ANNUAL MEETING UPDATE:  
PART I  

Toronto Revisited  
David C. Thomas, MD, MHPE, and Sharon E. Straus, MD, MSc  

Drs. Thomas and Straus are chair and co-chair of the Annual Meeting Program Committee.

The 38th Annual Meeting of SGIM was an opportunity to advance our knowledge around patient care, education, and research focused on the generalists in teams and to celebrate the terrific achievements of many of our talented SGIM members. At final count, 1,939 members from nine countries were able to share in these activities in Toronto, Canada; this is the second largest attendance at an annual meeting, just below the total of 2,000 participants who attended the annual meeting in 2014. This reflects an increase in attendance of almost 20% since the last time we held the annual meeting in Toronto. We set a new record for the largest opening plenary session with 1,350 attendees. Thank you to the SGIM membership for your tremendous support and enthusiasm in attending this meeting!

Some of the meeting highlights for us were the keynote by Jeff Turnbull, MD, on the role of the generalist in meeting the needs of our vulnerable populations and the 2015 Malcolm Peterson lecturer Malcolm Cox, MD, on advancing the science of interprofessional education. Both speakers challenged us to think about gaps in patient care, education, and research that could be met by our membership. We are strongly positioned as individuals and an organization to meet these needs. Dr. Turnbull challenged us to think about how to address health disparities in our populations. His work in Ottawa, Canada, provides an excellent example of how a general internist can be a force for system change, leading to improved quality of care for homeless people and providing an opportunity for trainees to develop skills in this area. Dr. Cox highlighted the need for practice redesign and rigorous evaluation of interprofessional education with consideration of relevant patient and health system outcomes, including economic analyses. We look forward to future meetings to learn how SGIM members tackle these challenges!

A particular highlight for us was the chance to work with the Program Committee and the more than 400 members who volunteered their time to prepare for this meeting by reviewing abstracts, scheduling sessions, and serving on awards panels. Several new features were tried at the meeting, including the unknown clinical vignette abstract session led by chief residents. This session was “standing room only,” and we thank... 

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FROM THE SOCIETY: PART I

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SGIM: Your Academic Home Stands Stronger than Ever

David Karlson, PhD

Dr. Karlson has served as the Executive Director of SGIM since 1997 and retired on June 5, 2015.

Over the last 18 years, my personal goal has been to keep SGIM a strong organization, even as the field of general internal medicine (GIM) saw most internal medicine graduates going into sub-specialty care. To keep SGIM strong, the key elements have been:

1. The rank-and-file members who kept coming to the national meeting—an astounding 50%—as well as to the seven regional meetings to present their work. These members also consistently paid their dues and continued their commitment to SGIM as their academic home.

2. The volunteers for the many committees, task forces, and work groups who are the backbone of SGIM programs and services. The annual meeting alone has nearly 200 volunteers. Volunteers have long been there when needed to carry on the good cause of keeping SGIM strong and able and representing academic GIM with great programs, services, and publication vehicles (e.g. JGIM, Forum, and GIM Connect).

3. Volunteer leaders who have thoughtfully guided the organization and responsibly managed scarce SGIM resources. Both Council (12 voting members) and Executive Committee (made up of officers only) meet monthly to ensure that all yearly goals are being met and that new goals are set each year. These committed volunteer leaders have contributed to making the house of SGIM strong with adequate resources to represent the field in all arenas, including other internal medicine organizations and Capitol Hill.

4. Finally, the staff who support all activities of the Society and have a collective history at SGIM of 75 years, excluding my 18 years! Many staff members have been with SGIM for more than 10 years, with some at 16 and 17 years. Along with items 1 through 3, this group of association professionals, fiercely dedicated to SGIM, has allowed me to be successful in my goal of sustaining the strong foundation that was built when I joined the Society’s ranks some 18 years ago. We have built on that foundation and have made SGIM a world-class organization—the academic home of thousands of members. It is an organization that, along with the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM), is prepared to carry on the fight for improving patient care and providing an academic home everyone wants to return to each year. In the case of ACLGIM, continued on page 13.
Students who rotate and are taught in poorly organized clinics and residents who care for patients in overburdened practices are trainees who may seek career paths other than primary care.

Over the past few months, SGIM Council has engaged in a strategic planning process to ensure that SGIM effectively addresses internal and external threats and opportunities. This planning included a lively brainstorming session with leaders of different SGIM committees and task forces at the 2015 Annual Meeting in Toronto and reaching out to members for their views through GIM Connect. It is a tricky time for SGIM. The policy and economic environments are rapidly shifting, creating a fertile setting for innovation. Traditional general internal medicine (GIM) is under siege financially while policymakers and administrators look to it for solutions to improve systems of care and patient outcomes.

A thoughtful long-standing member of SGIM recently told me that we as a society have to be careful not to do too much navel-gazing. I think he meant that we have a justifiably proud history as an organization but that we cannot view ourselves in isolation from the outside world. We must be informed by creative ideas as we devise solutions to the complicated challenges facing us.

In this spirit, Council has identified three priorities for 2015-2016: 1) to improve the work environment for primary care providers, 2) to ensure that reimbursement systems fairly compensate primary care providers for their work, and 3) to make SGIM more attractive to recruit and retain members. These priorities have been given to the various SGIM committees and task forces to help guide their planning for the upcoming year and their budget requests. I will now describe the three priorities in more detail.

**Improve the Work Environment for Primary Care Providers**

Work environment rose to the top of the priority list because it is essential to the survival of GIM. Physicians who work in inefficient clinics that are neither patient-centered nor designed to enable physicians to be as effective as possible are physicians at high risk for being frustrated, dissatisfied with their work lives, and burnt out. Students who rotate and are taught in poorly organized clinics and residents who care for patients in overburdened practices are trainees who may seek career paths other than primary care. The core of GIM—caring for the whole patient over time in a huma nistic way—is a beautiful ideal but one that becomes significantly less attractive in a difficult work environment.

Improving work environment will require the talents and expertise of all of SGIM’s members. What care transformations will lead to more satisfied physicians providing better care for patients and populations? What is the physician’s role in team-based care? What ways of training students and residents in the clinic create a better work environment and improved patient care? How can we increase physicians’ sense of autonomy so the system supports their provision of outstanding care rather than overwhelming them and giving them little control over their daily schedules and activities? Are there ways to improve our communication and messaging around primary care and the work experience? How can we tap into physicians’ innate professionalism and deep moral values and nurture the sense of mission, caring, and social justice that can make our jobs so satisfying and rewarding?

**Ensure That Reimbursement Systems Fairly Compensate Primary Care**

Related to improving work environment is fairly compensating primary care providers for their work. For years, SGIM’s Health Policy and Clinical Practice committees have engaged in a variety of education...
The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held April 22-25, 2015, at the Sheraton Centre Hotel in Toronto, ON, Canada. SGIM is proud and pleased to announce the recipients by category:

**Recognition Awards**

The Robert J. Glaser Award was presented to Nicole Lurie, MD, MSPH (assistant secretary, US Health and Human Services Preparedness and Response), for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

The Elnora M. Rhodes Service Award was presented to Susana Morales, MD (Weill-Cornell Medical College), for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine (GIM).

The Herbert W. Nickens Award was presented to Donna Washington, MD, MPH (VA Greater Los Angeles Healthcare System UCLA), for a demonstrated commitment to cultural diversity in medicine.

The David R. Calkins Award in Health Policy Advocacy was presented to Carolyn Clancy, MD (interim under secretary for health for the Department of Veterans Affairs), in recognition of her extraordinary commitment to advocating on behalf of SGIM.

The ACLGIM Division Chiefs’ Recognition Award was presented to Julia Arnsten, MD, MPH (Albert Einstein/Montefiore Medical Center). This award is given annually to the GIM division chief who best represents excellence in division leadership.

The Lawrence S. Linn Award was presented to Michael Reid, MD, MA (University of California, San Francisco). This award is presented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

The ACLGIM UNLTD (Association of Chiefs and Leaders in General Internal Medicine Unified Leadership Training in Diversity) Award recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. The 2015 recipients are Milda Saunders, MD, MPH (University of Chicago), and Elizabeth Leilani Lee, MD, MBS (Temple University).

The ACLGIM Leadership Award is given to a member of the ACLGIM at the junior-faculty level who inspires and mentors trainees to pursue GIM and lead the transformation of health care through innovations in research, education, and practice. The 2015 recipient of this award is Aleem Bharwani, MD (University of Calgary).

The Quality and Practice Innovation Award recognizes leaders of practice innovations who have improved care within the “quality” domains of safety, effectiveness, patient-centeredness, timeliness, efficiency, and quality or the patient-centered medical home goals of accessible, coordinated, patient-centered, team-based, and comprehensive care. The 2015 award was presented to the Continuous Care Initiative, Massachusetts General Physicians Organization, represented by Ryan W. Thompson, MD, MPH.

**Research Awards**

The John M. Eisenberg National Award for Career Achievement in Research was presented to Nancy Rigotti, MD (Massachusetts General Hospital), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

The Outstanding Junior Investigator of the Year was presented to Benjamin Sommers, MD, PhD (Harvard School of Public Health), for early career achievements and overall body of work that has made a national impact on generalist research.

The Mid-Career Research and Mentorship Award was presented to Michael Steinman, MD (University of California, San Francisco/San Francisco VA MC), in recognition of mentor activities as a GIM investigator.

The Best Published Research Paper of the Year was presented to Richard Saitz, MD, MPH (Boston University/Boston Medical Center), for his publication "Screening and Brief Intervention for Drug Use in Primary Care: The ASPIRE Randomized Clinical Trial." This award is offered to help members gain recognition for their papers that have made significant contributions to generalist research.

The Founders’ Grant was presented to Kevin Riggs, MD, MPH (Johns Hopkins School of Medicine), for his proposal titled “Surgeons’ Attitudes about Pre-Operative Medical Evaluations.” The SGIM Founders Award provides $10,000 in support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to establish a strong research funding base.

**Clinician-Educator Awards**

The National Award for Career Achievements in Medical Education was presented to Thomas Beckman, MD, FACP (Mayo Clinic), for a lifetime of contributions to medical education.

The Frederick L. Brancati Mentorship and Leadership Award was presented to Vineet Arora, MD, MAPP
(University of Chicago). The Brancati Award honors an individual at the junior-faculty level who inspires and mentors trainees to pursue GIM and lead the transformation of health care through innovations in research, education, and practice. Valerie Press, MD (University of Chicago), has been named the 2015 Brancati Leadership Scholar.

The National Award for Scholarship in Medical Education was presented to Carla Spagnoletti, MD, MS (University of Pittsburgh), for her individual contributions to medical education in one or more of the following categories: scholarship of integration, scholarship in educational methods and teaching, and scholarship in clinical practice.

The Mid-Career Education Mentorship Award was presented to Hollis Day, MD, MS (University of Pittsburgh). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education, research, and mentorship of junior clinician-educators.

Presentation Awards
The Mack Lipkin, Sr., Associate Member Awards are conferred to the scientific presentations considered most outstanding by students, residents, and fellows during the SGIM annual meeting. The award winners for 2015 are:

- Maggie K. Benson, MD (University of Pittsburgh), “The Hidden Curriculum in High Value Care Education: Resident Perceived Barriers to Practicing High-Value Care in a Training Environment”
- Aaron L. Schwartz, MD, PhD Candidate (Harvard University), “Low-Value Services in Year 1 of the Pioneer ACO Program”
- Melissa Y. Wei, MD, MPH (BIDMC/Harvard Medical School Medicine), “Multimorbidity and Mortality in Community-Dwelling Women: Simple Disease Counts, the Charlson Index, and a Novel Multimorbidity Weighted Index”

The Milton W. Hamolsky Junior Faculty Awards are presented to the scientific presentations considered most outstanding by junior faculty during the SGIM annual meeting. The award winners for 2015 are:

- Jennifer P. Goldstein, MD, MSc (Christiana Care Health System), “High Quality Transitions of Care Reduce Hospital Readmissions among Patients with PCI and CABG”
- Marc R. Larcheille, MD, MPH (Boston University School of Medicine), “Opioid Prescribing After Nonfatal Overdose and Association with Repeat Overdose”
- Mitesh S. Patel, MD, MBA, MS (University of Pennsylvania), “Workplace Wellness Incentives for Weight Loss—A Randomized, Controlled Trial”

The SGIM Clinical Vignette Oral Presentation Award recognizes the best clinical case presented by medical students, internal medicine residents, or GIM fellows (not faculty) at the SGIM national meeting. This year’s recipient is Sweny Guliati, MD (University of Florida College of Medicine), for the presentation “A Rare Yet Emerging Cause of Severe Myocarditis and Cardiomyopathy.”

The Outstanding Quality & Patient Safety Oral Presentation Award recognizes the most outstanding oral abstract presentation related to quality assessment, gaps in quality of care, medical errors, and quality improvement or patient safety in the inpatient or outpatient setting at the SGIM national meeting. This year’s awardees are Jennifer Cai, MD; Emily Campbell, MD; and James Richter, MD, for their presentation “Evaluation of Discordant Upper Endoscopy in Outpatients with Gastroesophageal Reflux Disorder.”

The Best Geriatrics Research Oral Abstract was awarded to Lillian Min, MD (University of Michigan), for “Net Harms of Aggressive Blood Pressure Control on Cardiovascular Events and Fall Injury in Older American Adults.”

The Best Geriatrics Research Poster Presentation was awarded to Ngoc-Phuong Luu, MD (Johns Hopkins University), for “Social Support and Its Relationship to Advance Care Planning.”

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Kaiser Permanente®

The Division of Research in Kaiser Permanente’s Northern California region is accepting applications for its July 2016 class of Delivery Science post-doctoral fellows. The application deadline is September 15, 2015 for fellows beginning July 2016

Location: Oakland, California

Eligibility: We seek outstanding candidates with health professional doctorate degrees and/or research doctorate degrees in related fields. Applicants must be eligible for US employment. Women and minority candidates are encouraged to apply.

Program Goals for Delivery Science Fellows: Enhancing skills to help highly-qualified researchers pursue successful research careers in delivery science; address critical health care delivery problems in priority areas and conduct research to help support advances in how medical care is delivered within the Kaiser Permanente integrated care setting and the U.S. health care system overall.

Learning Opportunity: Fellows will develop their delivery science research and writing skills for presentations and publications while being mentored by experienced scientists.

Questions and Application: Email DOR-Fellowship@kp.org or go to www.dorfellowship.kaiser.org
Two years ago the SGIM council, after a long debate, changed the SGIM “tagline” to “Creating Value for Patients.” I want to talk about what that means to us and could mean to our patients, families, and communities. As you know, the highest value care is the best quality or outcome at the lowest cost. For the moment, let’s just focus on cost.

We have heard the numbers so often we can repeat them in our sleep—the US spends almost twice as much per capita as the next most expensive industrial country, now at more than $9,000 per person. In 2013, total health care expenditures were $2.9 trillion! It is hard for me to get my head around $2.9 trillion. How do you put that number in context? For me the distance metaphor really doesn’t help. You know the one: “If dollar bills were placed end to end, they could go 4.6 light years…” or some such.

What is also hard to get my head around is the fact that two dramatically different entities—the Institute of Medicine and the Congressional Budget Office—have estimated that we spend 30% of health care dollars on care that “does not bring value to patients.” Actually, that was the IOM. The Congressional Budget Office just called it waste—$2.9 trillion, and almost a third is waste.

It is a little easier for me to understand the numbers when I see data on how those costs impact individuals, families, and communities. For example, between 2000 to 2010, the overall inflation rate was 27%, real wage growth was 36%, insurance premiums went up 114%, and workers’ contribution to premiums went up 147%. If you had employer-sponsored coverage, the lower your household income, the smaller the proportion of costs covered by your plan.

At the state level, a study of health costs’ impact on households showed that in 2003 health care costs were more than 20% of median household incomes in one state: West Virginia. By 2011, health costs were greater than 20% of household income in the majority of states.

One in every five dollars of household income went to health care. There are many equally dismal statistics showing that the huge costs of care directly impact patients and families.

There is another way to view health care costs. We know that care needs and outcomes for many of our patients are driven by social determinants of health. I think we all agree that health and longevity should not be pre-determined by gender, race, ethnicity, and especially zip code. What could we do with a small portion of the hundreds of billions of dollars that are wasted?

Economists use the term opportunity costs. This represents the concept that resources consumed in one sector of the economy—such as health care—are not available to be spent in another sector, such as housing, education, or social services. After all, money is money—the money spent on health care comes from personal income (with employer benefits such as health insurance substituting for earned income) and tax dollars from multiple sources. Money is fungible, so we can look at some opportunity costs to help us understand the tradeoffs we make by paying all this money for health care.

- 1 ED visit = one month’s rent
- 2 hospitalizations = one year of child care
- 20 MRIs ($2.6K) = a social worker
- 60 echocardiograms ($1K) = a public school teacher
- < 0.5% of an academic health center budget ($2B) = a new elementary school ($8M)

We can quibble about the dollar amounts and certainly wonder if those savings could actually be used in another sector, but right now we can’t have that debate because the money is gone—there is no opportunity—and a large proportion of those dollars are wasted.

In 2010, the Affordable Care Act (ACA) was signed, and we all breathed a sigh of relief. Finally, we were going to turn health care around. Access would be expanded and the workforce remodeled. Financial incentives would be re-aligned to support innovative care models: We would shift to patient-centered care, moving from “volume to value.” Don Berwick eloquently simplified the ACA goals by advancing the concept of “Triple Aim”—better health, lower cost, and a better care experience.

It is now five years later. After legislative roadblocks and countless votes to repeal the ACA in Congress, many court rulings, and even a small computer glitch, there has been a lot of progress. Insurance practices have been reformed, millions of people have gained coverage, and the cost curve is bending. Unfortunately, out of pocket costs are not bending as quickly, so the savings may not yet be accruing to patients and families.

But has health care reform reached a tipping point? I don’t think so. Health care reform is a long-term transformation that will only be sustained when costs are controlled. As you know, there are still a few folks and some segments of the health care industry that have not totally embraced health care reform and the ACA. Challenges continue. The upcoming Supreme Court decision on federal exchanges and the election in 18 months will be critical to ACA progress. Keep in mind, 23 states including my state continued on page 14
SGIM's 2015 Nomination Committee has concluded the ballot count of the 2015 elections, and we are pleased to announce the election results below along with a personal statement from each of the elected members. These Council members will each serve a three-year term in their positions.

SGIM President-Elect: Eileen E. Reynolds, MD

SGIM has been a central force in my medical life since I went to my first meeting as a primary care resident at UCSF. Ever since, I have found the Society and its meetings to be my professional home where I find energy, ideas, renewal, and shared values. My participation in SGIM has changed the way I think, how I relate to my patients, and how I view medicine. My goals for SGIM are:

1. To continue to build collaborative bridges with other national organizations. I will work to leverage SGIM’s influence and advocacy for members’ goals and core values, particularly around primary care access, payment, and research dollars. The threat to graduate medical education funding is among SGIM’s important issues, and I will collaborate with the Alliance for Academic Internal Medicine and the American College of Physicians on educational funding concerns.

2. To focus on our “pipeline,” our future members. Recent curricular changes in many schools have pushed primary care clinical experiences into the first weeks of the first year. We know many students arrive hoping to go into primary care; now we can access them earlier than ever and seek to sustain their primary care commitment. Every first-year student should be contacted by an SGIM member.

3. To work with the exceptional staff of SGIM to assist with their goals for the core work they do. The staff is the backbone of everything we can accomplish.

SGIM Treasurer-Elect: David C. “DC” Dugdale, MD

Since attending my first meeting, SGIM has been my academic home. Through mentorship and collegial relationships, SGIM has helped me grow personally and professionally, with an enduring commitment to balance. I am eager to “give back” to the organization that has so positively shaped my own career. I want to help members further their educational and research activities and learn the clinical and business/management skills needed to thrive in an environment that is often difficult for academic generalism. I believe that modeling by generalist faculty with “breadth and depth” is essential to training primary care and generalist physicians and to developing the best possible health care system. I look forward to building on my experience in medical care system management to promote work with SGIM members and leaders that will strengthen the influence of general internal medicine (GIM) and our organization. I will emphasize commitment to SGIM’s values of excellence, collegial support, partnerships, social responsibility, equity, and diversity while also working to improve SGIM’s financial health.

Council At-Large Members: Eva Aagaard, MD, FACP

I am truly passionate about GIM—both primary care and hospital-based medicine. In my former role as a community physician and current role as an academic, SGIM has consistently served as my professional home since 1999. The Society is a place to learn, a community to be a part of, and a place of opportunity for personal and professional growth and advocacy for the field I love so much. As a Council member, I will bring my passion for education, scholarship, and patient care and my longstanding knowledge of SGIM to bear. I am committed to balancing the priorities of SGIM to make sure we meet the needs of all of our members. My leadership style is one that focuses on listening and consensus building. I look forward to op-
portunities to bring creative solutions to challenging issues. In addition, I will continue to strive to enhance our work especially through collaboration with other organizations.

Jada Bussey-Jones, MD, FACP
Since my first southern regional meeting in 2000, SGIM has been my professional home. I have been happy to serve in a number of roles and am committed to do the following:

1. Advocate for patient-centered equitable care and social responsibility in the care of vulnerable, underserved, and diverse populations. I will support educational, research, advocacy, and service interventions that seek to address and improve patient-centered care and care of the underserved while mitigating inequity.
2. Develop innovative approaches to increasing the diversity of members at SGIM. I will support the membership by supplementing our wonderful mentoring program with other innovations for junior faculty, trainees, and students. I will search for additional funding to support travel and program development dedicated to increasing and enriching the experiences of junior faculty and learners at the national meeting with the goal of increasing and maintaining their interest in generalism and academic medicine.
3. Broaden the role of SGIM in the discussion of new models of primary care that improve outcomes and increase value. I will increasingly participate in the national debate, becoming a leader of both faculty and learners as academic practices transform to medical homes that utilize and advance scholarship around population management, team-based care, information systems, and other innovations.

SGIM Council congratulates the new officers and Council members and extends its sincere appreciation to all the candidates for their willingness to serve the Society. The SGIM Council also wishes to thank the members who served on the 2015 Nominations Committee: Eric Bass (chair), Bennett Lee, Shobhina Chheda, Martin Shapiro, Ellen Yee, and Marshall Chin.
Interest Group Activities
Toronto! Another outstanding SGIM meeting! While I could share many highlights from the colorful spectrum of exciting topics and experiences from Toronto’s meeting, I will share with you my yellow theme: Interest Groups.

It never ceases to amaze me how alike we all are. We deal with similar patients, political and financial barriers, and intricate academic promotion pathways among other challenges. The necessity for guidance and mentorship continues to occupy the junior academician’s mind no matter where he/she practices.

As the co-chair for the Academic Hospitalists Task Force (AHTF), I had the privilege of leading our interest group meeting. Despite the many amazing competing talks at 8 am on Thursday, attendance exceeded 30 people. Interest groups offer a venue to discuss common challenges of the profession. The AHTF members meet annually to share personal or institutional experiences that may help members network, seek collaboration, and triage “hot topics” that may need to be undertaken by a representing entity, such as the AHTF.

During our meeting, each attendee introduced him/herself and reflected on a personal or institutional challenge. Forty minutes into our conversation, after everyone had shared experiences, we grouped challenges by topic, and with the help of all attendees, identified the most important. Important topics were those that affected most members; posed a research question; aligned with the SGIM mission; and were not already being addressed by a task force, SGIM, or other representing society.

The top three topics selected were: 1) how to efficiently round at the bedside with a multidisciplinary team; 2) how to buy down time or obtain access to funding for academic/scholarly projects and research; and 3) how to optimize communication with other divisions, departments, or project leaders. These three topics have been added to the AHTF agenda. Additional topics currently being addressed via other avenues included the need for leadership and faculty development tracks, access to mentorship, standardization of job descriptions with performance metrics, and creating alternate or innovative promotion pathways.

I enjoy interest groups and attended many during the SGIM conference. Although interest groups may vary in their format or agenda, the ones I have attended provided me with a deeper understanding of the issues that pertain to that specific area of general internal medicine (GIM). Interest groups open the door to a network of possible future mentors, collaborators, and colleagues at SGIM.

—Maria (Gaby) Frank, MD

Pearls from April 23 Plenary Abstracts
Aligning with the meeting theme of teams, the MARQUIS study supports the use of trained staff, such as pharmacy techs for medication reconciliation on admission and pharmacists for discharge medications, in reducing potential medication errors at discharge. We learned that teamwork experiences can begin early in medical training, even for medical students learning from community health workers.

Open proposals using crowd sourcing can be a way to identify potential quality improvement ideas from the ground up but still require infrastructure and expertise for further selection and implementation of projects.

From the clinical vignette we learned that *Staphylococcus lugdunensis* is a pathogenic coagulase-negative staphylococcus that behaves like *S. aureus*; endocarditis can be particularly morbid and lethal with this organism.

—Chris Wong, MD

Award Presentation Highlights
Nicole Lurie, MD, winner of the Robert J. Glaser Award, urged members to live a “whole life” as opposed to a siloed work-life balance concept. She reminded us that although we are in a time of chaos in health care, “there is a lot of opportunity in chaos.”

Nancy Rigotti, MD, winner of the John M. Eisenberg National Award for Career Achievement in Research, was inspired by treating patients when their disease was at an advanced stage, leading to lifelong research in interventions to reduce smoking. She inspired us not to be discouraged if we had good ideas that were not initially supported. Dr Rigotti noted the successes of women “getting in the door” and the challenges of supporting women in academic medicine and enabling them to reach high levels of achievement. It is clear to Dr. Rigotti and to SGIM members that this year’s awardees (including Drs. Donna Washington, Susana Morales, Carolyn Clancy, Julia Arnstein, Vineet Aurora, and Hollis Day) are an encouraging demonstration that this trend is being reversed.

—Chris Wong, MD

Update in Women’s Health
These sessions highlighted a number of important findings in women’s health:

1. Ulipristal is a highly effective method of emergency contraception.
2. The newer HPV vaccine appears to be promising, but the improvement in efficacy over the current vaccine is incremental—small in comparison to the
and advocacy activities designed to reimburse primary care providers fairly for their work. Current methodologies and mechanisms to measure the value of primary care work and calculate payments do not accurately measure the full range of complex cognitive, coordinating, analytical, and management functions of the primary care physician who cares for complicated patients with multiple medical, behavioral, and social comorbidities.

Underpayment is a major problem for several reasons. Fewer resources are available to transform primary care systems to be more patient centered and to support physicians in their clinical practice. Less funding leads to lower prioritization of primary care by medical center leadership. Major inequities in salary mean many debt-ridden medical students will shy away from primary care and enter more lucrative specialties. Thus, ensuring fair reimbursement systems is a fundamental building block for GIM’s long-term viability.

Make SGIM More Attractive to Recruit and Retain Members
Core to any organization is providing outstanding value so people join it, remain in it, and participate actively. What programs can provide excellent career development opportunities? How can we effectively market SGIM both internally and externally? Are we innovating, and are we at the cutting edge of the field? Are we advocating for and working on the most critical issues of our members? SGIM is a dynamic organization. The importance of areas such as mentoring and networking is time-less. However, the context of today differs from that of yesterday, and the tools for networking and collaboration have also expanded. Are we meeting members’ needs through our current tools and programming? SGIM’s recent membership survey will help illuminate this area.

Define Our Identity as a Society
At the Toronto brainstorming session about strategic priorities, the top-rated issue was not a specific area but the wish for a clear and concise mission and vision for SGIM today. Who is SGIM? Council will devote almost half of its June 2015 retreat to discussing this area, with the other half scheduled for reviewing the proposed plans of each committee and task force for the next year and allocating the budget. I will report on the discussion about “Who is SGIM?” in a future Forum column.

I think we are in a good position as a society. The three strategic priorities around work environment, reimbursement, and the value of SGIM are major challenges yet ones in which we have significant expertise, experience, and prior work to build upon. Care transformation and reform of health care financing are critical issues for the entire health care system now, and our efforts as a society line up well with the ultimate goals of improving patient health. SGIM is at the forefront of health care reform, and our contributions will make a difference for GIM and our patients.

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Sheira Schlair, MD, and Kerri Palamara, MD, for their creativity and leadership in developing this event. The student, resident, and fellow programs were also more formally integrated with the planning of the annual meeting, and we thank Ryan Laponis, MD, and Meredith Niess, MD, for their inspired leadership in these sessions. Indeed, we are grateful to the Program Committee, SGIM volunteers, and SGIM staff who shared their time and enthusiasm with us.

We also enjoyed the opportunity to work with and learn from SGIM President Bill Moran, MD, over the past year. We appreciated his thoughtful advice and support. Bill, we look forward to seeing more of your sculptures now that you will have more time on your hands!

Finally, the annual meeting was our chance to celebrate the 18-year tenure of David Karlson as SGIM executive director. The reflections of past SGIM presidents on their experiences with David and lessons learned from him were meeting highlights. The affection and respect shown for David by SGIM members and staff was evident to all of us. David has mentored many on their pathways within SGIM, and his tremendous impact will be reflected in membership activities for many years to come. David, thank you for your inspirational guidance and leadership. You will be missed!

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which is made up of chiefs and leaders, their contribution to keeping the house of academic GIM growing is another key ingredient in our ability to keep GIM growing and inclusive.

As I retire, I especially will miss the multitude of SGIM members and staff who have made these 18 years of my career the highlight of my life’s work. Collectively, we have ventured on a journey that has made a difference in the lives of members and staff. I am truly pleased and grateful to be a part of the SGIM family—proud to be GIM, proud to be SGIM.
of South Carolina have not expanded Medicaid, and so there are still millions of uninsured.

Nonetheless, the administration is pushing forward with ACA implementation, and earlier this year in the *New England Journal of Medicine*, Secretary Burwell set out very aggressive goals for Medicare beneficiaries to be enrolled in delivery systems that focus on quality, value, and alternative payment strategies. The recently passed sustainable growth rate fix reinforces the focus on value and payment. (And by the way, another attempt to repeal the ACA was defeated in the process.)

The ACA has set the stage, and progress has been made, but leaders in our field are calling on all of us to take a more active role. We can no longer rely solely on the government to advance the health care reform agenda. Don Berwick and others recently wrote: “It is time to move from change forced from the ‘outside in’ to change led from the ‘inside out.’” Michael Porter and Tom Lee wrote in the *Harvard Business Review*, “Providers must lead the way in making value the overarching goal.”

So what should we in SGIM do? ACA as policy aligns with our values in SGIM—and specifically our value of “social responsibility and equity in health and health care.” Many members of SGIM are leading reform efforts, but we all need to play an active role. It will be difficult work, so I think we in SGIM should do three things.

First, we need to continue to advocate for reform given the ongoing threats to the ACA. More SGIM members need to join SGIM on Capitol Hill. We need to continue to advocate within the executive branch and agencies such as the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the National Institutes of Health, the Health Resources and Services Administration, and the Patient-Centered Outcomes Research Institute. We need to advocate at the state level and at our institutions. I am sure many of you have had conversations with learners and with patients about health care reform, and those conversations need to continue. Advocacy should become part of our work every day.

Second, we need to embrace the concept of value. We must study, practice, and teach methods to provide the highest value care for our patients. We have the professional knowledge, skills, and values to guide us in accomplishing that goal. SGIM members are training the next generation of internists—clinicians, educators, and researchers—and this will be the new professional world within which they will spend their careers. When we bring our values to our work—every time we see patients with our teams, every time we teach a student or resident, every time we write a grant or a manuscript—we create value for patients.

Finally, as we struggle over the coming years (perhaps decades) to eliminate hundreds of billions of dollars in non-value added care, we should consider how we will use those now-wasted resources in a different way: perhaps the opportunity to reduce the adverse impact of social determinants on the health of our patients, families, and communities. As we return home, we should consider the opportunities we have to create value. Every time we improve access and avoid sending a patient to the ED, it could save a month’s rent. If our care coordination avoids two hospital admissions, it could fund a year of childcare; if we avoid a few dozen imaging procedures, we could hire another teacher. And every morning as we walk into the palatial facilities we call academic health centers, remember that with just a fraction of a percent less in our budget, we could build a new school.

**References**


larger problem of overall low vaccination rates.

3. Menopausal vasomotor symptoms can persist for many years (median: 7.4 years). The widely quoted “two years” is not consistent with current data.

4. Estradiol (low dose) and venlafaxine show similar efficacy for menopausal vasomotor symptoms.

5. Risk factors for osteonecrosis of the jaw include duration of bisphosphonate exposure, age, diabetes mellitus, and rheumatoid arthritis.

—Chris Wong, MD

International Participation in the SGIM Annual Meeting

I was pleased to know that the meeting this year was to be held in Toronto, Canada, and I became even more excited when I saw that several other countries, in addition to the United States and Canada, were actively participating with posters and workshops.

As would be expected, Canada had the largest delegation with 63 participants. The next largest presentation was from Japan with 28 participants. There were also nine participants from Switzerland; two from the United Kingdom and Argentina; and one each from Singapore, India, and Australia.

I traveled to Toronto with five Japanese residents who were presenting posters. My residents were very impressed with the academic rigor of the meeting, and they returned inspired by the "Proud to be GIM" message. Many posters reflected the fact that we share similar challenges across our borders. For example, several posters from Japan described the challenges of caring for the elderly and end-of-life care, and a poster from Switzerland challenged the validity of the Vienna prediction model for recurrent venous thromboembolism in specific populations.

I congratulate the leadership for understanding that the SGIM goal of "increasing the visibility and status of primary care and general internal medicine" requires both national and international collaboration. I believe that the 2015 Annual Meeting was a complete success in meeting this goal!

—Sadia Santos, MD

The SGIM PCORI Initiatives

Patient-centered, patient engagement, meaningful outcomes—these are the buzzwords in medical research and funding initiatives today. The PCORI Research Engagement Initiative at SGIM was in full swing and took center stage at this year’s annual meeting. It began with the PCORI Keynote Address by Joe Selby, MD, and continued with workshops on learning health care systems and practices, pragmatic and patient-centered clinical trials, patient engagement in the PCORI process, and PCORNet big datasets. The SGIM Working Group on Engaging Primary Care Researchers in PCORI Research, lead by Jennifer Kraschnewski, MD, presented a balanced toolkit for GIM physicians new to this exciting area of research. The workshops were videotaped and will soon be posted on the SGIM Website. For more information on engaging in PCORI initiatives, contact Jennifer Kraschnewski or Leslie Dunn, SGIM director of project management, at dunnel@SGIM.org.

—Karen Horowitz, MD

SARET

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