NEW PERSPECTIVES

Wellness City: An Integrated Approach to Whole Person Wellness
Gene Johnson, CISW

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People with serious mental illness can and do recover. We have seen thousands of people who experience mental health and substance use challenges recover. We have seen it so many times that we have moved past hoping recovery will happen and into knowing recovery will occur. We expect it and eagerly await its arrival. However, we have also come to recognize that too often recovery happens in spite of us. Access to the range of health care and recovery supports is fragmented and complicated. Individuals served in the public system often have to navigate three or more agencies, providers, and systems. Primary health care is provided through the state’s Medicaid program. Mental health services operate in a silo and are separately funded. Employment supports are provided through the Rehabilitation Services Agency. Housing is delivered through specialized behavioral health-supported housing agencies. Recovery and peer supports are provided by yet another group of organizations. For people with multiple complex needs, the system is confusing at best. The result? People with serious mental illness (SMI) have a life expectancy of 25 years less than the general public due to chronic medical illnesses like diabetes, cardiovascular and metabolic disease, obesity, high cholesterol, dyslipidemia, respiratory problems, and cancer. The Recovery Innovations Wellness City offers an alternative.

While inability to communicate physical complaints is often cited as a root cause of poor outcomes among people with SMI, other factors may contribute to poor health. Stigma and discrimination against people with SMI may be institutionalized by primary care physicians themselves who report that patients with SMI are “difficult and time consuming” and feel a general sense of uneasiness working with them. Physician perceptions and feelings can result in two critical treatment failures. The first is “therapeutic nihilism,” which is a failure to provide enough information for patients to make informed decisions about their health. The second is “diagnostic overshadowing.” Diagnostic overshadowing occurs when the physician attributes physical illness to mental illness and assumes the person is attention seeking, exaggerating, or having panic. Diagnostic overshadowing can result in poor treatment, disregard of serious symptoms, and unnecessary mortality. The integrated holistic approach of Wellness City offers an alternative.

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A medical degree does not confer immunity to burnout. From the New York Times’ to Lancet,2 physician depression, suicide, and exhaustion have been covered extensively in the lay and scientific press. Most recently, Pauline Chen, MD, wrote “Doctors Badmouthing Other Doctors,”3 which reviewed the lack of cultural empathy we hold with one another. As 30 million more Americans become insured with the implementation of the Affordable Care Act and resident work hours demand more patient care in less time, the impetus to improve the health of physicians has never been more pressing.

The rate of depression among physicians is about that of the general population; however, suicide rates are much higher. Male physicians are about 40% more likely to commit suicide than other men, and female physicians are 130% more likely. The problem seems to start during medical school, but exact causes are unknown. Sharmila Devi, MD, in “Doctors in Distress”2 and Pauline Chen in “Medical Student Burnout and Risk of Doctor Suicide”3 suggest that students enter medical school with mental health profiles similar to those of their peers but end up experiencing depression, burnout, and other mental illnesses at higher rates.

“At medical school, competitiveness, the quest for perfection, too much autonomy coupled with responsibility, and the fear of showing vulnerability have all been cited as triggers for mental ill health,” states Devi. “Increased rates of self-medication, alcoholism, and other harmful [unprofessional behaviors] have been reported increased among doctors who try to cope with stress and burnout on their own for fear of losing their medical licenses if they report mental stress.” Additionally, medical students often begin a malignant learning of work-life balance described as “[work hard, play hard.]” This mantra has likely been applied in each of our lives at some point. Maybe it was said while studying all day for USMLE Step 1, with a plan to cut loose with fellow med student friends later that night at the local bar. Maybe it was during residency, when the holiday formal brought out the best and worst in us, with many showing up for work the following morning in less-than-top operating form. Maybe we live this way everyday, from one extreme to another, taking care of patients intensively during the day and then escaping the stress and emotions every night with the help of alcohol, marijuana, or pills. Maybe we think that behavior outside of work doesn’t affect what happens during the day.

Often the most successful physicians who have fine tuned the skill of emotional resiliency can go for years without detection by their peers. Despite spending enormous amounts of time together, the life of physicians, especially trainees, is incredibly busy. Sensing stress and illness in one other is often difficult. continued on page 10
Are We Creating Value for Patients and Members?
Eric B. Bass, MD, MPH

In our efforts to collaborate with other professional societies, we also wrestle with how to have a distinctive voice in advocating for innovative changes in clinical practice, education, and research.

When the SGIM Council meets for its mid-year retreat, we will face the daunting challenge of bringing strategic governance to an organization that has an extremely broad range of interests and activities. Indeed, as generalists we thrive on extending the breadth of our work while stubbornly resisting the urge to focus on a few priorities. As an organization, we remain firmly committed to supporting work in research, education, and clinical practice. At the same time, we continue to wrestle with the diverse roles of general internists and the shrinking number of members who remain involved in both inpatient and outpatient care. In our efforts to collaborate with other professional societies, we also wrestle with how to have a distinctive voice in advocating for innovative changes in clinical practice, education, and research. How can the SGIM president help the Council think strategically about all of the issues? Well, I plan to put our new tag line to use by asking Council members whether we are doing enough to create value for our patients (and for our members).

At the Council’s June retreat, we reviewed influences on the field of general internal medicine. We were conscious of the increasing emphasis on value in health care accompanied by rapidly expanding efforts to measure clinical performance. We applauded policy-makers’ interests in changing how physicians are paid since such changes could bring more support to primary care providers. We noted how general internists can capitalize on the growth of patient-centered medical homes. We agreed that general internists are well qualified to guide the growing use of health information technology and population-oriented approaches in health care. We acknowledged the enormous growth of hospital medicine as a distinct professional discipline. We also identified major developments in the approach to graduate medical education and continuing medical education. Lastly, we noted how the Patient-Centered Outcomes Research Institute will create new research opportunities for our members. Despite the opportunities to strengthen the role of general internists in our health care system, we expressed concern that our patients still lack a strong voice in how health care is delivered.

With that context, the Council reviewed the work of SGIM’s 10 committees (Research, Education, Clinical Practice, Health Policy, Ethics, Annual Program, Membership, Awards, Finance, and Development); five task forces (Women’s Health, Evidence-Based Medicine (EBM), Geriatrics, Academic Hospitalist, and Disparities); and three work groups (Veterans Affairs (VA), Board of Regional Leaders, and Maintenance of Certification (MOC)). The Council generally supported continuation of the excellent work being done by the groups and found very little that was not worth continuing—despite being urged to identify activities that could be dropped.

Several objectives emerged as priorities for the 2013-2014 academic year, including: 1) creating a communication strategy to attract trainees to general internal medicine and to support our health policy work; 2) revitalizing the mentorship program within SGIM to give more support to educators and investigators; 3) designing a curriculum for non-physician members of care teams, which could focus on their roles in improving quality of care; 4) developing additional MOC opportunities; and 5) preparing a business and dissemination plan for the TEACH Program, MOC initiative, and EBM Bottom Line project.

The Council identified other important action items, including: 1) hiring new staff to bring the SGIM office to 14 full-time positions and developing metrics to guide future staffing decisions; 2) asking the Clinical Practice Committee to create a...
Feet First: Reflections on Primary Care for Homeless People with Serious Mental Illness
Travis P. Baggett, MD, MPH

Dr. Baggett is a clinician-investigator at Massachusetts General Hospital, an instructor in medicine at Harvard Medical School, and a staff physician at Boston Health Care for the Homeless Program.

A 56-year-old homeless woman with untreated schizophrenia presents to a shelter clinic at the suggestion of shelter staff. She reports “molecular bubbles” on her teeth, tingling in her hands related to “lithium ion batteries,” and abdominal swelling due to “air pressure, water elements, and iron.” She has not seen a doctor in more than five years. On exam, her blood pressure is 180/110, her teeth are blackened and decayed, she has a 20-cm firm suprapubic mass, she has lice on her clothing, and her feet are macerated and foul smelling with elongated toenails that wrap underneath her toes. She declines imaging of her pelvic mass but accepts a foot soak, nail trimming, and new socks.

As the number of homeless individuals in the United States grew in the 1980s, some reports suggested that as many as 90% of homeless people had mental illness.1 Although we now know this prevalence to be considerably lower, the burden of mental illness among homeless individuals is nonetheless substantial. An estimated 14% of homeless people have schizophrenia,2 and more than 50% have a lifetime history of mental health problems.3

Homeless individuals with serious mental illness are arguably among the most vulnerable members of our society, and their complex needs are often not well met by traditional health care systems. In 2010, Boston Health Care for the Homeless Program partnered with the Massachusetts General Hospital Division of Public and Community Psychiatry and the Massachusetts Department of Mental Health to create a novel medical clinic embedded within a shelter for homeless people with severe and persistent mental illness, including psychotic disorders. The clinic provides primary and preventive care on a weekly basis and includes psychiatry residents who assist in the evaluation and management of patients.

Despite lofty goals, the clinic had a humble beginning. For the first two years, we saw patients in the women’s bathroom because it was the only private location with a working sink. The pink walls proved to have a calming effect on both me and my patients. Like many internists, I had received no special training in psychiatric illness, much less psychotic disorders, during residency. Still, I was instantly drawn to this work and to the remarkable people I encountered doing it. What follows are my thoughts on some of the most salient things I’ve learned in taking care of homeless people with serious mental illness over the past three years:

1. Go to them. While a homeless person with psychiatric illness strikes many of us as the prototypical “high utilizer,” my experience has suggested that on average this group of people is much more likely to underutilize or avoid health care services. This usually isn’t because of self-destructive tendencies but rather because of disorganized thinking; delusional paranoia or even well-founded mistrust of medical institutions; lack of insight about their own health needs; or inadequate knowledge about where, when, and how to seek health care. Locating our services in shelters and programs where our patients reside removes some of those barriers and allows them to approach us on more familiar terms without the need to navigate confusing hospital corridors, crowded waiting rooms, or requests for identification. Indeed, we’ve learned that if we wait for them to seek us out in a traditional medical setting, it’s much later in their course of illness, making it more difficult to alter their health trajectory.

2. Start with tangible needs. Many of the illnesses that comprise bread-and-butter primary care are often, at least early on, intangible disruptions of bodily homeostasis that bother physicians more than they bother patients. High blood pressure, high blood sugar, high cholesterol—these are usually not the issues that our patients are most concerned about. More commonly what brings them in the door and keeps them coming back is an issue with more tangible consequences, like dental pain, vision disturbances, skin rashes, or foot problems. Although these are often the issues we feel least prepared to treat, even a little effort to do so goes a long way. Since early in our clinical experience, foot care has been a cornerstone of our service model. We offer patients a foot soak at every visit, and oftentimes I dedicate entire visits to trimming toenails and shaving calluses. For a population with a heavy burden of trauma, this is a safe introduction to the concept of physical contact and a safe way to start health-oriented conversations outside the framework of traditional history-taking. Medically, the feet reveal a great deal about a person’s overall health and self-care, but more importantly, the simple act of...
Mental health disorders are among the most common conditions evaluated and treated by general internists. By some estimates, over one third of all mental health care in the United States is provided by primary care clinicians, and 70% of primary care clinicians’ time involves managing complex psychosocial issues. Furthermore, psychological disorders such as depression or post-traumatic stress disorder influence the incidence and prognosis of comorbid physical illnesses. This strong relationship between primary care and behavioral medicine provides a clear rationale for integrating behavioral medicine into the general internist’s practice. Yet, historically, medicine has segregated the care of the body and the mind into two silos. Economics have contributed to the isolation between general internists and behavioral specialists. Due in part to poor reimbursement from insurance companies, many of us are unable to link our patients with high-quality affordable behavioral specialists.

The last decade has been marked by two signature pieces of federal legislation that have promised to transform this paradigm. The Mental Health Parity and Addiction Law, enacted by Congress in 2008, requires group health insurers that offer mental health benefits to provide coverage for mental health conditions at the same level as provided for physical conditions. The Affordable Care Act (ACA) of 2010 mandates that Medicaid benchmark plans and plans operated by state-based insurance exchanges offer behavioral services. The ACA also fosters the development of integrated care models (e.g., primary care medical homes and accountable care organizations) that aim to replace fee-for-service with bundled payments for high-quality patient care. The hope is that this will create an economically viable model for integrating behavioral medicine specialists into primary care settings.

At the same time that policy-makers have been seeking to redress the imbalance between access to mental health and physical health services, researchers have been demonstrating the effectiveness of new approaches to integrating mental health with primary care. One of the studies that has revolutionized the field is the IMPACT trial. This study showed that a primary care-based program of enhanced depression screening and treatment can dramatically improve mental health outcomes among patients with depression. A key component of this program is the availability of a collaborative team of mental health specialists including a therapist trained in problem-solving therapy and a psychiatrist for the most challenging cases. Adapted versions of this model of care have successfully reduced depressive symptoms in patients with comorbid health conditions in a cost-effective fashion; in some studies, this team-based approach has improved physical health outcomes as well.

Given these recent advances in policy and evidence-based mental health medicine, we wondered if the general internists on the frontline of caring for patients with mental disorders were noticing any positive changes. Has there been an increase in the availability of mental health services for their patients? Are the decades-old cultural walls between physical and mental health specialists disintegrating? To answer these questions, we canvassed our colleagues in the SGIM Mental Health Interest Group to gain their perspectives. Below, we summarize some of the key themes that emerged from these interviews.

For many general internists—especially those practicing outside large cities—finding affordable mental health care for patients remains a challenge. Some internists even feel that access to specialists is going in the wrong direction, with shrinking primary care resources for co-located social workers or other behavioral specialists and ongoing challenges identifying external referrals. Some well-intentioned psychologists wishing to locate their practice in the academic primary care setting have found that divisions of general internal medicine, while sensitive to the need for increased access, do not have a viable model to fund mental health specialists in the academic primary care setting. Whether implementation of the ACA will increase accessibility to specialists in the coming years remains to be seen.

Many academic-based general internists observe ongoing barriers to accessing mental health resources within their own institutions. There is confusion as to how to refer patients to these resources. Whereas referring to medicine or surgical specialists often only requires a click in the electronic health record, psychiatry resources often require finding a mysterious phone number, faxing a form, or having patients make the appointment themselves. Psychiatry clinics are perceived to have inordinately long wait times for new assessments, and psychotherapy is often unavailable for individual counseling or in languages other than English. Even when patients are successfully referred to behavioral specialists, few receive any feedback regarding the referral, and notes are often kept in separate charts. Hence, cultural and structural barriers remain in place for many internists.
In keeping with this month’s theme of mental health, I interviewed fellow Research Committee member Gail Daumit about the mental health funding landscape. Dr. Daumit has sustained funding throughout her research career largely from the National Institute of Mental Health (NIMH). Her research focus has been on improving physical health and decreasing premature mortality for persons with serious mental illness. Other areas of interest to NIMH include depression and anxiety in primary care, Veterans’ health, post-traumatic stress disorder, suicide prevention, and autism. Dr. Daumit also mentioned that potential future avenues of research interest at NIMH may include adults with autism (and transitions of care between pediatric and adult settings), as well as research looking at the role of novel technologies (i.e. apps, text messaging, and Internet-based interventions) for mental health interventions. NIMH also has a division of HIV and mental health.

Other NIH institutes may fund mental health research when mental health is comorbid with another disease entity. For example, the National Heart Lung and Blood Institute (NHLBI) has funded studies of anxiety and depression in patients with cardiovascular disease. Studies are examining whether treating mental health disorders improves cardiovascular outcomes and the role of collaborative care models. Other friendly NIH institutes include the National Institute on Drug Abuse (NIDA) and the Agency for Health Care Quality (AHRQ) for systems-oriented work. Another institute worth exploring is the National Institute on Minority Health and Health Disparities (NIMHD), given the large disparities in health status and outcomes between persons with and without mental illness. Dr. Daumit also pointed to a lack of implementation and dissemination studies of interventions that have proven effective in randomized controlled trials. Regardless of the institute, it is well worth having a phone conversation with a project officer to discuss your research ideas and the fit with the institute. Dr. Daumit mentioned the R21 and R34 pilot grant mechanisms at NIMH, NIDA, and other institutes, which can serve as planning grants for future clinical trials. These mechanisms are ideal for junior investigators and are a good entrée into an NIH institute.

What about foundation funding? Unfortunately there are not many foundations that are friendly to mental health/primary care topics—at least not in serious mental illness. Dr. Daumit has had success from the Brain and Behavior Research Foundation, but they tend to fund smaller grants for pilot work. Some state-level foundations (e.g. in Texas) may fund local work, but applicants often need to reside in that state. Finally, the Patient Centered Outcomes Research Institute has identified mental health as a priority area.

Postscript: In today’s funding climate, grant writing can be discouraging (and even soul-crushing) at times. I noticed that the October issue of the Forum contained a number of articles on work-life balance. Last week, after having submitted two large grants (one on smoking and mental illness submitted to NIDA, by the way), I “played hooky” from work and attended a Thursday morning open rehearsal of the Boston Symphony Orchestra with my husband. Check out the 3rd movement of Brahms’ Symphony #3 on YouTube—I assure you, you will not regret it!
It’s time to set your calendars for April 23-26, 2014, for the 37th Annual Meeting in San Diego, CA. This year’s meeting theme—Building the Bridges of Generalism: Partnering to Improve Health—celebrates the depth and diversity of the connections that inspire and empower generalist medicine. We enthusiastically encourage submissions highlighting the diverse partnerships that foster excellence in clinical care, education, research, and advocacy in generalist medicine.

We are excited to announce our three plenary speakers, beginning with SGIM President Eric Bass, MD, who will kick off our first morning with his presidential address. On Friday, the Malcolm L. Peterson Lecture will be delivered by Mark D. Smith, MD, founding president of the California HealthCare Foundation (CHCF). During his tenure, Dr. Smith focused the CHCF on catalyzing efforts to improve health care quality and access for California’s most vulnerable and underserved residents. At our Saturday awards breakfast, we will hear from America Bracho, MD, executive director of Latino Health Access, a center for health promotion and disease prevention that assists with the health needs of Latinos in Orange County.

Our special symposia will address a wide range of innovative topics from understanding how the Affordable Care Act affects migrant health to implementing new educational milestones. We will again offer a spectrum of evidence-based updates organized by SGIM members. After a break of a few years, the US Preventive Services Task Force will once again present an update on prevention.

Two special programs will be offered to celebrate our theme of partnerships. One will highlight partnerships with patient and family advocacy organizations to enhance the quality of health care delivery. Another will focus on the integration of art and drama in medical education, including an offsite event to the San Diego Museum of Art. These events are presented in collaboration with faculty in the Medical Humanities and Arts program at the University of California, Irvine.

Programming for students, residents, and fellows has been expanded this year with two new offerings. A Career Development Retreat will be offered on Wednesday for general internal medicine (GIM) fellows. This will include a guided walk through of the opening poster session, which will feature posters submitted by GIM fellows. On Saturday, Primary Care Progress will present its highly rated advocacy workshop, titled “The Missing Link to Building New Primary Care Teams: Public Narrative.” SGIM Council has increased the number of registration scholarships for medical students from 25 to 50, so this is a great opportunity to encourage your most enthusiastic and energetic medical students to attend and learn about all of the wonderful career opportunities in GIM!

Finally, the 2014 meeting will offer the chance to celebrate the life and work of a leader in GIM with the inaugural Frederick L. Brancati Mentorship and Leadership Award, co-sponsored by SGIM and the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM). This award will recognize junior faculty who inspire trainees to pursue academic GIM; provide financial support for leadership training; and promote the transformation of health care through innovations in research, education, and practice as Dr. Brancati did.

The 2014 annual meeting is shaping up to be an exciting program with time to network and catch up with colleagues. While the Padres will be in DC, these new and innovative learning opportunities will meet all of your non-baseball needs. We’ll see you there!

For more information, go to: http://www.sgim.org/meetings/annual-meeting
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everal years ago, I attended my first SGIM Hill Day at the urging of my division director. At the time, I was finishing up a general internal medicine fellowship. While I was eager to please, I knew almost nothing about health policy. At SGIM’s dinner the evening before that first Hill Day, I listened to members of SGIM’s executive health policy committee rattle off an alphabet soup of acronyms: Title VII, SGR, RUC. As they eloquently spoke about these issues, I started doubting my ability to maintain an informed discussion with the legislators I would visit and was certain I would have no influence.

The following morning, during our briefing from CRD, which represents SGIM’s interests in government affairs, I remember being very nervous until one of CRD’s members reminded us that, as practicing physicians, we had expertise to share with these legislators. My colleague and I then set off to Capitol Hill to our scheduled meetings at the offices of both of our state’s senators and our congressman. At these offices, we saw many other advocacy group representatives, and I started to understand the “game” of advocacy. Although occasionally an SGIM member meets with his/her actual representative, we met with legislative assistants who were young college graduates. As we spoke about issues relevant to general internal medicine and left behind additional information, I realized that CRD was absolutely right. As general internists, we were able to convey meaningful stories about the importance of supporting legislation that promotes general internal medicine. We told stories about our patients and their struggles with health insurance. To emphasize the need for equitable payment reform, I discussed the reasons why I chose a career in general internal medicine when many of my residency classmates chose to pursue subspecialties. We discussed Title VII and the importance of continued funding for training of general internists. These personal stories and discussions seemed to resonate with the legislative assistants. By the end of the day, I felt that, even if nothing else ever came from our discussions and leave-behind materials, our stories were heard and would hopefully be remembered.

I felt much more confident the following year at my second SGIM Hill Day, and I better understood SGIM’s health policy agenda. That year, Congress passed a continuing resolution that was impacting me personally; funding for a grant I had submitted was dependent on a budget being approved by Congress. During Hill Day, I was able to speak personally about the importance of supporting health services research and gave examples of how research findings could directly benefit patients.

Although it is very difficult to measure the impact of SGIM’s Hill Day, in the past few years there have been several anecdotal successes. One SGIM member ended up inviting her congressman to her house for dinner to continue a discussion they had started during Hill Day about health disparities. Another SGIM member’s briefing to his congressman eventually led to the introduction of legislation to require an annual review of misvalued E&M codes. Many veteran SGIM Hill Day attendees have developed relationships with their representatives and maintain a dialogue throughout the year about health policy issues.

It’s been especially interesting to have attended Hill Days before, during, and after the passing of the Affordable Care Act. People have strong feelings about health care reform and are eager to express their beliefs about its strengths and limitations. As the implementation of the Affordable Care Act continues, it seems more important than ever to attend Hill Day to ensure that the policies included in the legislation that support general internal medicine and our patients are not overshadowed by rhetoric and controversy.

I don’t know how much impact I have personally had during Hill Day. I know that at each visit, I’m just one of many meetings each legislative assistant holds each day. I’m also not naive enough to believe that everything I say is passed on from the legislative assistants to the legislators. Nevertheless, I don’t think that it would be fair for me to criticize reimbursement inequity, the lack of universal coverage, inadequate Title VII funding, or limited research funding if I did not do everything possible to advocate for these issues. I know that by attending Hill Day, I am doing my absolute best to ensure that SGIM’s collective voice—representing general internists, our patients, and our students—is heard loud and clear on Capitol Hill.

I know that by attending Hill Day, I am doing my absolute best to ensure that SGIM’s collective voice—representing general internists, our patients, and our students—is heard loud and clear on Capitol Hill.
Recovery Innovations is a non-profit agency providing community-based mental health and addiction treatment services in 22 communities in six states using a recovery paradigm. While we celebrate the success of recovery, every week someone dies—sometimes by suicide but more often from poor health and inadequate health care. Barbara was 45 years old when she died. She completed the Recovery Innovations 80-hour training in peer support and was hired as a peer-support specialist by a local case management agency. Barbara had rediscovered herself. Her new job provided her with meaning and purpose once again. We maintained contact for several weeks, but then she stopped showing up for work, and we lost contact. A few weeks later we learned she had been hospitalized at a local psychiatric hospital where she died of kidney failure, undiagnosed and untreated. Stories like this are tragic and all too frequent.

The Wellness City framework offers an alternative through an integrated coordinated approach. Established and built upon the principles of freedom, equality, responsibility, and rights, Wellness City citizens develop their own personal recovery plan focused on the physical, emotional, intellectual, social, occupational, and spiritual domains of wellness. They are also supported to achieve success in community living, financial management, and recreation/leisure. Services are provided through wellness courses; recovery education; housing assistance; employment counseling; and coordination of social, financial, and emotional support. Wellness City improves access to integrated holistic care using an integrated team of healthcare professionals, peer-support specialists, and peer whole-health coaches.

Over the past several years, Recovery Innovations, which is based in Phoenix, AZ, has developed and delivered Wellness City programs in seven communities in four states. While we have refined the model, our efforts to help citizens achieve improved physical health and wellness have been marginal. Due to separate funding streams and service delivery systems, physical health care has not been integrated within Wellness City. However, recent breakthroughs in policies and funding have created the opportunity for an integration of physical and behavioral health care. Now a pilot initiative is being launched to add co-located and integrated primary care, along with nurse wellness coordinators and peer whole-health coaches. We expect to see increased wellness through easy access to care in settings where citizens feel safe and have a sense of belonging. Additionally, extra emphasis will be placed on patient follow-up. Peer coaches will be available to help citizens track and attend health care appointments and develop self-advocacy skills. Having the primary care physician co-located and integrated with the recovery team will create ease of communication and teamwork among Wellness City team members. Service quality will increase due to the interaction between peer-support team members in other Wellness City peer-run programs such as supported housing, employment counseling, recovery education, and recreational activities.

Over the past decade, Recovery Innovations has created a peer-support workforce that is regarded as the largest in the world. Two thirds of Recovery Innovations employees at 22 locations in five states and New Zealand are individuals in recovery (more than 425 employees) working in dedicated peer-support roles and engaged at every level of the organization. Recovery Innovations has trained and certified more than 5,000 peer-support specialists around the world. The result of this new mental health model has been a new recovery-based health care workforce. In addition to the increased wellbeing of people served by peer support, the people trained to provide peer-support services report enhanced self-esteem and empowerment as well as significant reduction in the use of public benefits. In a recent survey of Recovery Innovations peer-support employees, 59% reported discontinuation of cash benefits as a result of their employment. Furthermore, 45% reported no longer receiving Medicaid. Overlaying all of these positive outcomes of employment is the fact that during this study, $7.8 million was paid in wages to peer-support specialists, with $1.1 million paid in federal taxes alone. The creation of this new peer workforce will be continued and expanded through the Wellness City Integrated Health Home.

Another aspect of this innovative program is a proposed partnership with the residency training program at St. Joseph’s Hospital and Medical Center. An integrated medical care team will provide primary care at Wellness City. By learning and practicing from a recovery perspective, resident physicians and other staff members will acquire a deeper knowledge of the needs of people with mental health challenges and a more hopeful, less stigmatized perspective on caring for this population. As the new physicians go on to independent practice, the wisdom they gained through working on this unique project will exponentially increase understanding as they work side by side with their colleagues. Residents and their medical team members, within the context of a recovery model, will learn the skills of coordinating and connecting community-based resources to positively impact decision-making related to medical care and personal and social wellbeing while engaging patients in their own self-care.

We believe that we can improve the health and quality of life for people with SMI. Wellness City is one solution that will move us forward. We look forward to sharing the results of Wellness City as an integrated whole-health approach in the near future.
EDITORIAL
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The final clinical presentation may become one of crisis. Often this crisis can be the only factor that ultimately creates the opportunity for one to receive the medical attention that is needed. The culture that rewards physical stamina and emotional strength in the face of illness but does not allow an outlet for the healer to be human can often result in silence, physician impairment, and patient risk.

Current estimates are that approximately 15% of physicians will be impaired at work at some point in their careers. Although physicians may not have higher rates of impairment compared to other professionals, many factors may contribute to drug abuse and mental illness, particularly depression. It might be cliché to note that many physicians possess a strong drive for achievement, exceptional conscientiousness, and an ability to deny personal problems. In fact, we laud these characteristics and consider them advantageous for “success” in medicine; ironically, however, they may also predispose to impairment. The very act of identifying impairment is often difficult because the manifestations are varied, and physicians will typically suppress and deny any suggestion of a problem. Additionally, identification is often by a colleague or subordinate physician, afraid of damaging a career we all know was not acquired easily. However, identification is essential because untreated impairment may result in the loss of a license and a loss of life. Fortunately, once identified and treated, physicians often do better in recovery than others and typically can return to a productive career and a satisfying personal and family life. In efforts to protect physician privacy and patient safety when dealing with the health of physicians, programs specific to physician health have erupted all over the United States. Currently, most states have responded and developed programs that operate within the parameters of state regulation and legislation and provide many different levels of service to physicians in need.

In Pennsylvania, the Physicians’ Health Program (PHP) provides support and advocacy to physicians struggling with addiction or physical or mental challenges. From assessment to treatment, monitoring, and re-entry, this organization steps in to support the impaired physician and save careers while protecting patients. It functions as a liaison with legal entities, such as the licensure boards, on behalf of the physician and the hospital. The PHP is the designated impairment program for the State Board of Medicine and the State Board of Osteopathic Medicine. Plainly stated, if physicians enter the program and adhere to the advised treatment plan and long-term monitoring, licenses are not revoked for the use of substances or presence of mental illness alone, allowing the physician the opportunity to continue practicing medicine when well.

Residency programs and faculty may attempt to prevent the problem prior to need for such a program with yearly online modules or short lectures on resident wellbeing. However, these are only Band-Aids if the culture of silence is not addressed. The solution may seem daunting to administrators supervising hundreds of trainees and physicians; however, resources are available. The American Medical Association (AMA) brought formal attention to the topic by a landmark paper on mental health, titled “The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence.” In the spirit of prevention, the AMA has created CME courses and resources on their Website to address mental health, suicide, and substance abuse among physicians and trainees.

Most people have flown on an airplane and can state verbatim the presentation given by the airline attendant: “Please secure your oxygen mask before assisting others.” There is immense knowledge and value to be learned by this simple statement. Medical culture needs to turn an empathetic eye to the healers themselves, and the place to create that change is in how we prepare and teach future physicians. Pauline Chen writes, “There’s a lot of attention focused on the patient experience, but I think we need to work on improving the clinician experience as well.” Encouraging physicians to face and heal themselves not only gives richness to their own experience but to the patient–doctor relationship as well.

References
work group to collaborate with the American College of Physicians (ACP) on the High Value Care initiative; 3) asking the Membership Committee to make plans for recruiting more non-physician members of care teams and for increasing medical student attendance at regional SGIM meetings; 4) asking the Board of Regional Leaders to measure regional growth and success; 5) establishing a process for obtaining disclosures of potential competing interests before all Council meetings and calls; 6) asking the Finance Committee to review our reserves and make recommendations about reinvestment of last year’s surplus; 7) asking the Development Committee to create a new policy for internal fund raising; 8) clarifying the roles of the Finance and Development committees and determining whether they should be combined; 9) determining whether the Awards Committee should become a function of the Council; and 10) creating a Task Force for Health Care Transitions for Young People with Chronic Conditions.

To reinforce the importance of the priority objectives and action items, David Karlson agreed to incorporate related goals into the process we established for evaluating his performance as our executive director. These goals should be viewed as measures of the organization’s performance, so here is my assessment of our mid-term performance with five months left to make further progress.

**Goal #1:** Hire four new staff and get them oriented and trained. David and Kay Ovington (our chief operating officer) have hired and oriented four new staff members: Donté Shannon (manager of volunteer services); Brittany Benton (committee and initiatives assistant); Katherin Cooper (regional meetings assistant); and Tracey Pierce (regional meetings manager). They are already working hard in support of the organization’s priorities.

**Goal #2:** Establish a process for obtaining feedback from leaders of committees and task forces about the quality of staff support, demonstrate excellent staff support, and determine whether SGIM has sufficient staff to support all aspects of the strategic plan. This work is in progress.

**Goal #3:** Support all major initiatives. The SGIM office has supported three initiatives that have the potential to create value for patients by strengthening primary care. The first is the Health Policy Committee’s advocacy for physician payment reform. The committee has drafted three white papers on physician payment reform that have been submitted for publication. The committee may need additional resources in addition to narrowing its focus to achieve the goal of getting other organizations to support specific recommendations of the National Commission on Physician Payment Reform. For the High Value Care initiative, SGIM’s Clinical Practice Committee formed a work group to collaborate with the ACP. That work is proceeding on schedule. In the third initiative, the MOC Task Force has been working with the Disparities Task Force to create an MOC module. This work is a good example of how SGIM can have a distinctive voice in advocating for attention to disparities in health care. The Clinical Practice Committee considered the idea of designing a curriculum for non-physician members of care teams and found insufficient support to pursue that further.

The SGIM office also has supported initiatives intended to strengthen our overall capacity to achieve SGIM’s mission. Ann Natter has worked with Francine Jetton (director of communications and publications) and Julie Machulsky (social media community manager) to launch a communications work group, which had a retreat in early November. The Council will need to discuss preliminary recommendations of the group. The SGIM office has developed a business plan for sustaining the TEACH Program but has not yet developed a business plan for the MOC initiative or the EBM Bottom Line project. The Membership Committee was asked to work on several things, and the Council will need to review the committee’s progress. As the new director of membership, Jillian Gann has brought renewed energy to the Membership Committee. The Council will also need to review the progress of the Board of Regional Leaders in addressing geographic areas with little participation.

Since the June retreat, the Council has completed several action items. It established a process for disclosing competing interests before all Council meetings and calls. It reviewed and approved plans for the new Task Force for Health Care Transitions for Young People with Chronic Conditions. It decided to keep the Awards, Finance, and Development committees. We are waiting for the Finance Committee to make recommendations about an optimal level of reserves.

**Goal #4:** Foster collaborative relationships with other organizations. In the past few months, Council members have had productive meetings with leaders of the Alliance of Academic Internal Medicine, the American Board of Internal Medicine, the Association of American Medical Colleges, and Primary Care Progress. SGIM worked effectively with the Society of Hospital Medicine and the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM) in running the Academic Hospitalist Academy in October 2013. Council members will have their next meeting with the leaders of ACP in March. We have not had much recent engagement with leaders of the American Geriatric Society or the Society of Teachers in Family Medicine. We need to follow-up on the last meeting we had with leaders of the American Medical Student Association. We need to hear from the VA Task Force about opportunities to continue working with the VA leadership.

**Goal #5:** Foster growth of a leadership development program. The continued on page 12
SGIM office has been working with ACLGIM leaders to continue developing its leadership programs, including the ACLGIM Summit and the Hess Leadership Institute.

**Goal #6:** Prepare a business plan and/or obtain funding for at least two of the organization’s priorities. The goal was to obtain at least $150,000 in additional funding. To date, $30,000 has been obtained with several proposals pending. We hope that hiring additional staff will allow our director of development (Leslie Dunne) to devote more time to fund raising.

**Goal #7:** Obtain funding for the Brancati Mentorship and Leadership Award. We have succeeded in raising more than $50,000 for the Brancati Award with additional pledged donations pending.

**Goal #8:** Establish a new policy for internal fund raising. The Development Committee drafted a new policy that has been approved by the Council.

**Goal #9:** Ensure the Council has excellent understanding of major issues when making decisions about the organization’s budget. The SGIM office has made some changes to enhance the ability of all Council members to understand the complexities of the organization’s budget.

**Goal #10:** Ensure clear communication with the JGIM editors. The SGIM office has been working with the editors to enhance communication about JGIM’s revenue, expenses, staffing needs, Web site issues, and interactions with the publisher.

**Goal #11:** Increase submissions and registration for the annual meeting. The Program Committee is doing a fabulous job planning for the annual meeting in San Diego with the assistance of Sarajane Garten. Workshop submissions have exceeded the number in the previous year. We are optimistic about seeing an increase in abstract submissions and registration.

**Goal #12:** Finalize a new process for evaluating the executive director, and develop a plan for regularly reviewing the performance of the Council. This article is an example of how we have specified evaluation criteria linked to strategic priorities. This article is also an example of how we are trying to be more transparent about evaluating the performance of the Council so that we can continue to grow in our effectiveness as a governing board.

Many of the goals are intended to strengthen the capacity of SGIM to achieve its mission. To help us think strategically about how to prioritize our work, I would like for the Council to consider how specific activities will enhance our ability to create value for patients and for our members. I hope that SGIM will always be known for having a distinctive voice that speaks for the welfare of our patients.

**References**


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**CLINICIAN-INVESTIGATOR**

**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.
of soaking feet inverts the traditional patient-physician power dynamic and conveys to patients that we are there to serve them. As the relationship evolves, we use these types of encounters to gradually link patients’ tangible symptoms to less tangible conditions like diabetes and hypertension.

3. Understand the narrative. As internists, we’re trained to diagnose illnesses and treat them. We make problem lists, prescribe meds, and fix abnormal numbers. In the midst of these efforts, it’s easy to lose sight of the person in front of us and the story he/she has to tell. Engaging in a conversation with someone with a psychotic disorder is no easy task, and we’re tempted to think that a disorganized historian renders the history obsolete. In my experience, this isn’t true. Although a patient’s story may be tangential, it often contains crucial details of life as he/she perceives it. Beyond being useful from a diagnostic perspective, these details often tell us what makes our patients happy, what worries them, and what their priorities are—however delusional they may be. Without first understanding this narrative, making forward progress on anything else is impossible. This doesn’t require that a clinician participate in patients’ delusions, and it is certainly not useful to refute these delusions. When a patient expresses a distressing delusional idea (e.g. “The people who work here are spying on me.”), usually a brief statement of empathy is sufficient (e.g. “That sounds really stressful.”), followed by a conversational pivot that shifts the focus to the patient’s strengths (e.g. “Tell me more about how you handle that.”). At the core of these interviewing techniques is the goal of establishing, to the greatest extent possible, a trusting relationship as the foundation of healing and recovery.

4. Be patient. The case above illustrates a complex patient with numerous outstanding health issues. Our instinct is to try to fix all of these things at once. Sometimes this is appropriate, but it’s rarely necessary, and in some cases it can be counterproductive. One of the most valuable skills I’ve learned in caring for this population is how to take a deep breath in the face of chaos. None of these issues started today, and none have to be fixed today. We don’t ignore or give up on important issues like undiagnosed pelvic masses or untreated hypertension, but rather we allow for some flexibility in pursuing these issues at a pace that’s compatible with building trust and getting buy-in. In some cases this pace will be quick, and in other cases it will be glacial. I met with one patient every week for one year before she agreed to try an antipsychotic medication. Another patient wouldn’t get on an exam table for the first year I saw her because “only bad things like mammograms and Pap smears happen there.” In such cases, the usual metrics of primary care quality don’t readily apply. According to many of these metrics, my clinical performance is an abject failure. I think this highlights the need to better incorporate patients’ values and preferences, as well as their psychiatric and medical complexity, in the measurement of primary care quality; otherwise, there will never be a favorable incentive structure for making the long-term investment necessary to care for this population.

5. Collaborate. A single person cannot do this work alone. As physicians, we are often ill equipped to handle many of the challenges our patients bring to us. These challenges are bigger than any of us, and they require a skill set that extends far beyond our own. Because of this, multidisciplinary collaboration is an essential component of caring for this population. Each week, the shelter where I work hosts interdisciplinary case management rounds where key shelter staff, nurses, social workers, outreach workers, addiction specialists, mental health care providers, and primary care providers come together to discuss client-specific issues. We collaborate with community-based caseworkers and peer specialists who collectively weave a network of social support services to meet their clients’ needs. These are the unseen heroes of the entire process, and very little can be accomplished without their input and assistance.

By now it should be clear that I’m not really peddling new knowledge. Taking care of a population with sometimes-specialized needs creates the impression that the work itself requires specialized knowledge. For the most part it doesn’t. The basic principles of taking care of homeless people with serious mental illness are the same as those underlying good primary care in any setting. We strive to put the patient at the center of the process and to build the agenda collaboratively. We tailor our goals to reflect our patients’ values and preferences, and we exercise our best judgment in translating those values and preferences into shared decisions about testing or treatment. Sometimes that means we swiftly pursue five years of backlogged health maintenance tasks, but more often it means we soak their feet, listen, take deep breaths, and be present.
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Some internists practicing in settings that have co-located specialists report missed opportunities for integrating specialists into their practice. As a result, these internists continue to refer many of their patients to community sites even though they have in-clinic resources. The mental health specialists located in general medicine clinics, in return, express frustration due to high "no show" rates and due to patients who arrive without any understanding of the reason for the referral. While these co-located programs are often initially instituted with idealistic aspirations for integrated care, without physician champions, integration withers away.

We did hear stories that provide reason for optimism. In some institutions, notably at outpatient practices of the Departments of Veterans Affairs, general medicine and behavioral specialists know each other personally, can approach one another with questions, and are confident that their patients can be seen in a timely fashion with notes shared on the same system. The high burden of psychological problems among returning Veterans has provided the impetus for increased behavioral resources in VA settings. There have been positive changes in other settings as well. In some cases, positive experiences with collaborative care chronic disease management programs for physical disorders such as diabetes or heart failure have led to interest in similar programs organized around depression. In one especially successful program, a recently implemented IMPACT-style depression screening and treatment program identified and treated almost one third of a major academic clinic’s patients for depression! Ongoing difficulties in accessing specialty care reinforce the need for team-based mental health care in the primary care setting, and now the program is firmly entrenched at that site.

Initiatives to provide seed funding for primary care medical homes have also enabled the development of integrated care models in some clinics. Programs to prevent 30-day readmissions have also invested in behavioral resources that support general internists. In a cautionary tale, however, some general internists experience resistance from psychiatrists who are uncomfortable with primary care serving as the home base for mental health treatment—and even more so are uncomfortable with general internists leading such programs. This highlights the need for increased cultural exchanges between generalists and specialists when attempting to integrate the two silos. Other commonly reported barriers to sustainable integrated models include outdated assumptions about requirements for mental health carve-outs and for segregated billing, electronic health records, and hospital administrators who have not kept abreast of the latest legislative changes.

What is the way forward? How can we broaden and strengthen the integration of primary care with behavioral medicine? General internists almost universally recognize a need for better access to mental health services either through co-location or stronger linkages to specialists in psychiatry departments or in the community. Yet for practice transformation to take place, general internists must champion such programs. In a thought-provoking editorial in JGIM, the possibility of developing a new specialty in general internal medicine—the Primary Care Behavioralist—was proposed. This would enable us to train and promote a cadre of general internists with a passion for taking advantage of recent legislative and research findings to truly integrate primary care with mental health services. Another way forward may be to focus our efforts on internal medicine residency training. Unlike our colleagues in family medicine, we have few explicit requirements for behavioral medicine during our training even though mental health issues are central to the management of the whole patient. Another approach will be to harness the lessons of implementing depression care programs as a means to expand collaborative care mental health services for a wider spectrum of common mental disorders. Recent legislation does seem to be spurring the development of such integrated models in some settings. There is already abundant evidence that integrated care will lead to better outcomes for our patients. Now is the time for general internists to come together with mental health specialists to accomplish this mission.

References
The Demon Inside Me

Inside me rumbles a storm
That infects every cell like a parasitic worm.
It vowed to cleanse all my pain
And deepened my wounds with its acid rain.

Inside me persists the shame
That reminds me everyday that I’m to blame
For hurting those who love me
By not making efforts toward recovery.

Inside me mingles a fear
That continues to tease me year after year.
It has me caught in its arm
And will cease at nothing to provoke me harm.

Inside me exits courage
That finally broke free from all the rummage.
It helped me conquer my ED
And salvaged me from lying on my death bed.

Inside me abides a change
That feels exciting, yet at the same time, strange.
It inspires me with hope
And taught me the proper skills for me to cope.

Inside me prevails a peace
That radiates throughout and comforts me like fleece.
It’s helped me to stay on track
By reminding me to always guard my back.

Inside me dwells a demon
Who imprisons me and won’t give me freedom.
He tells me he’s my friend
And says he’ll be there with me until the end.

Inside me lives a monster
Who makes me suffer, to make himself stronger.
He controls half my brain
And makes dealing with reality a strain.

Inside me withers a beast
Who refuses to let me take the front seat.
He left me without a voice
And forced me to live with him without a choice.

Inside me lies a nightmare
That transformed my whole life into a fright fair.
It robbed me of all my dreams
And stabbed my aching heart just to hear my screams.

Inside me is a traitor
Who promised to provide me something greater.
He tells me that I’ll stay a kid
And sucked my childhood like a squid.

Inside me hides a devil
Who enjoys bargaining at every level.
He stole my only two eyes
And blinded me from all his pathetic lies.

Inside me love is born.
It’s mending the pieces that had once been torn
As I rustle through the storm
And emerge through the mist in a bright new form.

—Andrea Roman

Director of the Division of General Internal Medicine in the Department of Internal Medicine

The Carver College of Medicine at the University of Iowa seeks a Director of the Division of General Internal Medicine in the Department of Internal Medicine. With 90 faculty members, General Internal Medicine is the largest division in the Department and has an exceptional record of achievement in our tripartite mission of research, education, and exceptional patient care, along with a distinguished record of national and international leadership. A key strength of the Division is strong health services and patient centered outcomes research as evidenced by a strong record of publications and extramural funding. The Division is fortunate to have institutional leaders who direct the Institute for Clinical and Translational Science (ICTS), which has been funded by the NIH CTSA program; and the Center for Comprehensive Access and Delivery Research and Evaluation (CADRE) at the Iowa City VA Medical Center, which is funded by a VA HSR&D Center of Innovation award. An incredibly exciting new venture for UI Health Care and the Division is the Iowa Center for Outcomes Research (ICORE). ICORE aims to be the preeminent center for patient centered outcomes assessment that links institutional missions in research and training with the business intelligence needs of the entire institution and its affiliate partners. Our general internists also have an extensive clinical footprint in numerous practice sites including, multiple hospital led inpatient services at UIHC and the VA Hospital; a consult service specializing in the medical management of surgical patients; and a growing palliative care service. The Department looks to the Division to be leaders in the education mission providing undergraduate and graduate medical education in both didactic and clinical settings as well as serving and mentors and teachers for learners engaged in the mission of discovery.

Candidates must have a record consistent with appointment as a tenured associate or full professor of internal medicine. Minimum requirements include: an MD degree or equivalent; an outstanding record of accomplishments in research, teaching, and service; and eligibility for employment and licensure in Iowa. The successful candidate needs to have the demonstrated capacity to foster an environment in which excellence in teaching, research and scholarship can flourish and a demonstrated commitment to promoting a diverse academic environment. Successful candidates will have a record of innovative and effective administrative and fiscal leadership, national stature in academic internal medicine, and interpersonal skills, and enjoy interactions with students, staff and faculty.

The search committee will accept nominations and applications until the position is filled. Nominations should include a CV, and the names of three or more references. Please send inquiries to the Search Committee Chair, Dr. Gary E. Rosenthal at gary.rosenthal@uiowa.edu.

The University of Iowa is an equal opportunity and affirmative action employer. Women and minorities are strongly encouraged to apply.
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