and (as of this writing) six have not decided on whether to do so. We do not yet know how people financially eligible for Medicaid will receive insurance in those states.

continued on page 12
A Student’s Perspective on Chronic Care
Rachita Gupta

Ms. Gupta is a volunteer at St. Joseph’s Hospital and Medical Center in Phoenix, AZ.

In the summer of 2012, the St. Joseph’s Hospital Internal Medicine Department started its outpatient interview and coaching project. The goal of the project was to assess the degree to which lay volunteers could make a positive difference in patient care. First, as volunteers, we would educate ourselves on disease management. From there, we would meet with patients once a week to understand their diseases and educate them on improving their eating habits, exercise routines, and lifestyle choices. We wanted to know our patients, who were strangers to us, personally.

The patient assigned to me was a sweet elderly lady. I began by asking her to complete a physical and mental health status form and consent to participate. My patient answered positively to questions about her mental state, feelings, and social engagement but negatively to questions about her physical health and energy.

I then interviewed her about her health, asking her what was in her refrigerator that day as well as her long-term goals for improving her health. She chatted without much hesitation. I also discussed and gave her information on COPD and diabetes. At the end of the meeting, we set her first weekly goal: to eat whole fruits rather than drink processed fruit juices.

At the next meeting, I asked her about the foods he had eaten over the past few weeks, carefully recorded her answers, and told her what she should and shouldn’t eat. She had already started eating more whole fruits and cut back on drinking juices, so I gave her two complex goals. I told her to keep a food diary in which she would record the type and quantity of food she ate throughout the day—everything from toffee candy to steak. I hoped this would help her reflect on the food she was eating and make better choices. For the second goal, I asked her to move around as much as possible, whether it was climbing stairs or walking around the grocery store.

In the following weeks, I gave her more information to read on weight control and healthy eating. I advised her on food quality and quantity based on a food pyramid published in the American Diabetic Association’s Food For Life. I told her to continue keeping the food diary, to follow the chart I created on healthy food options, and to post her printed goals on the refrigerator. I hoped that every time she felt tempted to open the door, she would read the goals and make a healthy decision.

Unfortunately, my patient had limited success with my goals. It was hard for her to comply with my advice to the degree I wanted. She could not exercise much and didn’t always eat the food I recommended. I noticed small beneficial changes and continued on page 13
Do You Dare Ask Your Family for Feedback on Work-Life Balance?
Eric B. Bass, MD, MPH

...too often she feels held hostage by my job. Too often she feels that family commitments come second to work.

When was the last time that you asked a member of your family for feedback on how you are balancing the demands of work and family life? I’m embarrassed to admit it’s been a long time. So at the end of our recent family vacation, I asked my wife Katie and my son Jamie what they thought.

I started with Jamie. He now has 20 years of experience putting up with the demands of my professional career. He started his reply carefully. He said he was glad that I enjoyed my work. He appreciated that the work was important even though he had trouble understanding much of what I do. When Jamie was a little boy, he accompanied me when I visited Sankey Williams to talk about taking over the reigns as JGIM editor. Back then, Jamie wanted to know what an editor did. I think he understands the journal work better than most of the other work I’ve done.

I had to encourage Jamie to be more critical. He responded by saying that I always seem to be doing too much. He is aware of my struggle to juggle research, teaching, clinical practice, journal editing, and SGIM leadership responsibilities. He astutely observed that the struggle is intensified by two traits—being “too nice” (i.e. not saying no often enough) and never doing anything “half-assed.” He wondered why I couldn’t get away from work earlier or more often if I am the one in charge. He did express concern about my frequently working late in a part of town that still has more than its share of violent crime. Overall, his feedback was not as critical as I had anticipated.

That helped give me the courage to ask Katie. If you know Katie, you know that she’s not one to hold back on what she thinks. I told her I was thinking about writing this column, so she asked whether I really wanted to hear all her thoughts. I said yes. She started nicely by saying she was glad that I enjoy my work. She also has enjoyed the opportunities we’ve had through our work to meet interesting people and go to interesting places. Both Katie and Jamie loved Barcelona, for example. But too often she feels held hostage by my job. Too often she feels that family commitments come second to work. One of my worst habits is coming home late, putting more pressure on her to deal with issues and responsibilities at home. That makes her feel like I think my job is more important than her job. Like Jamie, she worries about me getting home safely when it’s late. What particularly troubles her is that I frequently seem preoccupied by work demands. She feels that it impairs my ability to give full attention to almost anything and that it limits my ability to completely enjoy other things like vacations and to fully participate and give attention to other parts of my life. In Katie’s words, “I feel you are never free of it.” Having a demanding and rewarding job of her own as a fertility specialist has helped her feel less resentful than she otherwise would feel. When she has had stressful problems in her clinical practice, she has appreciated my ability to understand the issues and provide appropriate support. She understands the challenges of working at a place like Johns Hopkins, having been on the faculty in the Department of Gynecology and Obstetrics before she entered private practice. She is proud of what I’ve been able to accomplish and amazed that I could survive 26 years at Hopkins.

SGIM has a long-standing commitment to promoting work-life balance and an interest group on personal-professional balance. Members of the Interest Group have led numerous workshops at regional and national meetings. JGIM has supported efforts to improve work-life balance by publishing many articles on the topic. Indeed, the June issue of JGIM includes a qualitative study of work-life balance issues from the perspective of faculty clinician-researchers and their mentors. The study reveals five major themes: 1) the importance of work-life balance for contemporary physician-researchers; 2) how gender roles and spousal dynamics make these issues more challenging for women; 3) the role of mentoring in this area; 4) the impact of institutional policies and practices intended to improve work-life balance.

continued on page 11
FROM THE EDITOR

The Glass Ceiling
Priya Radhakrishnan, MD

There has been an uptick in social media buzz around women, the workplace, and work-life balance. Justice, race, gender, and equality are dominant themes in our conversations. Perhaps celebrating the anniversary of the March to Washington has reminded us to re-examine our social fabric.

When Marissa Mayer, the chief executive officer at Yahoo, revoked permission for staff to work from home, many saw her as anti-woman and anti-family. Then came the uproar around her upside-down photograph on a playground slide. Opinions flowed back and forth on the meaning of the photo—women’s rights activists bemoaned the many steps back the women’s movement would take. Others claimed that it was a good picture, nothing more or nothing less.

What is fascinating is the fact that, today in 2013, very few people think that these concerns are irrelevant. When Alexander Putin poses bare-chested with wild horses, he’s just being the machismo president. Yet when Mayer poses fully clothed on a slide, we question her judgment.

You may wonder why I am writing about Mayer and Putin in the Forum. First, work-life balance has great importance to us and our profession. Many medical schools have reported a significant increase in female applicants, yet the number of women in leadership positions in medicine has not changed much. In another decade, as more highly educated women enter the workforce (undergraduate and medical school admissions are increasing), we do stand a chance of gender-based “affirmative action” developing. Still, women who train the same number of years and have the same student loan burden as men most often are paid less. While the total number of women physicians has been steadily increasing, women physicians tend to work fewer hours. Estimates of patient care hours worked per week from an unpublished Health Resources and Services Administration survey (2002 data representing approximately 46,800 physicians) show that even when controlling for age and specialty, women tend to work fewer hours per year than men. After adjusting for age, training, and practice characteristics, there still remains an unexplained 14% disparity in earnings.

Why are we not savvy enough to address this issue head on? Do leaders of academic institutions really believe that the value of women physicians’ work is less than that of their male counterparts? As a community are we not able to address these disparities?

The lack of women in the top echelons of leadership is a reality. I wonder why some women climb up the ladder and others don’t. Is the basic issue that fewer women aspire to climb the ladder, or is the journey so hard that only a few attempt to grab the first rung? Perhaps women physicians choose not to go the extra mile at work so that they can invest time elsewhere in their lives.

Can we see the forest for the trees? Some might argue that women choose the role of caregiver and let their careers take a back seat. As a parent of young children, I know that early-career women physicians often fall into the trap of managing day-to-day existence. When the sheer physicality of the routine is amplified by chronic sleep deprivation, there is a grave danger of losing happiness from work. Once lost, the joy is hard to get back. I remember the best advice that I received from my mentor was “to keep what you love in sight.” I have found that following that advice helps me focus. When I find myself being deafened by the background noise of my day-to-day routine, I hit the reset button. Simple goals like developing a curriculum, a project, or—my favorite—submitting an SGIM workshop help ensure career progression. Once in the habit of thinking this way, you will ensure that every year your “fun at work” continues. It no longer becomes “work” but something that nurtures you during lean periods.

Do we celebrate us? In general women do not self-promote. Celebrate your academic successes with your peers and your supervisors—no one will know of your successes unless you share. I have a folder titled “It’s all about me.” It contains anecdotes, patient and mentee thank you cards, and snippets of my workshops and papers. Make a whole wall if you need to. Nothing succeeds like success. This will sustain you even on the days when someone pulls you to the side and prepares to give you some “formative feedback.”

At the end of the day, as women, we have to want to lead. Leadership must not be foisted upon us but aspired to over time. Once that happens, the glass ceiling will give way to opportunity. There are enough of us in mid-level positions to band together, make critical decisions, and gradually achieve recognition for the work that we do. While there may be finite limits to a job, there should be no limits to rising to the top of one’s field. It is time for women to seek, achieve, and move up.

Now I’m off to get my photo taken. I will keep the details secret!
Care coordination is one of those things in medicine that makes so much sense that whenever I explain it to non-medical people they shake their heads and say “duh.” At its core lies good communication: 15 minutes on a phone here, 20 minutes writing e-mails there, and somewhere in between dealing with faxes, follow-up appointments, meetings, and paperwork all in the name of good patient care. It is something that physicians are perfectly adept at doing. We are taught these skills in medical school and residency! How many follow-up appointments did I make as a third-year student? How many specialist notes and consults did I hunt down as an intern? It’s nice that trainees learn how to do this type of work, but once residency is over, this idyllic way of practicing medicine abruptly stops—and many days, practicing clinicians seeing four patients an hour fly by the seat of their pants to keep from getting behind. Comprehensive management of complex patients becomes impossible as assessments and plans read “Problem A: managed by cardiology, follow with them. Problem B: managed by nephrology, follow with them. Problem C: dermatology appointment in two weeks. Problem D: LDL not at goal, increase statin and see in six weeks for recheck.”

It is not that primary care physicians do not enjoy managing A, B, and C—many just don’t have time. And this assumes they get notes, records, and reports for all tests, labs, and specialty visits to be able to do it! So referral rates and costs increase while patients receive comprehensive yet fractured care that lacks cohesion. If a physician cannot coordinate this, how can we expect our patients to do it?

Enter care coordination: the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. Instead, we think about it as a trained, committed, and licensed nurse or other health care provider who works with the patient, primary care physician, and specialists at all care sites, including the patient’s home, to coordinate care.

Care coordination achieves the “triple aim”—improved health of the population, enhanced patient experience of care (including quality, access, and reliability), and reduced or controlled cost. Patients really, really like it, too!

That care coordination is not a routine part of everyday US medical care is unfortunate—and all the more so for patients who receive care in the safety net. Our most vulnerable patients are a special population and would likely benefit most from coordinated care.

A first step to knowing how to do this in the safety net is a set of best practices: Although there is likely not one way of coordinating care for all safety net clinics across the country, we have some excellent detailed leads. A very well-written report from California showing how five counties integrate and coordinate care demonstrated last year that there are many ways to do this right. Ku and colleagues from George Washington University have shown in great comparative detail how a diverse group of six communities across the United States (Austin, TX; Brooklyn, NY; Indianapolis, IN; Marshfield, WI; San Francisco, CA; and St. Louis, MO) coordinates care successfully.

Care coordination for patients in the safety net is a hard, time-consuming, and high-stakes proposition. Why? Safety net patients face many barriers that other patients do not: Cultural, linguistic, financial, literacy, educational, and access barriers all underlie the complexity. These underlie the care of all the medical and mental health needs that are getting coordinated. When these barriers complicate care, it takes longer. Anyone who has ever seen a trapeze artist fall into a safety net knows what happens when the net breaks. We cannot let our patients hit the floor!

In piecemeal fashion, many safety net clinics and systems have long recognized the need to carefully shepherd these patients through the system. We now call this care coordination.
Attaining optimal work-life balance is important for all professionals, especially physicians. In the past, attention to the issue has focused on extremes of imbalance, namely burnout, impairment, depression, and suicide. The literature seemingly assumes physicians will be unwell, with the consideration being only to what degree.

Recently, the work-life balance focus has started to shift toward resilient, non-burned-out physicians and their strategies for success. In JGIM this summer, Strong and colleagues explored barriers to work-life balance among successful physician researchers and their mentors. The move in this direction is welcome, but it is only a start.

Education on work-life balance in medicine is sorely lacking. The Accreditation Council for Graduate Medical Education (ACGME) mentions physician self-care only once in the requirements for internal medicine training programs. The instruction to trainees states that, “patient needs…supersede self-interest.” With this lack of emphasis on work-life balance during training, physicians generally receive very little instruction on the topic. Young physicians do not learn tools to create symmetry in their personal and professional lives. They are left to learn from their mentors, who may or may not be the best examples of achieving balance. Physicians are often left to create their own solutions. For many, especially women, this leads to working part-time.

Part-time physicians are reported to have lower burnout scores, more job satisfaction, and a higher sense of control over work compared to full-time colleagues. At the same time, professional performance and success are significantly different for part-time physicians. Academic faculty working part-time are more likely to be on a clinician or clinician-educator track and less likely to report academic support or protected research activities. While these are not the only markers of success, they are of high impact for advancement and promotion in academic settings.

This is the era of Lean In. Sheryl Sandberg, chief operating officer for Facebook, is encouraging women everywhere to lead in their professional lives. She asks women to step up, to be involved, and to succeed. Her message is reaching hundreds of thousands of women and its immediate, astronomic popularity suggests the concept is welcome. Yet part-time physicians seem to be doing just the opposite. With limitations on their professional time, part-time physicians are basically leaning out. Or are they?

The choice to be a part-time physician can be a difficult one. Rather than achieving balance, part-time physicians often straddle home and work life with a sense of being unable to devote full energy and ability to either one. At the same time, part-time physicians have the privilege of a rewarding clinical practice while personally being present for children or other needs at home. This split identity requires intention, boundary setting, and a conscious effort toward gratitude.

Part-time positions are only one option for those striving toward balance between work and life. Limiting time at work comes with gains and costs, which are applicable to all physicians. Focus at both work and home is paramount. Work must be completed in the time allotted, and staying indefinitely is not an option. Being present at home is equally important. Attention should only be drawn back to work when absolutely necessary (i.e. call). All physicians must “lean in” when possible and where its impact is greatest; the rest should be let go. While you might delay your advancement or opportunities, applying and ensuring your own values at home is probably worth the trade-off.

With education and tools introduced during training, physicians could achieve better balance regardless of their full-time-equivalent status. Part-time might be the answer, but limiting time is probably closer to the solution. Physicians need to be taught and mentored in this practice. The medical culture also needs to change to allow for its emphasis. With proper mentoring and guidance, true balance will be within reach.

References
Mr. L is a 64-year-old man who presents to continuity clinic to establish care with a new provider for his chronic medical conditions. His medical history is significant for coronary artery disease, severe peripheral artery disease, diabetes, and hypertension. His surgical history includes coronary artery bypass grafting and multiple lower-extremity bypass surgeries. These procedures were complicated by graft occlusion, extensive critical illness, and ultimately bilateral leg amputations. He has a 20 pack-year cigarette use history, but he quit several years ago. In the last year he has been seen in ophthalmology, cardiology, and physical medicine clinics. Mr. L has also presented to urgent care for medication refills and to the resident walk-in clinic for right shoulder pain. At that time it was noted that Mr. L seemed to be “lost to follow-up,” and an order was placed for him to be scheduled with his new resident primary care provider (PCP).

Mr. L knew that his prior resident physician had left clinic and that he would have a new assigned resident PCP. He has been a patient in the internal medicine resident clinic for four years and has had four resident providers during that time, so this is not his first transition. His last primary care appointment was 12 months ago. His new resident PCP received no written or verbal hand-off communication regarding this gentleman from the prior resident provider.

Mr. L’s main concerns at the time of his first appointment with his new provider are elbow pain and medication refills. The resident’s main concern is a chest radiograph from a disability clinic visit showing a 1.9 cm left upper-lobe lung nodule not seen on earlier chest imaging. This test was performed 12 months ago, and there is no documentation of communication of test results or further work-up.

Transitions of care are currently a hot topic of investigation and intervention. Communication lapses and prescribing errors are sources of adverse patient outcomes and increased costs after hospital discharge. Increased attention has been focused on hand-off communication, medication reconciliation, and education of patients during transitions. This case involves a predictable but less studied event: the transition of the care of a patient between resident providers in a primary care teaching clinic. The American Board of Internal Medicine reports that there were 7,299 categorical third-year internal medicine residents in the United States in 2012. If their panels contain 50 to 100 patients, there are 350,000 to 750,000 patients of graduating internal medicine residents each year. If we consider other disciplines with continuity clinics (e.g. pediatrics, psychology, and family medicine), the number likely exceeds 1 million patients annually. While the literature examining this topic is growing, it is dwarfed by the volume of research involving the inpatient arena. Interventional investigations are rare.

Although there are many complex medical issues in this patient’s history, the resident PCP focuses the discussion with Mr. L on the abnormal chest x-ray. The patient reports never receiving the results of the chest radiograph despite having seen the ordering physician in the disability clinic after the results were available. The results typically would have alerted to his previous resident PCP and the supervising attending. This results reporting would have allowed the prior PCP and/or attending to react to the results even if they had not ordered the test. Unfortunately, both providers had left the health care system prior to the chest radiograph being ordered. In discussing the lung nodule with the patient and after considering its size, radiographic appearance, and location as well as the patient’s smoking history, a CT scan is ordered.

Unfortunately this case contains prime examples of adverse events documented in transitions in resident clinics. One recent study found large numbers of patients miss the first appointment with their new provider and end up seeing providers who are not assigned to them. ER visits and hospitalizations are increased in the year after a transition from a graduating resident to a new resident provider. That same study found that, six months after the transition, more than half of tests ordered by previous providers had no documented follow-up. A study of patient perceptions found deterioration of relationship and rapport, which is not a surprise. In this case, 12 months passed before Mr. L had an appointment with his new resident PCP. This long interval led him to visit an urgent care clinic for medication refills and seek care from non-assigned providers in walk-in clinics. Most notably, there was substantial delay in diagnosis and treatment when a radiology test resulted after his provider had left.

Computed tomography of the chest reveals that the left upper-lobe nodule has grown to a 4.2 cm mass. There is no evidence of adenopathy or metastatic lesions on this imaging. Lung cancer is considered the most likely etiology. This diagnosis is further discussed between the patient and his new resident provider. Radiologic staging with PET scanning and MRI reveal no distant metastases. The mass is FDG-avid on PET scan. An urgent consultation to pulmonology is ordered. Based on the pulmonologist’s recommendations, continued on page 11.
Demystifying Morning Report: How to Conduct a Stimulating Ambulatory Morning Report: Part II

Priya Radhakrishnan, MD

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

Ambulatory morning reports are traditionally harder to conduct for most of us, particularly for junior faculty and chief residents. Most often, the “story” does not follow the traditional format because the case history evolves over a period of time. While those puzzling diagnoses do occur with regular frequency, it is more common for residents to present psychosocial issues or noncompliance-related disease. As a result, facilitators often do not have a lot to say, and the learners can feel that the entire exercise is less valuable than the “more important” parts of the curriculum.

Preparing for an interactive ambulatory morning report should begin with the presenting resident and attending discussing the goals of the session. Participants want to feel that they have spent the hour learning something new about ambulatory medicine. As educators conducting an ambulatory session, we would ideally like to use this platform to stimulate ownership and interest in outpatient medicine.

Unlike inpatient morning reports that are usually directed at understanding symptoms, developing a differential diagnosis, and managing acute disease, ambulatory morning reports generally fall into one of the following categories:

Chronic Disease
The chronic disease format should involve a case presentation by the resident with a review of the physical examination. Focusing on a diabetic eye examination or how to auscultate for bruits in a patient with diabetes reinforces the value of physical diagnosis. Risk factor stratification (e.g. using Framingham scores or cardiac risk calculators; have students whip out their Medi-calc or Epocrates), reviewing family history, and assessing risk scores help residents realize the importance of a good history. If a patient has multiple comorbid conditions, consider using the session to teach medication reconciliation, optimal medical management for the disease state, or—in geriatric patients—Beers list. For the facilitator, this exercise becomes a helpful review of standard ambulatory medicine.

Ambulatory morning reports are also excellent venues for teaching systems-based learning. Having the social worker or med-psych case worker give insight into the referral and follow-up process may be helpful, particularly in the early part of the year. Population health learning—and the use of registries, meaningful use reports, or transitions of care—is often not included in the residency curriculum. The danger of devoting an entire session to the subject is that systems-based learning may lose the interest of the learners, particularly if done at a high level.

Morning reports are also excellent settings for discussing guideline updates, reviewing diagnostic algorithms, and teaching evidence-based practice. Using a problem-based learning (PBL) or small-group session format may be helpful in teaching evidence-based medicine.

Tying it back to the original patient and developing a plan of care—particularly if teaching systems-based practice—is essential and will ensure that the session does not become a lecture.

While facilitating sessions, ensure that all levels of learners are engaged. Having the different groups of learners state what they took away from the session reinforces the “pearls.” Chronic disease sessions allow us to plant the seeds of future quality improvement projects or ask a clinical question (PICO).

Interesting Case/Diagnostic Challenge
Due to the longer duration of illness, the interesting case format resembles the typical morning report and helps students follow the timeline of symptoms or events. The focus of the session should be on diagnostic algorithms and allow residents to discuss tests and their interpretation. This format is also great for teaching costs, the American Board of Internal Medicine Choosing Wisely campaign, or the American College of Radiology appropriateness criteria.

Biopsychosocial/Difficult Case/Communication/Ethics
Consultants, multi-disciplinary teams, ethics committees, or risk management staff can be introduced in the difficult case format. Plan the sessions in advance and use a healthcare matrix. These sessions promote collective learning, with the residents, attendings, and other health professionals interacting and teaching each other.

Ambulatory morning report is an important teaching method in residency and continuing medical education, particularly when it involves not just residents but faculty, practicing physicians, and health care teams.

Resources
1. Medportal: You need to register, but it’s free and has lots of teaching ideas (https://www.medportal.org)
2. Journal of General Internal Medicine
3. Annals of Internal Medicine (particularly the Annals for continued on page 13
The Society of General Internal Medicine (SGIM) has released a list of specific tests or procedures that are commonly ordered but not always necessary in general internal medicine as part of the Choosing Wisely® campaign, an initiative of the American Board of Internal Medicine (ABIM) Foundation. The list identifies five targeted, evidence-based recommendations that can support conversations between patients and physicians about what care is really necessary. “SGIM is delighted to support the Choosing Wisely campaign,” said SGIM President Eric B. Bass, MD, MPH, from Johns Hopkins University School of Medicine. “We believe that general internists have an important role to play in helping patients make informed decisions about tests and procedures that may otherwise be used too often.”

SGIM’s list identified the following five recommendations:

1. Don’t recommend daily home finger glucose testing in patients with Type 2 diabetes mellitus not using insulin.
2. Don’t perform routine general health checks for asymptomatic adults.
3. Don’t perform routine preoperative testing before low-risk surgical procedures.
4. Don’t recommend cancer screening in adults with life expectancy of less than 10 years.
5. Don’t place, or leave in place, peripherally inserted central catheters for patient or provider convenience.

“Physicians in general internal medicine have a special long-term relationship with their patients. Our goal is to maintain our patients’ health and function, to treat their acute and chronic diseases, and to coordinate care with other specialties on behalf of our patients. The Choosing Wisely topics seek to identify areas where we can engage our patients in conversations designed to enhance their health across this spectrum of practice. We are proud to engage in this specialty-defined Choosing Wisely effort to enhance care on behalf of our patients,” said Laurence F. McMahon, MD, MPH (University of Michigan Medical Center), chair of the SGIM ad hoc Choosing Wisely Committee.

The SGIM Choosing Wisely list was developed after months of careful consideration and review, using the most current evidence about management and treatment options. An ad hoc committee of SGIM was impaneled taking advantage of the clinical expertise of members from the existing Clinical Practice and the Evidence-Based Medicine committees within the Society. Members of the ad hoc committee were then solicited to determine possible topics for consideration. The topics chosen were selected to meet the goals of the Choosing Wisely campaign, taking advantage of the unique clinical perspective of members of the Society in ambulatory general medicine as well as hospital-based practice. The final topics were selected by a vote of committee members based on the strength of the existing evidence, the unique standing members of the Society have in addressing the clinical topics selected, as well as contributions the recommendations would make in terms of patient safety, quality, and economic impact. The final recommendations were approved by the governing Council of SGIM.

“SGIM has shown tremendous leadership by releasing its list of tests and procedures they say are commonly done in general internal medicine but aren’t always necessary,” said Richard J. Baron, MD, president and CEO of the ABIM Foundation. “The content of this list and all of the others developed through this effort are helping physicians and patients across the country engage in conversations about what care they need and what we can do to reduce waste and overuse in our health care system.”

To date, more than 80 national and state medical specialty societies, regional health collaboratives, and consumer partners have joined Choosing Wisely to advance conversations about appropriate care. With the release of more than 30 new lists in late 2013 and early 2014, the campaign will have covered more than 250 tests and procedures that the specialty society partners say are overused and inappropriate and that physicians and patients should discuss.

The campaign also continues to reach millions of consumers nationwide through a stable of consumer and advocacy partners, led by Consumer Reports—the world’s largest independent product-testing organization—which has worked with the ABIM Foundation to distribute patient-friendly resources for consumers and physicians to engage in these important conversations.
Don't recommend daily home finger glucose testing in patients with type 2 diabetes mellitus not using insulin.

Self-monitoring of blood glucose (SMBG) is an integral part of patient self-management in maintaining safe and target-driven glucose control in type 1 diabetes. However, there is no benefit to daily finger glucose testing in patients with type 2 diabetes mellitus who are not on insulin or medications associated with hypoglycemia, and there is negative economic impact and potential negative clinical impact of daily glucose testing. SMBG should be reserved for patients during the titration of their medication doses or during periods of change in patients’ diet and exercise routines.

Don't perform routine general health checks for asymptomatic adults.

Routine general health checks are office visits between a health professional and a patient exclusively for preventive counseling and screening tests. In contrast to office visits for acute illness, specific evidence-based preventive strategies, or chronic care management (e.g., treatment of high blood pressure), regularly scheduled general health checks without a specific cause, including the “health maintenance” annual visit, have not shown to be effective in reducing morbidity, mortality, or hospitalization and create a potential for harm from unnecessary testing.

Don't perform routine pre-operative testing before low-risk surgical procedures.

Pre-operative assessment is expected before all surgical procedures. This assessment includes an appropriately directed and sufficiently comprehensive history and physical examination and, in some cases, properly includes laboratory and other testing to help direct management and assess surgical risk. However, pre-operative testing for low risk surgical procedures (such as cataract extraction) results in unnecessary delays, adds significant avoidable costs, and should be eliminated.

Don’t recommend cancer screening in adults with life expectancy of less than 10 years.

Screening for cancer can be lifesaving in otherwise healthy at-risk patients. While screening tests lead to a mortality benefit, which emerges years after the test is performed, they expose patients to immediate potential harms. Patients with life expectancies of less than 10 years are unlikely to live long enough to derive the distant benefit from screening. However, these patients are in fact more likely to experience harms since patients with limited life expectancy are more likely to be frail and more susceptible to complications of testing and treatments. Therefore the balance of potential benefits and harms does not favor recommending cancer screening in patients with life expectancies of less than 10 years.

Don’t place, or leave in place, peripherally inserted central catheters for patient or provider convenience.

Peripherally inserted central catheters (or “PICCs”) are commonly used devices in contemporary medical practice that are associated with two costly and potentially lethal health care-acquired complications: central-line associated bloodstream infection (CLABSI) and venous thromboembolism (VTE). Given the clinical and economic consequences of these complications, placement of PICCs should be limited to acceptable indications (e.g., long-term intravenous antibiotics, total parenteral nutrition, chemotherapy, and frequent blood draws). PICCs should be promptly removed when acceptable indications for their use end.

Sources

**Home Finger Glucose Testing**


life balance; and 5) stereotypes and stigmas associated with use of these policies and practices. A few of the study’s quoted comments caught my eye. One woman said, “I’m in the first generation of people that refuse to do it the way all the older men have done it who were successful.” Another woman said, “The men I’m working with don’t ever perceive or vocalize family issues as a problem.” One male mentor observed that “as a male in particular, you have to be compassionate because you can’t pretend that you understand all of it because you don’t as a male.” I hate to admit that I’m one of the older men now, but the comments reinforced my belief that both male and female academic leaders must provide mentorship in helping junior faculty and trainees balance work with their personal lives. Leaders sharing their own experiences will help, warts and all. As you can see, my family has given me feedback that will help me do better. I dare you to ask your family how you can do better.

References

MOdERN ING REPORT
continued from page 7

Mr. L undergoes CT guided biopsy of the mass.

Mr. L and his family expresses anger over the delay in diagnosis caused by lack of appropriate follow-up after the transition of care. They are, however, appreciative of the new provider’s identification of the problem, efficient work-up, and frank discussion of diagnosis and next steps.

Even before the radiologic staging, the most likely diagnosis—based on the lesion’s size, location, and growth—is lung cancer. The smoking history and PET characteristics increase the pretest probability greatly. In appropriate candidates with no evidence of metastatic disease, it would be acceptable to proceed to resection of the mass rather than biopsy. Surgical excision is the preferred procedure in a patient with a solitary pulmonary nodule greater than 8 to 10 mm without biopsy-proven malignancy if suspicion for malignancy is high based on clinical and radiographic features, if the nodule is hyper-metabolic on FDG-PET imaging, and if a fully informed patient prefers undergoing a definitive diagnostic procedure.5 Persons proceeding to resection need to have acceptable cardiovascular function to tolerate the procedure and sufficient lung volumes by pulmonary function testing to permit excision of lung tissue surrounding the lesion. If a patient is not a surgical candidate, guidelines recommend biopsy confirmation of malignancy in patients desiring treatment.6 In this case, the patient’s extensive comorbidities made him a poor operative candidate. He opted to proceed with biopsy of his lung mass.

Pathology confirms the diagnosis of adenocarcinoma of the lung, stage IB (T2aN0M0). Just as his severe cardiovascular comorbidities preclude resection rather than biopsy at the diagnostic stage of care, his poor operative candidacy precludes any surgical treatment of his malignancy. After extensive discussion, Mr. L elects to undergo radiation therapy for treatment of his lung cancer.

Key Points
1. Outpatient transitions of care in resident continuity clinics affect hundreds of thousands of patients annually. Research on these transitions of care is limited, and hand-off communication is not common.
2. Resident clinic transitions of care have been linked to adverse patient events, including missed test results, increased hospitalizations, and detrimental effects on patient-doctor relationships.
3. Surgical excision is the preferred management approach of a solitary pulmonary nodule in selected cases. In patients who are poor surgical candidates but desire treatment, tissue biopsy is recommended.

References
Regardless, the individual mandate is nearly upon us. The core of the next phase, the exchanges, is modeled on similar plans in European countries. In the United States, participating insurance companies list benefits and costs under four broad areas of coverage: platinum, gold, silver, and bronze. The costs of the plans, their mandatory (e.g. no co-pay for preventive services) and optional benefits, and their limits are detailed. Computer programs allow individuals to enter diagnoses, medications, and budget constraints to generate a list of plans that fit their needs. For those who have difficulty with the enrollment process, the ACA has mandated that paid navigators be available to help. For qualified individuals, subsidies are advanceable and refundable. For those who opt out, the penalty will be assessed through income tax filings. Penalties will be low in 2014 ($95 for individual, $47.50 for children, $285 per family for those making less than $50,000, and 1% of income for those earning $50,000 or more) but will rise in 2015 and 2016, leveling off at a maximum of $2,085 per family or 2.5% of income.

If your patients express confusion, you can direct them to several non-partisan websites. For example, the Kaiser Family Foundation has a cartoon that illustrates the major components of the ACA. The Consumer Reports Foundation has published a straightforward, downloadable document that describes the main elements of the ACA, which is free and available on their website.

Regardless of its merits and deficits—and regardless of political scrambling to defund the ACA—there are no real plans to stop its next phase. It may get delayed, the rollout may be rough, and some states will lag behind others. Nonetheless, it will likely become a part of everyday life in the United States. Perhaps the greatest fear among our political wranglers is that people will like it.

**Suggested Reading**


Jones JM. In US, 43% of uninsured unaware they must get coverage. Available at http://www.gallup.com/poll/163280/uninsured-unaware-coverage.aspx (accessed on August 24, 2013).


changes in her diet based on my counselling, but it wasn’t enough. Her physical challenges were too great and my demands too strong for her to make a lasting change. As anyone knows, following a perfect diet is tough. Temptations, mood, and social expectations have to be kept in balance to prevent people from slipping into old habits. Finally, I simply decided to let her do as much as she could.

At the time of our sixth meeting, my patient developed a COPD flare. I was taken aback by her appearance. She had an oxygen tube running under her nose and took heavy tiring breaths. She seemed severely sleep deprived and had difficulty talking; we didn’t spend much time together during our session. I comforted her and said how I admired her courage and patience with me. I showed her a COPD wellness book and asked her how the past week had been. Despite the pain she was in, she started sharing humorous stories about her caretaker. My patient was laughing and joking, and I laughed with her.

That was my last meeting with her. She was hospitalized afterwards, so I was unable to give her an overview of everything we had discussed in the past few weeks, a few last minute tips, and a final goodbye.

I realized that no matter how hard health care professionals try to convince patients to outsmart their diseases by controlling their habits, the professionals still fight a losing battle. My patient was doing her best to take precautions, eat well, and stay healthy but with little to no improvement in her disease. If anything, her condition probably worsened.

Health management plans often fail for victims of chronic illness because they lack access to the necessary social and economic resources. Many have limited means to shop for groceries and exercise, which can be expensive and time consuming. Others lack transportation or cannot walk but short distances. The threat of disease worsening prevents people from participating in physical activities for extended periods of time, and some feel unsafe leaving the security of their homes. People confronting these obstacles can become easily discouraged and depressed.

This opportunity has made me aware of the frustration and joy of clinical care today. The frustration is promoting health despite economic and social constraints. The joy is helping people develop awareness about what they can change. I wish my patient luck in her journey to battle her diseases. I hope she took away as much as I did from our brief time together.

COMMENTARY
continued from page 2

SIGN OF THE TIMES: PART II
continued from page 8

Educators section): It walks you through great teaching tips.

4. NEJM videos: Show a procedure video of a paracentesis.

5. YouTube: Another great resource for videos, but remember to check the video in its entirety before using it. Also ask the resident or chief to download it beforehand to be sure it works, and keep a couple of questions handy for stimulating discussion.


7. ACP Journal club: A great source if you are looking for an article that you want to use for teaching or reference material. It spells out the stats, so it can be used easily for teaching without much prep.

8. SGIM: Find great handouts from meeting workshops (http://www.sgim.org/resource-library?k=ResourceLibrary)


12. Center for Evidence-based Medicine (http://www.cebm.net/?o=1036)

References


General Health Checks


Preoperative Testing

continued on page 15

Rhode Island Hospital, Division of General Internal Medicine, Department of Medicine, Providence, RI 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.
SIGN OF THE TIMES: PART II
continued from page 14

Screening with Life Expectancy Less than 10 Years


Central Catheters for Patient/Provider Convenience


About the ABIM Foundation
The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice. To learn more about the ABIM Foundation, visit www.abimfoundation.org.
Mentored Training Program
Hybrid Hospitalist / GIM Fellow

The Division of General Internal Medicine and its Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking a BE internist to participate in a GIM Hospitalist Fellowship. The program is designed for general internists who wish to develop careers as hospitalist clinician-investigators. The mentored program of training will consist of a 3-year experience that includes pursuit of a Master’s degree in our Clinical and Translational Sciences Research program, completion of a research project and thesis, and participation as a faculty member in our Cincinnati Center for Clinical Effectiveness and Patient-Centered Research. You also will have the opportunity to collaborate with researchers in our Center for Health Informatics. Methodological focus areas include patient-centered outcomes research, medical informatics, and improvement sciences.

As an Instructor in the Division of General Internal Medicine, which performs the bulk of resident and student teaching for the Department of Medicine, you also will participate as an attending on both traditional resident-led ward teams and hospitalist teaching teams consisting of one intern. Roughly 50% of your time will be protected to pursue the mentored training program and Master’s degree, while the other 50% will be dedicated to clinician-educator responsibilities.

Our hospitalists are leaders in improving both patient care and clinical processes at our primary location, UC Medical Center. Interested applicants should contact either Mark.Eckman@uc.edu or Kevin.Dell@uc.edu. We are recruiting for July 2014.

The University of Cincinnati is an affirmative action/equal opportunity employer. Women and People of Color are encouraged to apply. U.C. is a smoke-free work environment.