

HEALTH POLICY CORNER: PART I

Hill Day Recap: Telling Stories and Advocating for Primary Care

Theodore Long, MD

Dr. Long is a Robert Wood Johnson Clinical Scholar in the Yale School of Medicine.

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On March 12, 2014, 63 SGIM members assembled in Washington, DC, for the annual Hill Day. While this was my first Hill Day, there was a palpable sense of excitement among the leadership that so many people had come. With this many people, we knew we would have a significant voice. I started the day with meeting the other members of my advocacy team: a seasoned attending, another physician fresh out of residency, and a fourth-year medical student. As we began our meetings, the questions on my mind were what we could offer to the representatives and how we could help inform them about health care. To put it another way, I wanted to communicate ideas from our unique perspective, something that only we could discuss with authority.

We started our first two meetings with health policy advisors by emphasizing that SGIM supports repeal of the sustainable growth rate (SGR). Judging by their knowledgeable responses, it was clear that this was not the first time a physician had advocated for SGR repeal to them. We were quick to acknowledge it, as well as our own vested interest in getting the SGR repealed.

The brevity of our SGR discussion did not mean the issue was unimportant to us—we brought it up first for a reason. However, the implicit message was that this was not the issue about which we as representatives of SGIM had exclusive authority.

As each of the first two meetings proceeded, we transitioned to a conversation about our views on the primary care workforce from the perspectives of general internists in varying stages of career development. As we began to talk about how our experiences in training had impacted our decisions about entering primary care, I could tell that we had caught their interest. When we described SGIM’s progressive stance of promoting accountability in graduate medical education to address the current primary care workforce shortage due to the implementation of

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Medicare's Chronic Care Management (CCM) Code: Prepare now for 2015

John Goodson, MD, and Jeannine Engel, MD

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The Centers for Medicare and Medicaid Services (CMS) created a new service code to pay for the non-face-to-face (NF2F) care management needs of Medicare beneficiaries beginning January 1, 2015. As with other primary care-directed codes such as the annual wellness visits (AWVs) and the transitional care management (TCM) codes, CMS has detailed service expectations. CMS recognizes the deficiencies of the evaluation and management (E/M) service codes used by primary care physicians (PCPs). The post-visit time for the most common E/M service code, 99214, is 10 minutes. This vastly under recognizes the NF2F work of PCPs—work that includes answering patient phone and electronic messages, sorting through formulary changes, responding to labs or consultation recommendations, and providing weekend and night emergency coverage.

Which patients will be eligible for CCM code billing?

Any Medicare patient, "expected to live 12 months or until death," with two or more chronic conditions will be eligible for CCM services. This code "may be billed for periods in which the medical needs of the patient require establishing, implementing, revising, or monitoring the care plan." This is a "primary care-centric" definition that would apply to a broad range of Medicare patients. Though CMS cannot prohibit any physician from billing for this service, the intention is clearly to support the myriad of primary care NF2F tasks.

What will be the patient payment implications?

The service would be subject to a 20% copayment (or covered as part of a Medicare Part B supplement). Unlike other Medicare services, monthly CCM billing continues without face-to-face contact.

To bill for the services, the following are required:

- Documentation in the patient's medical record that all of the chronic care management services were explained and accepted by the patient;
- A written agreement that electronic communication of the patient's information with other treating providers is part of care coordination;
- Information about the availability of the services from the practitioner; and
- A written or electronic copy of the care plan that is provided to the

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Bryant and the Strength of Teams

William P. Moran, MD, MS

Integration and coordination of physician efforts with non-physician professionals and patients is critical to the success of generalists and health care reform.



Early in my career, Dr. Bryant Kendrick, a former navy corpsman, ordained Baptist minister, associate program director for primary care, and mentor, suggested that we use a “ropes course” to build team spirit among our primary care interns before they began their arduous first year of training. “Ropes” is a day-long team-building exercise, challenging a group to think and work together to solve a series of physical challenges. Five nervous soon-to-be-interns, several residents, and the program directors were challenged physically and mentally to overcome a series of obstacles in a wooded course. Early in the day, our ropes instructors told us that we needed to trust and rely on each other and work as a team to successfully complete the course. One of the first challenges was a “trust fall” whereby a team member stood on a 5-foot-high platform and, with arms folded, fell backwards off the platform to be caught by the rest of the team. Everyone needed to complete the trust fall before we moved to the next task, but as a team we asked a smaller team member to be first. Standing with palms up and arms interlaced “like a zipper,” the team lined up and tensed as the first team member nervously fell backwards into the group, and we were all relieved when we successfully caught and lowered our team member to the ground. Bryant was last to make the trust fall. Bryant was not a small man. A former football

lineman, Bryant weighed a shade more than 240 pounds and, not unaware of his girth, calmly ascended the platform. Five feet up, Bryant loomed over us, and I suspect five interns silently feared the consequences of dropping the program director, which seemed very likely. Standing with arms interlaced, the team tensed as Bryant confidently fell backwards...and the team held and caught him! Every year for almost a decade, Bryant confidently ascended the platform, and every year the team, including five new nervous interns, learned they were stronger than they thought. Sadly Bryant passed away in 2000, but when I look at his picture on my office shelf, I remember how confident Bryant was in the strength of his teams.

Maybe more daunting than the “trust fall,” academic general internists face a challenging future of rising clinical productivity demands, more patients as a result of health care reform, the challenge of electronic health records (EHRs) and “meaningful use,” and the incredible complexity of our patients. “Ropes” and Bryant taught me that people working in teams are more powerful than a group of individuals, which brings me to the theme the 2015 SGIM Annual Meeting in Toronto—*Generalists in Teams: Adding Value to Patient Care, Research, and Education*—scheduled for April 22-25, 2015. Health care reform focused on high-value patient-centered care is driving team-

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based delivery system redesign across the breadth of SGIM member interests. Team-based models of patient care—inpatient, outpatient, long-term, and transitional care—are rapidly evolving. The education and training experiences of general internal medicine physicians need to include knowledge of team member roles and responsibilities; new skills, such as team leadership; informatics; and quality and patient safety measurement.^{1,2} We need to develop and evaluate interprofessional training venues and encourage our own team members to participate in SGIM. Research methods will continue to evolve to provide high-value team performance information from existing and new data sources. Integration and coordination of physician efforts with non-physician professionals and patients is critical to the success of generalists and health care reform.

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What's in it for me?

Priya Radhakrishnan, MD

Several times this past week, I have heard this question in completely different contexts. Review a colleague's work. See an extra patient. Attend a meeting. Give an opinion. Of the hundreds of tasks that we perform both at work and at home, few really give us a sense of deep fulfillment. We cover call for colleagues when they are sick, offer to critique a project with fresh eyes or ears, or simply help others connect with mentors. As educators, we edit, rather painstakingly, draft manuscripts for students and residents. It is part of the job. However, it is not common to hear our ilk turn around and ask, "What's in it for me?" I wondered whether this was part of a new trend, generational gap, or simply the so-called February effect—as residents, physicians, and everyone else for that matter, we are tired and disgruntled.

The last time I heard this question was during a 7 pm run to Starbucks. I was grumpy, having spent an extra hour at work reviewing a last-minute report. This was yet another late day. I was feeling great pity for my tired self as I stood in line, hunched over my iPhone, pondering whether to have pastries or salad for dinner. Forget the salad, I

said, adopting the perfect Victim persona. I was mentally chastising myself for helping the colleague who couldn't see that I was buckling under the strain of a full clinic day where every patient showed up. In my mind, no one worked as hard as I did.

I was enjoying these feelings of under-appreciation when a nearby discussion piqued my interest. The group of teenagers in front of me was boisterous, loud, and debating the pros and cons of a last-minute project they had been given. Specifically, the teenagers were talking about doing some additional "busy work" in English class. Why should I do this project? What's in it for me? The questions and answers flew back and forth. Becoz. You want an A. An all-nighter won't kill you, man. By the end of the conversation, they decided, with good humor, that the teacher—while not their favorite—had treated them as adults and that they would graciously do the extra work. "Becoz." This was so contrary to my belief system; aren't teenagers the ones who make decisions by the seat of their pants? Just standing behind this group with their positive mojo had a more profound effect on me

than any Venti coffee drink. Here was a group of kids, late in the evening, also lamenting a busy day's work that culminated in more work. They figured out that saying "yes" was the right thing to do, simply because it was part of the work they had signed up for. Needless to say, by the time I made my way to the front of the line, I was ready to forgo the pastries in favor of passion tea and salad.

The teens reinforced my belief that we all do things to help others—just because it is part of our jobs. We try to coach colleagues, residents, and students with good intentions. As we rush headlong into the land of pay-for-performance and outcomes-based measures, we must not forget that there are some things that go way beyond any tangible measurable outcomes. Saying "no" is appropriate many times, but asking "what's in it for me?" may be a cry for help that all of us should heed. As a profession, we are the sum of our experiences. Sometimes doing things to make life easier for others is the right thing to do.

And learning often comes from unexpected sources; one has to be open minded.

SGIM

Postprandial Abdominal Pain in a Young Anorexic Woman

Kevin Quinn, MS4 (presenter); Mohamed Zghouzi, MD (discussant, in *italic*); and Priya Radhakrishnan, MD

Dr. Quinn is a fourth-year medical student from Creighton University rotating through St. Joseph's Hospital & Medical Center, and Dr. Zghouzi is a second-year resident in internal medicine at St. Joseph's Hospital & Medical Center in Phoenix, AZ. Dr. Radhakrishnan served as senior author on this case.

An 18-year-old female with anorexia nervosa and irritable bowel syndrome presents to clinic as a new patient with a complaint of abdominal pain after eating. She states that she experiences severe abdominal pain after eating and drinking even small amounts of food or liquid. Associated symptoms include postprandial fullness, bloating, and nausea. The patient states that she feels as if the food “just sits in her stomach.” She has a six-year history of anorexia nervosa requiring several hospitalizations for intensive management. This woman currently purges daily and states that self-induced vomiting helps to relieve her abdominal pain and anxiety. In addition to the abdominal pain, she complains of weakness, recent weight loss, nausea, vomiting, diarrhea, constipation, amenorrhea, and anxiety. Her medications include colace, ducosate, omeprazole, K-Lor, and seroquel.

This patient presents with likely complications from a long history of anorexia nervosa (AN). AN is a common psychiatric disorder most prevalent among female adolescents and young women. This disorder affects up to 1% of college-aged women and has a female to male ratio of 20:1.¹ AN is characterized by an inability or unwillingness to maintain a weight that is normal or expected for age and height. This is associated with a distortion in body image and an intense fear of gaining weight. AN is divided into two subtypes: restricting type and binge-eating/purging type. In restricting AN, individuals maintain a low body weight by limiting caloric intake or exercising excessively. Binge-eating/purging AN is characterized by episodes of excessive eating and/or purging behavior, including self-induced vomiting and inappropri-

ate use of laxatives or diuretics.² The management of patients with AN can be a real challenge for physicians due to its often persistent course, psychiatric co-morbidities, medical complications, and high mortality. Thus, it is important to be familiar with AN, the medical complications that may arise, and the treatment available for these patients.

Physical examination reveals a very thin woman who appears younger than her stated age with a blood pressure of 111/75 mmHg, heart rate of 98 beats/minute, weight of 82 lb, and BMI of 15.49 kg/m². Nine months prior, she had a documented weight of 109 lb. On physical exam, the patient appears cachectic with bitemporal wasting. Other pertinent findings include a scaphoid abdomen with epigastric tenderness to deep palpation. Review of her records shows a history of hospital admissions due to malnutrition and related complications, including bradycardia and various electrolyte abnormalities.

Cardiovascular complications contribute to the high mortality in patients with AN. These complications may present with both structural and functional abnormalities of the cardiovascular system. Structural abnormalities include decreased ventricular mass and size, pericardial effusions, and an increased incidence of mitral valve prolapse (MVP).² Extreme weight loss in patients with AN leads to atrophy of the myocardium and a resulting decrease in both heart mass and ventricular size. This results in decreased cardiac output, hypotension, decreased capacity for exertion, and fatigue.² MVP is also common due to atrophied myocardium in the presence of mitral valve structural tissue that remains unchanged in size. MVP often pre-

sents as chest pain or palpitations in these individuals.^{1,2}

Functional cardiovascular changes include bradycardia, hypotension, arrhythmias, and QT prolongation. Sinus bradycardia is the most frequently encountered cardiovascular abnormality in AN. This represents an adaptive response of the heart to a decrease in caloric intake and is thought to be due to increased vagal activity. These patients present with weakness and lightheadedness secondary to decreased cardiac output. In the setting of coexisting arrhythmias or QT prolongation, however, serious complications, including sudden death, may occur. There is controversy as to whether QT prolongation in the setting of AN is directly associated with AN or due to an associated electrolyte abnormality or underlying congenital long QT syndrome. Regardless, QT prolongation predisposes individuals to life-threatening ventricular arrhythmias, including torsade de pointes.² Due to cardiac arrest secondary to such arrhythmias, AN has the highest mortality rate of all mental disorders.¹ Thus, these patients need to be closely monitored and treated appropriately to prevent cardiovascular-associated mortality. Most cardiovascular abnormalities associated with AN eventually resolve with weight restoration and correction of electrolyte abnormalities.^{1,2}

Prior to her last admission three months ago, the patient was found to have several electrolyte abnormalities, including hypokalemia, hypophosphatemia, and hypochloremic metabolic alkalosis.

Electrolyte abnormalities are common in binge-eating/purging AN, while electrolytes in restricting AN are generally normal. Hypokalemia is
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FROM THE REGIONS

Northwest Regional SGIM Meeting 2014: Teaching, Patient-centered Outcomes, and Clinical Care

Christopher Wong, MD

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The Northwest chapter of SGIM opened the year in style at the elegant Hotel 1000 in downtown Seattle with the annual regional meeting on February 7, 2014. With a diverse, increasing number of participants from Boise, Seattle, Tacoma, Spokane, and Portland, we have outgrown the capacity of our previous venue near the University of Washington campus.

An unusually severe winter snowstorm hit Portland and southwest Washington the day before the meeting, making Interstate 5 nearly impassable. Still, many members managed the hazardous journey from Portland or, in one case, improvised a video-conference for the co-leaders of the patient-centered medical home workshop.

Bookending the meeting were our annual clinical updates. Matthew Hollon, MD, MPH (Spokane, WA), and Mary Pickett, MD (Portland, OR), jumpstarted the program with the Update in Ambulatory Medicine, navigating through new guidelines and risks of commonly used drugs. Susan Hunt, MD (Seattle, WA), concluded the day with material that she and Courtland Childers, MD (Portland, OR), developed for the Update in Hospital Medicine, discussing controversies surrounding treatments of acute stroke and hypertension.

We had two outstanding plenary sessions at this year's meeting. Dawn Dewitt, MD, MSc (Vancouver, BC), inspired us to activate and observe learners based on her worldwide experience in different educational settings. Additionally, David Hickam, MD, MPH (Washington, DC), from the Patient-Centered Outcomes Research Institute (PCORI) imparted guidance on writing successful applications for PCORI-funded research. Martha Gerrity, MD, MPH, PhD (Portland, OR, and SGIM treasurer-elect), and

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... many members managed the hazardous journey from Portland or, in one case, improvised a video-conference for the co-leaders of the patient-centered medical home workshop.



Truth in Advertising...Or Not

Madhusree Singh, MD

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Football season and its endless ads got me thinking about all the advertising messages that come our way. Even though I do not admit to watching “too much” television, my heart sinks every time I hear about a certain erectile dysfunction drug or how effective a certain “Low T” drug is. These ads are all over TV, magazines, and billboards, so I’m sure that these drugs are front and center in a lot of my patients’ minds, especially with the added nudge of “ask your doctor about _____”.

At least a few of my patients want to know their testosterone levels, as they think that their fatigue may be related to “Low T.” We then end up having a conversation about the possible causes of fatigue, often focusing on sleep quality and quantity; nuances of checking testosterone levels; and the risks and benefits of treatment, if it is indicated. Needless to say, this can take time away from other important medical issues. Again, advertising has made a disease popular while overlooking the nuances that medical decision making requires. There is no relationship between public health needs and the direct-to-consumer (DTC) advertising that we see around us (<http://archinte.jamanetwork.com/article.aspx?articleid=1726956>).

A recent article in *JGIM* talks about the lack of truth in advertising medications to patients and found that DTC advertising leads to misconceptions in patients (<http://online.library.wiley.com/doi/10.1046/j.1525-1497.1999.01049.x/full>). All this misinformation likely leads to higher costs in health care, too. Anecdotally, I can tell you that if I got a dime for every time a patient asked for a drug by name, I would not need to go to work. Luckily, I work for the Veteran’s Hospital, so we have a strict formulary that usually offers

the best value for the patient. Most often, when a patient requests a certain medication by name, I have to unpack the request and figure out what exactly he/she is thinking. Needless to say, this requires time that most primary care physicians (PCPs) do not have. I have noticed that even the World Health Organization sees this as a problem and that perhaps the tide is slowly turning (<http://www.who.int/bulletin/volumes/87/8/09040809/en/>).

As we begin thinking seriously about costs of care and ways to make health care both rational and cost-effective, as a society we will have to re-think the way we view DTC advertising. We are doing our patients no favors by allowing byte-sized, misleading advertising. I am looking forward to the day when broccoli is advertised during the Super Bowl, but I know I’m dreaming.

This also leads me to think about all the information that our patients get from various sources—especially the Internet. Our patients have many options for gathering information, and as PCPs we have a duty to help them find their way around this brave new world.

Here is a short list of things that we can encourage our patients to do when they seek health information. Of course, the list is subjective, and I encourage *Forum* readers to add their recommendations:

1. Be skeptical. Our patients vary in their level of health literacy, but during ill health and times of stress they may be less able to figure out hype from reality. We need to get back to the root of our profession. “Doctor” originates from the Latin root *docere*, meaning to teach. We need to be able to teach our patients how to take care of themselves.

2. Show patients reliable websites for health information—sites like Medline Plus and the National Library of Medicine. These sites are typically run by respected government, academic, medical, and non-profit organizations.
3. Understand the health education connected to electronic health records. The health care team should be aware of these resources and use them appropriately.
4. Tailor health messages to your patients, even though this will take time and energy. I remember a patient discussing the use of bitter gourd extract instead of usual care for type 2 diabetes; when I asked the patient where he found this information, he said that it was from the site where he bought the extract. Our patients will have varying levels of skepticism, sophistication, and education (just like us). In my experience, tailored education leads to important downstream gains, as patients who are involved in their health care make more informed decisions.
5. Involve the health care team. PCPs have many helpful resources that can be used for patient education, including peer educators.
6. It is so important that it bears repeating—be skeptical. If something sounds too good to be true, it probably is. All the pretty pictures on television make each disease look entirely curable with the right pill. As clinicians, our job is to help our patients understand their illnesses, deal with the uncertainty that goes along with ill health, and support their unique journey.

The Next Accreditation System: Faculty Development Needs in Competency-based Medical Education

Pete Yunyongying, MD; Kerri Palamara, MD; Margaret Lo, MD; Reena Karani, MD, MHPE; Eva Aagaard, MD; and Michael Rosenblum, MD

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The Accreditation Council for Graduate Medical Education's Next Accreditation System has ushered in the era of competency-based medical education (CBME) by describing the behaviors, attributes, and performance standards for residents. The transition from a time-based to an outcomes-based system is a challenging paradigm shift and has significant systemic implications for educators. Aside from changes in program structure, reporting, and accreditation, there are monumental shifts in how faculty practice the art of teaching and assessment. Indeed, faculty development is currently the limiting factor in the implementation of CBME.¹

Beyond medical knowledge expertise, faculty must refine their proficiencies in teaching and assessing all the core competencies. Moreover, faculty need to develop skills in critically observing learners on a frequent and regular basis. Additionally, they must link observations to larger and more definable professional activities while developing consistency between multiple observations of individual learners and improving inter-rater reliability. Faculty need to effectively and efficiently learn and incorporate new assessment methods and be able to probe and evaluate critical thinking and reasoning skills.

There has been little research on the ideal structure of faculty development, but real world examples can provide some direction for starting and refining programs, as there are no one-size-fits-all models.

When designing a program, consider the necessary time and logistics for faculty to participate, cost and space availability, existing skill levels of the faculty, and the mechanism by which faculty will need to directly observe learners. Another variable is the regularity and frequency of faculty contact with trainees. Is there a limited group of faculty who engage with the same trainees regularly to allow for more longitudinal experiences, or do faculty have irregular and intermittent contact with trainees? Four models currently in use are described in Table 1.

The Bolus Model

This model is organized as a large, one-time-only department-wide faculty development retreat. This retreat, spanning multiple days, can occur either on site or off site. Alternatively, a smaller scale retreat can be offered to core faculty and clinical competency committee members. These sessions may be used

as a train-the-trainer system, where attendees are expected to teach the rest of the faculty. Using a mix of didactic and interactive sessions, this retreat can provide in-depth exposure to CBME in a bolus format, beginning with an "Overview of Milestones" plenary followed by small-group breakout sessions. These sessions provide an intensive education on how to incorporate milestones into each rotation and how to complete evaluation forms. They can introduce new assessment tools or observation skills. These retreats provide an opportunity for standard setting among diverse faculty and create a shared mental model for appropriate assessments of learners. For programs seeking input on how to choose milestones for assessment, these sessions can be used to meet that need. Participants can be asked to q-sort milestones based on level of learner and rotation learning objectives.² The intensive nature of

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Table 1. Characteristics of Competency-based Models

Bolus Model	Recurring Model	Just-In-Time Model	Embedded Model
Large faculty retreat	Small individual sessions	Individual learning sessions	No extra sessions
One time only	Recurrent	Recurrent	Requires ongoing auditing and individual feedback to faculty
Plenary sessions with small-group breakout	Variable: can include didactics or small-group breakouts	Largely didactic, passive learning	
In-depth and intensive course	Introducing new skills briefly	Reinforcing already learned skills	Ongoing teaching

Mindfulness: Why All the Hype?

Denise Millstine, MD

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Mindfulness is not a new concept. Its modern conception dates back decades, and its premise has been around for centuries. Briefly explained, mindfulness means being present in the current moment without judgment. The concept is simple, but the practice can take a lifetime to master—if ever.

Still, what's old is new again. The cover story for the February 3, 2014, *Time* magazine is, "The Art of Being Mindful."¹ In 2014 alone, there have been 139 PubMed citations regarding mindfulness. Why? It seems to be working.

Mindfulness has been studied in nearly every population you can imagine. Most notably, its effects have been assessed in soldiers; students; physicians; nurses; and patients living with cancer, stress, and mood disorders. For anyone with a history of trauma, it seems to work. For those of us distracted by our work, family, home, and social responsibilities or notifications constantly "binging" onto our mobile devices and medical records, mindfulness can provide solace in the middle of the storm. Mindfulness can be applied to eating, walking, praying, meditating, and, according

to *Time* magazine, even managing our spending.

Physicians and health care providers have known the benefits of meditation for years. Studies have proven it to be helpful in stress, insomnia, anxiety, depression, pain, obesity, and other conditions.² Somehow, only a minority of patients—and ourselves for that matter—are successful with traditional meditation as a longitudinal practice. If we know it will make us healthier, why can't we do it?

According to Amit Sood, MD, professor of medicine at the Mayo Clinic and author of *The Mayo Clinic Guide to Stress-Free Living*, the brain is a very busy place. Within its "default mode," the brain has countless connections of neurons and hundreds of neural networks that are firing frequently and constantly. This background brain chatter makes quieting the mind difficult for those untrained and inexperienced. The associated frustration leads to the abandonment of meditation practice.

Instead, Dr. Sood's program—and mindfulness in general—places the focus outward with intention. By focusing on your surroundings,

you enhance your experience of the world. By setting intentions of gratitude, compassion, acceptance, and forgiveness, you become kinder, gentler, and more joyful. The brain quiets, and you calm. Do you know anyone who would not benefit from that?

Our American lives are stressful, and our happiness tends to be low. This remains true even when external threats are lacking. Most of us are not surviving natural disasters or being chased by predators. Still, our sympathetic nervous systems are on overdrive from responsibilities, deadlines, projects, and dreams. Perhaps we have started to realize that. Perhaps we are tired of being drained of energy from this excessive worry. Perhaps this is why mindfulness has found its time.

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SGIM

A Systems Approach to Negotiation

Eric Linson, MBA

Mr. Linson is the division administrator of general internal medicine at the University of Iowa Hospitals and Clinics.



Much like medical students who acquire the skills to take a history and physical assessment, the science and art of negotiation requires a similar approach. General internists in particular can identify with this approach given their education and practice in assessing multiple organ systems. In this same way, performing a review of systems as part of any negotiation can provide invaluable information in achieving a desired outcome.

A tool found to be effective is referred to as *Spotting and Changing the Game*,¹ based the development of the seven-element framework by the Harvard Negotiation Project.² Like any “H&P” template, a tool that seeks to aid in identifying a patient’s signs and symptoms, these elements inform the negotiator of opportunities in making a diagnosis and devising a course of action or treatment. These seven elements are: 1) interests, 2) legitimacy, 3) relationship, 4) alternatives, 5) options, 6) commitments, and 7) communication.

Recently, I was working with a medical director to develop the clinical schedule for the next year. In doing so, one of the medical director’s interests was distributing holiday assignments across all faculty. When the notification went out, one of the faculty questioned the legitimacy of the holiday assignments

given that his clinical duties were only a small fraction of others. It was felt that these holiday assignments should be proportional to attendings’ clinical duties in the number of holiday assignments per year and the frequency of being assigned any specific holiday from year to year. Reaching agreement, however, required the medical director to communicate these expectations. In questioning the legitimacy of these expectations, the faculty member proposed an option. Because the option was fair, an agreement was reached while maintaining the collegiality of the relationship.

To use this technique in other situations, spot the elements that are specifically being used or not being used. These signs and symptoms will inform you in diagnosing the causes, purposes, and how you contributed to the response. By doing so, you can devise a plan or strategy to change the direction of the negotiation in reaching a satisfying outcome. In deciding upon your plan, ask yourself:

- How can I change the way a particular element is being used by my counterpart?
- How can I shift the focus to a different element?
- How can I call out my counterpart’s “game” altogether and propose a new approach?

In my experience, people (including general internists) are either quite active or vocal about calling out a counterpart’s game or passive to the point of eroding morale over time. Being vocal is acceptable as long as the person understands that this can come at a price to the relationship element. Conversely, passivity is the lack of appreciation for the communication element. If I am the negotiator—or in many cases

the senior colleague, leader, or even administrator who uses the element of communication to convey my interests, in the absence of reciprocity—I will often invoke silence as a convenience for an agreement or a commitment. This interplay often leads to misunderstandings and can also fray the relationship element. So not only is awareness of these elements essential but the way in which each is used or not used can have an effect on the outcome. In the end, clarity of agreement is required to achieve the best long-term result.

Negotiation is a process, a practice, and a skill—not a disease. General internists should have confidence in the ability to incorporate this kind of systems approach to negotiation. Your education and training provides the prerequisite skills to successfully incorporate it into practice. The approach itself is a paradigm much like learning the “why” and “how” to performing a good history and physical assessment—one that (like negotiation) requires understanding and practice. Reflect on instances and situations you experienced recently and the seven elements that you and your counterpart used or did not use and how you could have changed the situation. Consider using these elements and the tool *Spotting and Changing the Game*¹ the next time you find yourself negotiating for a new position, requesting additional resources for your area, or just maintaining what you already have!

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HEALTH POLICY CORNER: PART I

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the Affordable Care Act, I knew that we had found a topic that could benefit from our unique perspective.

The common tactic going into an advocacy or lobbying meeting is to try to tell a story based on your experiences. Using personal experience and anecdotes lends credibility to your words and creates a dialogue that the person you are speaking with will remember. Based on our experience with Hill Day, I would add that your story should involve an

issue that you are passionate about and that you have a unique or personal perspective on. As we continued to go to our meetings throughout the day, our team spontaneously and without previous planning or discussion began telling stories about training in primary care. We used these experiences to demonstrate our take-home point that graduate medical education funding should support training that grows the primary care workforce.

At the end of the day, we had all told our stories and excited some interest from the representatives we met. I was impassioned by our ability to reach out to representatives and health advisors and am already looking forward to repeating the experience next year. In the meantime, I will continue to reflect on the stories my team told and the intersection between our experiences and policymaking.

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PRESIDENT'S COLUMN

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David C. Thomas (chair) and Sharon Straus (co-chair) will lead the 2015 Annual Meeting Program Committee. They have assembled their own incredible team to plan the meeting focused on how teams increase value. There is a dearth of data about the structure, function, training, roles, and accountability of interprofessional teams in new primary care delivery system models such as the patient-centered medical home and VA's patient-aligned care team—not to mention inpatient care teams focused on quality, patient safety, and care transitions.³ The Association of Chiefs and Leaders in General Internal Medicine (ACLGIM) is considering a program for interprofessional team leadership,⁴ and a critical ingredient will be methods to include patients and other stakeholders in team-based care. We hope SGIM members will also hear how many organizations are now developing payment and financing strategies to support team-based care in the form of accountable care organizations and provider networks. SGIM members are involved in innovative informatics applications supporting teams that provide high-value patient care and health services research to evaluate team impact on the value of care provided to patients. Finally, SGIM and other organizations are

participating in building coalitions to continue delivery system transformation to teams that provide high-value care to patients, high-value research, and team-centered education. Please consider submitting to the 2015 meeting in Toronto, and especially consider volunteering to help the Annual Meeting Program Committee plan an outstanding SGIM annual meeting.

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FROM THE REGIONS

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Melissa Hagman, MD (Boise, ID, and Northwest SGIM regional president), gave the national and regional updates over lunch, discussing SGIM's focus on the regions, communication, technology, and SGIM's advocacy efforts.

Along with these sessions, the meeting included five workshops, a poster session, and the always-popular oral clinical vignette presentations from associates. We received a total of 70 submissions from around the region. Winners of the poster and vignette session were Adam Rodman, MD (Best Clinical Vignette Poster); Joseph Simonetti, MD (Best Research Abstract Poster); Tiffany Chen, MD (Best Clinical Innovations Poster); and Mitra Barahimi, MD (Best Oral Clinical Vignette). The regional awards were bestowed to Melissa Hagman, MD (Clinician-Educator Award), and Devan Kansagara, MD (Clinician-Investigator Award).

Thank you to all those who attended, our reviewers, the planning committee (Moe Hagman, Bill Weppner, Todd Korthuis, Kay Johnson, Carol Sprague, Betsy Haney, Susan Merel, Paula Wichienkuer, Chris Wong, Scott Smith, Julie Silverman, Danielle Orchard), the national office support (Katherin Cooper, Tracey Pierce, Kay Ovington), and all our judges and distinguished faculty.

See you in 2015 in Portland!

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HEALTH POLICY CORNER: PART II

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beneficiary and recorded in the electronic health record (EHR).

The CCM code cannot be billed concurrently with home health care (VNA) supervision (HCPCS G0181), hospice (HCPCS G0182), TCM services (99495-6), and all service codes applicable to patients in a facility (e.g. nursing home). E/M, AWW, and initial preventive physical examination (IPPE, Welcome to Medicare) service codes can be billed, but none of these is required.

What are the stipulated services for CCM billing?

CMS has provided only a partial list of the services required. The final list will be available at the end of 2014. A physician or a non-physician clinician (e.g. NP, PA, clinical nurse specialist, certified nurse midwife) can bill as long as the state's scope of service license permits independent billing. CCM services provided in the name of the non-billing clinician must be performed by an employee of the billing clinician or an employee of a practice. This effectively precludes the outsourcing of certain elements of CCM services to contract employees or care management corporations or services.

CCM will be a time-based code—20 minutes of service for every 30 days of billing (CMS implies a strict 30-day billing cycle). Documentation tools will have to record both time and services provided. CMS expects the following from CCM clinicians:

- Continuity of care with a clinician or practice
- Care management that provides the following:
 - A systematic assessment of medical, functional, and psychosocial needs
 - A system-based approach for timely delivery of preventive services
 - Medication reconciliation, both prescription and non-prescription, and a review of interactions and adherence

- The creation of an updatable patient-centered plan of care that:
 - Addresses all health care issues (including but not limited to the following: “a problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and/or social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identification of the individuals responsible for each intervention, periodic review and, when applicable, revision”)
 - Is congruent with patient values and choices
 - Is based on a physical, mental, cognitive, psychosocial, functional, environmental assessment
 - Is based on an inventory of resources and supports
- Management of all care transitions (the TCM stipulated services, TCM cannot be billed separately)
- An EHR that is available 24/7
- Opportunities for patient-to-provider communication via telephone or secure asynchronous NF2F messaging (e.g. secure Internet messaging)

CMS is considering even more service expectations, but many professional organizations have complained about the level of CMS intrusion into the details of practice management. The unresolved stipulations are the following:

- Higher EHR standards,
- Precise expectations for the non-clinicians who deliver CCM

services (CMS may provide job descriptions),

- The need for detailed written protocols, and
- Patient-centered medical home or the equivalent certification.

What will be the RVU value of the CCM code?

The most critical issue will be the relative value units (RVUs) assigned to the CCM service code and how they are distributed between work RVUs (the clinician share) and practice expense RVUs (the payment for the care management provided and the infrastructure). Since there is no risk adjustment and only one service time expectation, practices will have to consider how to amortize the costs so that those patients who consume higher resources are balanced by those who consume fewer resources, knowing that all patients will receive a minimum 20 minutes of care every 30 days.

The AMA's CPT has developed three CCM service codes for patients, but these codes were designed for patients with much higher levels of instability and included face-to-face care. CMS has no requirement to resolve these differences. Non-Medicare carriers have no obligation to pay for CMS or CPT-defined services.

CMS has established the framework for the CCM code, though there are important details yet to come. Now is the time to address the workflow, personnel, documentation, and payment considerations. Some combination of these factors together will influence each practice or enterprise's decision of whether to support this service code.

Recommended Reading

<https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#h-310> (pages 186-198)

OUTPATIENT MORNING REPORT

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relatively common and is a result of excessive vomiting and diuretic or laxative misuse. Hypochloremic metabolic alkalosis often occurs with hypokalemia in individuals who vomit excessively or abuse diuretics. However, in the setting of laxative abuse, the loss of excessive potassium and bicarbonate in the feces leads to hypokalemic, hyperchloremic metabolic acidosis.³ Hypophosphatemia, hypomagnesemia, and hypocalcemia may also occur as a result of AN or as part of the refeeding syndrome.³ Additionally, patients with AN may have a reduced glomerular filtration rate, leading to an inability to concentrate the urine and subsequent dehydration. Prior to refeeding, patients should be properly rehydrated, and electrolytes should be repleted.²

Further history and workup reveals a several-month history of amenorrhea, hypoglycemia, and abnormal thyroid function testing (T_4 4.5 ug/dL, T_3 53 ng/dL, and TSH 4.86 mU/L).

Amenorrhea is present in more than 95% of all females with AN.¹ In patients with AN, the normal pulsatile release of gonadotropin-releasing hormone from the hypothalamus is reduced. This leads to decreased follicle-stimulating hormone and luteinizing hormone release from the pituitary and ultimately to decreased levels of estrogen. This functional hypothalamic amenorrhea prevents ovulation.² The best way to restore menses is weight gain, although 10% to 30% of patients remain amenorrheic despite return to normal weight.^{1,2}

A number of other endocrine complications are associated with AN. Mild hypoglycemia is common due to depleted hepatic glycogen stores and disruption of hepatic gluconeogenesis as a result of dietary restriction, weight loss, and excessive exercise.² Although usually asymptomatic, severe hypoglycemia suggests a poor prognosis.¹ Thyroid function test abnormalities are also common. This typically presents as euthyroid sick syndrome, which con-

sists of low to normal serum T_4 and T_3 , normal TSH levels, and increased levels of reverse T_3 . Thyroid replacement therapy is not indicated in this setting, as these abnormalities correct with weight gain.¹

Upon further review, a DEXA scan in the last year shows the presence of osteoporosis in the patient's lumbar spine and osteopenia in her left hip.

Osteoporosis is seen in up to 50% of females with AN and is of big concern due to potentially permanent complications, including an increased risk of debilitating fractures.¹ The lumbar spine is the most affected site, and bone loss in patients with AN is thought to occur at a rate of 4% to 10% per year.² The pathogenesis of osteopenia and osteoporosis is multifactorial. The severity of bone density loss appears to be closely linked to amenorrhea age of onset and duration along with the degree of weight loss.⁴ In addition to hypoestrogenemia, however, other factors attributed to the development of osteoporosis include severe malnutrition, decreased calcium intake, excessive exercise, hypercortisolemia, and decreased levels of IGF-1. It is recommended that any patient with AN and amenorrhea for more than six months should undergo testing for baseline bone mineral density with a DEXA. Repeat testing should be done every two years.^{1,2} The most important treatment is early weight restoration and resumption of menses. Other therapies include supplemental calcium and vitamin D. Although controversial, supplemental estrogen and bisphosphonates may have a role in more severe cases.^{1,4}

Due to chronic postprandial abdominal pain, the patient is referred to a gastroenterologist and eventually undergoes an upper endoscopy to assess the nature of her dyspepsia. EGD shows mild gastritis and poor gastric fundus accommodation likely secondary to AN.

Gastrointestinal complications are common in AN. Frequent complaints include constipation, abdominal pain,

bloating, early satiety, and nausea after eating. Many of these symptoms are the result of impairment in the upper part of the GI tract, leading to gastroparesis, or delayed gastric emptying, and prolonged GI transit time.⁴ Gastroparesis occurs with food restriction and with weight loss of 10 to 20 lbs. Typically gastroparesis resolves with weight restoration in four to six weeks. In the meantime, however, it can be managed conservatively with early ingestion of liquid food supplements, multiple small meals, and avoiding excessive fiber. Metoclopramide, which increases gastric emptying and motility, may also be useful.² Constipation that frequently accompanies weight loss in AN may also be managed conservatively with hydration, low doses of fiber, polyethylene glycol, and osmotic laxatives, such as lactulose, as a last resort.^{1,2} Although both gastroparesis and constipation typically resolve with weight restoration, the accompanying symptoms of pain and bloating may hinder weight gain by discouraging eating.²

Despite regular follow-up involving several health professionals, this patient has continued to struggle with her AN. She continues to binge and purge regularly and has a current weight of 84 lb.

Management of AN is often difficult due to its protracted course and various medical and psychiatric comorbidities. Thus, this disease is best managed with a multidisciplinary approach, consisting of a primary care physician, psychiatrist, and dietitian, among other specialists. Despite this approach, prognosis remains poor, as 16% of patients still meet criteria for AN 10 years after initial diagnosis.¹ Mortality rates for all causes of death have been reported to be up to six times higher than for the general population.⁴

Typically, AN can be managed on an outpatient basis with close follow up. However, in more severe cases or when certain complications are present, inpatient management may be necessary. Although no set guide-

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OUTPATIENT MORNING REPORT

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lines exist, there are several generally accepted indications for inpatient treatment, including body weight 25% to 30% below ideal body weight, rapid and severe weight loss that fails outpatient management, heart rate less than 35 to 40 beats/minute, symptomatic hypotension, syncope, arrhythmias, or QT prolongation.⁵

As mentioned throughout, treatment for AN and its multitude of medical complications centers on weight restoration. Target goal weight is typically within 90% of ideal body weight.¹ To achieve this goal, outpatients and inpatients are encouraged to gain 1 lb and 2 to 3 lbs per week, respectively.¹ During this time, patients should be monitored very closely with weight checks and frequent measurements of electrolytes to avoid refeeding syndrome.¹

Key Points

- AN is a fairly common psychiatric disorder that may present with a number of acute and chronic medical conditions involving many organ systems. It is important to be familiar with these complications, available treatment options, and indications for inpatient management.
- The most important treatment for AN is nutritional replenishment, as many of the associated medical complications resolve with weight restoration.
- Management of patients with AN requires a multidisciplinary approach, with active involvement of a primary care physician, psychiatrist, and dietitian, among others.

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SIGN OF THE TIMES

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these retreats may be ideal for faculty who do not have a strong background in the new assessment skills required of CBME. These sessions would need to be facilitated by faculty who have expertise and could require significant time, space, and financial resources that may be prohibitive for some programs.

The Recurring Model

This model is organized into shorter, more frequent sessions delivered on a recurring basis (e.g. quarterly). These sessions provide an overview of milestones, explanation of the new evaluations, review of expectations for direct observation, and time for questions. They are ideal for introducing new concepts briefly or reinforcing skills for faculty with solid foundations in CBME skills and principles. They are less time and cost intensive than retreats but still require recurrent involvement for faculty development leaders and may not provide active faculty engagement. If there is inconsistent faculty attendance, it can be difficult to build on foundational knowledge and skills over time. It may become frustrating for faculty who consistently attend who must learn with those who intermittently attend sessions.

The Just-In-Time Model

The Just-In-Time Model is based on point-of-care or just-in-time training.

These sessions can be very short (e.g. 15 to 30 minutes) and are conducted just before an evaluation cycle. They can be live or pre-recorded as webinars or podcasts and distributed to faculty electronically before their assigned evaluations. During these online learning events, faculty are given mini-tutorials on CBME, how milestones are used to assess residents' development throughout their training, expectations for direct observation, and how to complete the evaluation. These sessions are ideal at reinforcing already learned skills and can be used to reach large numbers of faculty quickly and easily. However, they require faculty buy-in and willingness to engage with the technology, as well as adequate infrastructure to deliver the content.

The Embedded Model

This model embeds faculty development within the structure of the evaluations. As assessments for each rotation are developed by a core group of engaged educators, so are anchors and questions that clearly state how to observe learners. The assessment tools are guides for faculty without the need for the major time and cost investments of the previous three models. However, this model does require faculty to have reviewed the evaluation form prior to the start of rotations. After embedding, the

competency committee and program leaders audit evaluations to identify outliers and provide feedback to calibrate faculty and improve their skills. Monitoring and feedback must be performed in an ongoing way to train new faculty and reinforce or adjust behavior in those who are more experienced with the system. This feedback process can be time consuming for the competency committee and program leadership.

We anticipate these models will provide a guide for programs looking to design new faculty development programs or refine existing ones to meet CBME needs and requirements. More than one model may be needed to effectively address the unique needs of a program. Further research is needed to determine the highest-priority learning objectives for faculty. Moreover, new research should assess the relative impact of each faculty development program.

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