

On September 4, 2016, SGIM Council voted to join a consortium of medical societies, patient groups, pharmacists, and healthcare providers in endorsing The Campaign for Sustainable Rx Pricing (CSRxP), see editorial page 4. To learn more, go to: [www.csrxp.org](http://www.csrxp.org).

HEALTH POLICY CORNER:  
PART I

## New SGIM Career Development Initiative: Leadership in Health Policy (LEAHP) Program

Mark D. Schwartz, MD, and Thomas Staiger, MD

*Dr. Schwartz is faculty in the Department of Population Health at the New York University School of Medicine, and Dr. Staiger is chair of the Health Policy Committee and medical director of the University of Washington Medical Center.*

### CONTENTS

1. Health Policy Corner: Part I . . . . .	1
2. Essay . . . . .	2
3. President's Column . . . . .	3
4. From the Editor . . . . .	4
5. Sign of the Times . . . . .	6
6. Health Policy Corner: Part II . . . . .	7
7. Morning Report . . . . .	8
8. New Perspectives . . . . .	14

**W**e live in a time of unparalleled change in how medicine is paid for and practiced. A few recent examples include: the Affordable Care Act, the replacement of the Medicare Sustainable Growth Rate (SGR) with the Medicare Access and CHIP Reauthorization Act (MACRA), dozens of experiments underway by the Center for Medicare and Medicaid Innovation, the Centers for Medicare and Medicaid Services shifting payment from fee-for-service to value-based models, and increasing recognition by policymakers of how current payment models undervalue general internal medicine (GIM) and other cognitive specialties.

SGIM's opportunity to influence these policies and its need for robust advocacy have never been greater. SGIM's Health Policy Committee (HPC) has been highly effective in advocating for our Society's core missions of generalist practice, education, and research. But the time has come to expand our impact, deepen our bench, and build a sustainable pipeline of future health policy advocates, teachers, and leaders.

Therefore, SGIM has established an exciting new career development initiative based on the successful models of the TEACH (Teaching Educators Across the Continuum of Healthcare) and the Association of Chiefs and Leaders in General Internal Medicine's LEAD programs. Application for the new program is open to all SGIM members; the only prerequisite is a passion for learning about health policy and a desire to affect policy change.

The *Leadership in Health Policy (LEAHP) Program* has launched with the following aims:

- To develop an expanding national cadre of HPC members and future HPC leaders, effective and active health policy advocates, and local experts and teachers of health policy; and

continued on page 10

# “Death is here, and I am thinking of an appendix!”: On Reading *The Death of Ivan Ilyich*

Abraham M. Nussbaum, MD, MTS

*Dr. Nussbaum is chief education officer at Denver Health and associate professor of psychiatry at the University of Colorado School of Medicine.*

## SOCIETY OF GENERAL INTERNAL MEDICINE

### OFFICERS

- President**  
**Eileen E. Reynolds, MD** Boston, MA  
 ereynold@bidmc.harvard.edu
- Immediate Past-President**  
**Marshall Chin, MD, MPH** Chicago, IL  
 mchin@medicine.bsd.uchicago.edu
- President-Elect**  
**Thomas H. Gallagher, MD** Seattle, WA  
 thomasg@uw.edu
- Treasurer**  
**David C. Dugdale, MD** Seattle, WA  
 dugdaled@uw.edu
- Secretary**  
**Said A. Ibrahim, MD, MPH** Philadelphia, PA  
 said.ibrahim2@va.gov
- Secretary-Elect**  
**Somnath Saha, MD, MPH** Portland, OR  
 sahas@ohsu.edu

### COUNCIL

- Eva Aagaard, MD** Aurora, CO  
 eva.aagaard@ucdenver.edu
- Jada C. Bussey-Jones, MD** Atlanta, GA  
 jcbusse@emory.edu
- April S. Fitzgerald, MD** Baltimore, MD  
 Afitzq10@jhmi.edu
- Ethan A. Halm, MD, MPH** Dallas, TX  
 ethan.halm@utsouthwestern.edu
- Eboni G. Price-Haywood, MD, MPH** New Orleans, LA  
 eboni.pricehaywood@ochsner.org
- Marilyn M. Schapira, MD, MPH** Philadelphia, PA  
 mschap@upenn.edu
- Health Policy Consultant**  
**Lyle Dennis** Washington, DC  
 ldennis@dc-crd.com
- Executive Director**  
**Frank Fortin, CAE** 1500 King St., Suite 303  
 Alexandria, VA 22314  
 fortinf@sgim.org  
 (800) 822-3060, (202) 997-5405 fax
- Director of Communications and Publications**  
**Francine Jetton, MA** Alexandria, VA  
 jettonf@sgim.org  
 (202) 887-5150

Some stories are over-assigned but under-read. While we pass these stories around, we dodge the challenges they pose to our practices.

Consider Leo Tolstoy’s *The Death of Ivan Ilyich*, perhaps the most frequently anthologized and taught story in the medical humanities. Our leading physician writers, Abraham Verghese and Atul Gawande, have both recently engaged the story,<sup>1,2</sup> which still reads like a contemporary illness narrative. The story is psychological; the significant events occur within the protagonist’s mind. The story is also allegorical; it teaches a lesson.

The reader gets a sense of this lesson when Tolstoy writes, “The story of Ivan Ilyich’s life was of the simplest, most ordinary and therefore most terrible”<sup>3</sup> (p. 109). From the beginning, the tone is regretful, and the setting is commonplace, but even in that sentence, Tolstoy paradoxically promises to tell about Ivan’s “life,” despite the story’s title declaring Ivan’s death. Life or death? Which one will Ivan’s story be about?

Throughout the story, Tolstoy shifts

the relationship between these ostensibly opposite poles of human existence—life and death—to challenge our assumptions.

Tolstoy chiefly challenges the bourgeois assumption that we can avoid suffering by making socially approved choices. We exercise, drink in moderation, and follow US Preventive Services Task Force recommendations, but can we avoid illness and death? Ivan would have exercised regularly. After all, he was the good son, the dutiful student, the social climber who lived “the decorous life approved by society”<sup>3</sup> (p. 116) as an examining magistrate.

And yet, he falls while hanging curtains in his home one day. Pain ensues. His wife insists he be seen by a physician. When Ivan meets the doctor, we find that “The entire procedure was just the same as in the Law Courts. The airs that he put on in court for the benefit of the prisoner at the bar, the doctor now put on for him”<sup>3</sup> (p. 126). Ivan’s doctors were, like Ivan himself, enthralled by the ritualized powers of their positions.

Ivan asks his doctors one thing—“was his case serious or not?”<sup>3</sup> (p. 127)—but never receives an answer. Prognosis is forever delayed. Ivan’s doctors instead try to mollify his distress by seeking a diagnosis. Ivan asks, again, whether he will live or die. The doctor becomes so frustrated with Ivan’s questions that he terminates their encounter: “‘I have already told you what I consider necessary and proper,’ said the doctor. ‘The analysis may show something more.’ And the doctor bowed”<sup>3</sup> (p. 127).

The doctor leaves with his proper bow. Ivan leaves with his fundamental—continued on page 10

### EX OFFICIO COUNCIL MEMBERS

- Chair of the Board of Regional Leaders**  
**Bennett B. Lee, MD** Richmond, VA  
 bennett.lee@vcuhealth.org
- ACLGIM President**  
**Elizabeth A. Jacobs, MD, MPP** Madison, WI  
 eajacobs@medicine.wisc.edu
- Co-Editors, *Journal of General Internal Medicine***  
**Mitchell D. Feldman, MD, MPhil** San Francisco, CA  
 mfeldman@medicine.ucsf.edu
- Richard Kravitz, MD, MSPH** Sacramento, CA  
 rkravitz@ucdavis.edu
- Editor, *SGIM Forum***  
**Karen R. Horowitz, MD** Cleveland, OH  
 Editor:SGIMforum@gmail.com
- Associate Member Representative**  
**Madeline R. Sterling, MD, MPH** New York, NY  
 mrs9012@nyp.org

## Hillary, SGIM, Glass Ceilings, and Transparency

Eileen E. Reynolds, MD

...as I've advanced in years and in my career—or perhaps as I've picked my head up out of the sand—it has started to become obvious to me that the system is not always set up to encourage transparency and equity or to discourage bias.



As I write this column, it is looking more and more as if Hillary Clinton will rise above our country's most visible glass ceiling to become president of the United States. There are so many reasons I hope she wins—reasons more important than the fact that she is a woman, although I've been thinking a lot about that fact. Maybe I just want to be able to say someday that she and I were both president at the same time. More seriously though, I've been thinking about the importance of a woman as president both because of some ongoing work I'm doing in my day job and because a host of recent research studies and articles in the lay press shows there is still a glass ceiling for women in medicine—or at least, there is still a lot of gender inequity in many parts of clinical and academic medicine. Lower pay for the same work, gender differences in National Institutes of Health funding, slower rates of academic advancement, and disproportionately low representation in leadership positions continue to be problems for women in academic medicine (and for minorities in many of the same ways, also) despite no difference in initial career aspirations.<sup>1-5</sup>

Just over two years ago, I was asked to “fix the women's problem” in my department of medicine. During lunch for a visiting professor, the frustration of a large group of women faculty was palpable. The professor then reported back to our department chair about the lunchtime con-

versation. He proceeded to assemble a group of women faculty he knew relatively well and asked us to work on the issues brought forward.

Until recently, I had not really looked at my work environment through a gender-oriented lens. My medical school class had 40% women, my primary care residency program was about half women, and in my first two faculty jobs there were many women role models and enough women leaders that I didn't feel a landscape or a future determined by my gender. My major professional society, SGIM, always seemed to have plenty of women members and leaders.

However, as I've advanced in years and in my career—or perhaps as I've picked my head up out of the sand—it has started to become obvious to me that the system is not always set up to encourage transparency and equity or to discourage bias. In my work in my home department, we have learned that most leadership jobs are given out without a “process.” These are positions that don't require national searches but might be very substantial leadership roles with protected time and power. Examples include medical director of a practice, a division's research chief, or even a residency program director. A chair's convenience sample of potential candidates might not include the best or most innovative faculty member; jobs given out without a formal process can lead to the per-

### SGIM Forum

#### EDITOR IN CHIEF

Karen R. Horowitz, MD [editor.sgimforum@gmail.com](mailto:editor.sgimforum@gmail.com)

#### MANAGING EDITOR

Christina Slee, MPH [tinaslee@me.com](mailto:tinaslee@me.com)

#### EDITORIAL BOARD

Seki Balogun, MD, MBBS, FACP	<a href="mailto:sab2s@virginia.edu">sab2s@virginia.edu</a>
Alfred P. Burger, MD	<a href="mailto:aburger.md@gmail.com">aburger.md@gmail.com</a>
Amanda Clark, MD	<a href="mailto:amandavclark@gmail.com">amandavclark@gmail.com</a>
Utibe Essien, MD	<a href="mailto:uessien@partners.org">uessien@partners.org</a>
Michele Fang, MD	<a href="mailto:michele-fang@uiowa.edu">michele-fang@uiowa.edu</a>
Maria Gaby Frank, MD	<a href="mailto:maria.frank@dhha.org">maria.frank@dhha.org</a>
Kittu Garg, MD	<a href="mailto:jindal.kittu@gmail.com">jindal.kittu@gmail.com</a>
Shanu Gupta, MD	<a href="mailto:Shanu_Gupta@rush.edu">Shanu_Gupta@rush.edu</a>
Patricia Harris, MD, MPH	<a href="mailto:pharris@mednet.ucla.edu">pharris@mednet.ucla.edu</a>
Jeffrey Jaeger, MD	<a href="mailto:jeffrey.jaeger@uphs.upenn.edu">jeffrey.jaeger@uphs.upenn.edu</a>
Francine Jetton, MA	<a href="mailto:jettonf@sgim.org">jettonf@sgim.org</a>
Farah Kaikow, MD, MPP	<a href="mailto:fkaikow@tulane.edu">fkaikow@tulane.edu</a>
Ben I. Mba, MD	<a href="mailto:benjamin_mba@rush.edu">benjamin_mba@rush.edu</a>
Attila Nemeth, Jr., MD	<a href="mailto:Attila.Nemeth@va.gov">Attila.Nemeth@va.gov</a>
Avital O'Glasser, MD	<a href="mailto:avitaloglasser@gmail.com">avitaloglasser@gmail.com</a>
Clifford D. Packer, MD	<a href="mailto:cdpacker39@gmail.com">cdpacker39@gmail.com</a>
Tanu Pandey, MD, MPH	<a href="mailto:tanumd@gmail.com">tanumd@gmail.com</a>
Archana Radhakrishnan, MD	<a href="mailto:aradhak3@jhu.edu">aradhak3@jhu.edu</a>
Shobha Rao, MD	<a href="mailto:shobha_rao@rush.edu">shobha_rao@rush.edu</a>
Heather Sateia, MD	<a href="mailto:hsateia1@jhmi.edu">hsateia1@jhmi.edu</a>
Leigh H. Simmons, MD	<a href="mailto:lhsimmons@partners.org">lhsimmons@partners.org</a>
Kevin R. Smith, MD	<a href="mailto:kevin.smith78@gmail.com">kevin.smith78@gmail.com</a>
Christopher J. Wong, MD	<a href="mailto:cjwong@u.washington.edu">cjwong@u.washington.edu</a>
Gopal Yadavalli, MD	<a href="mailto:gopal.yadavalli@bmc.org">gopal.yadavalli@bmc.org</a>
Steven Yale, MD, FACP	<a href="mailto:steven.yale.md@gmail.com">steven.yale.md@gmail.com</a>

The SGIM *Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM *Forum* is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Phuong Nguyen ([ptnnguyen@gmail.com](mailto:ptnnguyen@gmail.com)).

ception of bias even when the best candidate gets the job.

Like at many of your institutions, photos of former department chairs (all men), former chairs of the board (all men save one), and former hospital presidents (all men) line many of our boardrooms and corridors. These visual cues send implicit messages to women students and residents, not to mention faculty members. Even in speaking invitations for the residents' noon conference or the department's medical grand rounds, organizers can unintentionally contribute to unequal distribution of opportunity for advancement. My department's salary system relies on individual negotiation; raises typically come only to those who ask (and we know from many previous studies which gender

continued on page 9

## Drug Pricing and Health Care Expenditures

Karen R. Horowitz, MD

**E**piPen, Colcrys, Daraprim, Glumetza, Humulin R U-500, Diovan, Lipitor. What do these products have in common? They are each drugs that have been on the market for years whose prices have recently become grossly inflated. At a time when the phase of investment in research and development for these products has concluded, hunger for financial profits has continued to drive these increases.

You probably have heard about the EpiPen pricing controversy by now. As reported in the *New York Times* on August 25, 2016, the manufacturer, Mylan, has raised the price of a pack of two pens by 500% since 2007, from “little more than \$100” to a current price of \$609. Thanks to a petition launched on the website *Petition2Congress.com* titled “Stop the EpiPen Price Gouging” by Mellini Kantayya (whose husband uses the product), a consumer awareness campaign begun on Facebook by patients and their families, and a Twitter campaign that has gone viral (#EpiGate), this issue is now making national and international headlines.

The reason for this pricing increase is quite simply lack of competition in the marketplace.

To compound the insult of these usurious cost increases comes the necessity to replace EpiPens on an annual basis. According to the man-

ufacturer’s website, the product cannot be considered reliable after the expiration date on its label—the stated shelf life is approximately 12 months. We should, however, question the built-in obsolescence of products such as these with short shelf lives and ask if expiration dates are determined by scientifically demonstrable decreases in clinical efficacy or by the desire on the part of manufacturers to create increased demand on a more frequent basis.

The issue has come to the attention of congressional leaders including Senator Amy Klobuchar (D-MN), Senator Richard Blumenthal (D-CT), Senator Joe Manchin III (D-WV), Representative Elijah E. Cummings (D-MD), and Senator Charles Grassley (R-IA). It has caught the interest of the Senate Special Committee on Aging, and an inquiry into this issue has been suggested for both the Senate Judiciary Committee and the Federal Trade Commission. Democratic presidential nominee Hillary Clinton as well as her former rival Bernie Sanders have also echoed the importance of this issue. But, in reality, how much can be legislated?

Current systems of cost containment for health care spending fail when they allow:

- Monopolies that lead to usurious price fixing for essential medications,

- Extended patent protections long after a reasonable time has lapsed to recoup research and development costs,
- Pharmacy benefits management companies to strike deals that prioritize products with inflated prices and to pass those inflated prices on to consumers in the form of direct pharmacy costs for those on high-deductible plans,
- Commercial profits to take precedence over bending the curve on health care spending,
- Backroom deals that delay the rollout of competitive product, and
- Offshore corporate relocation for the purpose of financial gain.

The Choosing Wisely campaign has served as a wake-up call for physicians in every medical discipline. Bending the health care spending curve, however, cannot be the burden of physicians alone. As we have targeted ways to reduce expenditures in the last few years, our efforts have been dwarfed by increases in drug costs, health insurance costs, and even by health care systems themselves that seek to maximize billings by exploiting currently allowed processes. To slay this beast will truly require Herculean efforts. Providers cannot do this alone. First and foremost will be to gain the buy in of industry stakeholders including insurers, pharmaceutical manufacturers, regulators, and legislators. It seems like an insurmountable problem and is beyond the scope of a small organization like SGIM to take on. That is not to say our voices cannot make a difference. The recent success of patients’ grassroots efforts to raise awareness regarding these issues should inspire us all.

As we have targeted ways to reduce expenditures in the last few years, our efforts have been dwarfed by increases in drug costs, health insurance costs, and even by health care systems themselves that seek to maximize billings by exploiting currently allowed processes.

## TEACH and LEAD application period is now open!

### Looking to improve your skills?

SGIM offers the following one year hybrid in-person and online certificate programs:

- **LEAD** - for junior to mid-career faculty wanting to further develop leadership skills.  
*To learn more visit <http://www.sгим.org/acgim-tools--programs/lead>.*
- **TEACH** - for junior clinician educators wanting to improve their teaching skills.  
*To learn more visit [www.sгим.org/go/TEACH](http://www.sгим.org/go/TEACH).\**

\*Attendance is required at two consecutive annual meetings with online activities during the year between.

## 2016 ACLGIM Winter Summit - December 4 - 6 "Maximizing your Role as a Leader in GIM"

**Register Now!** We hope you'll join us at the 2016 ACLGIM Winter Summit, December 4 - 6 at *The Driskill* in beautiful downtown Austin, Texas! The theme of this year's ACLGIM Winter Summit is "Maximizing your Role as a Leader in GIM".

Our ACLGIM and SGIM community members have many inspiring and informative stories to share, including examples of our success in areas such as:

- Strategic planning for academic leadership
- Skills and challenges across the leadership continuum
- Maintaining the educational mission under increased pressure for clinical dollar
- Hospital medicine integration and collaboration
- Value based payment for care
- MACRA and more!

The Summit promises to be inspiring, interactive, and to offer practical skills and strategies you can bring home to your institution. Visit <http://www.sгим.org/acgim-meetings/summit> to see this year's incredible lineup of speakers and register today!

Contact Jillian Gann at [gannj@sgim.org](mailto:gannj@sgim.org) with questions.



UNIVERSITY OF PITTSBURGH  
CENTER FOR  
Behavioral Health +  
Smart Technology

### Assistant/Associate Professor

The Center for Behavioral Health and Smart Technology invites applications for full-time tenure-track investigators at the rank of Assistant/Associate Professor to join a successful community of health services investigators who collaborate with faculty across the University of Pittsburgh, the University of Pittsburgh Medical Center, Carnegie Mellon University, and the VA. Candidates must have an MD (board-certified) and/or PhD degree with training and experience in two or more of these areas: online-delivered interventions, consumer health technology, social media, biomedical informatics, behavioral economics, comparative-effectiveness trials, and/or implementation science.

Interested individuals should send a statement of interest and CV to:

**Bruce L. Rollman, MD, MPH**

*Director, Center for Behavioral Health and Smart Technology*

Division of General Internal Medicine

Suite 600, 230 McKee Place, Pittsburgh, PA 15213 or email:

[rollmanbl@upmc.edu](mailto:rollmanbl@upmc.edu)

Applicants must have U.S. citizenship or permanent resident status.

The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

<https://www.healthtech.pitt.edu/>

## New Medical Information

Richard Frankel, PhD, and Leslie Dunne, MPA

*Dr. Frankel is professor of medicine and geriatrics at the Indiana University School of Medicine, and Ms. Dunne is the Director of Development at SGIM.*

SGIM is completing a three-year Agency for Healthcare Research and Quality (AHRQ)-sponsored project to investigate how primary care providers stay current on medical information in a broad and crowded network of new and traditional sources—journals, social media, news media, online clinical reference tools, and government reports. The goal of this project was to identify and assess how providers and other medical professionals learn and make practice-changing decisions based on the availability of new medical information. Updated and new evidence from a variety of sources is constantly flowing along the information highway used by physicians, researchers, trainees, and teachers. How health care professionals access this information is a matter of preference and capacity, including whether the format is accessible and if the information is timely and/or comprehensive.

This program was led by Principal Investigator Richard M. Frankel, PhD, professor of medicine and geriatrics, Indiana University School of Medicine, with a team of SGIM experts who shared their unique perspectives and experience throughout the project. These included Vineet M. Arora, MD, MAPP, associate professor, University of Chicago Department of Medicine; Bradley H. Crotty, MD, MPH, FACP, associate director for informatics training, Beth Israel Deaconess Medical Center Clinical Informatics; Neil B. Mehta, MBBS, MS, *Journal of General Internal Medicine (JGIM)* web editor assistant dean, Cleveland Clinic; and Alexander K. Smith, MD, MS, MPH, associate professor of medicine, University of California, San Francisco, School of Medicine.

We began by focusing on the process for providers to access new research from AHRQ and other sources and to identify how different social media platforms affect how they share that information with their patients for prognosis and treatment options. A 2014 survey targeting SGIM, the American College of Physicians, the Society of Hospitalist Medicine, and the American Geriatrics Society highlighted the type and modality of resources that impact physicians' learning and behavior with patients.

Survey results indicated that despite regular efforts to stay apprised of new medical information, most general internists in this sample found it difficult to keep up. Reliance on guidelines, topic updates, and e-mail alerts may signify an increasing reliance on pre-digested data in this fast-paced information age. Interestingly, print was the most highly ranked medium for reading in-depth overall and a very close second to the web among early adopters of technology. Social networks had a mixed result, partially due to the separation of those for personal vs. work use.

Information sources that provide synopses and context to busy generalists, with links to the primary articles, may help better disseminate new knowledge. Despite the increasing trend for journals to abandon print media, print media was considered the best source for in-depth reading. Engaging peers and reputable colleagues in spreading this information may be synergistic.

Initial findings of the surveys were presented at a scientific abstract poster session at the 2015 SGIM Annual Meeting in Toronto, Canada. A poster titled "Stop the Presses? A Survey of Information

and Learning Preferences among General Internists in the Information Age" provided opportunities for our lead group members to interact with conference attendees and gather additional feedback on their personal experiences. In addition, we conducted two focus groups at the 2015 SGIM Annual Meeting to delve more specifically into participants' responses to the initial survey. Survey respondents were asked a series of follow-up questions, which revealed several themes. Because people obtain information through a variety of approaches, participants valued most those that were systematic, came from a trusted source, and did not just add to the myriad of multiple information sources. The final results from the study will be presented in a journal article planned for submission later this year.

During the course of the project, the team reviewed strategies used to share information, including the Bottom Line publications created by the SGIM Evidence-Based Medicine Task Force. Bottom Line is an ongoing series of summaries on specific research designed for providers to use in discussing new medical knowledge with their patients. To view the list, currently housed on the *JGIM* and SGIM websites, go to <http://www.sgim.org/communities/task-forces/evidence-based-medicine/ebm-current-projects>.

At the 2016 SGIM Annual Meeting in Hollywood, FL, we held a symposium titled "Navigating the Information Highway." This session presented skills-building techniques and tools to filter out the "noise" of information coming to participants through e-mails, social media, and journals. The purpose of the in-

continued on page 12

## SGIM Responds to the Proposed Implementation of MACRA

Erika Miller, JD, and John Goodson, MD

*Ms. Miller is senior vice president and counsel at Cavarocchi–Ruscio–Dennis Associates, a Washington, DC-based government relations firm. Dr. Goodson is an associate professor of medicine at the Harvard Medical School and a physician at Massachusetts General Hospital in Boston, MA.*

The changes imposed by MACRA (Medicare Access and CHIP Reauthorization Act) have settled over the physician community as a dark cloud. Though widely hailed by Congress as an innovative response to the combined challenges of an aging demographic and increasingly expensive health care, the implications of the “value-based” paradigm have suddenly jumped into hyperfocus as the regulations proposed by the Centers for Medicare and Medicaid Services (CMS) have been reviewed and digested by the physician community. “High quality” and “cost control” are broad aspirational goals, but the day-to-day work of physicians and their enterprises do not lend themselves easily to rapid change. Furthermore, there has been scant attention to patients and doctors. Will patients buy into a payment model that can penalize their doctors or their site of care on the basis of the tests ordered? How will it feel to know that your work will be watched for every action you take?

Congress passed this “fix” due to the annual failure of the sustainable growth rate—the dreaded SGR—as the volume-based target dictated cuts in physician reimbursement each year. SGIM and physician specialties went hat in hand each year to ask Congress for yet another reprieve from the mandated cuts.

We all cheered in relief last year, but now we know better after sifting through CMS’ almost-1,000-page proposed rule implementing the new payment system. Beginning in 2019, MACRA requires that physicians either participate in the Merit-Based Incentive Payment System (MIPS) or an alternative payment model (APM). However, 2019 comes more quickly than expected. The first performance period for MIPS and APMs will be based on

practice patterns starting in 2017. SGIM and virtually all other professional societies called for a delay, and CMS has created three options for reporting in 2017. However, the first adjustments will start in 2019 unless Congress intervenes. It would be unwise to be complacent.

CMS will issue a final rule on these programs later this year, leaving less than three months to prepare to report either under MIPS or as part of an APM. In our response to the proposed regulations, SGIM addressed key elements of MACRA, outlined below, that demand ongoing attention either within the rulemaking by CMS or by Congress.

### MACRA and the Flawed Physician Fee Schedule

CMS is building this new payment system using the very same poorly defined and undervalued evaluation and management (E/M) codes that have plagued primary care since the beginning of the resource-based relative value scale (RBRVS) payment in 1992. In our comments, we continued to advocate for CMS to develop new E/M codes based on a strong research base:

*SGIM believes it is critically important that new models of care delivery be built from trustworthy building blocks. CMS must prioritize the reworking of the E/M service codes using a strong evidence base. With a well-constructed and valid representative knowledge-base, new service codes can be defined and provided with appropriate relative valuations that recognize the complexities and demands of current medical practice.*

### Actionable Data

Physicians cannot make meaningful changes if data are late or unreliable. SGIM made the following suggestion:

*It is critical that physicians receive as close to real-time feedback as possible so they have sufficient time to correct any deficits and successfully report before the close of the reporting period. SGIM urges CMS to provide participating providers with a comprehensive feedback report on a quarterly basis and ensure that the final report is provided no later than October 1 of the reporting year. This would provide more regular feedback and also allow those participating to have a more complete picture of where they are succeeding and areas in which they may be subject to penalties. CMS should make these reports available to practice staff designated by the provider, as well as the provider.*

*Feedback reports should allow primary care physicians to see the impact of their own decision making on resource use, as well as how other providers’ decision making influences resource use for their panel of patients. For example, it should enable them as much as possible to look at resource use measures for local specialists so this can be considered in referral decisions. However, it will be essential that all feedback be based on statistically valid measures and that appropriate risk adjustment methods be used to provide meaningful and accurate feedback.*

### The Case for Risk Adjustment

Appropriate risk adjustment is critical to ensure that physician performance is properly evaluated in quality reporting programs. CMS will not have a new risk-adjustment methodology ready for 2017. We expressed concern that this methodology must be accurate and transparent to prevent physicians from cherry picking their patient panels in an attempt to avoid

continued on page 13

## A Man with AIDS and Abdominal Pain

Istiaq Mian, MD (presenter), and Sam Ives, MD (discussant, in italic)

*Dr. Mian is an internal medicine resident at Hennepin County Medical Center, and Dr. Ives is an associate program director at Hennepin County Medical Center.*

**A** 38-year-old man with HIV (last CD4 count 75) comes to clinic with three weeks of abdominal pain. The pain is diffuse and crampy and associated with bloating and loose stools. He reports intermittent emesis, poor oral intake, and about a 15-pound weight loss. He denies fevers or night sweats. He also notes increased urination. He does not drink alcohol or use NSAIDs.

He takes antiretrovirals and pneumocystis prophylaxis and denies any recent new medications. He has a history of cytomegalovirus (CMV) viremia. He does not smoke.

*The differential diagnosis for abdominal pain in a patient with HIV and a low CD4 count is long. The two main concerns would be infections or malignancy, but we should also consider common causes of abdominal pain unrelated to the HIV.*

*Regarding infections, the subacute nature of symptoms (i.e. three weeks) argues against an acute bacterial or viral gastroenteritis. Subacute causes of gastroenteritis are possible such as CMV, parasites (i.e. giardia, cryptosporidium), or mycobacterial infection (i.e. TB or Mycobacterium avium intracellulare (MAI)). He notably does have a history of CMV viremia, so gastrointestinal symptoms from CMV colitis are very possible.*

*Although he lacks fever or sweats, malignancy should be considered especially with the weight loss. Lymphoma or Kaposi's sarcoma (KS) are two concerns, the latter of which can present with gastrointestinal involvement without skin disease.*

*Lastly, common diagnoses should be considered that are not necessarily related to HIV. Peptic ulcer disease could cause diffuse pain and weight loss via food avoidance. Gastroesophageal reflux disease should not cause weight loss, and pancreati-*

*tis would lead to a more acute presentation. Electrolyte abnormalities could cause gastrointestinal distress, such as hypokalemia or hypercalcemia, but these would not cause weight loss (although they could explain polyuria).*

*On physical exam, I would look for KS lesions on the skin and do a careful exam for lymphadenopathy and hepatosplenomegaly, which could suggest underlying malignancy.*

On exam, his blood pressure is 107/67 with a normal heart and respiratory rate. No lymphadenopathy or skin lesions are noted. Heart and lung exam is normal. On abdominal exam, he has slight suprapubic tenderness without rebound or guarding.

Initial lab studies show white count of 3.3, hemoglobin of 12, and platelets of 80. A metabolic panel shows a creatinine of 2.3 and a calcium of 17.4.

*The striking findings from the initial labs are the pancytopenia, acute kidney injury, and marked hypercalcemia. Hypercalcemia causes an inability to concentrate the urine leading to polyuria, so the patient's renal failure could simply be due to both low intake and excess fluid loss.*

*However, an additional concern is a bone marrow problem, such as disseminated infection or malignancy, leading to both the low blood counts and hypercalcemia.*

*Primary hyperparathyroidism and malignancy account for about 90% of causes of hypercalcemia, so investigation of these causes is critical. A first step in the workup of the hypercalcemia would be to get a parathyroid hormone (PTH) level, which if high or normal would suggest primary hyperparathyroidism or familial hypocalciuric hypercalcemia (FHH).*

*In contrast, if the PTH is appropriately suppressed, a broader list of causes of hypercalcemia should be*

*considered, including malignancy or granulomatous due to TB or MAI, which could be related to his HIV.*

*For the renal failure and hypercalcemia, he should be given IV fluids and a bisphosphonate. I would recommend abdominal imaging to look for lymphadenopathy.*

PTH is low at 5.4 pg/ml. CT abdomen shows prominent mesenteric adenopathy suspicious for lymphoma. No masses are seen. The patient is given IV fluids, calcitonin, and a bisphosphonate with improvement in his acute kidney injury and reduction in serum calcium.

*With the appropriate low PTH, we can rule out primary hyperparathyroidism and FHH as causes of hypercalcemia. Malignancy or granulomatous disease remain the top two concerns.*

*The lymphadenopathy is concerning for malignancy or an opportunistic infection (i.e. TB or MAI). While fungal infections like histoplasmosis could lead to pancytopenia, the prominent adenopathy would be less common.*

*The patient should undergo a lymph node biopsy or bone marrow biopsy for further evaluation of the pancytopenia. Additionally, a PTHrP and 1,25-OH vitamin D should be checked, the latter of which can be elevated with some lymphomas or granulomatous disease.*

A PTHrP was negative, but a 1,25-OH vitamin D returns elevated at 164 pg/mL. As there is no easy target for lymph node biopsy, a bone marrow biopsy is performed that demonstrates non-caseating granulomas. Rare acid-fast bacilli are visualized within the granulomas, consistent with mycobacterial infection. Cultures eventually grow MAI.

For the MAI, he is started on ethambutol, azithromycin, and ri-

continued on page 13

## PRESIDENT'S COLUMN

continued from page 3

asks more often). As we've tried to review salaries in the department, we have come to appreciate not only the complexity of our system and the many salary inputs but also the variety of resources that contribute to income, such as rooms, procedure suite time, or the assignment of fellows or nurse practitioners.

The combination of national politics and my own work-based political challenges around gender equity led me to wonder how SGIM, the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM), and our organizations' members are doing in leadership achievement by gender. Many thanks to Kay Ovington and Jillian Gann from the SGIM office for pulling these data regarding the proportion of women who are members, professors, and division chiefs (Table 1, personal communication, August 12, 2016). Many division chiefs aspire to become department chairs; thanks to Bergitta Controneo and Sheila Costa for sharing information from the Alliance of Academic Internal Medicine (AAIM) about how many women (both generalists and specialists in AAIM) hold educational leadership positions (e.g. clerkship director, residency director) and who are department chairs (personal communication, August 8, 2016).

What do I take away from Table 1? First, about SGIM. Unexpectedly (at least to me), our society has continued to have substantial increases in the percent of members who are women since 2000. Women are now the majority of our members. In the early decades, men were the majority of members and held most leadership positions in the organization, but since 2000, nearly half of SGIM presidents have been women. It's great news that we are doing well with women as leaders; however, we have not done nearly as well with the winners of our major awards. Listed on the SGIM website are three "career achievement" awards—the Glaser (achievement across generalist domains), the

**Table 1. Representation of Women by Category: SGIM, ACLGIM, AAIM<sup>6</sup>**

	Total	Number of Women	Proportion of Women
<b>SGIM Members:</b>			
2000	2,763	774	28%
2005	2,971	1,188	40%
2010	2,891	1,388	48%
2015	3,107	1,616	52%
<b>SGIM Full Professors</b>	487	218	45%
<b>SGIM Presidents, 1978-</b>	39	9	23%
<b>SGIM Presidents, 2000-</b>	17	8	47%
<b>SGIM Career Achievement Awards Glaser 1986-</b>	31	4	19%
<b>Career in Med Ed 1996-</b>	21	4	19%
<b>Eisenberg 2001-</b>	16	3	19%
<b>ACLGIM Members</b>	179	72	40%
<b>ACLGIM Division Chiefs</b>	73	17	23%
<b>ACLGIM Presidents</b>	15	6	40%
<b>AAIM Members (MD only)</b>	7,797	2,807	36%
<b>AAIM Clerkship Directors</b>	195	83	43%
<b>AAIM Program Directors</b>	415	135	33%
<b>AAIM Chair/Interim Chairs Dept of Medicine</b>	134	22	16%

Eisenberg (career achievement in research), and the Career Achievement in Medical Education awards.<sup>6</sup> Examination of the lists of past winners shows that a very small fraction of award winners has been women—even for awards begun in 1996 and 2001. In fact, the Career Achievement in Medical Education Award, an area where women have been leaders for many years, saw its first female awardee nearly 15 years after it was created in 2010.

ACLGIM's statistics are interesting. ACLGIM's name, "Chiefs and Leaders," suggests that membership is limited to those who are leaders of some variety; members must somehow self-identify as leaders and then join. Psychologists report that women often downplay their roles and take less credit than they are due. It's therefore encouraging that 40% of ACLGIM's members are women. However, it's disappointing that only 23% of members who are general internal medicine division

chiefs are women.

AAIM is also an organization made up of leaders. Under the AAIM umbrella sit five member organizations, including the Association of Professors of Medicine (the organization of chairs of internal medicine departments), the Clerkship Directors, and the Association of Program Directors in Internal Medicine. It is encouraging to see the substantial proportion of educational leaders who are women. And although the number of women who chair departments of medicine is a small percentage, the absolute number is much higher than I had thought it would be.

How many future SGIM women will follow Wendy Levinson and Katrina Armstrong—two SGIM leaders and former general medicine division chiefs who have gone on to chair major academic departments of medicine? To ensure a pipeline, our medical centers and departments

continued on page 12

## HEALTH POLICY CORNER: PART I

continued from page 1

- To offer career development resources and opportunities to all SGIM members and broaden engagement in the Society's health policy efforts.

The LEAHP program is the first national health policy career development program of its kind. As part of a larger effort to expand career development opportunities for SGIM members, LEAHP is a year-long program (starting at one SGIM annual meeting through the next) focused on federal health policy knowledge and advocacy skills and aligned with SGIM's core missions. Participants in the program will learn to:

- Describe the key structures and functions of the US health care system;
- Analyze innovative health care delivery and economic models;
- Explain the impact of health care reform on the practice of medicine, education, and research in GIM;
- Critically evaluate current health delivery and policy problems; and
- Conduct in-person advocacy with policymakers.

Co-led by current and past HPC chairs (Tom Staiger and Mark Schwartz), program faculty will be drawn from recent HPC subcommittee chairs, former SGIM presidents, and other SGIM health policy experts. Ten to twelve trainees will be selected for the 2017-2018 program and will begin their LEAHP year with an in-person half-day workshop on Wednesday, April 19, 2017, at the SGIM annual meeting in Washington, DC. This workshop will orient participants to the program, introduce them to others in the national cohort, and begin teaching core health policy knowledge and skills. Participants will have one-on-one mentoring with program faculty based on common interests and career goals throughout the year. Mentors will help participants draft an individual development plan (IDP).

During the 2017–2018 educational year, LEAHP trainees will participate in:

- Quarterly webinars led by core LEAHP faculty with curriculum presentations, a *Washington Post* journal club, and case discussions;
- Quarterly health policy/advocacy teleconferences for health policy updates;
- Monthly phone calls with mentors to check in on progress on the IDP, guide learning, and discuss challenges and opportunities;
- HPC subcommittee work and monthly phone calls;
- Multiple asynchronous resources curated on SGIM's website: a core set of books, key papers, online sources on policy basics, and a daily news feed on health policy;
- Direct advocacy at SGIM's Hill Day in Washington, DC (March 2018); and
- End-of-curriculum in-person workshop/reporting out at the 2018 SGIM annual meeting in Denver, CO (April 2018).

LEAHP trainees will also complete a capstone project consisting of at least two of the following products:

- A health policy white paper/perspective article;
- A curriculum in a health policy topic;
- An advocacy project with leave-behind materials and talking points; and
- A workshop in health policy to be delivered at an SGIM meeting.

While most program activities are specifically designed for LEAHP trainees, several resources will be available for all SGIM members, including: access to curriculum components of the annual pre-course, select call-ins for quarterly webinars and teleconferences, and online health policy/advocacy resources at [www.sgim.org](http://www.sgim.org).

The competitive application for LEAHP will open October 15, 2016. The deadline for submitting an application is December 15, 2016. Applications must include a CV, personal statement, and nomination letter from a chief or chair. Eligible applicants may be at any career level but must be SGIM members

To apply or receive more information, visit the advocacy section of the SGIM website at <http://www.sgim.org/communities/advocacy>.

SGIM

## ESSAY

continued from page 2

tal question—*life or death?*—unanswered. In the absence of an answer, Ivan's identity is now narrowed from son, husband, and magistrate to a patient following doctor's orders: Ivan's "principal occupation became the exact observation of the doctor's prescriptions regarding hygiene and the taking of medicine, and watching the symptoms of his malady and the general functioning of his body"<sup>3</sup> (p. 128). Was Ivan's life overwhelmed by his status as a patient, by his entry into the sick role? The narrator believes so, telling us that Ivan's "condition was rendered worse by the fact that he read medical books and consulted doctors"<sup>3</sup> (p. 129). Ivan obsessively reads medical texts and visits "medical celebrities"<sup>3</sup> (p. 129), just as, in our own moment, the wealthy visit renowned specialists seeking miracle cures. Ivan finds that doctors, with their conflicting diagnoses and treatments, distract him from realizing his illness will kill him. Ivan has moments when he sees the truth—"Death is here, and I am thinking of an appendix! I am thinking of how to get my bowels in order, while death knocks at the door"<sup>3</sup> (p. 136)—but continues visiting the doctor to divert his attention. He knew he was dying, the narrator assures us, but "he simply did not and could not grasp it"<sup>3</sup> (p. 137).

continued on page 11

## ESSAY

continued from page 10

We know the ending of the story. Ivan Ilyich dies. It is the usual ending of every life, our shared future. We are all, whether abruptly or gradually, diminished unto death. And yet, Tolstoy tells us that death is the beginning because it is only in death that we become aware that the marriages, jobs, friendships, and rituals of the bourgeois are expected courtesies. Their disingenuous formalities distract us from the reality of our existence, namely that we will all die. Tolstoy implies we die twice—first when we submit to cultural expectations and again when we literally die.

That seems obvious, a cliché even, but the story still attracts readers because it offers a clear hope, embodied in Ivan's servant Gerasim, that we can resolve the confusion between life and death. Ivan's doctors could neither diagnose his illness nor explain why death would intrude into Ivan's decorous life. In contrast, Gerasim provides a clear-eyed explanation for why Ivan suffers illness and death. In every way, Gerasim stands in counterpoint to Ivan and his intimates. Gerasim is youthful and strong, while Ivan is aging and weak. Gerasim is cheery, while Ivan is dully embittered. So Ivan recruits Gerasim to sit with him. In Gerasim's company, Ivan does not feel as though he has to maintain what he calls "the pretence, the lie, ... that he was merely ill and not dying, and that he only need stay quiet and carry out the doctor's orders"<sup>3</sup> (p. 142). Alone among the people Ivan encounters, Gerasim dissolves deception, telling Ivan that since we all suffer and die, it is not disconcerting to attend to a dying man. Gerasim solves the problem of

the confusion of life and death, telling Ivan: If we embrace the reality of our death, we can truly live.

Tolstoy suggests this understanding is embodied by a particular class, the peasantry, and is unintelligible to another class, the bourgeois. When the doctor witnesses Gerasim's attention to Ivan, he dismisses Gerasim's care as "foolish fancies" and reiterates his groundless belief that Ivan will survive<sup>3</sup> (p. 148). Every doctor deceives Ivan about his death. Gerasim nurtures Ivan as he dies. Tolstoy encourages his readers to identify with Ivan, but he wants his readers to emulate Gerasim. Tolstoy places hope in a peasant who knows that we all die but cheerfully endures anyway. Gerasim is the hope of the story. He is also the contemporary equivalent of a hospice volunteer. When we celebrate this story in the medical humanities, we rarely reckon with its suggestion that young people could better serve the ill as hospice volunteers than as medical students. After all, Tolstoy identifies the peasant class as the *only* people who can have true empathy.

Too often, we teach medical students that they should embody the empathetic care of Gerasim even as they aspire to a social position more analogous to Ivan's decorous life as a judge. Tolstoy offers little hope within the story that one can have Gerasim's peasant wisdom and Ivan's decorous life. Yet when we read this story to students in contemporary academic medical centers, we imply that this very thing is possible. We implicitly encourage students to read the text against itself.

We do this even though Tolstoy seems to anticipate many of our contemporary humanistic hopes.

Could we not make Ivan's experience more humane by calling in his wife, doctor, or priest? Death is near? Here is a family meeting, here is a PCA pump, here is the chaplain; that is what we offer for the existential questions posed by Ivan. In the story, Tolstoy tells his readers again and again that Ivan's wife, doctor, and priest are the curators of the veils that shield Ivan from the truth of his existence: "All you have lived for and are living for is a lie and a deception, hiding life and death from you"<sup>3</sup> (p. 158). The gift of truly reading this text is that it anticipates all of our contemporary hopes, reveals their flaws, and then offers a radical critique that still pertains today.

After all, do not we physicians think of our patients' organs instead of the reality of their existence, as in Ivan's self-reproaching statement that he is thinking of his appendix as death nears?

Many students enter medical school to, in part, assure themselves of lives of bourgeois propriety. So we teach students to abstract people into syndromes, disorders, case series, and teaching points. We also teach them to abstract people into billing codes, RVU reports, promotion portfolios, tax shelters, and second homes. We can disrupt this teaching by reading this over-assigned text seriously and asking ourselves how to care for an ill person as Gerasim does. Can we, as physicians, help patients avoid the traps that Ivan falls into as he, in the company of doctors, thinks only of his appendix as death nears?

### References

1. Charlton B, Verghese A. Caring for Ivan Ilyich. *JGIM* 2010; 25(1):93-5.
2. Gawande A. *Being mortal: medicine and what matters in the end*. New York: Metropolitan Books, 2014.
3. Tolstoy L. *The Death of Ivan Ilyich and other stories*. Translated by R. Edmonds. New York: Penguin, 1960.

And yet, Tolstoy tells us that death is the beginning because it is only in death that we become aware that the marriages, jobs, friendships, and rituals of the bourgeois are expected courtesies.

## PRESIDENT'S COLUMN

continued from page 9

still have a long way to go toward gender equity and the promotion and retention of women leaders.

There is a complex web of reasons why inequity persists, and there are no simple solutions. However, simple transparency plus cataloging and counting are places to start. Here are a few simple no-cost interventions that might make a difference where you work; they form the basis of some of my group's initial strategy within our department:

1. All positions that bestow title, money, or power should be offered publicly with a transparent selection process.
2. Every unit or division should commit to an annual salary review looking specifically at salary equity but also at space, equipment, and personnel if pertinent.
3. Visible signals matter; survey your hallways and conference rooms with fresh eyes, and be sure that what is on your walls sends the message you intend.
4. Be sure that each faculty member has appropriate named mentorship, and learn how to best reward and value those mentors.
5. Not everything that can be counted counts, but counting is a great first step. Develop an

annual dashboard: number of applicants and demographics for each open position even if internal; proportion of grand rounds speakers who are women (and minorities); proportion of photos of women in your annual report and on your website; and number of women and men put up for promotion each year. Make the dashboard and its results transparent.

Hillary Clinton has announced that she plans to be sure at least half her cabinet members are women.<sup>7</sup> I'm not a big fan of that strategy—I would think she would want the best candidate for each of those jobs—and I bet a good number of those would be women. I hope she will use a fair, open, and transparent process to choose those cabinet members. And I hope that, after the election, we have a picture of a woman president to hang on the walls with all the paintings of men.

### References

1. Jena AB, Olenski AR, Blumenthal DM, Jena AB. Sex differences in physician salary in US public medical schools. *JAMA Intern Med* 2016; Jul 11 [Epub ahead of print].
2. Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ* 2016; 7:353.
3. Saint Louis C. Dr. paid less: an old title still fits female physicians. *The New York Times*, July 11, 2016. Available at: <http://www.nytimes.com/2016/07/12/health/women-doctors-salaries-pay-gap.html> (accessed on 8/2/2016).
4. Kaatz A, Lee YG, Potvien A, et al. Analysis of National Institutes of Health R01 application critiques, impact, and criteria scores: does the sex of the principal investigator make a difference? *Acad Med* 2016; 91(8):1080-8.
5. Jones RD, Griffith KA, Ubel PA, et al. A mixed-methods investigation of the motivations, goals, and aspirations of male and female academic medical faculty. *Acad Med* 2016; 91(8):1089-97.
6. SGIM awards and grants. Available at: <http://www.sgim.org/career-center/awards-and-grants> (accessed on 8/21/16).
7. Healy P. 'President Hillary Clinton?' She wants progress on immigration and to drink with G.O.P. *The New York Times*, July 3, 2016. Available at: [http://mobile.nytimes.com/2016/07/04/us/politics/hillary-clinton-president.html?\\_r=0](http://mobile.nytimes.com/2016/07/04/us/politics/hillary-clinton-president.html?_r=0) (accessed on 8/21/16).

SGIM

## SIGN OF THE TIMES

continued from page 6

teractive symposium was not only to impart usable information but also to assess participants' projected and actual behavior change regarding how they respond to new medical information. Neil Mehta, Bradley Crotty, and Richard Frankel presented on information management strategies that help generalists proactively access and use information. The session evaluation indicated that most participants felt only somewhat confident in the information they learned on a regular

basis and that ease of use of various modalities, as well as reliability of the information provided, were highly valuable. Further, they identified a need to distill the best medical information, and they felt this session gave practical guidance to accomplish this.

This project continues to generate interest from within and outside SGIM. In 2016, we started a collaboration with Brent Thoma, MD, at the University of Saskatchewan and a Canadian team participating in

their study to assess whether using infographics to promote new medical literature leads to increased article readership and dissemination. In an effort to answer this question, the study authors will prospectively assess the effects of promoting articles with infographics over the course of several publication issues of the *JGIM* and the *Canadian Journal of Emergency Medicine*. We look forward to sharing the results of this project.

SGIM

## HEALTH POLICY CORNER: PART II

continued from page 7

the sickest patients. Inaccurate, incomplete, or invalid risk adjustment could adversely affect patient access to care and would be especially detrimental in areas where access to care is already limited.

### Attribution of Cost

CMS has been experimenting with patient attribution models in its existing quality programs. SGIM made the following recommendation to CMS:

*...we recommend that MIPS and APMs use a prospective attribution method with a retrospective review process at the end of the payment period to correct for actual utilization patterns. A patient who is prospectively attributed to one provider, but then receives most of their primary care from a different provider, should be attributed to the second provider rather than the first. Patients should be asked to designate their primary care provider, and providers should be able to review their panel at the beginning of each monitoring period. This method would enable primary care providers to have a clear idea of the patients they are responsible for, while not holding them responsible for care they do not participate in. This would also facilitate the use of*

*“population health” and preventive care strategies to proactively intervene to help patients achieve optimal health outcomes. At the same time this would help ensure that patients have a designated source of care while still enabling them to choose freely among providers.*

### The Special Circumstances of Academic Medical Centers

The attribution methodology poses unique challenges for providers in academic medical centers (AMCs). General internists in these settings serve highly complex patients and receive the same MIPS composite score as all of the physicians reporting in that group. How will CMS capture the diversity of care and priorities for quality improvement of many different specialties?

Furthermore, CMS did not address the challenges that attending physicians who supervise residents will face in AMCs. These physicians typically oversee multiple residents who may work under different attending physicians. These shifting supervisory relationships and patient panels will impact performance in these sites, making the need for improved feedback paramount. SGIM called on the agency to address this issue.

### Small Practice Pressures

CMS estimated that nearly all (almost 90%) practices with fewer than ten clinicians will face penalties. SGIM is extremely concerned about the impact that MACRA will have on the financial viability of these practices, particularly primary care practices, as well as the potentially strong incentives to consolidate or sell a smaller practice to a larger entity. The education, training, and technical assistance promised by CMS is insufficient to support these practices. SGIM recommended amending the low-volume threshold to include more of these practices.

### Next Steps

We await CMS' response to the hundreds of comments they have received. However, much of what physicians fear about MACRA was baked in by Congress, including the 2019 start date, the 9% maximum penalties by 2022, and the high bar for APM participation. We will continue to focus our efforts to achieve better payment for primary care work within the fee schedule to ensure that improvement in payments for primary care services will have a beneficial impact that enables general internal medicine to thrive in the world of MACRA. SGIM

## MORNING REPORT

continued from page 8

fampin. In clinic follow-up two months later, his blood counts have improved, and his calcium levels have remained normal.

*Hypercalcemia has been described in granulomatous disease, most commonly in TB and sarcoidosis. Other granulomatous diseases to consider include histoplasmosis, coccidiomycosis, and other mycobacterium (such as MAI). Activated macrophages within granulomas convert 25-OH vitamin D to 1,25-OH vitamin D leading to hypercalcemia.*

*While primary hyperparathyroidism is the most common cause of hypercalcemia, in a patient with*

*HIV and a low CD4 count, malignancy or granulomatous infections should be considered.*

*A high 1,25-OH vitamin D should suggest granulomatous disease, with treatment of the underlying infection leading to resolution of hypercalcemia.*

### Learning Points

1. The vast majority of cases of hypercalcemia are due to either primary hyperparathyroidism or malignancy.
2. A high or normal PTH level is due to either primary hyperparathyroidism or FHH.

3. In hypercalcemia with low PTH, granulomatous disease is suggested by a high level of activated vitamin D (1,25-OH vitamin D).

### Suggested Reading

- Aly ES, Baig M, Khanna D, Baumann MA. Hypercalcaemia: a clue to Mycobacterium avium intracellulare infection in a patient with AIDS. *Int J Clin Pract* 1999; 53(3):227-8.
- Minisola S, Pepe J, Piemonte S, Cipriani C. The diagnosis and management of hypercalcaemia. *BMJ* 2015; 350:h2723. SGIM

## What's New in Maintenance of Certification

Eric H. Green MD, MSc; Deborah Kwolek MD; and Alpesh Amin MD

*Dr. Green is program director of the internal medicine residency program at Mercy Catholic Medical Center and clinical professor of medicine at Drexel University College of Medicine; Dr. Kwolek is clinical instructor of medicine at Massachusetts General Hospital and chair of the SGIM MOC Task Force; and Dr. Amin is professor of medicine at the University of California, Irvine.*

**A**fter almost 20 years of minimal incremental change, the maintenance of certification (MOC) process by the American Board of Internal Medicine (ABIM) is in a period of almost explosive change. The pace is at times dizzying. On behalf of the SGIM's MOC Task Force, we want to update our membership on the current state of MOC.

### What is MOC?

ABIM was founded in 1936 to "answer a public call to establish more uniform standards for physicians."<sup>1</sup> MOC was adopted by ABIM in 1990 and explicitly acknowledges that competence at the end of residency (i.e. initial certification) does not automatically equate to competence throughout a doctor's professional career. ABIM feels that MOC represents a physician's "keeping up" with the knowledge and skills of a modern internist.

### How long am I certified?

Depending on when you were initially certified, this answer is different:

- If you certified or most recently recertified after 2014, your certification is valid *only as long as you remain current in MOC*.
- If you originally certified from 1990-2013, your certification is valid for 10 years from your certification or most recent recertification.
- If you were initially certified before 1990, you will remain certified indefinitely.
- However, *regardless of the type of certification you hold, the ABIM website will also state whether or not a physician is "participating in MOC."*

### What do I need to do to remain current in MOC?

In the past, physicians needed to complete a number of medical knowledge and practice assessment modules at defined intervals. Medical knowledge self-assessment modules were multiple-choice question-based learning activities. These activities were produced by ABIM as well as third parties, including SGIM. Each module was worth a set number of points, which were proportionate to the number of questions asked. A self-reflective examination of a physician's practice, either using a structured tool developed by the ABIM or others, was also required. Finally, a secure computer-based closed-book exam was required every 10 years.

Over the last two and a half years, the landscape has changed.

ABIM has partnered with the Accreditation Council for Continuing Medical Education (ACCME) to approve certain CME activities for dual credit for MOC points. Many CME activities, including live conferences, journals, and online materials, meet ABIM's criteria for MOC-granting CME. SGIM anticipates that this year's annual meeting will allow for MOC as well as CME. MOC credit for these activities is granted according to the number of CME hours claimed. In addition, it is still possible to gain MOC credit from the "traditional" multiple-choice question modules, either produced by ABIM or other organizations (including SGIM).

In 2015 ABIM put "on hold" the requirement for self-assessment of practice. While physicians can still earn MOC points for completion of practice assessment activities, they are not required through at least December 31, 2018.

ABIM has acknowledged that the "traditional" 10-year secure exam should not remain the only method for MOC assessment. They are currently investigating a variety of strategies, including "open" vs. "closed-book" exams, home or office-based computerized testing, and different intervals (i.e. two or five years). They are planning on an alternative to the 10-year exam by the end of calendar year 2016 with implementation beginning in 2018. It is expected that the traditional 10-year exam will remain an option. Finally, the ABIM has recognized that MOC has a financial cost and has frozen fees through 2017.

Putting this all together in order to remain current in MOC (or remain certified if your certificate was issued in 2014 or later) you must:

- Enroll in MOC and pay required fees;
- Complete at least one MOC activity every two years—this can be CME-based MOC, multiple-choice-question-based MOC, or practice self-assessment;
- Complete 100 points every five years—this is the equivalent of 100 hours of MOC CME; and
- Pass a secure exam every 10 years.

### What about recent graduates? Researchers? Educators?

For recent graduates, ABIM gives a one-year MOC program fee waiver for newly certified internists. In addition, ABIM grants an MOC program fee "credit" each year for physicians who successfully complete an ACGME-approved fellowship. Fellows are also granted 20 MOC

continued on page 15

## NEW PERSPECTIVES

continued from page 14

points for each year of fellowship. No program fee credit or MOC points are awarded for non-ACGME approved fellowships like a GIM fellowship.

ABIM otherwise treats clinically active physicians alike, regardless of their job description. To no small degree this reflects ABIM's obligation to the public. With the increased number of MOC opportunities available through MOC-based CME, it is hoped that we will be able to find more MOC activities relevant to our current practice. A comprehensive list of MOC-CME is available through the ACCME (<http://www.cmefinder.org/>).

### What is SGIM's role in MOC?

Although MOC is a program of ABIM, the concept behind MOC—ensuring the public can identify high-quality internists who are “keeping up”—resonates with each of us. ABIM is actively seeking input from both internal medicine specialty societies and internists in general as it reshapes its MOC program. SGIM has provided representation to

ABIM in its efforts to “co-create” a future MOC program that we hope will include robust ongoing self-regulation that the public has confidence in.

In addition to advising Council in this effort, SGIM's MOC Task Force has created three different MOC modules and is working actively with both the Annual Meeting Planning Committee and regions to incorporate MOC into all of our meetings.

### What should I do in this rapidly changing landscape?

For many of us, the last thing we wish to do is try to understand a potentially confusing and ever-evolving set of requirements. Given the potential consequences to hospital and insurance credentialing status for lapsed board certification, it is important to not procrastinate in this process. At a minimum:

1. Log in to ABIM's web site (<http://www.abim.org/>). ABIM's portal clearly states your progress under the current rules in effect (Figure 1). If you have questions

about your status contact ABIM at [request@abim.org](mailto:request@abim.org).

2. Make sure to pay required fees and complete some MOC activity every year—this will ensure you remain active in MOC.
3. If your certificate expires before the new MOC assessment is available, plan to fulfill current requirements, including the secure exam.
4. If you have a certificate expiring in 2019 or 2020, pay careful attention to the ABIM's announcements over the next year. It is very likely that you will have flexibility to complete the shorter assessment option.
5. Make sure your voice is heard. Go to <http://transforming.abim.org/>. Read what the ABIM is saying, and fill out the Get Involved form!

### References

1. About ABIM. Available at: <http://www.abim.org/about/default.aspx> (accessed on August 5, 2016).

SGIM

Figure 1. My MOC Status

The screenshot shows a web browser window displaying the 'myMOCStatus' page for Eric Howard Green. The page title is 'myMOCStatus' and the URL is 'https://www.abim.org/online/moc.aspx'. The page content includes:

- Related Information...**
  - [MOC Program Requirements](#)
  - [View Your Completed Activities](#)
  - [View Examination Results](#)
- MOC Status for Eric Howard Green**
- Internal Medicine: Certified, Participating in MOC**
- You will be **publicly reported** as participating in MOC for all certification areas as long as you are participating in at least one certification area.
- Paid through 12/31/2016**
- Requirements & Deadlines**
- To be "certified, participating in MOC", you must be:
  - Enrolled
  - Complete required activities
  - Pass exam(s) by the date(s) listed below
- Points you earn count toward the milestones for all certifications you have chosen to maintain.
- By 12/31/2017:**
  - [Complete any MOC activity](#)
- By 12/31/2019:**
  - [Complete any MOC activity between 1/1/18 and 12/31/19](#)
- By 12/31/2021:**
  - [Pass the Internal Medicine MOC examination](#)  
Your first MOC exam attempt, per certificate, earns 20 MOC points.
- [View Your Completed Activities](#)

## University of Cincinnati College of Medicine General Internal Medicine Opportunities as Academic Hospitalist

The Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking Board Eligible Internists to join our faculty as academic hospitalists. Hospitalist faculty are members of the Division of General Internal Medicine, **which performs the bulk of resident and student teaching for the Department of Medicine.**

Responsibilities include:

- Providing patient care in several settings, including attending on traditional resident-led ward teams, attending on the resident-led medical consultation service, and leading a hospitalist team including an intern;
- Teaching in our Internal Medicine Residency program which has been granted status as an ACGME Educational Innovations Program; and
- Teaching medical students on clinical rotations.

Academic opportunities include:

- Direct teaching of medical students in all four years of our new clinical curriculum;
- Collaboration with researchers in our Center for Clinical Effectiveness and Center for Health Informatics; and
- Participation in Hospital quality improvement activities.

Opportunities also exist for training in Improvement Sciences and traineeships with mentored research experiences in Outcomes and Clinical Effectiveness leading to a Master's degree in Clinical and Translational Research.

Our hospitalists **are leaders in improving both patient care and clinical processes** at the University of Cincinnati Medical Center and have a **passion for teaching and improving patient care.**

Salaries are competitive, with opportunities for increases based on productivity.

If you are interested in joining the University of Cincinnati in Hospital Medicine, applicants should contact: Mark Eckman, Director, Division of General Internal Medicine at [Mark.Eckman@uc.edu](mailto:Mark.Eckman@uc.edu); or Justin Held, Interim Director, Hospital Medicine via email at [Justin.Held@uc.edu](mailto:Justin.Held@uc.edu).

**We are recruiting for July 2017.**

*The University of Cincinnati is an affirmative action/equal opportunity employer.*

