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HEALTH POLICY CORNER

Medicare's Sustainable Growth Rate: Fix It or Fail

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At a Capitol Hill briefing on September 30, 2014, leaders of three medical societies representing primary care physicians called on Congress to take advantage of the upcoming lame-duck session to replace the Medicare physician reimbursement system with one that actually rewards better patient outcomes.

Citing a report by the National Commission on Physician Payment Reform, the panel set out a roadmap for fixing a problem that threatens the health of seniors and drains the economy.

Members of the panel representing the Society of General Internal Medicine (SGIM), the American College of Physicians, and the American Academy of Family Physicians noted that spending 20% of US gross domestic product only buys us the 37th-best health in the world. The physicians went on to cite projections that US health care spending will grow an average of 6% over the next decade with no sign that the nation's collective health will get any better.

According to SGIM President William Moran, MD, "The current Medicare payment system challenges the rules of common sense." He notes that under the current Medicare system physicians are paid for each service they provide, regardless of the patient's outcome, and that high-cost technology-intensive services like surgery are valued at disproportionately higher rates than long-term management of chronic illness.

"We're paying for more—and more expensive—medical procedures and less to help seniors learn how to properly manage their diabetes or keep their congestive heart failure in check," Dr. Moran added.

Over the past several years, Congress has failed to come up with a permanent fix to the payment formula, opting instead for temporary patches that thus far have cost more than $170 billion. Panelists at the

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Behind the Scenes at *Forum*

Karen R. Horowitz, MD

It's been six months since I took the reins at *Forum* from my predecessor, Priya Radhakrishnan, MD. As a direct result of her leadership and hard work, *Forum* has continued a strong tradition as the voice of SGIM. Priya was generous with her time and mentorship last summer during our transition, and for this I would again like to express my appreciation. Now our current board is in the process of reviewing our early successes and planning for an exciting year ahead. Here I offer a short summary of our vision, short-term accomplishments, and future plans for *Forum*:

Overarching Goals

1. To represent the public image of the Society by presenting the best of SGIM
2. To provide a public forum for discussion of the diverse interests and opinions of SGIM members
3. To report on initiatives and activities of the Society to the greater membership
4. To highlight the positive impact of SGIM member activities
5. To demonstrate appreciation for the work of SGIM members
6. To promote networking and opportunities to engage new members in SGIM activities, including writing for *Forum*
7. To create value for SGIM *Forum* contributors and the editorial board by promoting opportunities for collaboration, scholarship, and career development
8. To have fun while contributing with pride to our academic community

Early Accomplishments

1. The new editorial board now includes 20 actively engaged associate editors (AEs) representing every SGIM region.
2. Recruitment of new authors by AEs has led to participation by a large diverse group of SGIM members.
3. Outreach to committees and interest groups has resulted in collaborations on more than 20 articles that describe the activities of these groups and offer opportunities for engagement by new members.
4. Three theme issues have allowed us to increase awareness and advocacy for: LGBT Health Care (October 2014), Correctional Health Care (January 2015), and Hospitalist Medicine (March 2015).
5. Improvements in communication have been achieved through the following activities:
   - The Information for Authors statement was developed and posted on the *Forum* web page.
   - AEs have been drawn from every region of SGIM and are available to all members as mentors in developing articles for *Forum*.
   - We have utilized GIM Connect as a mechanism for communicating internally as an editorial board and also with the larger SGIM community. Postings on GIM Connect have led directly to the development of topics for *Forum* articles and served as a vehicle for writers to collaborate on articles.

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Will we return to a time when millions of people are afraid they will get sick?

William P. Moran, MD, MS

For most people, insurance benefits are a little more clear; elimination of copayments for preventive care and closing the doughnut hole for Medicare recipients have been addressed.

It was Sunday morning and my 29-year-old daughter sounded very scared when she called her doctor-dad on the way to a Washington, DC, emergency department (ED). Overnight she had experienced high fever and shaking chills. In the early morning she had developed a severe headache and stiff neck—I told her I agreed with her decision to go to the ED. Relatively soon thereafter I got the next text: "They want to do a spinal tap." I tried to reassure her that the test was the right thing to do, but she was understandably anxious. After a very long hour of waiting, a new text: "The fluid was normal, no meningitis." We were all relieved. Three weeks later she called again from New York, but this time she was crying: "I just got the hospital bill—$8,000! When I was in DC I had just left my last job—I don't know if I was covered by insurance!" I could hear her fear—for three hours of care the bill was more than three months' rent for her tiny New York apartment.

There is no excuse for the fact that Americans spend almost twice as much per capita on health care than the next most expensive country in the world. Both the Congressional Budget Office and Institute of Medicine agree that almost a third of this cost does not add value to patients' care. Health care reform and passage of the Affordable Care Act (ACA) have begun the process of changing the organizing principles of US health care. The most egregious insurance abuses—benefits rescission, pre-existing condition exclusions—are now illegal. For most people, insurance benefits are a little more clear; elimination of copayments for preventive care and closing the doughnut hole for Medicare recipients have been addressed. State and federal exchanges make the purchase of health insurance more transparent, and subsidies make insurance more affordable. Importantly, exchanges have begun to disconnect the link between employment and individuals' access to health insurance—itself an accident of history dating back to the wage and price freeze of World War II. Some state governments that initially refused Medicaid expansion are quietly reconsidering that decision.

The key to sustaining reform, however, is to slow the unsustainable rise of per capita cost, and there is evidence that this is occurring. Health care providers and payers have begun the fundamental shift from buying and selling health care transactions under fee-for-service to value-based sale and purchase of services that maintain or improve patient health. The new alphabet soup of reform—ACO (accountable care organization), PCMH (patient-centered medical home), MSSP (Medicare shared savings plan), CMMI (Center for Medicare and Medicaid Innovation), PCOR (patient-centered outcomes research)—represents incentive shifts and organizational changes that will continue to "bend the curve" of health care expenditures in the United States. I am reticent to admit that electronic health records, with which we have a love-hate relationship as they evolve, are a critically important enabling technology for measuring (however imperfectly) the value of that care to patients and populations.

The November mid-term elections may threaten this progress. Although wholesale repeal of the ACA is unlikely during the Obama administration, many believe Congress will try to limit budgets that support ACA implementation to inflict "the death of a hundred cuts."[1] The Supreme Court ruling on federal ex-

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Get Ready for the 38th SGIM Annual Meeting in Toronto!

David C. Thomas, MD, MHPE; Sharon E. Straus, MD, MSc; Sheira Schlair, MD, MS; Kerri Palamara, MD; and Sarajane Garten, MA

Drs. Thomas and Straus are chair and co-chair of the Annual Meeting Program Committee, Drs. Schlair and Palamara are chair and co-chair of Annual Meeting Clinical Vignettes, and Ms. Garten is SGIM director of meetings.

It's time to set your calendars for April 22-25, 2015, for the 38th Annual Meeting in Toronto, Ontario, Canada. This year's meeting theme is "Generalists in Teams: Adding Value to Patient Care, Research, and Education." Health care reform focused on patient-centered care is driving team-centered delivery system redesign and is a salient interest for SGIM members. This theme has relevance to SGIM members interested in clinical care, education, administration, and research. Team-based models of patient care are rapidly evolving and require rigorous development and evaluation. The education and training of general internal medicine physicians must include knowledge of team member responsibilities and, in some cases, development of new skills such as team leadership, quality, and patient safety measurement. As such, interprofessional training venues need to be developed and training methods evaluated. Research methods will continually evolve to provide valued performance information from existing and new data sources. Integration and coordination of physician efforts with non-physician professionals are critical for reform to be successful. We therefore believe the meeting theme will be of interest to all health care professionals.

Our three plenary speakers will be SGIM President Dr. William Moran, Dr. Jeffrey Turnbull, and Dr. Malcolm Cox. Dr. Moran will kick off our first morning with his presidential address.

On Friday, our keynote speaker will be Jeffrey Turnbull, MD, FRCPC, chief of staff of the Ottawa Hospital. Dr. Turnbull is an expert on poverty and its effect on health nationally and internationally. He is founder and current medical director of the Inner City Health Project for the homeless population in Ottawa. He has been involved in education and health services initiatives to enhance community, institutional capacity, and sustainable development in Bangladesh, Africa, and the Balkans. Dr. Turnbull is the recipient of several national and international grants and awards, including the Order of Canada and the Queen Elizabeth II Diamond Jubilee Medal.

The Malcolm L. Peterson Lecture will be delivered on Saturday morning by Malcolm Cox, MD. Dr. Cox is an adjunct professor of medicine at the University of Pennsylvania. He most recently served for eight years as the chief academic affiliations officer for the US Department of Veterans Affairs (VA) in Washington, DC, where he oversaw the largest health professions training program in the country and repositioned the VA as a major voice in clinical workforce reform, educational innovation, and organizational transformation. His presentation is titled "Building Health Care Value Through System Redesign: Leverage at the Point of Interprofessional Care and Education."

In response to comments gathered from annual meeting attendees, we have made many changes this year. Scheduling has been adapted to include both 90- and 60-minute time slots. The clinical vignettes program will focus on innovation and team-based approaches to health care delivery and education. Members of the Student/Resident/Fellow Interest Group have been working to encourage trainee submissions and to offer guidance on crafting quality submissions. The clinical vignettes will include a special oral presentation session moderated by chief medical residents (CMRs) who will receive telephone-based coaching on facilitation skills by faculty experts prior to the annual meeting. This will be a great opportunity to foster peer mentoring and coaching skills in our trainees. This special vignette session will be held during Session H—one of the meeting's 60-minute sessions—on Friday at lunchtime and will be titled "Clinical Vignettes with the CMRs." For those who wish to focus their attention on a specific topic or topics, the program will direct you to content tracks in women's health, medical education, and other areas of interest.

You can choose from several special series in 2015. Katrina Armstrong, MD, MSCE, will be the eighth SGIM Distinguished Professor of Women and Medicine; Gail Sullivan, MD, MPH, will be the 12th Distinguished Professor in Geriatrics; and Craig C. Earle, MD, will be the sixth SGIM Distinguished Professor in Cancer Research. The VA series has been expanded and includes five workshops this year. New in 2015 will be a Patient-Centered Outcomes Research Institute (PCORI) series.

Interest group meetings will be scheduled in four time slots, but none will be scheduled on Saturday! This innovation in the schedule means fewer groups will be meeting at the same time. The interest group schedule is available at: http://connect.sgim.org/annualmeeting/programming/ig-schedule.

For those who haven't been to Toronto since 2007, you will find the city is as entrancing and interesting as ever. Love the theater? After London and New York comes Toronto. Shoe lover? Visit the Bata Shoe Museum. Sports fan? Visit the Hockey Hall Of Fame or buy reduced-price tickets to see the Blue

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News from the Women and Medicine Task Force

Jennifer McCall-Hosenfeld, MD, and Amy S. Gottlieb, MD

Drs. McCall-Hosenfeld and Gottlieb are chair and co-chair of the Women and Medicine Task Force.

The Women and Medicine Task Force (WAMTF) is SGIM's primary vehicle for promoting women's health and the academic careers of women in medicine. The WAMTF facilitates communication among interest groups related to women's health, promotes women's health as a generalist issue in both clinical practice and health policy, and supports the career development of academic women physicians.

During the past seven annual meetings, the WAMTF has sponsored the Distinguished Professor of Women and Medicine (DPWM, formerly Distinguished Professor in Women's Health). At the 2014 annual meeting, Dr. Melissa McNeil presented her keynote address, "Life Lessons Learned: Things I Wish I Had Known," to a standing-room-only crowd. Dr. McNeil also served as expert discussant for the women's health oral abstract and poster sessions.

We are pleased to announce that the DPWM at SGIM's 2015 Annual Meeting in Toronto will be Dr. Katrina Armstrong. Dr. Armstrong is physician-in-chief of the Department of Medicine at Massachusetts General Hospital and a world-renowned investigator in the areas of medical decision-making, quality of care, and cancer prevention and outcomes. As the DPWM at the 2015 annual meeting, Dr. Armstrong will deliver a keynote address titled "Ambulances, Epidemiology, and the End of the Week." In this presentation, she will discuss how understanding what is meaningful to each of us individually and as members of a team is critical for success in academic medicine and how our experiences in clinical training can drive this process across our careers. Dr. Armstrong will also serve as expert discussant for the women's health oral abstract and poster sessions in Toronto. The WAMTF will once again employ a peer-review process to recognize high-quality oral abstracts and posters addressing women's health.

At the 2012 annual meeting, the WAMTF launched its Career Advising Program (CAP), a large-scale initiative to help female junior faculty successfully navigate the academic promotion process. CAP is a two-year longitudinal mentoring experience that focuses on CV preparation, targeted committee membership, and strategies for relationship-building with external letter writers. The third class of CAP advisee-advisor pairs will be matched just prior to the 2015 annual meeting in Toronto. As in prior years, potential participants will be identified from SGIM's on-line mentoring survey. Advisor candidates may be men or women and should be associate or full professors. Advisee candidates should be women at the assistant professor, instructor, fellow, or resident level. For questions about the CAP, please contact Dr. Amy Gottlieb at Amy_Gottlieb@brown.edu.

The WAMTF will complement its CAP at the 2015 annual meeting with two workshops focused on professional development. Specifically, WAMTF members will offer a workshop titled "Executive Presence, Coaching, and Sponsorship as Tools for Leadership Development." This workshop will introduce SGIM members to career development concepts that are mainstays in the business community and engage in exercises to begin developing these attributes to facilitate advancement within academic medicine. Additionally, members of the WAMTF in collaboration with SGIM's Women's Caucus will offer a workshop titled "Writing for Impact: From Idea to Perspective Piece." This workshop will be highly interactive. Editors from several medical journals will serve as guest facilitators, previewing and then helping to develop ideas of junior faculty mentees eager to share their writing.

The WAMTF and the Maintenance of Certification (MOC) task forces are collaborating to develop a dedicated Women's Health MOC module.

The WAMTF and the Maintenance of Certification (MOC) task forces are collaborating to develop a dedicated Women's Health MOC module. This module will provide participants with an in-depth review of the most important topics in women's health and will be available in the spring of 2015.

The WAMTF looks to SGIM membership to support its mission of rewarding high-quality scientific content in women's health at our annual meetings, hosting the popular Distinguished Professor of Women and Medicine keynote address, and sponsoring the very successful Career Advising Program—SGIM's model program for career development mentorship. Please consider supporting our mission. Information on donating can found at http://sgim.org/about-us/support-sgim.

An Emerging Medical Education Competency: Lifestyle Medicine

Camille Clarke, MD; Ingrid Edshteyn, DO; and Colin Zhu, DO

Dr. Clarke is clinical fellow of medicine at Harvard Medical School and senior internal medicine resident at Cambridge Health Alliance; Dr. Edshteyn is a preventive medicine resident at Yale-Griffin Hospital and Columbia School of Public Health; and Dr. Zhu is a senior family medicine resident at Manchester Memorial Hospital.

The majority of chronic diseases are preventable as they are significantly influenced by lifestyle choices.[1] The Centers for Disease Control states that these diseases, which include heart disease, stroke, cancer, diabetes, obesity, and arthritis, are among the most common, costly, and preventable of all health problems.[2]

In the past decade a growing body of research has provided evidence supporting the role of healthy lifestyle behaviors in the prevention of chronic disease. While understood to reduce risk and thereby prevent chronic disease, lifestyle change as a therapeutic intervention has been inadequately accepted and applied in clinical practice. Studies, however, show that lifestyle intervention can and should be utilized for secondary and tertiary prevention.

Lifestyle medicine is defined as "the systematic practice of assisting individuals and families to adopt and sustain behaviors that can improve health and quality of life."[3] This is a core competency of preventive medicine and provides value by using lifestyle interventions, including nutrition, exercise, and stress management, as the primary and preferred modalities for both the prevention and treatment of chronic diseases. The first national curriculum on lifestyle medicine is in the final stages of development. By targeting primary care providers, this curriculum is designed to change the paradigm for therapeutic interventions in clinical medicine through a focus on lifestyle modalities.

These changes are consequential and urgently needed, as practice guidelines for chronic disease prevention and management recommend that treatment begin with evidence-based lifestyle medicine.[3] However, physicians cite inadequate confidence and lack of knowledge and skill as the barriers to counseling patients about lifestyle interventions.[4] Medical curricula are also lacking in this area, as students report inadequate preparation on counseling patients on the vital role of lifestyle behaviors in managing chronic diseases.[4]

The past three years have seen a rise in student-led lifestyle medicine interest groups (LMIGs). A recent study explored the motivation, goals, and challenges for the student leaders of LMIGs at Harvard, Loma Linda, Stanford, and Western universities. While most participants recognized the importance of training in lifestyle medicine within medical education, the majority stated that their medical schools inadequately equipped students to provide lifestyle recommendations for patients. Personal interest was cited as a central motivation for starting the LMIGs along with lack of content in both medical curriculum and other interest groups. Many LMIG student leaders identified the lack of educational and supportive resources as barriers in starting and maintaining the LMIGs. Despite the overwhelming responsibilities of clinical training, lifestyle medicine has been passionately embraced by this dedicated group of young clinicians from California to Massachusetts, and their accomplishments have been most impressive.

At Harvard Medical School, the Lifestyle Medicine Interest Group has been closely tied with the Institute of Lifestyle Medicine since 2009. They have sponsored a lunchtime lecture series to "empower the next generation of physicians to tackle lifestyle-related illness in an effort to reduce morbidity and mortality" from preventable disease.

The Loma Linda University School of Medicine Preventive and Lifestyle Medicine Interest Group developed as a result of the school's long-standing commitment to the promotion of healthy lifestyle choices for the prevention and treatment of disease. Located in North America's only "Blue Zone"—where it currently leads the United States in life expectancy—Loma Linda University School of Medicine continues to challenge its students to promote lifestyle medicine both locally and internationally.

The students at Stanford University School of Medicine have been instrumental in developing an "Introduction to Lifestyle Medicine" course that offers medical students "exposure to topics that are rarely mentioned during medical education but integral to a patient's health." Truly innovative, they take an interdisciplinary approach by inviting Stanford undergraduates as well as business, engineering, and law students to participate.

Students at Western University College of Osteopathic Medicine of the Pacific-Northwest have taken an inventive and proactive approach to clinical lifestyle medicine by combining counseling with diabetes education classes and the nutrition in medicine lecture series.

The mission of the LMIG at David Geffen School of Medicine at the University of California, Los Angeles, is to "serve as a source of innovative evidence-guided health knowledge for medical students to use for the promotion of improved patient health through lifestyle choices." They have created events such as Annual Lifestyle Medicine Week and implemented exercise breaks between medical school lectures in "instant recess," in addition

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Academic Physician Administrators and Leaders Interest Group

Thomas O. Staiger, MD

Dr. Staiger is associate professor in the Division of General Internal Medicine at the University of Washington and the medical director of the University of Washington Medical Center. He is the current leader of the Academic Physician Administrators and Leaders Interest Group.

> If your actions inspire others to dream more, learn more, do more and become more, you are a leader.
>
> —*John Quincy Adams*

Health care organizations require strong physician leadership to be successful. Imperatives for improving quality, safety, education, and care efficiency have created a growing number of opportunities for physicians to take on leadership roles within academic medical centers, departments, and divisions. The Academic Physicians Administrators and Leaders (APAL) Interest Group was started over a decade ago to create a forum for SGIM members with leadership and administrative roles and for those interested in learning more about leadership and leadership opportunities. Interest group meetings are an opportunity for networking and are generally devoted to one or more of the following: sharing best practices and innovations, discussing current challenges and options for addressing those challenges, and identifying opportunities for workshops and scholarly activities to help promote leadership development within SGIM. The majority of attendees are in a current leadership role, such as division head, clinic director, residency program director, or hospital administrator; however, the group is also open to attendees who have never held a leadership position but are considering taking one in the future.

A number of SGIM workshops, including workshops on change management, negotiation, and medication reconciliation, were conceived at APAL meetings. The idea to survey chairs of departments of medicine to better understand promotion opportunities for work in quality and safety and to address the challenge of rewarding faculty for this work had its origins at an APAL meeting.[1] An issue brought up at one meeting by a fellow who said he wasn't finding many opportunities within SGIM to pursue his interests in quality and safety led to the establishment of the Quality and Safety Subcommittee of the Clinical Practice Committee.

References

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Fecal Microbiota Transplant for Recurrent *Clostridium difficile* Infection: A Primary Care Perspective

Tanu S. Pandey, MD, MPH, FACP; Michael Jean, MD; Rajinder Kaushal, MD

Drs. Pandey, Jean, and Kaushal are assistant professors of medicine at the David Geffen School of Medicine, University of California, Los Angeles.

Clostridium difficile infection (CDI) has surpassed methicillin-resistant *Staphylococcus aureus* as the leading cause of health care-associated infections in the United States, with an estimated annual cost of $1 billion.[1] Up to 25% of patients with CDI will experience recurrence within 30 to 90 days, with some experiencing multiple recurrences.[1] Fecal microbiota transplant (FMT) has been in the news for the last few years as an effective though cringe-inducing treatment for recurrent severe CDI. Also known as stool transplant, it was first reported in 1958 for the treatment of pseudomembranous colitis.[1,2] FMT involves the infusion of a fecal suspension from a healthy donor into the gut of a patient with CDI. This article provides a brief outline of a procedure that is often mysterious to the average primary care provider but denotes a paradigm shift in the understanding of the importance of intestinal microbes.

What are the indications?

According to the FMT workgroup guidelines published in 2011, the primary indications for FMT are: 1) recurrent or relapsing CDI (i.e. three or more episodes of mild to moderate CDI and failure of a six- to eight-week taper with vancomycin with or without an alternative antibiotic), 2) moderate CDI not responding to standard therapy (vancomycin) for at least a week, and 3) severe or fulminant CDI with no response to standard therapy after 48 hours.[3]

How does it work?

The imbalance of commensal intestinal flora, also known as microbiota, is known as dysbiosis and can lead to recurrent CDI. These organisms help maintain a balanced and protective immunologic gut physiology. Antibiotics can breach this protective barrier and encourage colonization by *C. difficile*. It appears that abnormally low levels of intestinal *Bacteroides* and *Firmicutes* species may predispose a patient to recurrent CDI, although other organisms are likely involved.[1] As stool is biologically active, FMT from a healthy donor has been proven to correct dysbiosis, restore the normal bacterial milieu, eradicate *C. difficile*, and prevent recurrence.[1]

What is the evidence?

There is growing evidence of the effectiveness of FMT. Case series, systematic reviews, meta-analyses, and a single randomized controlled trial (RCT) have demonstrated that FMT is a highly effective treatment for recurrent CDI. In an RCT done in Amsterdam, patients with recurrent CDI were randomized to either FMT versus a standard two-week treatment with vancomycin.[4] The former group had an 81% resolution with one infusion and 94% after a second infusion among those who had recurrence. In the latter group, only 31% in the vancomycin group ($p < 0.001$) achieved resolution. Of note, a second randomized trial is ongoing. Another multicenter study designed for long-term follow-up revealed a primary cure rate of 91% and a secondary cure rate of 98% for a mean follow-up of 17 months.[2]

How is it done?

A fresh stool sample less than six hours old is recommended. In a blender provided by the patient, the donor stool is blended with non-bacteriostatic saline. After a proper slurry-like consistency is achieved, the mixture is filtered through gauze pads to remove particulate matter. The liquefied stool is then collected in 60 cc catheter tipped syringes. The stool is introduced into the recipient in either of two ways: 1) the upper GI tract via a nasogastric or nasoduodenal tube or 2) directly into the lower GI tract, via colonoscopy or retention enema, which can be self-administered. For lower GI tract administration, a colon lavage prior to the procedure is usually recommended, and patients are encouraged to take two tablets of loperamide an hour prior to help retain the donor stool. For colonoscopy, a minimum of 50 grams is recommended, as patients who received less that 50 grams of stool had higher recurrence rates of CDI.[5] For upper GI tract administration, smaller amounts are typically used. Prior to FMT, all antibiotics need to be stopped for a minimum of two days. After FMT is performed, it is important that the recipient remain off antibiotics, indefinitely if possible. It should be noted that the optimal protocol for FMT has yet to be determined, and further research is needed in this area.

Choice of Donor

Donors have to be carefully screened for transmissible infections such as hepatitis B and C, HIV, and syphilis. Donor stool is cultured and tested for ova and parasites as well as *C. difficile* to screen for asymptomatic carriers. Other exclusion criteria used to screen potential stool donors include: antibiotic use in the last three months, high-risk sexual behaviors, recent incarceration, and recent body piercings/tattoos. Relative exclusion criteria include history of inflammatory bowel disease, intestinal malignancy, and immunosuppression because such patients have increased risk of underlying dysbiosis.

The donor may be a close relative or an unknown volunteer—there is no significant difference in the resolution rates. Patients may designate their donor and even, on occasion, self-administer the fecal sample. It typically

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Zostavax: Does it work every shingle time?

Sivasubramanium Bhavani, MD

Dr. Bhavani is assistant professor of internal medicine at the Baylor College of Medicine and Michael E. DeBakey VA Medical Center in Houston, TX.

A 65-year-old Caucasian male presents to clinic with a painful rash on the left side of his forehead. Three weeks prior to presentation, he received the Zostavax vaccine. Five days prior to presentation, he noticed intense tingling and pruritis on the left side of his forehead, followed by eruption of the rash. He also noticed redness in his left eye but denied any visual changes. The patient denies any sick contacts, recent travel, or skin exposure to any new agents. He denies any previous history of rashes. The patient has a history of type II diabetes mellitus (diet-controlled), chronic hepatitis C (without cirrhosis, and not on antiviral therapy), and major depressive disorder (not on anti-depressants).

The patient is afebrile with stable vital signs. His rash is characterized by grouped vesicles overlying an erythematous base over the left side of his forehead and nasal bridge (distribution in the V1 dermatome). The patient exhibits conjunctival injection in the left eye. The patient has no neurological or visual deficits. His labs are unremarkable.

Infection with the varicella-zoster virus (VZV) causes two distinct diseases. Primary infection with the varicella-zoster virus results in chickenpox; the virus then lays dormant in the dorsal root ganglia. Reactivation of this virus causes the clinical manifestation known as herpes zoster (HZ) or shingles. Diagnosis of HZ is primarily based on history and classic physical findings—specifically, the painful vesicular rash limited to a single dermatome. Herpes simplex virus (HSV) infection may mimic HZ and should be suspected in a patient with a recurrent zosteriform rash. Differentiating between HSV and VZV infection requires PCR testing of the lesion.

Given the patient's classic rash limited to the V1 dermatome, he is diagnosed with HZ. The vesicular lesion is swabbed and sent for PCR testing. Given the ocular symptoms, there is concern for herpes zoster ophthalmicus. The patient is evaluated by the ophthalmologist and is diagnosed with blepharoconjunctivitis secondary to HZ. The patient is given a 10-day course of acyclovir.

HZ carries a risk of post-herpetic neuralgia, super-imposed bacterial skin infection, and ocular involvement. Herpes zoster ophthalmicus occurs when reactivation of the VZV involves the ophthalmic division (V1) of the trigeminal nerve. Herpes zoster ophthalmicus can involve any ocular structure depending on the nerve branch involved. Blepharoconjuncitivitis is a superficial infection involving the eyelid and conjunctiva. Patients with herpes zoster ophthalmicus are treated with oral antiviral agents for seven to ten days. Studies report alleviation of pain and decreased incidence of post-herpetic neuralgia with anti-viral treatment, especially if initiated within the first 72 hours.

After six weeks, the patient is seen in our clinic for a follow-up visit. The vesicular rash has healed with minimal scarring. His left eye is without conjunctival injection. He does not report persistent neuralgia. His PCR results are positive for VZV, confirming the diagnosis of HZ. Given the temporal relationship between the episode of shingles and Zostavax administration, the patient has several questions for the physician.

"Doc, did the vaccine give me shingles?"

In addition to demonstrating the efficacy of Zostavax, the Shingles Prevention Study (SPS) and Zostavax Efficacy and Safety Trial (ZEST) studied the side effect profile of Zostavax. Between the two studies, more than 30,000 subjects received Zostavax. In the six-week post-vaccination period, eight of these subjects developed PCR-confirmed HZ. Wild-type VZV was detected in all eight subjects, while the Oka/Merck strain VZV was not detected in any subject.[1,2] Since these clinical trials have not found an incidence of HZ secondary to Oka/Merck strain VZV, it is safe to presume our patient developed HZ secondary to wild-type VZV. The temporal relationship between the vaccination and illness was purely coincidental.

"Why didn't the vaccine protect me from the virus?"

Several studies have demonstrated an age-related decline in VZV-specific T-cell mediated immunity (VZV-CMI), which is believed to be the immunological basis for the age-related increase in incidence of HZ.[3] Zostavax has been shown to boost VZV-CMI, and this is thought to be the mechanism of its conferred protection. The SPS included an immunology sub-study in which subjects were tested for VZV-specific markers of immunity prior to vaccination (baseline), six weeks post-vaccination, and annually for three years. The study retrospectively compared the VZV-specific immune response in subjects who developed HZ to those who did not. The subjects who developed HZ had lower baseline and post-vaccination VZV-CMI.[4] Therefore, the patients who develop shingles after vaccination are likely unable to mount an adequate T-cell mediated immune response to vaccination.

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Maximizing Mentorship: A Mentee Approach

Anna Volerman, MD; Valerie G. Press, MD, MPH; and Wei Wei Lee, MD, MPH

Dr. Volerman is assistant professor at the Pritzker School of Medicine, Section of General Internal Medicine, University of Chicago; Dr. Press is assistant professor at the Pritzker School of Medicine, Section of Hospital Medicine, University of Chicago; and Dr. Lee is assistant dean of students and assistant professor at the Pritzker School of Medicine, Section of General Internal Medicine, University of Chicago.

Mentorship is essential for success in academic medicine. Studies demonstrate that mentoring is associated with many benefits: professional advancement, career performance, research productivity, career satisfaction, and work-life balance. Furthermore, both the mentor and mentee derive positive outcomes through a collaborative and reciprocal relationship.[1]

A mentor is traditionally a faculty member with advanced rank and experience who fosters the personal and professional development of individuals who are junior to them. Irrespective of their role as a student, resident, fellow, or junior faculty, the mentee plays a crucial role in establishing and cultivating the mentoring relationship.

"Managing up," a model derived from the business world that describes the relationship between an employee and his/her supervisor, has been applied to mentoring in the academic setting. It implies that the mentee assumes a key role in guiding the relationship with the mentor.[2]

In academic medicine, mentees can adopt five practices as they work toward "managing up":[2]

1. *Self-reflect*. First, mentees should consider prior experiences with mentorship and identify their individual values and work style. The mentee must ask: What motivates me? What do I value in my mentors and relationships? How do I learn best? What structure or direction do I need to succeed? The mentee should also consider specific knowledge and skill areas in need of development. Some examples include: networking, understanding a department's priorities, learning research methodologies, writing grants or papers, choosing jobs or opportunities, developing presentation skills, and working toward work-life balance. In addition, it is important for the mentee to establish career goals for both the short (i.e. three to 12 months) and long term (i.e. five to 10 years). Goals may connect back to the knowledge and skills areas previously identified. One useful framework for establishing goals is the "SMART" pneumonic: specific, measurable, achievable, relevant, and time-bound.[3] This framework provides a well-defined pathway and builds motivation for success.

   Key point: By defining his/her professional and personal needs and career aspirations, the mentee is in a position to maximize mentoring relationships.

2. *Identify mentors*. Individuals can seek mentors through a variety of channels. They can approach an assigned mentor or a faculty member they have met or worked with previously. Peers or those a few years more advanced can also recommend effective mentors. The mentee should meet with potential mentors to learn more about them and their academic work. During these meetings, mentees should evaluate whether this individual will be an effective mentor. Areas to consider include: competence in a professional field, confidence in his/her skills and ability to serve as a role model and advocate, and commitment to mentee development. Mentees should also ask individuals they meet to suggest potential mentors. As a mentee meets potential mentors, there is no requirement to move forward with developing a formal mentoring relationship. After the initial meeting, it is helpful for the mentee to reflect on if and how this individual can meet his/her specific mentorship needs. It is important to remember that mentees benefit from having more than one mentor, with each advising about different needs and goals. Mentors at different stages in their careers also provide valuable perspectives to mentees.

   Key point: Mentees should dedicate time to identifying mentors and consider establishing a mentoring relationship with multiple individuals possessing various skills and levels of training.

3. *Establish the mentoring relationship*. Once a mentor has been identified, the mentee should meet with him/her to evaluate his/her mentoring style and to establish and define the mentoring relationship. This is an opportunity for the mentor and mentee to share their backgrounds and establish their values, work style, needs, and goals as defined in the self-reflection stage. Once both individuals agree to work together in this capacity, the pair should establish objectives and

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takes five to seven days for donor testing to be completed. It should be noted that the cost of screening the donor is approximately $500, which may not be covered by health insurance plans. An alternative is to use a stool bank, where volunteer donors may be reimbursed for their sample.

Stool Bank and Cost of Treatment

Donor stool specimens are available through stool banks, which carefully screen donors and prepare stool samples for FMT. Massachusetts General Hospital in Boston has its own stool bank. Commercial stool banks like OpenBiome provide stool samples for the general medical community. Through OpenBiome, samples can be ordered for overnight delivery in urgent situations. Each frozen stool sample costs $250 and must be stored in a proper medical freezer prior to use. Once the sample is thawed, it can be used in the same manner as a freshly prepared stool sample. The cost of obtaining frozen samples from a stool bank may or may not be reimbursed by health insurance. Future steps include the development of a standardized frozen preparation and the use of a universal donor, both of which are underway. The Food and Drug Administration (FDA) is currently considering whether the patient and physician need to know the demographics of the donor.

Safety Issues

In July 2013, the FDA labeled FMT as an investigational new drug (IND), which usually requires an IND application. After much uproar from the medical community, concerns were raised that requiring an IND would make this potentially life-saving treatment out of reach for many patients. Subsequently, the FDA decided that it would exercise enforcement discretion for recurrent CDI. Physicians would be able to proceed with FMT without filing for an IND, provided appropriate informed consent was obtained and documented. Patient safety remains a concern, especially in the immunosuppressed, although recent studies have shown that it may not be as dangerous as initially thought. Short-term adverse events include diarrhea, cramping, belching, and constipation.[5] Rarely there may be a flare of underlying chronic inflammatory diseases like ulcerative colitis. Long-term follow up has confirmed the benign nature of the procedure without significant negative outcomes.[1,3] Careful informed consent must be obtained and documented. Patients must be made aware that although FMT is very effective, it is still an investigational treatment. Given the complexity of fecal microbiota, the possibility of unforeseen consequences must be discussed.

Our Experience and Future Possibilities

At Henry Mayo Newhall Hospital in Santa Clarita, a 238-bed community hospital affiliated with the University of California, Los Angeles, nine patients have undergone this procedure of which eight achieved complete cure. This 90% success rate is consistent with literature reports. The ninth patient had a relapse initially treated with prolonged vancomycin followed by another severe relapse and a repeat emergency stool transplant. Despite initial clinical improvement, the patient eventually died from his many concurrent illnesses.

In our experience, FMT is an effective life-saving procedure that is affordable and can be performed at community hospitals with significant success. In a recent open label feasibility study published from Massachusetts General Hospital, frozen encapsulated inoculum from unrelated donors (the stool pill) was found to be effective and safe.[6] Patients with recurrent CDI were treated with 15 capsules on two consecutive days and followed for up to six months. This breakthrough treatment modality addresses practical barriers and safety concerns associated with conventional FMT and will hopefully be widely available as standard therapy for recurrent CDI in the future. Formal guidelines are needed to ensure the best possible outcomes and minimal adverse events in a multidisciplinary approach.

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SGIM

HEALTH POLICY CORNER

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briefing implored Congress to repeal the sustainable growth rate (SGR) and replace it with a system that rewards quality over volume and includes several other measures.

SGIM convened the National Commission on Physician Payment Reform to assess how Medicare reimburses physicians and how pay incentives are linked to patient outcomes. The blue-ribbon panel, co-chaired by former Senator Bill Frist, MD, and Steven Schroeder, MD, from the University of California, San Francisco, published a series of recommendations for transforming the US health care system into one that actually rewards better outcomes and pays for quality rather than patient volume. The report recommends the following:

1. Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.
2. The transition to an approach based on quality and value should start with the testing of new models of care over a five-year time period, incorporating them into increasing numbers of practices with the goal of broad adoption by the end of the decade.
3. Because fee for service will remain an important mode of payment into the future, even as the nation shifts toward fixed-payment models, it will be necessary to continue recalibrating fee-for-service payments to encourage behavior that improves quality and cost-effectiveness and penalize behavior that misuses or overuses care.
4. For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes should be frozen for a period of three years, except for those that are demonstrated to be currently undervalued.
5. Higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated.
6. Fee-for-service contracts should always incorporate quality metrics into the negotiated reimbursement rates.
7. Fee-for-service reimbursement should encourage small practices (i.e. those having fewer than five providers) to form virtual relationships and thereby share resources to achieve higher quality care.
8. Fixed payments should initially focus on areas where significant potential exists for cost savings and higher quality, such as care for people with multiple chronic conditions and in-hospital procedures and their follow-up.
9. Measures to safeguard access to high quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients should be put into place for fixed payment models.
10. The SGR should be eliminated.
11. Repeal of the SGR should be paid for with cost savings from the Medicare program as a whole, including both cuts to physician payments and reductions in inappropriate utilization of Medicare services.
12. The Relative Value Scale Update Committee (RUC) should make decision-making more transparent and diversify its membership so that it is more representative of the medical profession as a whole. At the same time, CMS should develop alternative open, evidence-based, and expert processes to validate the data and methods it uses to establish and update relative values.

A copy of the report can be found at http://www.physicianpaymentcommission.org/report/.

SGIM

NEW PERSPECTIVES

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to hosting lifestyle medicine career panels.

Given the rising interest in lifestyle medicine among trainees across the nation, the American College of Lifestyle Medicine Professionals in Training was formed in 2013 to address the need for lifestyle medicine in medical education. They have developed an executive board, created a scholarship for students to attend the annual lifestyle medicine conference, and partnered with students and faculty members nationally to create student chapters for lifestyle medicine within medical schools.

In 1902, Thomas Edison said, "The doctor of the future will give no medicine, but will instruct his patient in the care of the human frame, in diet and in the cause and prevention of disease." Although Mr. Edison was perceptive for his time, it has taken more than 100 years for non-medicinal approaches to health to gain ground in the overall picture of "conventional" medicine. A strong call is audible for change in the training and delivery of medicine, and medical students nationwide have begun building the bridges between treating chronic illness and focusing on upstream determinants of health.

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SGIM

FROM THE EDITOR

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- Communication with the Board of Regional Leaders (BRL) has led to development of "Guidelines for Submissions from the Regions," which were distributed to BRL members and discussed on a BRL conference call early this fall.
- A template for articles that preview regional and national meetings has been developed and will soon be available to facilitate publicity for these events.
- A link to the Springer Author Academy has been added to the *Forum* web page. This series of tutorials offers new writers a crash course in manuscript preparation, editing, and publication.
- In development: An expanded list of *Forum* departments and explanation of each will soon be posted on the *Forum* web page.

6. A policy for HIPAA compliance has been developed and a "Permission for Publication" form (modeled after *JGIM*) has been posted on the *Forum* web page.
7. A mechanism for appreciation, recognition, and career advancement opportunities for *Forum* writers and AEs has been developed.
   - To increase recognition for contributors to *Forum*, a list of contributing authors has been posted on the *Forum* web page and will be updated every six months.
   - A new career development agenda for AEs includes mentoring opportunities, opportunities for development of national collaborations on *Forum* articles and future projects, development of a *Forum* portfolio that can be included in the teaching portfolio at each AE's home institution, and an annual letter of recognition for participation on the editorial board.

Future Initiatives

We have developed several programs for the SGIM 2015 Annual Meeting in Toronto. We hope that these programs will provide opportunities to engage members and increase contributions to *Forum*. These include:

- A new SGIM *Forum* Interest Group
- A new SGIM *Forum* Networking Session (both for current and future contributors)
- A workshop for potential authors titled "Write it for *Forum*!"

Our workshop will include: 1) formal introductions (i.e. statement of interests and areas of expertise), 2) grouping of participants by area of interest, and 3) development of an outline for a future *Forum* article. AEs will participate as workshop facilitators who will mentor participants during the workshop and throughout the writing process. Come ready with your "elevator speech," and leave with a new group of collaborators and a commitment for a future article for *Forum*!

On behalf of the entire *Forum* editorial board, I hope to see you in Toronto at the 2015 annual meeting! Come behind the scenes at *Forum*. Meet the current *Forum* editorial team at the interest group and networking sessions. Join us for our first workshop, "Write it for *Forum*!", and help us continue to be the national voice of SGIM.

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MORNING REPORT

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"So why didn't my body respond to the vaccine?"

Advanced age and untreated depression are potential causes of inadequate post-vaccination VZV-specific immune response. The SPS immunology sub-study confirmed previous studies demonstrating an age-related decline in VZV-CMI.[3] In addition, this study showed an age-related VZV-CMI decline in response to vaccination.[4] The SPS depression sub-study found that patients with untreated depression also had diminished VZV-CMI response to Zostavax when compared to patients with treated depression and patients without depression.[5]

Besides advanced age and depression, there may be other clinical comorbidities that affect immune response to Zostavax. Patients with these comorbidities may benefit from booster vaccinations or higher potency vaccinations. Further research is needed to identify these comorbidities and to design more personalized vaccination strategies for specific patient populations.

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PRESIDENT'S COLUMN

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change subsidies is another threat. But federal and state governments are not the only concerned stakeholders—employers and employees are beginning to appreciate the impact of reform strategies, and insurers are developing products and services for this new reality. Despite a dysfunctional federal government, I am optimistic that the shift from volume to value has taken hold. We need to be vigilant as the new congress convenes. We also need to intensify our patient-focused advocacy by vocally supporting those private sector reforms that are within our power to advance.

I think we need a new catch phrase to accompany the principle of "volume to value"—one that reassures patients that they need not fear overwhelming bills or bankruptcy just for getting the care they need. Perhaps we could call it "trepidation to trust."

On the phone my daughter was still afraid. I walked her through the $8,000 bill, starting with the title "Explanation of Benefits—this is not a bill." She had still been covered by insurance, and the insurance worked: Young and healthy, my daughter needed emergency care, she got the care she needed, and the care did not cost her several months' pay. She laughed through her tears, "I guess I should have read that first!"

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SGIM

ANNUAL MEETING UPDATE

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Jays play the Baltimore Orioles on Thursday evening. For the first time, we have arranged for tickets in two different sections at two different prices, so take your pick. The last time a group attended a baseball game during the meeting more than 200 people bought tickets, so don't worry about going on your own!

It's time to start planning to attend. Encourage your colleagues to join you. Encourage your trainees to submit! To learn more, visit our new meeting website: http://connect.sgim.org/annualmeeting/home. It's easy to navigate and includes detailed information on hotel reservations, travel planning, and more. Plan ahead to have a current passport! (Your passport cannot expire within six months of when you travel.) VA employees should plan ahead to obtain approval for VA funding and must apply for a government passport as well. For more on this, check with your local VA travel office. Non-US students will need to apply for a visa through a Canadian embassy. Finally, non-US students will need a SEVIS Form I-20 signed by their designated school official (DSO) prior to traveling.

The excitement is mounting! 2015 is here, and we are ready, SGIM! See you in Toronto!

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Have you ever come to SGIM's Hill Day? Don't you think it's time you joined us?

Each March, SGIM members travel to Capitol Hill to advocate on issues important to primary care. Everyone from medical students to experienced politicos meet with their representatives and participant in the democratic process—educating the legislature on issues that affect our daily practice.

Being able to sit down in one of my senator's offices for a 30 minute exchange of ideas was very exciting. I have attended local events with that senator, but to be in her office on the Hill advocating for issues that affect my career was so exciting.

Join us this year on the Hill March 10-11.

Details at
http://www.sgim.org/communities/advocacy

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structure for the relationship. This includes delineating the purpose and goals of the interaction as well as a specific plan for feedback and evaluation. A mutual understanding of expectations is important for individuals to interact effectively. Key logistics to define include: meeting details (i.e. time, frequency, location); agenda format and topics (i.e. fixed vs. rotating topics, short term vs. long term, projects vs. goals); and preferred method of communication between meetings. These discussions lay the foundation for a working relationship built on mutual respect, well-defined expectations, and measurable outcomes.

Key Point: The mentee/mentor must establish clear objectives and guidelines prior to moving forward with the mentoring relationship.

4. *Cultivate the relationship*. Effective mentorship requires both individuals to take an active role. With an understanding of each individual's background and work style, the mentee can take responsibility for guiding the relationship. This model enables the mentor to most effectively provide support to the mentee based on his/her needs and goals. Regular communication and meetings allow the mentoring pair to continually work toward established goals. Due to busy schedules and competing academic demands, meetings should be structured with an agenda balanced between ongoing projects and presentations and short- and long-term goals. The mentee should set the agenda for each meeting and come prepared with updates, ideas, and questions. During meetings, the mentee should communicate clearly, listen actively, and clarify discussion points. Each meeting should conclude with a review of action items and plan for follow-up and future meetings. Between meetings, the mentee should communicate regularly, follow through on tasks, and seek assistance as needed. Clear communication fosters the mentoring relationship and advances the proposed plan.

Key Point: The mentee has responsibility for maximizing the mentoring relationship.

5. *Refine or conclude the relationship*. Each mentoring relationship reaches a point where it achieves its defined goals or encounters change. Regardless of the reason for re-evaluation and separation, the mentee and mentor should, if possible, reflect on the relationship and strategize about the transition. There may be associated emotions of anxiety and loss that arise for the mentee. Communication about this with the mentor allows for the planning of next steps and future mentoring relationships.

Key point: As a mentoring relationship changes or ends, the mentee should re-evaluate his/her mentoring needs.

As a mentoring relationship ends, the mentee must return to the self-reflection stage, often fostering the start of a new cycle of mentorship (Figure 1).

Through these five practices, mentees can manage the support and advising they receive throughout their careers. Although each mentor-mentee pair is different, key principles of self-reflection, open communication, and managing up foster productive relationships.

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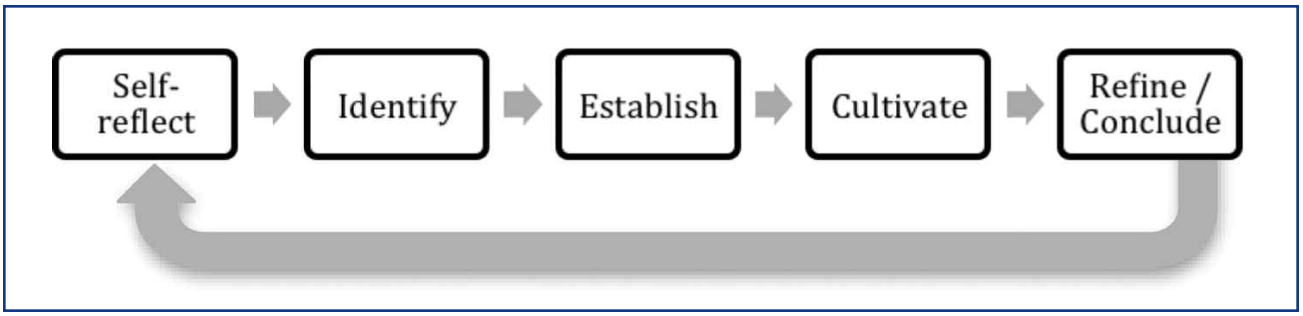
Figure 1. The Mentoring Relationship



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GENERAL INTERNAL MEDICINE FELLOWSHIP—HARVARD MEDICAL SCHOOL

A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 7/1/16. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. Research areas of special interest include common primary care health conditions, preventive medicine, vulnerable populations and healthcare disparities, and patient safety and quality of care. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year.

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The 2016 application deadline is 3/1/15. There may potentially be a second application deadline in September 2015 depending on the availability of fellowship positions. The participating institutions are equal opportunity employers. We encourage underrepresented minorities to apply.

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