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COMMENTARY

Open Letter to VA Administration Regarding ACES

Karen Horowitz, MD

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I just returned from the Society of General Internal Medicine annual meeting. It is a gathering of academic general internal medicine (GIM) internists who influence the teaching, research, and leadership agendas of internal medicine departments nationally. The VA traditionally has a large representation at this meeting and sponsors a day of programs that promote opportunities for participation in VA research and system redesign. SGIM serves a networking function for primary care and has been influential in promoting the agenda of such programs as the Patient Aligned Care Team/Patient Centered Medical Home beyond the confines of the VA. At SGIM, best practices are shared and collaborations develop that have impact on GIM nationally and internationally. VA physicians are leaders in innovations in primary care, evidence-based medicine, applications of meaningful use of the electronic medical record, and interprofessional collaboration—all highly valued by SGIM. The theme for next year's SGIM meeting is, in fact, inter-professional collaboration.

Unfortunately, the success of the VA and its large influence in SGIM is also its downfall—a large number of VA internists are primary care physicians who would like to attend this meeting. Many were kept away because of the rationing of travel opportunities inherent in the Attendance and Cost Estimation System (ACES) process. (Some may have been willing to go on their own nickel if time for attendance at the meeting were not prohibited for those not approved by ACES.) Ironically, if internists want to go to an esoteric and highly specialized meeting, they have a better chance of approval for that travel than for approval to attend the SGIM annual meeting.

As we consider high-value care and allocation of resources, the VA should develop a model that allocates resources for programs with *impact*. The VA should consider the value added by the SGIM annual meeting and make it a priority to include rather than exclude our primary care colleagues from participating.

Next year's SGIM meeting will also be appropriate for attendance by interprofessional team members. It is an opportunity for VA members to collaborate and lead. The meeting is in Toronto, which will add another layer of complexity to the travel process for VA providers.

SGIM is a leader in promoting primary care careers for future physicians. These initiatives will have a lasting impact on the students we teach and on our future VA workforce. I hope that we can overcome the barriers to attendance at this meeting and support those who would innovate on behalf of GIM at the VA. SGIM

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Physician Advocacy: How Newtown Changed the Way I Practice Medicine

Doug Olson, MD

Dr. Olson is a member of the Forum *editorial board; his Twitter handle is @DoctorOlson.*

The killing of 20 children and six adults in Newtown, CT, on December 14, 2012, changed the way I practice medicine. As time has passed since that tragedy, and with the addition of countless homicides to our national statistics, one question comes up again and again: How can we as a society decrease firearm deaths and hopefully prevent another Newtown?

I don't have the answer to how we can prevent another senseless act of murder. I do know I have tried as a physician to make a difference one patient at a time.

Since the early part of January 2013, I have begun to ask many of my patients if they have firearms in their homes. As a clinician with the health of my patients and society at large entrusted to me, I have an obligation to protect and improve both. In the same way that I ask about cigarette smoking, drug and alcohol use, unsafe sexual practices, and the use of seatbelts or bicycle helmets, I have included asking about guns in my routine review of the social history. For me, this was new. It was something I was taught to do in medical school in encounters with pediatric patients and their parents but not with adult patients. Pediatricians have been asking and counseling about this for years—they are the true leaders in this arena—but much of the rest of medicine has omitted it.

> If by counseling my patients about gun violence prevention I can reduce their risk of harm—and perhaps that of their family members and the community—from further gun violence, I feel it is my professional responsibility to do so.

Pediatricians have shown time and time again that this practice improves household safety, but for some reason, it has not moved beyond the care of children.

There is good reason for me to start doing this: The risk of suicide, homicide, assault, and injury are several times greater in homes with firearms. Despite an ongoing debate on "best practice," there is growing consensus that it should be "routine practice" to ask about firearms.

A typical conversation goes something like this and takes less than 30 seconds:

Physician: You know, since the shooting in Newtown, I have started to ask many of my patients if they have a gun in the home. I'm not asking because I either agree or disagree with your having it. I am just asking so that if you do have one, I can let you know the most

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SGIM Annual Meeting: Breaking Records at 37, SGIM is Inspired, Vibrant, and Growing

William P. Moran, MD, MS

Seventeen SGIM leaders spanning four decades met with Eric Bass, Marshall Chin, SGIM staff, and me to convey their thoughts about how SGIM was doing as a "Society"...

When I arrived in San Diego, it was already clear that the annual meeting would be an amazing experience and prove that SGIM is a healthy and vibrant organization in its 37th year. Among the notable numbers, SGIM set a new record: The annual meeting in San Diego was the largest in SGIM history! At last count, attendance of 2,034 shattered the previous attendance record of 1,839 in Chicago in 2004 and included almost 800 fellows, residents, and medical students and more than 50 international attendees. In contrast to the modest gains in the recent match,[1] the meeting reflected the growing strength and popularity of general internal medicine (GIM).

Records aside, the meeting also had many important "firsts," and I will mention a few. The highly successful TEACH program, led by Eva Aagaard, graduated its first class, while the inaugural GIM fellows' symposium was wildly popular. The Society bestowed the first Frederick L. Brancati mentoring and leadership award, named for a wonderful and exceptional generalist who was devoted to his faculty, mentees, SGIM, and the Association of Chiefs and Leaders in General Internal Medicine. And with a trial fit for a Patient-Centered Outcomes Research Institute grant, the Program Committee conducted a trial of shortened abstract presentations and arranged a concurrent control group as a comparator, completing the first pragmatic clinical trial ever performed entirely at an SGIM annual meeting!

Most of us attend the annual meeting to reconnect with old friends and colleagues, make new friends, network, and re-energize. This year the energy and enthusiasm were incredible. I can only mention a few of the many outstanding presentations. Monica Vela, MD (Herbert W. Nickens Award), told us of her moving journey as the daughter of immigrant Mexican parents, first conquering entry into the American schools and then breaking away from the traditional role of a young Latino woman in a very traditional family to her current role as Dean for Diversity. In a rousing keynote address, America Bracho, MD, scolded, exhorted, and encouraged the audience to "rethink how to strengthen our partnerships with communities" using lessons from her community and her personal journey leading Latino Health Access. Mark Smith, MD (Malcolm Peterson Award), recently of the California Healthcare Foundation, reminded SGIM members "under 40 or 45" of the great founders of the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) who had dreams and romantic notions about the future of primary care. Acknowledging the difficulty pronouncing this acronym, Dr. Smith told us that the Society changed its name to SGIM. The romance persists as SGIM has in many other ways adapted and evolved over the past 37 years and continues to grow and thrive in the current reality of the Affordable Care Act (ACA), accountable care organizations, and the patient-centered medical home.

The most impressive, humbling and somewhat intimidating gathering I attended was the Presidents' Breakfast. Seventeen SGIM leaders spanning four decades met with Eric Bass, Marshall Chin, SGIM staff, and me to convey their thoughts about how SGIM was doing as a Society and how SGIM was adapting to the new reality of ACA policy and implementation. Their advice and wisdom will guide us over the next few years. The achievements of two of those past presidents were recognized with awards. In accepting the Robert J. Glaser Award, Martin Shapiro, MD, told us of his incredible accomplishments and his fear that his uncle would even now disagree that Mar-

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Update on Physician Payment Reform

Mark Schwartz, MD

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In March 2013, the National Commission on Physician Payment Reform released its report with 12 recommendations aiming to reform how physicians are paid, link incentives to care quality, and restrain rising health care costs.[1,2] The independent commission was established by SGIM and funded by the Robert Wood Johnson and California Healthcare foundations. Its report provided a five-year plan to move the United States from the current fee-for-service model to a blended payment system that better aligns practice and payment policy with the triple aim of improving patients' experience of care, improving population health, and reducing health care costs.[3] A recent set of comments in *JGIM* highlighted the report's recommendations and advocated for their implementation.[4-7]

SGIM joined most other physician organizations to advocate for the repeal and replacement of the flawed sustainable growth rate (SGR) law. The SGR sets aggregate spending targets for Medicare services by physicians, and each year since 2002 it has compelled CMS to threaten significant cuts in Medicare payment rates. Each time the cuts loom, Congress heeds the shouts from the physician community to avert the cuts by passing a short-term patch or "doc fix." The most recent patch was set to expire April 1, 2014, with a 24% cut looming. However, for the first time, there was bipartisan agreement in the Senate and in the House on a policy to replace the SGR. While there was broad agreement on the policy, no agreement was reached on how to pay for the roughly $120 billion, 10-year cost of permanently repealing the law. The Congressional Budget Office (CBO) scores it as a cost because it is required to compare all proposed changes to current law, which assumes the SGR cuts will take place, even though they won't. Thus, Congress passed its 17th patch (0.5% increase through 2014) until March 31, 2015.

In the wake of this near-miss opportunity to transform physician payment policy to one that promotes value over volume, SGIM is reissuing the commission report and pressing Congress to return to the bargaining table to reach an agreement on how to pay for the new physician payment policy. The American Academy of Family Physicians and the Society for Hospitalist Medicine—joining the American College of Physicians, Catalyst for Payment Reform, CIGNA, CVS Caremark, and Health Care for All—have recently endorsed the commission report. We anticipate many others to follow.

With a combination of grassroots (letter writing and op-eds) and grasstops (Congressional briefings) advocacy, SGIM is advocating for passage of the new policy before the current patch expires and it becomes even more costly due to increases in the CBO score.

SGIM will continue to work toward these policy aims to reform physician reimbursement strategies to better align with the triple aim.

SGIM will continue to work toward these policy aims to reform physician reimbursement strategies to better align with the triple aim. We welcome comments and engagement in this task by SGIM members.

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Shared Decision Making: Decision Aid Tools to Build a Patient-Centered Medical Home

Leigh H. Simmons, MD, and Karen R. Sepucha, PhD

Drs. Simmons and Sepucha are faculty in the Health Decision Sciences Center at Massachusetts General Hospital.

On a recent afternoon in clinic, two of my patients made the following statements after we reviewed an online tool focused on cardiovascular disease risk reduction:

"Some people might look at those numbers and say 92 people still don't have a heart attack in the next 10 years, pill or no pill. But I look at these numbers and think, wow, four people were saved from a heart attack by taking the pill. I'm a father, with three kids in school. I need to be around for a long time. I'm ready to take a pill."

"Doc, I look at these numbers and think, I have to take a medicine every day for 10 years, and chances are either way, I'm probably not going to have a heart problem. You know how I feel about pills. It's not worth it to me!"

Two conversations in one clinic session. Two men with very similar cardiovascular risk profiles (approximately a 10-year atherosclerotic cardiovascular disease risk of 8%). Two very different opinions on taking a statin medicine for cardiovascular risk reduction. These conversations resulted in different care plans for each of these men who, on paper, look very similar but who have very different preferences for reducing cardiovascular risk. These two conversations were facilitated by a decision aid that clearly displayed the risk of a myocardial infarction in the next 10 years and the absolute risk reduction achieved by taking a statin medication. The patients readily expressed their opinions about adding a statin medicine to their regimen after walking through the decision aid. As my own practice has made the transition to a patient-centered medical home (PCMH) model, we've placed a high priority on ensuring that the care plans we develop incorporate patients' preferences and values. This task is made much easier by having decision aids available at the point of care.

The PCMH model that is being developed and promoted broadly in primary care practice has four cornerstones: primary care, patient-centered care, new-model practice, and payment reform.[1] A core component of patient-centered care is ensuring that patients and families are informed and involved in the decision-making process and that they receive treatments that meet their needs and goals. The process of achieving this goal has been termed "shared decision making."[2] Shared decision making is a much-discussed topic in research and policy circles but less so in the clinic. Many practice leaders and clinicians may be curious about how to implement shared decision making in routine clinical care and use this method to achieve patient-centered care goals.

A model for shared decision making in clinical practice, described as a sequence of "choice talk, option talk, and decision talk," was recently outlined by Elwyn and colleagues.[3] This framework addresses the use of patient decision support tools, also known as decision aids. These tools come in several forms, including detailed video programs that patients can view before or after visits, web-based decision aids that can be accessed in the office visit or independently, and paper forms such as option grids that are designed for use during an office visit with clinicians. Many of these decision aids are readily available online for use by clinicians and patients. However, many aids have stayed in the research realm and have not yet reached broad implementation in routine practice.

A core component of patient-centered care is ensuring that patients and families are informed and involved in the decision-making process and that they receive treatments that meet their needs and goals.

At Massachusetts General Hospital, our Shared Decision Making Program (www.massgeneral.org/decisionsciences) supports our clinicians and patients to make better decisions about medical tests and treatments. Here we describe some tools, freely accessible online, that can be downloaded for use in the office visit. Below are some of the programs we have found most useful to our clinicians aiming to implement shared decision making in routine practice, particularly those hoping to improve conversations in the office visit to focus on shared decisions:

1. **Choice Reports (http://www.massgeneral.org/decisionsciences/):** These short tools were developed by the authors at Massachusetts General Hospital. They are used to promote shared decision-making conversations around treatment of high cholesterol, high blood pressure,

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Teaching Educators Across the Continuum (TEACH): Year One of the Innovative Program

Eva Aagaard, MD; Reena Karani, MD, MHPE; Shobhina Chheda, MD, MPH; and Michael Rosenblum, MD

Drs. Aagaard, Karani, Chheda, and Rosenblum are TEACH *certificate faculty.*

The inaugural scholars of the SGIM TEACH Certificate Program graduated at the 2014 annual meeting in San Diego. Twenty-two scholars completed the year-long program that was designed and implemented by members of the SGIM Education Committee to address the needs of junior clinician-educators. The program included a full-day of content the day before the annual meeting and participation in a minimum of three workshops over two years at consecutive annual meetings. The participants in the program received direct observation and feedback on their teaching skills across the year by faculty at their own institutions. Additionally, scholars participated in an online community and journal club and completed a Teacher's Portfolio to document their educational activities and the impact of their work in teaching and learning. Graduates also become members of a life-long learning community.

Through an iterative process, the SGIM TEACH certificate faculty worked to improve the program through feedback and reflection. We asked our faculty group to describe some of their strongest impressions from the program.

"The development of an interactive learning community was the most impressive and fun aspect of the TEACH experience for me. I was amazed by the insightful comments and diverse approaches to issues that many of us regularly face. Illustrative examples include working with the struggling learner, trying to better balance work-life, and teaching on the fly. Contributors from the learning community would describe their experiences and successful techniques, thereby creating opportunities for all of us to try them within our practice."

—Mike Rosenblum, MD

"The 2014 TEACH scholars are impressive in their accomplishments and committed to becoming leaders in medical education. Their active participation in the TEACH precourse and workshops was matched only by the warm camaraderie they developed as a community of learners. I was motivated by their higher-order questions and efforts to delve deeply into issues of teaching and learning. What a privilege it has been to be a part of TEACH!"

—Reena Karani, MD, MHPE

"I was lucky to serve as a coach for a scholar from my home institution. It was truly wonderful to watch him develop as a teacher over the year. I feel very fortunate to be surrounded by so many wonderful educators at SGIM."

—Eva Aagaard, MD

"The graduation of our first class of TEACH scholars was surprisingly emotional for me. I knew we could deliver content and that the participants would learn new material, but I wasn't as sure about our ability to truly build a community. This success of TEACH became clear to me as I heard our graduates give advice to the incoming class: 'Learn from your TEACH peers, get suggestions from your TEACH peers.' They learned so much from each other, and I learned so much from them."

—Shobhi Chheda, MD, MPH

The new 2014-15 scholars began their work on April 22, 2014, at the annual meeting through participation in the core course. Content included practical sessions on establishing an effective learning climate, writing goals and objectives, feedback and assessment, and portfolio development. TEACH workshops offered during the annual meeting included teaching at the bedside, identification and remediation of struggling learners, and education as scholarship. The new class is comprised of 23 scholars and includes junior faculty from across all of the SGIM regions who

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Twenty-two scholars completed the year-long program that was designed and implemented by members of the SGIM Education Committee to address the needs of junior clinician-educators.

Obesity-related Attitudes and Practice Patterns of Primary Care Providers in an Urban Safety Net Public Hospital

Tanu S. Pandey, MD, MPH, FACP; Anthi Katsouli, MD, MPH; and Sarah Imran

Dr. Pandey is assistant professor of medicine at RUSH University Medical Center and patient safety officer at John H. Stroger Jr. Hospital of Cook County. Dr. Katsouli is a hospitalist at Loretto Hospital, and Ms. Imran is a pre-med student at University of Illinois at Urbana Champaign.

Obesity in the United States is approaching epidemic proportions with 70% of the adult population being considered overweight (body mass index (BMI) 25-29.9) or obese (BMI > 30).[1] Inadequate physical activity and poor dietary habits are important contributors to this condition. Obesity increases the risk of diabetes, hypertension, coronary artery disease, arthritis, depression, and many cancers. It results in 300,000 deaths annually and costs $16 billion dollars in direct medical expenses every year.[2] However, a substantial proportion of such individuals do not have an appropriate diet or physical activity plan.[3] Primary care physicians (PCPs) most often encounter overweight patients and are perfectly placed to influence their lifestyle. Research reveals that only 42% of obese patients get weight loss advice from their physicians.[4] The US Preventive Services Task Force (USPSTF), American Heart Association, and American Diabetic Association recommend that all patients be screened for obesity and that PCPs provide counseling for obesity as a modifiable risk factor for coronary artery disease.[5-7] The USPSTF recommends intensive counseling for obese patients; however, there is lack of evidence regarding the effectiveness of low or moderate counseling.[5]

Practice patterns among primary care physicians have been studied in the United States as well as Europe.[8-10] Barriers to optimum obesity management include lack of time, inadequate training, negative health beliefs about weight, and lack of motivation.[11] There are few studies that examine the attitudes of resident physicians toward obesity counseling.[12] In one study, 31% of internal medicine residents believed that treating obesity was futile, and only 44% felt qualified to treat obese patients.[13] The perspective of PCPs on obesity-related care is vital to improving outcomes, and the challenges associated with day-to-day management of obesity can be understood by investigating provider experiences, attitudes, and values.

Obesity is a common disorder among patients seen at John H. Stroger Jr. Hospital of Cook County in Chicago. However, the attitudes, beliefs, and practice patterns of PCPs in the general medicine clinic (GMC) regarding obesity-related care remain largely unknown. We conducted a simple descriptive study to investigate obesity-related practice patterns among PCPs in the GMC. The objectives of the study were to: 1) examine self-reported weight management practice patterns and competency among PCPs at our institution, 2) describe barriers to effective management of obesity in the GMC, and 3) assess an opportunity for a potential intervention and/or faculty development project to improve obesity care.

The study was conducted at a large safety net hospital within an urban public health care system that serves mostly under- and uninsured patients. In this study, we developed an online questionnaire that was e-mailed as a web link to all attending and resident physicians who have a continuity clinic in the GMC. Attending physicians in the Division of General Internal Medicine and Primary Care and physicians from other departments who provide direct primary care in the GMC were included. No incentives were given to the respondents. The questionnaire was developed and validated in a focus group of PCPs.

> Our study provides evidence that physicians provide inadequate weight-related counseling to obese patients. There is no standard practice related to obesity by PCPs, and few studies have been conducted at public institutions to address barriers to obesity-related care.

We developed a ten-item survey tool to explore the practice patterns and self-reported competency level of physicians. Survey questions addressed the following domains: participant characteristics, frequency of use of BMI in the clinical setting, comfort level discussing weight with patients, documentation of obesity as a separate problem in the problem list, time spent discussing lifestyle changes with patients, barriers to obesity care in the GMC, suggestions for improving care, self-reported competency

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EDITORIAL

Pain Management: Are We Upside Down?

Denise Millstine, MD

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Pain management can be one of the most challenging aspects of primary care. Concern for medication adverse events, lack of objective diagnostic tests, and fear of litigation contribute to the unease felt commonly by providers.

Pain is common and comes in many forms. Acute pain from acute injury can be easily identified and often corrected with short-term care. Sub-acute pain can also be improved with proper attention and treatment strategies. Chronic pain can be difficult to specifically diagnose and to treat with efficacy.

Still, we are asked to discuss pain with patients on a regular basis and to show documented effort to improve symptoms and suffering. In our toolbox, we have exercise, physical therapy, over-the-counter analgesics, and potent pharmaceutical-grade pain medications. We rely on our patients' subjective reporting on their treatment response, and we remain fully cognizant of the abuse potential of our therapies. If we are lucky, we have a pain specialist in our local community with adequate access to provide a sub-specialized opinion and set of recommendations.

It's possible, however, that we have been approaching pain in a suboptimal way. Pain results from a heightened stimulus of discomfort from the body, of course, but also from the mind, patient beliefs, and/or past experiences. Most often, we focus our history and differential on the physical site of the pain. We forget—or better yet have never been trained—to be open to the other contributing factors.

Integrative medicine, in which health and healing are the focus of care and all effective modalities are considered, has been shown to be effective in the management of pain. For chronic low-back and neck pain, yoga, acupressure, biofeedback, and qi gong have shown efficacy. For fibromyalgia, tai chi, mindfulness meditation, and yoga are significantly beneficial. Other pain conditions have other effective strategies.[1]

Additional strategies have been recommended for pain evaluation as well. At a recent talk, a doctor who focuses on hypnosis as part of his therapeutic strategy recommended exploring the onset of pain and the surrounding situation. He offered the need for forgiveness, of self or others, as a common barrier to resolution or improvement of the symptoms. Others describe the gate theory of pain, which is a learned and established response that must be relearned and retrained with intention. In neither of these approaches does numbing the pain or distracting away from it lead to prolonged healing and symptom relief.

In general internal medicine, our training and experience in managing pain is generally poor. We, the providers, feel helpless, and our patients are dissatisfied. Perhaps we have it wrong. Perhaps we need to take pain head on and explore it more, which would be easier with more tools, more openness, and a broader framework for its assessment.

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The Week on Twitter

Madhusree Singh, MD

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A lot has been happening on my Twitter timeline, as it always does (whether I'm looking or not). These are a few of the stories that I learned from, and maybe you will find something of value here, too. After our recent, well-attended SGIM national meeting in San Diego, I was especially primed to seek out all the information that could help me be the best generalist that I can be. This list has a decidedly medical feel to it, even though Twitter has the capability of exploring issues more broadly—depending on whom you follow and how you navigate the flow of conversation.

The first person with Middle East Respiratory Syndrome (MERS), which is caused by coronavirus, was found in the United States recently. This disease has been a significant public health issue in Saudi Arabia since late 2012, and its spread to the United States led to an almost SARS-like panic, at least on my timeline. I managed to get a fair amount of reliable information from these sources.

@WHO
On 2 May 2014, the **#US** reported a lab-confirmed case of Middle East respiratory syndrome in a US citizen who lives in **#SaudiArabia #MERS**

@Medscape
Everything you need to know about the **#MERS** outbreak **http://bit.ly/1sbM1Es**

@AnnalsofIM
A recent editorial questions the pandemic potential of **#MERS**. Read, 'Medusa's Ugly Head Again: From SARS to MERS-CoV' **http://bit.ly/1kM4rsg**

Polio was another disease that was mentioned often. This made for depressing news considering that India has not had a single polio case for more than two years. Seems like polio is on its way back, especially in war-ravaged countries like Pakistan, Syria, and Iraq.

@WHO
This year during low season of **#polio** transmission (Jan-Apr), there had been 59 cases in **#Pakistan**, compared to 9 the same period last year

@UN
News: **@WHO** declares the spread of wild **#polio** virus to date in 2014 as a Public Health Emergency of Intl Concern http://goo.gl/Bzcvq4

@Laurie_Garrett
Two years ago we were on edge of victory over **#polio**. Now we are in crisis mode. Unusual emergency statement from WHO: **http://www.who.int/mediacentre/news/statements/2014/polio-20140505/en/** …

Another common topic of discussion was the resurgence of vaccine preventable disease.

@mmatiasv
MT **@picardonhealth** Anti-vaxxers just won't quit - even as preventable diseases spread **http://ti.me/1mv2mjX** via **@TIMEHealth #vaccineswork**

@drflanders
Such an important concept - MT **@DrFriedenCDC** Our most impt achievements are outbreaks that didn't happen. **#vaccineswork**

@Pezzapezzi
#Vaccines are one of the most successful tools to protect your health **pic.twitter.com/kxNxRtkWzG**

#vaccineswork would you drive without brakes?

A pediatrician tweeted about the need to be able to recognize resurgent vaccine-preventable diseases that we have not seen in a long while.

@DoctorNatasha
Sadly, you're going to need this one. → How to recognize measles from **@WashingtonPost: http://ow.ly/wkC40 #vaccineswork**

Another issue discussed widely was the increased incidence of diabetes in children despite news that diabetes complication rates are down.

@USATODAYhealth
Diabetes rates skyrocket in kids and teens. Type 2 prevalence up 30% 2000-2009; type 1 prevalence up 21%, **http://usat.ly/1flhhlW**

@AARPCA
Diabetes-related complications seen declining among US adults: **http://bit.ly/1mwn9EJ #health**

Medical students' choice of specialty was on our minds, as were discussions about costs of care and how this impacts the practice of medicine.

@KHNews
Who Should Get Pricey Hepatitis C Drugs? **http://khne.ws/1iQrle7 #healthcosts pic.twitter.com/vdPC0GeCpc**

@KHNews
Who Really Pays For Health Care Might Surprise You, **@JayHancock1** reports: **http://khne.ws/1nJp7o1**

@TimLaheyMD
Bright **#medstudents** pick plastic

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Access and the Patient Centered Medical Home: Of Love and War

Priya Radhakrishnan, MD

"Improving access to care is one of the fundamental building blocks of the patient centered medical home (PCMH). The revised PCMH standards list enhanced access and continuity as the first of the six standards in PCMH recognition to accommodate patient's needs with access and advice during and after hours, give patients and their families information about their medical home, and provide patients with team-based care."

Our PCMH journey was very rocky. Our first iteration got blown to smithereens when our hospital announced its purchase of an electronic medical record. None of us ever believed that it would happen—it was something that was always promised "next year" (for the first six years of my job). So when we decided to convert to a PCMH, no one really knew or cared enough to let us know. As a result, we sacrificed a small forest completing our paper application.

Finally we went live and decided—quite like warriors—that we were going to pursue accreditation or go bust, which we nearly did. As a practice in sync with the economic downturn, we suddenly had time to pursue the recognition simply because patients could not afford to come in. If they came to the doctor's office, most of them would lose their jobs. Our clinic volumes plummeted, and we were once again in quicksand.

As an NCQA practice with limited resources, we have focused on improving access as an important measure of quality. The trouble with access is finding the sweet spot between utilization of existing open slots and blocking slots. We conducted many plan-do-study-act (PDSA) cycles to evaluate our processes, including balancing the impact of physicians who heavily overbooked with those who refused to add one extra patient to their schedules, thus requiring appointment slots being blocked. Despite the barriers, we eventually arrived at a structure where any patient who called into our practice had the opportunity to see a physician within 48 hours. What was interesting, reflecting back on those times, is the constant state of flux we were in managing many small changes. Minor issues such as shifting schedules to accommodate a physician on sick leave caused massive ripple effects. At the end of the day, open access has come to mean having slots or not.

Once we recovered from the financial downturn and the implementation of our PCMH, we got buried under terabytes of big data. Now we spend our time figuring out what is valuable and what is noise—all in the middle of seeing patients, attending meetings, teaching, seeing patients, and attending yet more meetings.

I often equate transformation with war: The strategies are similar and fall into offensive, defensive, and strategic concepts. As I was writing this article, I came across the Wikipedia article that lists the Principles of War according to the US Army Field Manual 3.0. As I reflected on this information, the parallels to our PCMH recognition process were huge:

1. **Objective:** Direct every military operation toward a clearly defined, decisive, and attainable objective (military). *March steadily toward NCQA standards (PCMH).*
2. **Offensive:** Seize, retain, and exploit the initiative (military). *Seize data by cajoling, then stare blankly at reams of data. Finally seize the systems analyst, and exploit the data sources (PCMH).*
3. **Mass:** Concentrate combat power at the decisive place and time (military). *Achieve critical mass and then work to maintain commitment (PCMH).*
4. **Economy of Force:** Allocate minimum essential combat power to secondary efforts (military). *Allocate minimum staff for monitoring—never mind that clinics are falling apart (PCMH).*
5. **Maneuver:** Place the enemy in a disadvantageous position through the flexible application of combat power (military). *Consider big data both the friend and enemy (PCMH).*
6. **Unity of Command:** For every objective, ensure unity of effort under one responsible commander (military). *Unite docs, care coordinators, and champions in a single simple refrain—We are the champions today of big data! (PCMH).*
7. **Security:** Never permit the enemy to acquire an unexpected advantage (military). *Embrace the VPN (virtual protected network) and guard against virus intrusion (PCMH).*
8. **Surprise:** Strike the enemy at a time, at a place, or in a manner for which he/she is unprepared (military). *Enjoy the serendipity of stumbling on a success and then ensure that it spreads throughout the system like wild fire (PCMH).*
9. **Simplicity:** Prepare clear, uncomplicated plans and clear, concise orders to ensure thorough understanding (military). *Repeat the mantra of the PDSA over and over and over again (PCMH).*

So you see, PCMH transformation is quite like going to war—with data, with words, sometimes your own colleagues. Did I just say data? Sounds miserable, but I am sitting pretty with the end of the tunnel in sight…buried under big data. SGIM

PRESIDENT'S COLUMN

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tin has "done enough." Tom Inui, MD (Elnora A. Rhodes Service Award), reminded us of SGIM founders and leaders whose accomplishments, in the face of adversity, we must remember. Finally, Eric Bass challenged us, asking if SGIM was strong enough to take on issues where we as a Society disagree. The subsequent reasoned and thoughtful town hall meeting, airing differences of opinion about SGIM Choosing Wisely recommendations, confirmed that we are a strong, unified Society able to work constructively together despite our differences—and that working through those differences actually makes SGIM stronger.

There is not enough space to highlight the innovative and creative depth and breadth of the 37th Annual Meeting in San Diego. Next month, SGIM *Forum* will highlight many more exceptional parts of the meeting. For now, congratulations and thank you to the Program Committee—chaired by Neda Ratanawongsa, co-chaired by Happy Menard, and supported by Sarajane Garten and the wonderful staff of SGIM—for the exceptional meeting! They have set a high bar for David C. Thomas and Sharon Strauss for the 2015 SGIM Annual Meeting in Toronto, whose theme is *Generalists in Teams: Adding Value to Patient Care, Research and Education.*

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FROM THE SOCIETY

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work in both ambulatory and inpatient care at academic and community teaching settings.

For those interested in the program, the application period opens July 15, 2014. For more information and to apply, visit www.sgim.org/go/TEACH

2013 TEACH Scholars Who Received Their Certificates in San Diego

- Adam Abraham, University of Colorado Denver
- Shannon K. Boerner, University of Nebraska
- Christopher P. Bruti, Rush University
- Sumanta Chaudhuri Saini, Medical College of Wisconsin
- Dominique L. Cosco, Emory
- Daniel Cottrell, Boston Medical Center
- Rachael R. Dirksen, University of Iowa
- Melanie Gordon, Cook County Hospital
- Rachel Havyer, Mayo Clinic
- Keri T. Holmes-Maybank, Medical University of South Carolina
- Danielle Jones, Emory
- Laura Loertscher, Providence St. Vincent
- Katherine Lupton, Cambridge
- Christopher J. Moreland, UTHSC San Antonio
- Anne Pizzi, University of Kansas
- Yasmin Sacro, University of Chicago
- Jaren G. Thomas, Medical College of Wisconsin
- Yelena Titko, Yale
- Sadie A. Trammell Velásquez, UTHSC San Antonio
- Corina Ungureanu, Ohio State
- Athina Vassilakis, Montefiore
- Emily S. Wang, UTHSC San Antonio

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secure way to store the gun and the ammunition to keep you and your family safe.

Patient: Yes, I have one. No one has ever asked me that before. I don't want you putting me on some list or anything.

Physician: No. Like I said, that is not my intent. I want to make sure you keep your gun and the ammunition locked up, separately if possible. If you have kids or there are kids in your home, they should not have access to it. The gun should always be unloaded when not in use.

Patient: I do all that already.

Physician: There's an almost five times increased risk of suicide and an almost three times increased risk of homicide in a home with firearms. Since you have a gun in the home, I want to make sure you and your family and everyone in this community are kept as safe as possible.

Patient: OK. Thanks, doc.

I firmly believe politics should not enter the exam room. As a physician, I work hard to make sure that when I discuss lifestyle factors like diet, exercise, and smoking, my patients understand that I do so because of the potential impact these factors have on their health. If by counseling my patients about gun violence prevention I can reduce their risk of harm—and perhaps that of their family members and the community—from further gun violence, I feel it is my professional responsibility to do so. My patients seem to understand and appreciate the care behind my efforts. Someday soon, I hope that we will have solid research on best practices in counseling patients on these issues, but for now, we as physicians are doing the best we can for our patients. If nothing else, it at least lets my patients know I care a bit more.

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SIGN OF THE TIMES: PART II

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depression, and diabetes. A video demonstrating their use is available on the website.

2. **Statin/Aspirin Choice Decision Aid (http://statindecisionaid.mayoclinic.org/):** This decision aid was developed by the Knowledge and Evaluation Research Unit, led by Victor Montori at the Mayo Clinic, and facilitates a discussion of cardiovascular risk tailored to the individual. Patients can view in graphic form the absolute benefit of adding a statin and/or aspirin to their regimen. The decision aid includes personalized documentation language that can be pasted into any electronic medical record and retained for later reference. This tool may be particularly useful for clinicians and patients for whom this clinical decision may need to be revisited in light of recently updated guidelines on statin use for cardiovascular risk reduction.

3. **Option Grids (www.optiongrid.org):** These tools were developed by the Option Grid Collaborative, led by Glyn Elwyn on the Dartmouth Center for Health Care Delivery Science. These short tools are for comparing treatment options that are designed to be printed and used in the office visit. Grids for 27 conditions are currently available (with additional grids available for use in Spanish), including carpal tunnel syndrome, prostate cancer treatment, and osteoarthritis. A video demonstrating their use is available on the website.

4. **AHRQ Effective Health Care Program (http://effectivehealthcare.ahrq.gov/index.cfm/tools-and-resources/patient-decision-aids/):** This program was developed by the Agency for Healthcare Research and Quality and involves online interactive decision aids that prepare patients to discuss what is most important to them when they consult with their clinicians. Patients can review these decision aids in advance of a visit or be referred to the site after a consultation. Currently, the site offers decision aids on urinary incontinence, osteoporosis, and localized prostate cancer.

Ongoing areas for further study include the implementation of shared decision-making practice by the entire care team and expanding the use of decision aids beyond the doctor/patient encounter to include pre-visit preparation and non-visit based care. However, for a practice interested in trying out shared decision-making tools, the decision aids listed above are an excellent entry point to enhancing patient-centered care in routine practice.

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in management of obesity, and interest in seeking obesity management training. For barriers to obesity care, we included items similar to those that were previously described in a study conducted at a Veteran's Affairs (VA) medical center, recognizing that the core patient populations at VA institutions are comparable to those at ours.[15] Answers to questions were collected as a percentage range, number, or scale. A standardized set of responses was used to address barriers to obesity care, and up to three choices were requested. Free text was used to collect suggestions for improving obesity-related care in the GMC. Two reminders were sent to complete the survey at the interval of two weeks each.

The primary data source was an online web collector that was used to collect and analyze the responses. The survey was anonymous, and no personal identifiers were collected or used. We used descriptive statistics to analyze the responses to each item. The study was approved by the Institutional Review Board of Stroger Hospital.

Initially, 186 providers were invited to respond, of whom 51 were attending physicians, three were mid-level providers, and 133 were residents. The survey was offered in the summer of 2012 when 43 residents graduated, so no reminders could be sent to them as they left the institution or moved on to the next phase of their career within the hospital. Of the 51 attending physicians, two did not provide direct patient care in the GMC and did not complete the survey. A total of 55 respondents participated out of 141 eligible respondents (39% response rate).

Of the 55 respondents, 33% reviewed the BMI of their patients more than 75% of the time, and 56% reviewed it more than 50% of the time. However, only 12.7% discussed the BMI with their patients more than 75% of the time, and 62% discussed it less than 50% of the time. Additionally, 67% of respondents felt very comfortable discussing weight with their patients. Only 22% of respondents documented obesity as a separate problem more than 75% of the time, and 29% documented it less than 25% of the time. Overall, 55% documented it less than 50% of the time. A majority of providers (55%) spent only three to five minutes discussing therapeutic lifestyle changes with their patients, whereas 22% spent less than two minutes, 13% five to 10 minutes, and 11% spent more than 10 minutes.

The providers considered "lack of time for patient counseling" (67%), "high complexity of the patients" (66%), and "lack of infrastructure support of weight-related referral services" (51%) as the three most important barriers to providing optimal obesity-related care in the GMC. Other factors that were considered barriers are shown in Table 1.

A total of 58% providers did not consider themselves competent in the management of obesity, and 64% were very interested in seeking obesity management training. The suggestions to improve obesity care were many, as expected. The majority of providers felt that a coordinated program of trained staff (i.e. dedicated dietary counselors, nurses, and health educators trained in obesity counseling), support groups, and motivational mentors for all overweight patients in the GMC were critical elements of optimal obesity management. Availability of resources for patients that would not cost them any money were also suggested, like help with buying healthy food in their neighborhood or finding them an exercise program close to home. Educational materials like posters in the waiting areas, flyers or booklets with healthy diet and exercise instructions, and videos were identified as important tools that would enhance the message of self-care for obesity. A significant number of respondents thought that training for providers was critical and must include an ongoing program of lectures, workshops, and informational material that would be easily available, especially for the resident physicians. Other interesting suggestions included increased taxation for soda and fast food, tax exemption for park district exercise facilities, and a miracle drug.

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Table 1. Barriers to Obesity Care*

Lack of time for patient counseling	67.3%
Complex patients: more serious comorbid conditions demand majority of visit time, and older patients may have functional limitations that prohibit physical activities	65.5%
Lack of infrastructure support of weight-related referral services	50.9%
Lack of patient interest, resources, and readiness for change	38.2%
Inadequate training in effective weight counseling, nutrition, behavioral modification	30.9%
Lack of knowledge about weight management services	20.0%
Perception that obesity counseling and treatments are futile and ineffective	16.4%
Discomfort discussing weight-related matters with patients	1.8%

**Forman-Hoffman et al.15*

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NHANES (2007-2008) data revealed that 34% of US adults are overweight (BMI 25-29.9), 34% are obese (BMI 30-39.9), and 6% are morbidly obese (BMI ≥ 40). The prevalence of obesity in the General Medicine Clinic of John H. Stroger Jr. Hospital of Cook County in Chicago is comparable—32% are overweight, 35% are obese, and 13% are morbidly obese, with the last two indices being higher than the national average. The top three common diagnoses at this clinic are hypertension, diabetes mellitus, and dyslipidemia—all of which are related to obesity.

Our study provides evidence that physicians provide inadequate weight-related counseling to obese patients. There is no standard practice related to obesity by PCPs, and few studies have been conducted at public institutions to address barriers to obesity-related care. Unless we clearly understand how providers practice, effective interventions will not be realized. The USPSTF guidelines recommend screening all patients for obesity, which is practiced in the GMC as evidenced by documentation of BMI by medical assistants in the electronic medical record. However, the USPSTF also recommends that patients with a BMI of more than 30 be referred for intense lifestyle counseling, which is not practiced by many PCPs due to lack of resources. The initial results suggest that providers understand that obesity is a major problem in the GMC, and a majority of them are interested in receiving further training to address this disorder more effectively. The data also suggest that non-physician services need to be an integral part of daily care in the GMC in order for any intervention to have a positive impact. Contrary to prior studies done,[16] our study did not show that physicians have the perception that obesity counseling and treatments are futile and ineffective, and only one third thought that lack of patient interest and readiness for change was a significant barrier.

This study has several limitations including response bias due to the small number of physicians participating. Responders may be more interested in obesity than non-responders. We were unable to analyze the responses based on whether the respondents were attending or resident physicians due to poor response from resident physicians likely due to their busy schedules and possibly lack of interest in the topic of obesity. We also conducted simple descriptive statistics only and did not analyze in depth the difference in attitudes based on years of experience and/or training level. Further, we could not precisely determine the physician demographics due to low response rate. The strength of this study was that it represented our first attempt to address primary care management of obesity in the GMC and can perhaps provide a foundation for more profound research as well as clinical interventions to improve overall weight-related care. These findings can be shared with other institutional programs, like "Obesity Awareness Week," to develop simple patient education tools like banners, flyers, and audiovisual material.

PCPs are well positioned to address the rapidly emerging public health problem of obesity in the United States—even in resource-limited settings. However, many barriers for optimal management of obesity remain ingrained in daily practice. Addressing the attitudes and beliefs of PCPs is likely to provide future avenues for studies to assess their impact on obesity-related care. Valuable obesity management services like dieticians, health educators, peer educators, and educational materials for patients can improve the quality of obesity-related care. A multidisciplinary program modified to recognize provider- and system-related barriers will be critical to incorporate evidence-based practice into a quality improvement initiative.

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surgery over medicine. Beyond money, why? via **@jjaeger3 @thinkalot #meded pic.twitter.com/dJ97hDbQFc**

@Rock_Health
73 drug brands whose prices increased 75% or more. **http://bloom.bg/1ll4czx**

@dopaminergic13
America's Broken Health Care System: The Role of Drug, Device Manufacturers **http://buff.ly/1fhcQou**

Finally, there were some ways to make health care better, safer, and maybe even cheaper.

@brookmanknight
Friday Feedback RIP Annual Check-ups? **http://www.medpagetoday.com/PrimaryCare/GeneralPrimaryCare/45565?isalert=1…** Interesting range of comments. Statistics vs individual benefit.

@LouiseAronson
RT **@tomleblancMD:** New evidence: early **#palliative** care in advanced **#cancer**: shorter LOS, less death in hospital: **http://ow.ly/weQgH #hpm**

@doctorwes
MT **@medrants:** Which should we emphasize—knowledge or wisdom? **http://wp.me/pdYtH-20A**

I would love to hear your thoughts about anything that caught your eye here. Thanks for reading.

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