

FROM THE SOCIETY: PART I

Interested in Advocacy? Join Virtual Hill Days in the New Online SGIM Legislative Action Center

Francine Jetton, MA

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This year, SGIM integrated a new legislative action center into the SGIM website and Facebook page in order to better serve the advocacy needs of our members. This new center, called Congress Web, is supported by SoftEdge and appears seamless to the SGIM membership, making it easy for our advocates to send messages to their legislators and others in support of SGIM’s key issues.

Congress Web was also the cornerstone of the first ever “Virtual Hill Day” held in conjunction with Hill Day 2014. Virtual Hill Day was an opportunity for those members who could not physically attend advocacy events on Capitol Hill to advocate for SGIM issues from their homes and offices. Members of the Health Policy Committee crafted an advocacy alert and sent it to all SGIM members, asking them to advocate from their armchairs on graduate medical education reform. SGIM members then sent more than 100 e-mail messages and tweets to their members of Congress, broadening the reach of the Society and reinforcing the message of members who were making physical visits to their representative that day.

Due to the success of the first Virtual Hill Day and the participation in the Twitterverse with the hashtag #sgimadvocacy, SGIM will be hosting additional Virtual Hill days throughout the year. On these days, and through the use of the legislative action center, SGIM’s advocates will be able to:

- *Send messages to congressional representatives.* Advocates can harness the real power of Congress Web through options for message creation and delivery. Messages can be sent to members of the Senate, the House, the White House, or all of the above. We can also use the phone-call method for a last-minute pre-vote campaign.
- *Send letters to the editor.* SGIM members can search for their local newspapers and other media outlets and send an e-mail or letter to

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An Interview with Robert Centor, MD

Amanda Clark, MD

Dr. Clark is a member of the Forum Editorial Board and an academic hospitalist at the Louis Stokes VA in Cleveland, Ohio. She can be reached at amandavclark@gmail.com.

Robert Centor, MD, completed medical school, internal medicine (IM) residency, and chief residency at the Medical College of Virginia (MCV). He has served as the chair of the division of general internal medicine (GIM) both at MCV and the University of Alabama at Birmingham (UAB). He is currently the regional dean of UAB Huntsville Medical Campus where he is a professor of medicine. In the past, he has served as president of the Society for Medical Decision Making, the Association of Chiefs of General Internal Medicine, and the Society for General Internal Medicine. He currently serves as chair of the Board of Regents of the American College of Physicians. Follow his blog at www.medrants.com or on Twitter @medrants.

Tell us about a career accomplishment and its impact on general internal medicine?

Local accomplishments are always the most important. Creating the division of GIM at UAB has, I believe, had a major impact on our institution, our students, and our residents. We have focused on clinical

education and helped develop major local, regional, and national leaders in medical education. Impacting GIM is best done through the people we impact.

Who/what influences your work?

Since my first week as a third-year medicine student on the IM rotation, I have loved IM. The field has allowed me to have a vocation that is also an avocation. I have the opportunity to give back to IM, and that influences my attitudes and daily work. When students and residents enjoy IM, I beam with joy.

Do you think maintenance of certification (MOC) should be changed? If so, how?

To me the major point of MOC is for physicians to provide better care for their patients. Thus, we should be looking at a formative process—one that encourages us to improve rather than just pass a test.

What made you decide to start blogging and using social media? What, if any, impact has it had on your career?

I started blogging to improve my writing. I went through a period of writer's block, and the blog was my method for overcoming that obstacle. Along the way, I found that frequent writing stimulated my thought processes. I have written several articles that arose from blog posts. Social media has provided me brand recognition. My readers understand the breadth of my interests better because of the brand.

Other than social media, what is a hobby or something you are passionate about?

While my traditional answer is golf, recently I have become a passionate

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SGIM Creating Value for Patients: How Can We Prevent the Evaluation Cascade?

William P. Moran, MD, MS

Academic health centers under fee-for-service payment provide little counterbalance to ordering more. As faculty we think, 'Let's just be sure—why not?'



The other day I was in clinic when a second-year resident sat down to check out a 76-year-old woman who was “doing well.” The past two years had been very stressful for her. She had been diagnosed with breast cancer, and treatment included surgery, radiation, and chemotherapy. She developed interstitial thickening in the radiation field but was very functional and symptomatic only on prolonged exertion. During an extensive evaluation for pneumonitis and fibrosis, she was found to have a 6 mm pulmonary nodule. With fibrosis and a nodule, an extensive evaluation ensued, including seven CT scans, two echocardiograms, semi-annual pulmonary function testing, a false-positive bone scan precipitated by a complaint of neck pain, and pages of laboratory tests. She saw three different residents in medicine clinic over a two-year period and five specialists with dozens of clinic visits. Although on nocturnal oxygen (which she found difficult to use), her symptoms had not worsened, and her treatment had otherwise not changed. The patient was described as “a little anxious,” and to me that was understandable given the events of the past two years. The resident wanted to refer the patient back to pulmonary clinic “so she can be followed once a year,” and I sensed that the resident was a bit anxious, fueled by the uncertainty she also felt. Refer? Why not?

I recalled a perspective by Rothberg called “The \$50,000 Physical” where he recounted the complication-riddled cascade of evaluation and treatment of his father.¹ Every decision to evaluate a finding was correct,

and a string of false-positive findings fueled the cascade. Every imaging study and procedure was evidence-based and every decision justified—except the first one. The evaluation cascade was triggered by an unconfirmed suspicion of aortic enlargement on abdominal palpation—a physical examination finding that has very poor reliability.

We have all seen evaluation cascades, and looking back, we wonder if any could have been avoided. In retrospect, it seems clear that the tests and imaging did not add value to care of the patient and certainly subjected the patient to unnecessary risk. Where did we go wrong? How can we prevent it?

Our practice environment is part of the problem. The increasing pressure to see more patients gives us less time to ponder the evidence and downstream consequences and much less time to explore patient preferences and values around these decisions.² Academic health centers under fee-for-service payment provide little counterbalance to ordering more. As faculty we think, “Let’s just be sure—why not?”

The pressure to prevent cascades is intensifying. With implementation of the Affordable Care Act and inexorable pressure to reduce cost from payers, the practice environment is transforming rapidly. Patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) are sprouting like weeds, and in some areas of the country, the “business case” is dramatically shifting academic health centers “value proposition.”

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Citing the “Choosing Wisely” campaign and the American College of Physicians-sponsored high value care initiative,³ Marcotte et al. recently suggested that professional societies can be effective advocates to convene, develop, resource, and disseminate high-value care and delivery system change within their membership.⁴ SGIM committed to high-value care last year announcing the new tag line, “Creating Value for Patients.” At the time, Eric Bass reflected on why the tagline and the word “value” are appropriate for SGIM to promote and support.⁵

Well before the tagline was adopted, SGIM members had been at the forefront of advocating for high-value care and were developing

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Own Your Expertise

Karen R. Horowitz, MD

Changes are coming in general internal medicine (GIM). Some are big; some are small. More primary care physicians (PCPs) are desperately needed. How we recruit, retain, and inspire these future physicians is of great concern to us all. The burning question is how to accomplish this.

Image. Appeal. Authority.

Charisma. Panache. Bling. These are words that advertising executives live by. General internists...not so much.

GIM physicians are smart, talented, committed, driven, and passionate about so many things. We are expert in differential diagnosis. We are expert in utilization of resources. We are expert in coordination of care, system-based practice, and evidence-based medicine. What we are not expert in is self-promotion.

You have to be humble to be a PCP in this health care environment. Changes in medical practice are happening so fast that it's easy to be reactive rather than proactive in your approach to medical practice and career development. But to increase the appeal of GIM we need to *sell it* to medical students and housestaff before they are seduced by the glitz of other areas of medicine.

In his 2014 Malcolm L. Peterson Honor Lecture at the SGIM 37th Annual Meeting, titled "Primary Care: Romance and Reality," Mark D. Smith, MD, MBA, founding president of the California HealthCare Foundation, said, "There's nothing sexy about GIM!" Do you believe this? Is it so? If it is, the future of GIM is truly bleak.

So what makes GIM sexy? What makes you wake up in the morning with enthusiasm for your work and commitment to your patients? What makes a tough day at the office worthwhile? What does the general internist know about GIM that others should know about? Here are some things I know:

- The general internist knows more than anyone else about *the total patient*.
 - The general internist knows more about the *interactions of the health care system* than anyone else.
 - The general internist makes it a priority to respect patient autonomy, collaborate with other health care providers, and optimize utilization of resources.
 - The general internist knows more about what *everyone else* is recommending for the patient and can see the complexity from all sides.
 - The general internist is an advocate, teacher, and coordinator of care who knows how to put the patient first.
- I am proud to tell my patients, "The task stops here. You can rely on me for that. I will be your counsel and help you navigate the system. I know how to guide you."
- So what's missing from GIM? Swagger... Authority...Ownership. Let's start creating a different message for trainees. How can you do this? *Own your expertise!*
1. Let them know what you know! Give lectures. Speak up in your department meetings and grand rounds. Don't let the subspecialists own the discussion.
 2. Be visible. Participate in school of medicine and hospital committees, mentoring committees, and teaching venues. Be a curriculum leader and innovator, not just a participant in projects that deliver someone else's curriculum. Be an advocate. Write an editorial. Teach colleagues, staff, *and patients!*
 3. Don't let opportunities slip by!
 4. Speak of your involvement in the school of medicine and medical societies.
 5. Present your work publicly; document what you do, and "make it count twice"!
 6. Teach from primary sources, and model your ability to understand and interpret the evidence. Avoid guidelines and summary articles as the primary means of teaching outpatient medicine. Demonstrate the academic rigor that goes into excellent primary care.
 7. Teach housestaff how to write a review article, and get one published.
 8. Engage in quality improvement projects, and make changes that affect your work environment.
 9. Limit the negativity. Stop whining, and start managing the practice.
 10. Build your career; have short- and long-term goals; be purposeful in the projects you choose and the assignments you accept; tell your residents and students; and tell your boss!
- For GIM physicians, SGIM is our academic home. What does this mean? This means it is a means to connect with other academic internists who share our interests, expertise, and enthusiasm for GIM. It is a community of like-minded professionals who understand the opportunities, challenges, and potential of a career in GIM.
- To maximize the impact of your membership in SGIM, let's all "*lean in*" for GIM! Volunteer to be part of planning committees and mentoring panels. Review abstracts. Present your work at local and national meetings. Join an interest group. Become an advocate for GIM through participation in Hill Day or Virtual Hill Day. Most importantly, join the discussion! There are more vehicles than ever before for the individual physician to be heard. Respond to a letter on GIM Connect. Start a blog. Post a tweet. Write for *Forum!*
- The case for GIM is ours to win or lose. If you believe that GIM is necessary for the future of medicine, it's time to spread the word. Let's get sexy, SGIM. Own your expertise, and redefine the image of GIM. Together we can make GIM flourish for the next generation of internists. *SGIM*

An Introduction to the Perioperative Medicine/Medical Consultation Interest Group

Steven L. Cohn, MD

Dr. Cohn is the coordinator of the Perioperative Medicine/Medical Consultation Interest Group and professor of clinical medicine at the University of Miami Miller School of Medicine.

The Perioperative Medicine/Medical Consultation Interest Group was established more than 25 years ago and is intended as a vehicle for communication and collaboration among physicians involved in these areas. Our group includes physicians with extensive experience in perioperative medicine—many of whom are directors of preoperative clinics and medical consultation services—but all physicians with an interest in perioperative medicine are encouraged to join. In addition, our members have authored and edited several textbooks, online lectures, topics in UpToDate and shmconsults.com, and journal articles.

Every year at the SGIM annual meeting, we present an Update in Perioperative Medicine that is a review of the major publications in the past year. At our interest group meeting, we facilitate networking by having attendees introduce themselves, including their academic affiliations, roles, and interests. This is followed by a short clinical presentation, ideally by junior faculty; a review of our activities during the past year; a discussion of new and controversial issues; an open forum for discussion; and plans for the next year.

Our goals are to encourage online discussion between members regarding interesting or difficult patient management cases, to update the group as new articles of interest are published, to collaborate on writing projects, to develop a clinical research group and database, and to share educational tools and curricula for resident education. We invite all

SGIM members with an interest in perioperative medicine to join our group and actively participate.

Update Articles Published by Members of Our Group

1. Cohn SL, Mauck KF, Dutta S, Jaffer A, Smetana GW. Update in perioperative medicine 2013. *Hosp Pract* 2013; 41(4):15-23.
2. Ménard GE, Grant PJ, Cohn SL, Smetana GW. Update in perioperative medicine 2012. *Hosp Pract* 2013; 41(2):85-92.
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8. Smetana GW, Cohn SL, Lawrence VA. Update in perioperative medicine. *Ann Intern Med* 2004; 140(6):452-61.

Guidelines Authored by Our Group

1. Smetana GW, Lawrence VA, Cornell JE. American College of Physicians. Preoperative pulmonary risk stratification for

noncardiothoracic surgery: systematic review for the American College of Physicians. *Ann Intern Med* 2006; 144(8):581-95.

2. Lawrence VA, Cornell JE, Smetana GW. American College of Physicians. Strategies to reduce postoperative pulmonary complications after noncardiothoracic surgery: systematic review for the American College of Physicians. *Ann Intern Med* 2006; 144(8):596-608.
3. Qaseem A, Snow V, Fitterman N, Hornbake ER, Lawrence VA, Smetana GW, et al. Clinical Efficacy Assessment Subcommittee of the American College of Physicians. Risk assessment for and strategies to reduce perioperative pulmonary complications for patients undergoing noncardiothoracic surgery: a guideline from the American College of Physicians. *Ann Intern Med* 2006; 144(8):575-80.

Books with Chapters Authored by Our Group

1. Cohn SL, ed. *Perioperative Medicine*. London: Springer, 2011.
2. Cohn SL, Smetana GW, Weed HG, eds. *Perioperative medicine—just the facts*. New York: McGraw Hill, 2006.
3. Cohn SL, ed. *Preoperative medical consultation*. *Med Clin North Am*. Philadelphia: W.B. Saunders, Vol. 87(Number 1), January 2003.

Call for Volunteers: Collaborative Group on Teaching Health Policy

David Popiel, MD; Cara Litvin, MD; Theodore Long, MD; and Mark Schwartz, MD

Drs. Popiel, Litvin, Long, and Schwartz are members of the Health Policy Outreach Subcommittee.

As medical educators, we are faced with the challenge of preparing our students and residents to succeed in the ever-changing health care climate. In addition to being sound clinicians skilled in providing evidence-based patient care, we want our learners to meaningfully navigate the health care system, advocate for population-based interventions, control costs, improve patient safety, maximize health equity, and know how to participate in the policy process. Simple enough, right?

Unfortunately, nobody has designed the one-size-fits-all curriculum for this yet. Any attendee of the SGIM annual meeting can tell you about the increasing number of academic centers that are demonstrating an interest in developing and expanding medical education on population health, public health, medical economics, and health equity. A key-stone piece of all of these educational interventions is health policy education. Although health policy education for medical students

and residents is highly variable across different institutions, many of us will agree with the current literature that health policy education needs to be integrated into medical education at both the undergraduate and graduate medical level.^{1,2}

Although the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) stop short of any competencies that include health policy education, the SGIM Health Policy Committee recognizes that many leading institutions are exploring collaborations and partners to strengthen their own health policy education. We are exploring ways in which SGIM can serve as a catalyst for further creation and development of health policy educational material between institutions.

Over the next year, we'd like to develop a learning collaborative of members interested in developing and teaching health policy educational materials. Our plan is to share

these health policy curriculum "best practices" at the 2015 annual meeting. We envision using GIM Connect as a platform to facilitate this sharing of resources. To start, we'd like to identify the health policy educational needs of SGIM members, fellows, residents, and students. How do you think SGIM can best create a health policy curriculum for its members and students? What resources would be helpful for you? How can SGIM share these resources? Please join us in this collaborative by contributing to our "open forum" discussion on GIM Connect.

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2. Patel MS, Davis MM, Lypson ML. Advancing medical education by teaching health policy. *N Engl J Med* 2011; 368(8):695-7.

SGIM

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- the editor about issues important to the Society.
- *Search for elected officials.* The legislative action center is now a key resource for SGIM advocates regarding their elected officials with a zip lookup, state lookup, in-depth information about individual elected officials, and special sections for Congress and the president.
 - *Learn about elections and voter information.* In future elections, SGIM can now be a "get out the vote" powerhouse with voter registration information, absentee ballots, and up-to-date election information for presidential, congressional, and state

elections. SGIM members will be able to evaluate candidates with detailed biographical information and make informed decisions.

- *Track legislation and vote history.* SGIM will help keep you informed about legislation that is important to general internal medicine though information on bill details, co-sponsorship, and vote results.

Advocating on behalf of SGIM may seem daunting, but the new legislative action center makes it easy and accessible—even for new members. This month we are asking members to contact their representatives to stress the importance of

Congress passing an omnibus appropriations bill rather than settling for a continuing resolution. The National Institutes of Health, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration will likely benefit from such a bill. Visit the legislative action center online at <http://www.congressweb.com/sgim> to compose your own message to Congress from the talking points and sample e-mail provided, and make sure you tweet your message and share on your own social networks. Together we can all make a difference on Capitol Hill and achieve our goal of "Every SGIM member an advocate!"

SGIM

Do RVU-based Compensation Models Undervalue Primary Care Physicians?

Andrew Dervan, MD, MBA; Tom Staiger, MD; and John Goodson, MD

Dr. Dervan is an internal medicine resident at the University of Washington in Seattle; Dr. Staiger is medical director of the University of Washington Medical Center and associate professor of medicine at the University of Washington School of Medicine in Seattle, WA; and Dr. Goodson is associate professor of medicine at the Harvard Medical School, Massachusetts General Hospital, in Boston, MA.

The service codes used by most internists, each with a five-digit billing number, are part of a convention that lies at the core of physician compensation. Each code, as defined in the American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*, is associated with a narrative description. The Centers for Medicare and Medicaid Services (CMS) issues valuations for each of these codes annually on January 1. Few physicians are aware of how these assigned values are determined. The AMA-sponsored Relative Value Scale Update Committee (RUC) of 31 (mostly specialist) members substantially influences this process. Understanding the seminal role and composition of the RUC is critical for internists to persuasively advocate for primary care payment reform.

Overview of RBRVS/RVUs

There are thousands of CPT codes, and new codes are created every year. Office-based visits use a small subset of CPT codes, often referred to as evaluation and management (E&M) codes. Medicare pays providers based on the relative value units (RVU) assigned to each CPT code multiplied by a dollar amount called the conversion factor (2014 CF = \$35.82). The conversion factor is adjusted up or down each year by Medicare and Congress based on budget targets and past Medicare spending in an effort to control total Medicare costs. Each RVU has three components: 1) the amount of "work" (e.g. stress, intensity) it takes to perform the task; 2) the associated overhead for said task; and 3) a small additional amount for malpractice liability. Most RVUs are roughly half work and half overhead. For example, a level 3 established patient

visit (CPT 99213) is valued by Medicare at 2.14 RVUs.

When Medicare began in 1965, RVUs did not exist. Reimbursements were based on physicians' "customary, prevailing, and reasonable" charges. This led to variability in charges and quickly rising costs. In the late 1980s, a team led by William Hsiao, a Harvard economist, devised the resource-based relative value scale (RBRVS). The goal of the RBRVS was to benchmark every visit, procedure, and service against one another in terms of stress, intensity, time, and practice expense by using a newly created measure, the RVU. Hsiao created initial estimates by aggregating doctors from dozens of selected specialties into advisory groups to define services, interviewing thousands of doctors by questionnaire and then compiling the data into a master fee schedule. The AMA established a council of experts to give advice on updating RVU values, and thus the RUC was formed. The AMA claims to do so under its First Amendment right to petition the federal government as part of its research and data collection activities and in connection with the CPT development process.

RUC Structure

The RUC currently has 31 members. They meet three times a year to adjust the RVU value of existing codes and assign values to new codes. The RUC then makes non-binding recommendations to CMS, but CMS has accepted the recommendations more than 90% of the time since 1992 (though this proportion dropped to 76% in 2014). Only six current representatives (21% of the voting members) make most of their income from office-based, non-proce-

dural visits. The RUC rules require a two-thirds majority to approve any recommendation, making any substantial change difficult to achieve.

Comparison of RVUs of Non-procedural vs. Procedural Services

The RUC-documented processes for assigning and updating the valuations assigned to services have failed to account for the efficiencies that arise as procedures become faster, easier, and less risky. For example, in 1992, when the code for a diagnostic colonoscopy was valued, the AMA estimated that the basic colonoscopy took 75 minutes of a physician's time. Today the total time the average physician spends performing a colonoscopy is about half what it was in 1992, although the work component of a screening colonoscopy has remained at 3.69 since 2000. As a comparison, the work RVU component of a level 4 return office visit is 1.5, which when billed based on time requires 25 minutes of face-to-face time. The work RVU of cataract extraction is 8.52 with a time justification of 84 minutes. More recent published estimates show the surgery is typically performed in 30 minutes today (nearly tripling the effective payment rate per surgery). There is room for debate as to the comparable intensity and stress of these procedures compared to an office visit, but given the growing complexity of primary care for an aging Medicare population, this payment discrepancy is remarkable.

Major Criticisms of the RUC

For a committee that influences how \$87 billion is allocated, there is little transparency. RUC meetings are not

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In the article “The Search for Wisdom in Choosing Wisely,” Christopher Wong, MD, reflects on discussions related to SGIM’s inclusion of annual physicals on its Choosing Wisely list. Stemming from his observations of this debate, he outlines a myriad of issues he says the campaign is facing, claiming the “campaign has larger challenges in the movement itself” and suggesting possible improvements and future states. I appreciate Dr. Wong’s thoughtful critique of the campaign. Choosing Wisely—and any ambitious effort of its kind—could certainly be improved. But I was disappointed by the narrow focus of the suggestions, which missed an opportunity to instead explore the broader picture of how Choosing Wisely can be used as a pathway to improve patient care.

Dr. Wong states that there are conflicting statements regarding the purpose of Choosing Wisely and suggests a refined mission statement. The campaign has always had a clear and consistent aim: to encourage clinicians and patients to engage in conversations about reducing unnecessary tests. This is really about culture change—stopping and thinking about the tests and procedures ordered out of routine or protocol and having conversations about what is best for patients. Given the complexity of health and our health care system, achieving a goal like this needs to be approached from multiple avenues, such as raising awareness of overtreatment and waste, encouraging practice changes, and developing communications skills training to support clinicians in conversations with patients.

Dr. Wong also questions the process undertaken by societies in identifying the items on their lists, claiming a variation in character and scope. He notes that many societies used task forces that did not necessarily represent the membership body as a whole.

We believe the society lists are a means to an end—the conversations that ultimately take place between clinicians and patients about what tests and procedures are most appropriate. However, we recognize the utility of these lists in how they might be applied in other areas of health care, such as the work done at Cedars-Sinai to embed them in their electronic health records or resident-led utilization improvement efforts at Vanderbilt University Medical Center. We intentionally created a framework that gave each society some degree of latitude to address areas of waste in its specialty. Additionally, we ensured a level of consistency across the entirety of the campaign by asking partners to abide by four principles: 1) Each recommendation should be a test or procedure that is used

frequently and/or that carries a significant cost; 2) there should be generally accepted evidence to support each recommendation; 3) the process should be thoroughly documented and publicly available upon request; and 4) each recommendation should be within the control of the specialty.

Dr. Wong suggests that the language used in the recommendations—notably the frequent use of “don’t” or “avoid” to begin most statements—runs counter to the campaign’s aspirations to propagate conversations. We believe this direct language, and the clarity derived from its brevity, has done just the opposite.

These short initial statements serve as an entry point to a more substantive conversation. Each recommendation is followed by much lengthier descriptions of the recommendation, along with instances where such a test or procedure would be appropriate.

Several of these recommendations are further explored as topics in education modules developed to enhance physician communication skills. Created by the Drexel University College of Medicine in partnership with specialty societies, a topic such as “Don’t x-ray for low back pain” serves as the basis for a seven-part training covering areas such as eliciting patient concerns, showing empathy, and creating partnerships.

Underscoring the importance of these conversations and the relationship between physicians and patients, Consumer Reports, working with the societies, has created patient-friendly brochures (now more than 60) based on many of the recommendations and is disseminating them through a bevy of consumer partners like AARP, the National Business Group on Health, and Wikipedia.

It is because of the leadership of specialty societies like SGIM that Choosing Wisely has taken root in health care and helped shape a national dialogue on eliminating waste and overuse. There is still much work to be done, but we are encouraged that others are building on the campaign and using it as a starting point to advance their own initiatives to reduce unnecessary care. We are optimistic about the future as societies create new lists, and we welcome new clinician organizations to Choosing Wisely.

*Daniel B. Wolfson, MHSA
Executive Vice President and
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Announcement of Presentation Award Winners from the 37th Annual Meeting

Bonnie Roberts

Ms. Roberts is the awards program coordinator at SGIM and can be reached at awards@sgim.org.

The Society of General Internal Medicine is proud to announce the following award decisions based on presentations made during the 37th Annual Meeting in San Diego, CA, held April 23-26, 2014.

The Exemplary Clinical Workshop Award recognizes those who present an outstanding clinically focused workshop at the SGIM annual meeting. All workshops presented at the annual meeting are considered for this award. This year's recipient is:

- **Deborah DiNardo, MD, of the VA Medical Center at the University of Pittsburgh School of Medicine** for the workshop titled "Assuring Breast Cancer Survivors Are Not 'Lost in Transition': The Generalist's Guide to Breast Cancer Survivorship Care"

Three David E. Rogers Junior Faculty awards are given to junior faculty for workshops judged the most outstanding among those presented at the SGIM annual meeting. To be

eligible, the workshop coordinator must be an SGIM member and faculty at the instructor or assistant professor level at the time of presentation. The Zlinkoff Fund for Medical Education endows these awards. The 2014 recipients are:

- **Kerri Palamara, MD, of the Massachusetts General Hospital** for the workshop titled "Need Directions? A Roadmap to Understand and Assess Ambulatory Milestones"
- **Mariecel Pilapil, MD, of the Hofstra North Shore-LIJ School of Medicine** for the workshop titled "Preventive Screening in Young Adults with Special Health Care Needs (YASHCN): A Primary Care Perspective"
- **Stefani Russo, MD, of the Icahn School of Medicine at Mount Sinai** for the workshop titled "Talking the Talk: Optimizing Communication Between Residents and Multidisciplinary Care Team Members in Academic Primary Care Practices"

Two awards are given to acknowledge the best women's health-focused presentations: one for an oral abstract presentation and one for a poster presentation. Trainees and junior faculty members who submit abstracts in the women's health category at the SGIM annual meeting are eligible. The 2014 recipients are:

Best Women's Health Oral Abstract:

- **Karen Freund, MD, MPH, of the Tufts University** for the presentation titled "Progress or Stalemate in Academic Gender Disparities? 15-year Follow-up of the National Faculty Survey"

Best Women's Health Poster Presentation:

- **Holly Thomas, MD, of the University of Pennsylvania Medical Center** for the presentation titled "Correlates of Sexual Satisfaction in Midlife Women: Communication is Key"

We congratulate you all!

SGIM

The SGIM 38th Annual Meeting April 22-25, 2015 Toronto, Ontario, CANADA

The theme of the 2015 SGIM annual meeting is
Generalists in Teams: Adding Value To Patient Care, Research And Education.

IMPORTANT DATES—Mark on Your Calendar Now!

- **September 3, 2014:** Online submission site opens for submission of workshops, updates, and interest groups
- **September 23, 2014 (11:59 PM Eastern Time):** Early submission fee period ends (\$75.00)
- **September 24, 2014 (12:00 AM Eastern Time):** Late submission fee goes into effect (\$85.00)
- **October 6, 2014 (8:59 AM Eastern Time):** Submission deadline for workshops, updates, and interest groups
- **November 17, 2014:** Online submission site opens for submission of scientific abstracts, clinical vignettes, innovations in clinical practice, and innovations in medical education
- **November 20, 2014:** Acceptance notifications e-mailed (target date) for workshops, updates, and interest groups
- **January 8, 2015 (8:59 AM Eastern Time):** Submission deadline for scientific abstracts, clinical vignettes, innovations in clinical practice, and innovations in medical education

Oath of Professionalism

Case Western Reserve University Class of 2018

The White Coat Ceremony has become a tradition at US medical schools—a rite of passage marking the beginning of the academic year and an opportunity to welcome another class of students to the medical profession.

As we welcomed the incoming class of 2018, the Case Western Reserve University School of Medicine held this event at Severance Hall on July 13, 2014. For our future physicians, this is the culmination of a month of study and reflection on the meaning of becoming a physician. As I read the Oath of Professionalism composed by this year’s freshman class, I am proud of our WR2 Curriculum and the purposeful inclusion of a values-based agenda for the beginning of medical training.

I hope that *Forum* readers will feel as I do—inspired by the words, optimistic about the future of our profession, and confident in the knowledge that such thoughtful students will soon become our colleagues.

—Karen Horowitz, MD
Forum Editor

We, the entering class of Two-Thousand Fourteen, now embark upon our journey to become physicians who practice with integrity, altruism, and cultural competence.

To our patients:

We promise to listen to your story; to heal with empathy and compassion; and to care while curing. We will respect your individuality and protect your right to flourish. We will nurture an environment of mutual trust.

To our colleagues:

We promise to be exemplars of our profession, dedicating ourselves to research, discovery, and life-long learning. We will collaborate across disciplines

and be worthy of our peers’ respect. We will humbly commit ourselves to high ethical standards. We promise to be resilient in the face of adversity and confront challenges with courage.

To our community:

We promise to be your advocates and allies, honoring human agency and dignity. We appreciate the social and personal identities of all people and the barriers that may accompany them. We commit ourselves to overcoming these injustices. We pledge to lead inside and outside the hospital walls, providing equal and sustainable care for all.

We will practice and propel the art and science of medicine. Our role as healers begins now.

SGIM

LEADERSHIP PROFILE

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runner. I ran in my first 5K at age 65 and loved it.

You’ve been to the SGIM annual meeting 34 times. How do you use this meeting to support your career, and why should others consider attending the meeting?

It is impossible to overestimate the impact SGIM has had on my career. SGIM members have served as my support group, intellectual stimulators, and colleagues for many years. Each SGIM meeting allows me to

get ideas, exchange ideas, and re-fuel my batteries. SGIM provides validation that what we are doing has great importance. Many colleagues look forward to the meetings for the same reasons.

How do you suggest other members receive maximum value from SGIM?

Simple answer—attend and participate. Start with regional meetings—meet people and learn how things are done at other institutions. Then

“borrow” ideas to improve your own institution.

What piece of advice regarding leadership do you wish you had known 20 years ago?

You cannot do everything. When you are offered a new responsibility, you must decide what you are going to replace. You should regularly figure out what parts of your job you love and what parts you like. If at all possible, do more of the love and less of the like.

SGIM

High-value Care Interest Group

Robert L. Fogerty, MD, MPH; Anthony Accurso, MD; and Arnab K. Ghosh, MD, MA

Dr. Fogerty is assistant professor at the Yale School of Medicine, Dr. Accurso is an instructor at Johns Hopkins Bayview Medical Center, and Dr. Gosh is a resident in the department of medicine at New York University.

The High-value Care Interest Group began over a warm pretzel in the lobby of the Manchester Grand Hyatt in San Diego at the 2014 SGIM Annual Meeting. A small group of us had previously met through networks, contacts, and home-grown projects in high-value care, and we sat down socially to share ideas. We began with discussing how the status of health care expense in the United States has been well documented. It is sufficient to say that we spend too much money and get too little back in health. We get lots of drugs, procedures, and appointments, but what we really want is health—perhaps best defined as the lack of pain, disease progression, or preventable injury. We also believe that value isn't just about saving money—the principle of value can also increase health. By removing unnecessary testing and procedures, we can reduce cost and harm. With that motive, who wouldn't want more value in their health care?

We went around the table sharing projects, resources, and initiatives at our home institutions. We were inspired and impressed with the accomplishments of our colleagues. However, at the same time, we were startled that we hadn't yet found a forum for sharing and collaboration. To meet this need, we formed the High-value Care Interest Group.

Our group members are active. The "Do No Harm" project at the University of Colorado encourages trainees to write up clinical vignettes that illustrate when overtreatment leads to patient harm. The success of the group led to the Teachable Moments column in *JAMA Internal Medicine*, shifting national attention to the dangers of overtreatment.

Johns Hopkins Bayview Medical Center is home to Providers for Responsible Ordering (PRO), a grassroots effort directed at trainees and faculty to reduce unnecessary testing. They have created an online pledge and are undertaking local projects and training in an effort to reduce low-value practices.

The Interactive Cost-Awareness Resident Exercise (I-CARE) is a new curriculum tool for teaching trainees in a multi-site initiative. It began at Yale and has now spread to Johns Hopkins Bayview and Jefferson with more sites expressing interest.

New York University, through both Bellevue Hospital and New York University Medical Center, is investigating how to best assess trainees to ensure no harm comes to patients from under-treatment through the use of novel assessment tools both in real time as well as in other formats.

Weill Cornell has completed a survey confirming what we all suspect: Residents are interested in learning more about cost and value.

Colleagues at the University of Pennsylvania are assessing institutional variation of high-value learning and practice. They are correlating trainee performance on high-value care board questions with utilization data from the Dartmouth Atlas.

We use GIM Connect to share exciting resources and news on health care financing, reduction of waste, and creative interventions.

The High-value Care Interest Group is new but active. The topic of high-value, cost-conscious care is gaining momentum, and we are excited to collaborate on the subject and share best practices. We are always looking for new members, so join us on GIM Connect or come introduce yourself in Toronto!

SGIM

The Inmate Exception: A Medicaid Loophole with Serious Consequences

Elisabeth Poorman, MD, MPH

Dr. Poorman is a medical resident at Cambridge Health Alliance.

As a medical resident in Massachusetts, I'm fortunate to expect that my patients have access to health insurance regardless of their income. In most states, Medicaid eligibility is extremely restrictive; living below the federal poverty line is enough to qualify patients in only a handful of states. This is about to change in the majority of the country with the Affordable Care Act (ACA) and its expansion of Medicaid to adults living below 138% of the federal poverty level. Now, the impoverished will have access to basic health coverage.

But a loophole in the original Medicaid law was preserved—a clause known as the “Inmate Exception” that bans people in jail or prison from receiving Medicaid.¹ During incarceration, the county or state government (or private company) takes over care, providing some basic medical services. With these disruptions in coverage, many chronic medical issues fall through the cracks, and few jails or prisons connect people to care when they re-enter the community.

Many states have even interpreted the Inmate Exception as an opportunity to shrink their Medicaid rolls, with official policies to disenroll jail inmates upon incarceration, even if they haven't been charged with a crime. Although they have access to emergency medical care while incarcerated, when they leave their previous Medicaid is not automatically reinstated despite the fact their qualification still stands. This is particularly dangerous because in the

first two weeks after release, parolees are at 12 times the risk of death of the general population.²

For patients with chronic medical conditions, just being picked up and spending a night in jail can be a dangerous proposition, as they leave without medications, follow up, or coverage. The Affordable Care Act does not address this issue. Although the Medicaid expansion will insure more people, they will have a tough time staying insured. This is a bureaucratic nightmare, with the potential for unnecessary harm, hospitalizations, cost, and mortality.³

Incarceration is a fact of life for millions of people every year, especially in poor communities and communities of color. A third of black men who are born in 2001 will be imprisoned during their lifetime, and my preliminary findings suggests that those who qualify for Medicaid by income status are twice as likely to be incarcerated than those with higher incomes over a 12-month period. Upon release, access to primary care or medications for chronic diseases is not a foregone conclusion. This has ripple effects across families and entire communities, with loved ones left to care for sick relatives now without insurance who are often sicker when they leave jail or prison than when they entered. Caring for patients from these communities means we cannot ignore incarceration and the harm caused by the Inmate Exception.

Does this affect your practice? Using data from the Bureau of Jus-

tice Statistics, I estimate that just over 5 million Americans who would otherwise qualify for Medicaid will potentially lose it because they will be incarcerated in the next 12 months. That translates to 60 out of 1,000 Medicaid patients on your panel losing their insurance in a 12-month period and then waiting months to be re-enrolled.

Sitting across from my sickest, poorest, and most socially complex patients, I often feel overwhelmed. The medical knowledge that my fellow interns and I are so hungry to learn often feels pointless. What medication is affordable for this patient? What medication will the patient tolerate and actually use? After I am able to make some headway on these complex issues and after months of visits, the needle moves a little bit forward, and these tiny positive changes are a source of great joy. But this progress relies on continuity and consistency and continuity and consistency are impossible when many of my patients frequently lose their insurance. I implore SGIM to take this on as an issue. We must take a stand on behalf of our most marginalized patients. Together, we can raise our collective voice and demand an end to the Inmate Exception.

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For patients with chronic medical conditions, just being picked up and spending a night in jail can be a dangerous proposition, as they leave without medications, follow up, or coverage.

SGIM Participates in ABIM Summit on Maintenance of Certification (MOC)

Eric H. Green, MD, MSc, FACP

Dr. Green is program director of the Internal Medicine Residency Program at Mercy Catholic Medical Center, clinical associate professor of medicine at Drexel University College of Medicine, and chair of the SGIM Maintenance of Certification Task Force.

Medical societies like SGIM allow a community of physicians to speak with a single voice. Recently, many individuals have contacted SGIM as well as the American Board of Internal Medicine (ABIM) (directly) to express concern over the recent changes in MOC requirements. SGIM has joined with other medical societies to relay these and other concerns to the ABIM and work collaboratively to improve the MOC process. On July 15, 2014, ABIM convened a meeting of internal medicine leaders in Philadelphia, PA, to respond to concerns over changes in MOC. Fifty-three delegates representing 27 societies participated. SGIM representatives were Eric Green, chair, MOC Task Force, and Eric Bass, immediate past president of SGIM. Representing ABIM were ABIM's executive staff as well as many members of ABIM's board of directors and council.

The meeting opened with an opportunity for each society to relay concerns expressed by its members. Although the opinions of individual speakers ranged from supportive to frankly critical, there was widespread agreement that many physicians felt that the new MOC requirements were "overwhelming" or might be the "straw that broke the camel's back." While participants endorsed a commitment to the principles of life-long learning, they agreed that there were many opportunities to improve the MOC process and that this was a key time for the internal medicine community to unite in this effort.

Although some speakers expressed unique concerns to their specialty or subspecialty, in general most of the feedback was consistent. A number of areas of concern emerged from the discussion, including:

1. Lack of proven overall benefit of the revised MOC program due to

dearth of research in this area and possible unintended consequences, such as departure of older or part-time clinical physicians from the clinical workforce;

2. Costs of MOC, both in terms of actual dollars paid to ABIM and time and opportunity costs required by the MOC process;
3. Fairness of the new process to physicians who were certified before 1990 and previously were exempt from MOC;
4. Implementation of the MOC program, which needs to address harmonization between activities previously undertaken by physicians and MOC, the ability of both physicians and others to use and create ABIM-approved MOC products, and opportunities for physician-researchers and administrative physicians to meet MOC requirements; and
5. The secure exam, including the relevance of material and format, its utility as a formative feedback mechanism, and the burden placed on sub- and subspecialists.

As a society, our remarks highlighted the importance of an MOC process that could support internists practicing in ambulatory care, hospitalist-based, research-based, and administrative settings.

It is clear after this meeting that ABIM's leadership has a clear understanding of the concerns of current ABIM diplomates. At the time of writing of this column, ABIM has already committed to:

1. A one-year "grace period" should a physician fail a recertification exam (Otherwise, those individuals might have lost certification while awaiting a

- second attempt on the exam.);
2. A more flexible approach to approving MOC modules that should allow professional societies (like SGIM) to more easily produce modules that serve physicians' diverse needs;
3. Transformation of a previously announced "patient survey" requirement into a "patient voice" requirement that is more flexible (The ABIM will release more details for this requirement, not mandated in 2018, at some point in the future but will allow current work to be applied retroactively for this requirement.); and
4. Reduction in requirements for data collection for "practice assessment" modules (formerly practice improvement modules), including facilitating use of quality improvement and practice assessment projects already ongoing.

In addition, the ABIM has pledged to continue its efforts to change the secure exam and make its own finances more transparent.

The ABIM has also indicated that further change is likely as the board of directors and council respond to the constructive feedback that has been offered. As your representatives to the ABIM, we will continue to both relay your concerns to the board and the board's ongoing refinement of MOC to you.

Addendum: On July 28, ABIM responded in writing to the concerns raised by professional societies. In addition to the changes referenced above, there is a strong commitment to improving communication between societies and the ABIM to help the "house of medicine" continue to improve the MOC process.

PRESIDENT'S COLUMN

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resources and educational strategies to support members in that effort.⁶⁻⁸ As those members have eloquently argued, we need time with patients to elicit their values and preferences and rapid access to reliable evidence about both the disease and the value of testing. We need to advocate for policy change in medical education and primary care reform. We need to teach management strategies, including better patient continuity and frequent follow-up (i.e. in person, by phone or secure e-mail) as a substitute for more images, labs, and doctors. We need to reassure both patients and learners that more testing is not always the answer.

As I looked through the electronic health record tabs at imaging, special studies, lab, and notes, I suspected I was looking at an evaluation cascade.

Listening to a somewhat anxious resident presenting her plan for an anxious woman with several serious but stable conditions, I needed to formulate a new plan. I needed to prevent a new cascade, and I needed to begin with the patient's values and preferences, good evidence, and an alternative plan that would allay the anxiety. So rather than "Why not?" my new question to ponder and ask the anxious resident was "Tell me why?"

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SGIM

COMMENTARY

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open for public comment. Only partial minutes are published; even these are delayed. The RUC relies heavily on specialist society surveys to determine what work RVU should be used for new codes, creating an inherent conflict of interest. While primary care physicians make up 40% of physicians nationwide and provide nearly half of Medicare physician visits, they have less than 20% of the votes on the RUC. Beyond Medicare, the service code valuations are used by virtually all commercial carriers and have been the basis for payment models in the evolving accountable care organizations (ACOs). Inequalities in RVU-based payments are felt in large part to be responsible for the specialist-generalist income gap.

Reforms or Alternatives to the RUC

Multiple alternatives or reforms to the RUC have been proposed. The American Academy of Family Physicians has made the case that E&M services provided by primary care practitioners today are substantially different from specialist office visits—all of which are billed currently under the same codes. Thus, primary care should receive distinct codes and relative values. US Representative (and psychiatrist) Jim McDermott (D-Wash.) introduced a bill (Accuracy in Medicare Physician Payment Act of 2013, HR 2545) that would make the RUC an official federal advisory committee, adding patients, purchasers, and economists to the committee; making meeting notes open and available for comment; and giving more support to CMS to oversee the RUC. The Affordable Care Act officially tasked CMS to study its own valuations processes, but the results of these studies have not been made public. To account for the quick evolution of technology, some have argued there should be an established schedule of RVU reductions set in advance for new procedures that are likely to become less risky and less difficult as technology improves. These reductions would be subject to modifica-

tion later if evidence shows that the reductions have been too large or too small. Finally, this pay disparity is based on a fee-for-service payment modality. It is possible that bundled payments, such as those that occur in ACOs, will allow for more equitable payment schemes. However, these payments will only become more equitable if current biases are recognized. Using RBRVS benchmarks as they currently exist will perpetuate the undue influence of the RUC on physician payments.

Suggested Reading

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