SIGN OF THE TIMES

Personalized Health Care Five Years Later

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CONTENTS

The year was 2010. It was seven years since the completion of the Human Genome Project in 2003, and the excitement and anticipation of the promise of genomics was palpable. Our hope was that genomics would finally allow the ability to more precisely predict disease risk, customize therapies, and prevent disease—the concept of which is commonly referred to as "personalized health care." But in 2010, we rarely used genomic technologies in clinical practice. Why was it taking so long for us to see the fruits of this project?

When I entered the field of personalized health care, the charge I was given by our visionary leader and chief executive officer Toby Cosgrove, MD, was to integrate genomics into mainstream clinical practice. The timing was ideal, I thought, as President Obama had just brought to national attention the crisis of health care spending in the United States. We were spending more than any other developed country on health care[1] and yet scoring the worst in measures of access, quality, equity, and efficiency of care.[2] As a general internist, I knew this was true. We were ordering too many unnecessary tests, we allowed care to be delivered haphazardly by specialists who were only focused on one piece of the puzzle, and we were incentivized to do more—particularly more procedures. My hope was that by leading this charge at Cleveland Clinic, a national model for coordinated care, I might be able to help shift the curve of health care spending, allowing us to deliver more precise care—the right care for the right patient—that might result in targeted interventions and screening, higher quality, and lower cost.

I am a primary care general internal medicine physician, trained in the 1990s when genomics was a very very small piece of the medical school curriculum. First on my list was to read up on genomics to separate hype from fact. In my mind, personalized genomic health care served two purposes: predicting risk and customizing therapies. What I found from scouring the medical literature was that there were very few genomic tests that could predict risk for disease accurately because most of the diseases we see as internists are multi-factorial. Even if we carry a gene or group of genes that are associated with a

1

Part-time Academic Male Physicians: A Call for Role Models

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People reading this title may remark that they are not aware of any male colleagues in academics or full-time clinical practice who have chosen to work part time. The few men I know who have scaled back are nearing the end of their careers and not—like me—at the beginning. In 2015, I began a new academic position with one and a half days free to provide child care or attend to other family responsibilities. I chose this consciously, but my only role models in this choice have been female physicians. Why is it that in 2015 many of us are aware of female but not male colleagues working part time?

The last few decades have seen a serious change in gender roles within the home and the workplace, with women increasingly taking their place in the workforce in medicine and elsewhere and men taking more of a share of domestic tasks. Many of the non-physician young fathers I know have an expectation of hands-on parenting, carving out of their careers more time to parent. I have a sense that young male physicians inclined toward prioritizing time at home with family may be choosing specialties other than general internal medicine, given that I have not encountered male physicians working part time in our field.

Surveys indicate that in the United States 20% to 30% of female physicians are practicing less than full time compared to 4% to 9% of their male counterparts.[1] Most frequently, the reason cited for this is to provide care for family members. Certain specialties, such as outpatient pediatrics, have higher numbers of men working part time.[2]

Personally, I've received a variety of positive and negative reactions to my plans. One female colleague said, "Oh, if you do that, your division won't involve you in much of anything. It was only when I went full time that I began to be included in projects." Another senior mentor said, "That sounds like a wonderful way to manage the rigors of academic medicine."

There are multiple reasons why male physicians may not consider part-time employment. Many may not consider it an option, given that they do not see others doing it. Most of us are still influenced by a narrowly defined cultural expectation around men and women's spheres of influence. Medical school debt is also highly influential, and thus limiting work time and earnings seems simply impracticable. Additionally, many are concerned about implications for career advancement and promotion and may believe that they cannot succeed without working full time and giving up many of their evenings and weekends as well. The *New York Times* recently profiled millennial men, who have more egalitarian views than previous generations but

Improving Work and Practice Environments

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> A major focus for improving the physician's work and practice environments involves creating systems that enable physicians to succeed in caring for diverse patient panels.

Improving the general internal medicine (GIM) work and practice environments is one of the six strategic priorities for SGIM and a fundamental issue for the survival of GIM. Surveys indicate that many physicians experience burnout and that a fair number of physicians would not enter a career in medicine if they were to choose again.

The times are changing. The days of highly reimbursed fee-for-service care are waning as reimbursement rates are reduced and more care is paid for with capitated global payment mechanisms. Value and efficiency are buzzwords now, and most physicians at academic health centers are tracked, evaluated, and at least partially rewarded or penalized based upon their productivity as measured in RVUs.

My outpatient continuity clinic is the Primary Care Group (PCG) at the University of Chicago. PCG is in the middle of transformation. We're about three years into implementation of our Epic electronic health record (EHR), and we are actively trying to manage population health, improve team-based care, and implement care management. Like many other academic medical centers, we realize that the old ways of doing things won't suffice. We understand the general principles that should guide the way we organize and provide care, and our challenge is to figure out how to achieve them. Chicago supports a predominantly fee-for-service market, but various forms of value-based payment and global payment are increasing. When the market transitions predominantly to alternative payment and delivery models, the change will probably be fast. This uncertainty causes anxiety for each of us, yet we can embrace the very exciting opportunity to consider new innovations.

The highs of clinical medicine are truly great—connecting with and helping patients; figuring out diagnostic challenges and working with patients to develop therapeutic plans that will work; being the person who patients and families entrust to be their advocate and healer; entering people's lives and learning more about humanity, life, and oneself. However, the daily challenges of being a clinician are considerable.

I think it comes down to having the time, resources, and team necessary to care for diverse patients, many of whom are medically and socially complex. Perhaps the most immediate challenge is the EHR. No doubt being able to access records immediately is a big plus. Nowadays, however, clinicians are subject to the tyranny of feeding the computer during the patient visit, giving new meaning to the phrase the "third entity in the room." In addition, more work has shifted to the physician (e.g. medication refills, referral forms, lab test ordering, click, click, click, etc.).

I think an equally big challenge is caring for those patients whom you know will take a lot of time. When you see your schedule for the day, you know who those time-consuming patients will be. If you have a number of these patients during a session and maybe a surprise patient with an urgent problem, and on top of that a student working with you, something will suffer—whether it's failing to cover each issue thoroughly, shortchanging the patient with the quality of your interpersonal communication and interaction, cutting back on your teaching, or eating into family time as you stay late at the office or complete notes at home. You feel that you're not providing the care you want to provide and that you're not the type of physician, teacher, or partner/father/mother/friend you want to be.

About a dozen years ago, Bill Tierney, formerly of Indiana University and now at the University of Texas at Austin, gave a plenary talk at the national SGIM meeting in which he predicted that general internists would eventually take care of only the sickest patients. He predicted that risk stratification would occur and that all the clinicians in a team would practice to the top of their license. Physi-

The Members Speak: Results from a SGIM Member Survey about Maintenance of Certification (MOC)

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In January 2014, the American Board of Internal Medicine (ABIM) created the world of Maintenance of Certification (MOC) 2.0, increasing the requirements for demonstrating up-to-date knowledge in internal medicine (IM) as well as including new patient safety and "patient voice" requirements. In the new era of MOC, those with "grandfathered" status (i.e. certified prior to 1990) would be labeled as "not meeting MOC requirements" if they did not sit and pass the secure exam by 2024. These changes prompted an outcry from the IM community. The ABIM listened and has since made a number of significant changes. In February 2015, the president of the ABIM sent the now famous "We got it wrong" letter to diplomates,[1] which was followed by regular updates throughout the course of the year. Some of the changes that the ABIM has made include:

- Suspending the practice assessment, patient voice, and patient safety requirements through December 31, 2018;
- Changing the wording describing physician status reported on the ABIM website from "meeting MOC requirements" to "participating in MOC";
- Revising the blueprint for the secure MOC exam to focus on topics commonly addressed by internists; and
- Partnering with the Accreditation Council for Continuing Medical Education (ACCME) to allow selected continuing medical education (CME) activities to also count for MOC.

Most recently the ABIM released a commissioned report, Assessment 2020, that among other things recommended replacing the every-10-year exam with more frequent, smaller, likely home-based assessments.[2] The ABIM is currently reviewing this report and discussing whether and how to implement these types of changes.

In an effort to understand how SGIM members feel about the MOC process, the SGIM MOC Task Force surveyed the SGIM membership via GIM Connect from January through April 2015. The survey contained eight items and inquired about members' overall impressions of MOC at that time, their opinions about the 2014 increased requirements for MOC, and their preferences for specific medical knowledge, practice assessment, patient safety, and patient voice modules.

Since the survey closed at the end of April (after the annual meeting in Toronto), there have been additional changes to MOC. Interestingly, our survey found the changes in MOC requirements to be largely congruent with the SGIM membership's opinions expressed in the survey. We are releasing our results here to stimulate further reflection and discussion.

Over the four-month survey period, 146 out of the approximately 3,400 GIM Connect subscribers completed the survey. The survey was designed as a needs assessment to solicit opinions from our members but not as a scientifically rigorous instrument. The respondents were a self-selected group who may be expressing particularly strong views of MOC.

Of the 146 respondents, 98.6% were currently ABIM certified, and 85.3% were currently enrolled in MOC. Of those not enrolled in MOC, 40% were certified before 1990 and were "grandfathered" into the program, and an additional 33% planned to enroll in MOC but had not yet had a chance to do so. Of the remaining respondents not enrolled in MOC, several commented that enrolling in MOC was not worth the time and the cost.

Just over half (56%) of survey respondents agreed/strongly agreed with the statement: "MOC is an important professional responsibility." In contrast, the majority of respondents disagreed/strongly disagreed with the 2014 changes that significantly increased MOC requirements as shown in Table 1.

Regarding the new patient safety requirement, 49% of the respondents disagreed/strongly disagreed that it was a positive change, and an additional 45% were neutral about the change.

In line with these survey results, the ABIM has suspended the patient voice and patient safety requirements through December 31, 2018. The ABIM has not made any changes to either the requirement for some MOC activity every two years or to the requirement for 100 points of MOC activity every five years. Allowing continuing medical

4

Home Health Care Oversight: From Burden to Opportunity

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The management of complex chronic disease and fraud are among the two largest drivers of rising home health care (HHC) costs.[1,2] In an effort to rein in costs, the Affordable Care Act included provisions that increased physician responsibility for overseeing the utilization of ongoing HHC services. While HHC services are important for implementing care plans that are developed in the office setting, we found that residents and their supervising attending physicians who work in our resident continuity clinic (RCC) were frustrated with the complexity of the oversight process and infrequently billed for the oversight services they provided. Developing efficient and instructive workflows has helped our practice save time, reduce frustration, and improve financial performance.

Form 485, usually referred to as simply "485," is the Home Health Certification and Plan of Care Form. This is the primary means by which physicians and HHC agencies communicate orders and care plan updates for their patients. An attending physician's signature is required on the 485 for a HHC agency to bill for the services they provide. Renewal of services must be approved by a physician every 60 days. It is the physician's responsibility to review diagnoses, orders, and patient updates located in the 485 and, based on his/her knowledge of the patient, determine whether the services are appropriate.[3]

However, HHC agencies are reimbursed for the complexity of the care they provide, and they have become adept at detailing patients' complex medical conditions and the services they provide in the 485s. From 2000 to 2007, 90% of the case-mix complexity increase observed in patients receiving HHC services was related to changes in coding practices as opposed to increases in complexity of care.[1,4] This translates to more complex 485s and greater challenges for physicians who try to provide appropriate oversight. The Healthcare Common Procedures Codes G0180 (physician certification of HHC services) and G0179 (physician recertification of HHC services) are meant to help reimburse physicians for their time spent establishing HHC care plans, communicating with HHC agencies regarding patient care, and reviewing 485s. Estimated reimbursement for G0180 is $50 to $60 while G0179 reimburses between $40 and $50.[5]

In our RCC, more than 250 patients receive HHC services. Additionally, many patients receive services from multiple agencies. As a result, we estimate that physicians and staff associated with the RCC process more than 2,000 HHC-related forms annually. This is in addition to work associated with filtering duplicate forms and responding to phone calls from HHC agencies. However, when polled in August of 2014, only 30% of our preceptors stated that they were billing for HHC services; 37% of preceptors stated that they did not know that billing was possible. The lack of adequate office visit note documentation supporting a patient's need for continuing HHC services was frequently cited as a reason not to bill for oversight services. As a first step, we focused on improving the documentation of patients' HHC needs by leveraging tools within the electronic health record (EHR). Our EHR has a problem list available for documenting patients' active problems. This is a universally accessible and editable list. For every patient receiving HHC services, residents are asked to update the problem list to reflect that the patient is receiving HHC services. Within the HHC section of the problem list, residents are asked to include information detailing why the patient is homebound, why the patient needs HHC services, what services the patient is receiving, and the last date HHC was addressed in an office visit. During an office visit, residents are asked to verify and include this information in their office visit note and indicate whether HHC services should continue. After an office visit in which HHC services are discussed, the information in the problem list is updated by the resident. Patients receiving HHC services have complex medical conditions, and routine follow-up for these conditions is often warranted every three to six months. If it is noted that a patient has not been seen in more than six months, outreach to the patient or HHC provider is performed to ensure that the patient is medically stable and to arrange a follow-up visit. This system allows for regular review and documentation of the patient's ongoing HHC needs. With improved documentation and education, attending physicians felt more comfortable billing for their oversight services (Table 1).

Improved documentation led to improved billing practices in our RCC but did not necessarily decrease resident and faculty frustration with the volume of work associated with overseeing HHC services. In the past, 485s were not tracked as they passed among office personnel. Subsequently, duplicate forms were often processed when one member of the team was unaware that another member of the team already completed the work. Additionally, HHC agencies frequently called asking for 485 completion status updates, which resulted in redundant messaging among staff, residents, and preceptors.

5

Alert Fatigue

Karen R. Horowitz, MD

It's Saturday morning, and I am sitting at my kitchen table for another session of "death by mouse-click!" Like every primary care physician (PCP) in America, I try my best to keep up with alerts. I complete my progress notes and encounter forms at the point of care. I review and correct deficiencies in documentation as soon as I am notified that they exist. I try to address abnormal lab results as soon as I receive them. There are weeks, however, when the tasks are too many, the meetings are too intrusive, and my "administrative time" is sacrificed in the name of other priorities. Where did the time go this week? It may have been spent planning and presenting a lecture, meeting with students, completing TMS (i.e. mandatory online training), completing student evaluations, or finishing a maintenance of certification module before the end of the year. There are department meetings, quality improvement (QI) projects, and the occasional writing commitment. Dare I mention I have a family? I try not to commit to all of these in the same week, and I'm not writing this to complain. On the contrary, I am no different than any other general internal medicine (GIM) physician in an academic medical center. I saw patients this week, and the electronic health record (EHR) is an unrelenting taskmaster. And so, on this quiet winter morning, the family is sleeping, the coffee is brewing, and I begin.

I logon to the EHR remotely and click "messages" to sort my alerts.

Pharmacy alerts. I usually start here, as they are the most straightforward. Renew a diuretic—potassium, ok? Check…renew…sign. ACEI…check creatinine…normal… renew…sign. Methotrexate… check diagnosis RA…check CBC…normal …renew…sign. These were all appropriate for the PCP to manage.

But docusate, acetaminophen, calcium, and alcohol wipes? Does it really require a five-step process— messaging from patient to a pharm tech to the PCP and back—to renew these?

GI notes for co-signature. I have referred my patient for colonoscopy. There are notes to cosign acknowledging: 1) patient attendance at orientation session, 2) the procedure note, 3) the biopsy result, 4) the consultant's note with recommendations, 5) updates to the problem list ("tubular adenoma, repeat procedure in 3/5 years"), and 6) the patient results letter.

Normal test results. I often receive duplicated notifications about normal test results. A "Birad-1" mammogram generates two radiology reports, a note to cosign from women's health, and a patient results letter. Every vascular ultrasound and pulmonary function test is reported separately when the technician does the test and again when the specialist reviews the result. Every inpatient radiology report comes to me. So do referrals for ambulatory physical therapy, home health care and other services, and "no show" notes from every specialty to cosign when patients miss appointments.

ER visits. Each lab and X-ray report comes back separately in addition to the ER note, which I review and cosign. My PACT team nurse calls every patient, and we do follow-ups for every ER visit and discharged patient. Why do we need to review every result separately? How many different alerts does this generate?

I have now identified multiple QI projects for the coming year. Next steps? It's time to create interest, time to build interdisciplinary collaborations, time to identify targets for change, time to form committees,

time to create solutions, time for provider engagement. It takes time.

Each time I batch my alerts and complete an EHR marathon, I see things a little differently. This exercise gives me an overview of the tasks and the workflow that has been created for the PCP by well-intended but ever-expanding systems of care. "Evolved" is a better word than "created" because rather than develop with purpose and oversight, EHR tasks have been assigned to the PCP from every department and interest group as a final common pathway. We have assumed the role of insurers of patient safety and the ultimate contact point between the health care system and the patient. We may have brought this on ourselves as a remnant of the "PCP as gatekeeper model" from the 1990s. But while everyone else is working "at the top of his/her license," the PCP is serving the efficiency needs of the institution and working for every other department. This needs to change.

I am not writing this to incite anarchy in our profession. Instead, this is a call to arms. GIM divisions everywhere are struggling under the burden of an ever-expanding list of tasks. We can learn from each other. We must share our best practices to reshape the burden of EHR-related tasks. We cannot leave this to the commercial EHR vendors and institutional IT teams. Without our collaboration and input, things will not change.

What have you done to address EHR workflow challenges in your division? Let's start a conversation. Please respond to Editor. SGIMForum@gmail.com or post a response on GIM Connect. Let's get the workflow under control. We owe it to ourselves and to the future of GIM.   *SGIM*

Eight Tips for Presenting Patients in an Academic Primary Care Clinic

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Trainees at the West Haven VA Center of Excellence in Primary Care Education Clinic include physician interns and residents and nurse practitioner residents. The nurse practitioner residency is a full-time 12-month intensive primary care training program for new nurse practitioner graduates. In these clinics, where there is a fair amount of cross coverage of patients within teams, both trainees and preceptors often struggle to maximize efficiency while ensuring that sufficient information is provided to preceptors who may not know the patients.

Here are eight tips that we developed for our interprofessional trainees on the art of presenting in a busy team-based ambulatory clinic setting:

1. *Provide a preamble.* Before starting your presentation, give a brief overview to your preceptor. Indicate if this is an urgent visit or a regularly scheduled follow-up; state how well you know the patient, and include any pressing questions or challenges. Your preceptor wants to know what you'd like to get from this precepting session.

   - "This elderly man, a retired policeman, just moved here from Las Vegas, and he has a new liver mass that hasn't been worked up yet."
   - "This is a middle-aged woman who is a manager at Stop and Shop, and it's the first time I'm seeing her. She has a lot of chronic conditions plus new abdominal pain and a lot of financial problems."
   - "This is a regular patient of mine, a high-school principal, and you've met her several times; I just want to go over her diabetes management."

   - "This patient is here with vomiting and diarrhea and a fever, and I'm worried about him. I think *he may need to be admitted.*"

   Preambles help your preceptor get an immediate sense of the big picture and allow you to focus your presentation.

2. *Appreciate the difference between the case presentation and the written note.* The note is a medicolegal document and should be in the SOAP (subjective, objective, assessment, plan) format. The case presentation may be more conversational, depending on your preamble and the context.

3. *Appreciate that preceptors have different styles.* Some will interrupt and ask for clarification during your presentation; others will listen to the whole case and then pose questions. The more streamlined and organized your presentation, the easier it will be to read your attending and adapt as you go.

4. *Ask for bedside precepting.* Many patients appreciate the transparency that comes with precepting in the clinic room. Presenting in front of the patient is much more patient centered than disappearing for five or ten minutes and coming back with a plan. Your patients will feel listened to and taken seriously. Your preceptor will have the chance to see you interact with the patient and can give you better feedback. Plus, bedside precepting often takes less time. When you're describing the history, present to the patient as much as to the preceptor, and make sure

you get the story right. When you need to veer into medical jargon, explain to the patient that you're going to use medical language for a few minutes.

5. *Don't look at your notes while presenting.* You remember more than you think you do, and you come across as more patient centered, intelligent, and competent to both your patient and your preceptor. Refer to your notes for lab results and medication doses if you must, but memorize the HPI (history of present illness) and other pertinent information. If you don't remember some small details, it's unlikely that they're important for your presentation.

6. *Ask for feedback.* Most preceptors are happy to give you feedback on your presentation but may not offer it if you don't ask. Let your attending know—before you present—if there's a particular area (e.g. some aspect of history-taking, physical exam skills, patient education, communication skills, note

> Presenting in front of the patient is much more patient centered than disappearing for five or ten minutes and coming back with a plan. Your patients will feel listened to and taken seriously.

7

21st Century Cures

Nancy Keating, MD, MPH

Dr. Keating is chair of the Health Policy Research Subcommittee.

One role of the SGIM's advocacy efforts in research and health policy involves closely following proposed legislation that might impact SGIM researchers. Since last spring, the Research Subcommittee of the SGIM Health Policy Committee has been following bipartisan legislation titled the 21st Century Cures Act.

Last July, the US House of Representatives overwhelmingly passed the 21st Century Cures Act (HR 6) by a vote of 344-77. The bill, sponsored by Representative Fred Upton (R-MI), had unanimous support (51-0) in the House Energy and Commerce Committee. The bipartisan legislation seeks to expand funding for medical research and streamline approvals and regulations for drugs and devices. In its most widely discussed provision, the bill will establish a temporary innovation fund for the National Institutes of Health (NIH) and the Food and Drug Administration (FDA) with a goal of supporting major challenges in biomedical research that have the potential to lead to therapeutic breakthroughs. The fund is a mandatory appropriation, which means that it is not subject to the annual budgets that must be approved by Congress. The fund will direct $1.75 billion per year for five years to the NIH and $100 million per year for five years to the FDA. This innovation fund will be offset (i.e. matched with cuts elsewhere in the federal budget) by future savings, with the idea that money spent now will develop treatments and cures that will lower spending on health care in the future. The legislation also proposes to increase the authorized ceiling on appropriations to the NIH by about 3% per year for three years and includes provisions to invest more resources in the next generation of scientists.

Another major focus of the legislation is to streamline the drug and device approval process at the FDA with the goal of accelerating the pace of approvals for promising therapies. Nonetheless, these provisions have led to some concerns that standards for approvals could be lowered too much. Examples of such provisions include allowing expanded approval of drugs based on biomarkers and blood tests rather than relying on improved clinical outcomes. In seeking to get effective therapies to market, the legislation would also allow consideration of drug approvals based on clinical experience and "real world evidence" from patients rather than well-designed clinical trials. Antibiotics could be approved based on animal and *in vitro* studies and very small trials in patients. Approvals of medical devices, which some already view as too lenient, would be relaxed further, allowing high-risk devices to be approved based on case studies, registries, and articles in the medical literature while also allowing changes to devices with only notification but not review by the FDA.

David Kessler, MD, a former FDA commissioner, coauthored an editorial in the *New York Times* where he described the FDA as a flexible and creative institution where new drug approvals have become the fastest in the world. He and his coauthors raised concerns that the 21st Century Cures Act could substantially lower the standards for approval of many medical products resulting in unnecessary risk of injury or death. Another provision highlighted by critics of the bill is its proposal to eliminate disclosure requirements intended to limit the influence of pharmaceutical companies on physicians, with a provision allowing physicians to receive speaking fees

and gifts from companies without disclosing them as long as they are for medical education.

The bill includes several other provisions intended to accelerate the development of new therapies.[1] First, it seeks to improve access, sharing, and use of de-identified health data generated in research and clinical settings with a goal of increased research collaboration. Second, it removes regulatory uncertainty for the development of new medical apps for cell phones and devices that are designed to improve clinical care with a goal of speeding the creation and adoption of these tools. Third, it provides new incentives for the development of drugs for rare diseases.

Other specific pieces of the House legislation relevant to SGIM researchers include requirements that NIH issue a strategic plan and also work on streamlining the grant process for researchers and decrease administrative burdens. The legislation also improves loan repayment programs for NIH researchers and encourages the NIH director to expand programs for young emerging scientists at NIH. It also seeks to refocus national efforts on making information technology systems interoperable and to increase price transparency at the site of service for Medicare beneficiaries.

Lamar Alexander (R-TN) and Patricia Murray (D-WA) from the Senate Health, Education, Labor and Pensions Committee have been working on similar legislation, currently identified as the Senate Innovation Initiative. The goal of this bipartisan initiative is "to examine how we get drugs, devices and treatments from the discovery process through the regulatory process into our medicine cabinets and doctors' offices."[2] The

find themselves taking a more traditional bread-winner role.[3]

Leaders in academic and clinical medicine are grappling with these issues for both male and female physicians. Addressing male physicians' need to contribute in the home may actually foster opportunities for their spouses. As Nancy Andrews, dean of Duke School of Medicine stated, "Many of the most successful women physician-scientists owe their success, at least in part, to enlightened partners who have made their own unrecognized and unrewarded career sacrifices to help the women succeed."[4] The effect of male physician partners taking more of a role in the home assisting in the careers of their partners may be amplified, since academic women physicians are more likely than men to have physician spouses and spouses who work full time.[5] Additional benefits of part-time work include decreased burnout, lower stress levels, higher work-related satisfaction, and a better sense of control over work life.

A number of leaders and organizations have taken steps to create a more egalitarian supportive culture in their institutions:

- SGIM supports part-time careers through interest groups and a career development award, the Mary O'Flaherty Horn Scholars Progam, for junior faculty seeking to support an academic career while raising children.
- The Alliance for Academic Internal Medicine in 2009 sponsored a task force report with recommendations for academic leaders. The task force has challenged us to conduct research to determine "best practices" in part-time hiring that will enhance the attractiveness of internal medicine careers and improve recruitment, retention, and productivity in a cost-effective manner.
- Online forums like "Mothers in Medicine" allow opportunities for women physicians to share

personal experiences, successes, and frustrations. I am not aware of a similar resource for men.
- The American College of Physicians has included guidance for trainees considering part-time work on their career counseling website.
- Some divisions directly confront negative stereotypes and encourage part-time providers. During my fellowship, my division proudly highlighted the number of part-time faculty in the division in reports to departmental and institutional leaders.

During my residency and fellowship, I received the indispensable guidance of multiple women who work part time. They gave valuable advice about navigating logistical problems related to clinical time, employee benefits, and career advancement and recognizing the potential for stigma. These stories and advice are unlikely to be shared unless students, residents, and faculty feel safe and supported in telling them.

Why is this issue so important for me? Put simply, I have seen the benefits among my non-physician male friends and family of prioritizing time for family. The most significant example—one that remains a regular reminder—was my brother-in-law Karl, who died unexpectedly at the end of my intern year. At the end of a long overnight call, I was jarred by an urgent call letting me know that Karl, a healthy 40-year-old man, had died suddenly in his sleep. For years he had been one of my role models. He had chosen to teach high school rather than pursue a more lucrative career because he wished to achieve work-life balance and be at home with his children after school and during the summer. After he died, friends and family repeatedly remarked on how well he had used his time.

Coming during a time when I was deeply immersed in the work culture of medicine, I saw the sharp

contrast between Karl's path and my own. My perception of the medical work culture contributed at times to my feeling as if my absence from work unfairly added to the workload of my fellow residents. During the days around his funeral, I worried about a lack of continuity for my primary care patients; I even worried that I was ineffectively using valuable downtime. In the ensuing years, remembering Karl's example has assisted me in maintaining perspective and setting priorities for achieving balance between home life and career. By having mentors who modeled the kind of balance I desired, I created my own approach for managing these pressures. My mentors never gave me a false sense that working part time in academic medicine was easy; rather, they have shown me that it is possible to do and worth aspiring to.

A growing body of literature suggests that it is possible to have an impactful personally meaningful academic career while working part time. Recent evidence suggests that part time providers may have more satisfied patients.[6] As many female (and a few male) part-time colleagues have shown, being open about one's intentional choice to work part time can help to create opportunities for community, mentorship, and improved strategies for improving our professional contributions. More men should share our thought processes, experiences, and results in navigating part-time employment. Let us ask important testable questions about these choices. For those who are curious about part-time practice, look for examples within your institution or in larger professional organizations of those who seem to have the work-life balance that you seek. I believe that greater sensitivity to these issues will positively transform academic medicine and lead to more satisfied physicians (and, potentially, patients). I am convinced that the results for our families and ourselves will be well worth the effort.

specific disease, we usually need some sort of environmental or other exposure to actually change phenotype and trigger expression of the disease. While scientists continued to search for the right combination of genes that would enable accurate prediction of disease risk (and offer potential drug or vaccine targets to prevent disease), it was clear from the medical literature that the best predictor of disease risk continued to be family health history (FHH). FHH is often overlooked, and while crude, it encompasses a combination of both genetic and environmental risk factors. Yes, it's true! FHH, a portion of the history that we clinicians often spend less than 2.5 minutes collecting and that the literature indicates we do not routinely discuss with patients,[3] has been proven repeatedly to be a better predictor of risk than genomic testing for many conditions we see in clinical practice—breast cancer, colon cancer, diabetes, and AAA, to name a few.[4]

In contrast, when it came to predicting response to therapies, there were many evidence-based successes in the realm of cancer genomics (Table 1) with broad acceptance and implementation of these already taking place in major medical centers such as mine. I also found a large body of scientific literature in the field of pharmacogenomics (i.e. genes that predict drug response and adverse events) and rising national interest in the use of pharmacogenomics in standard medical practice. One such national group is the Clinical Pharmacogenomics Implementation Consortium (CPIC), a branch of PharmGKB that has since published 34 peer-reviewed recommendations on the use of pharmacogenomics in clinical practice.[9] A few examples of clinically relevant pharmacogenomic tests are outlined in Table 2. CPIC's recommendation statements provide useful guidance on how to change clinical management based on a pharmacogenomic test, but we still do not have clear

Table 1. Examples of Clinical Indications for Cancer Genomics

Disease	Indicator	Therapy	References
Non-small cell lung cancer	EGF-R over-expression	Gefitinib/erlotinib	5, 6
Chronic myeloid leukemia	BCR-ABL Philadelphia chromosome +	Imatinib	7
Breast cancer	BRCA1 mutation	Parp inhibitors	8

Table 2. Examples of Clinically Relevant Pharmacogenomics Tests from CPIC Website

Drug	Test	Clinical relevance	FDA warning exists
abacavir	HLA-B*5701 positive	High risk for hypersensitivity	Yes
allopurinol	HLA-B*58:01 positive	High risk for severe cutaneous adverse reactions (SCAR)	No
carbamazepine	HLA-B*1502 positive	High risk for severe cutaneous reactions (SJS/TEN)	Yes
warfarin	CYP2D6/VKORC1	Result may guide initial dosing	Yes
clopidogrel	CYP2C19*17 allele	High risk for bleeding	Yes

consensus on when these tests should be ordered.

What was clear from my investigation was that we were very early in the process of integrating genomics into mainstream clinical practice and that the opportunities for implementation fit two categories: 1) the consistent collection and systematic use of FHH for disease risk prediction and 2) laying a framework and structure for the integration of pharmacogenomics into clinical practice. These became our initial projects, and along with a team of talented and dedicated individuals, we built a FHH collection and risk assessment tool with clinical decision support (MyFamily) and an alert-based pharmacogenomics program (Personalized Medication Program) that are both still in use today. The importance of these programs is not only in their current use but also in the foundation they provide for future incorporation of genomic information into clinical practice. At the same time, we recognized that many clinicians, myself included, who were trained before 2000 had limited knowledge of ge-

nomics and understanding of when genomic tests are clinically helpful or how to interpret them. As such, we dedicated large amounts of time and effort providing education around topics of FHH, pharmacogenomics, and basic principles of genetics and genomics. I am incredibly grateful to my personalized health care team members; to my mentor David Bronson, MD; to the many clinicians who supported our efforts; and to the Personalized Medicine Coalition, an advocacy group under the direction of Ed Abrahams, MD, who provided us with education and advocacy opportunities and helped us to forge key strategic collaborations.

We made great strides in the integration of genomics into clinical practice, and I am incredibly proud of the work we did. We also learned some important lessons. This investment in the future of medical practice was costly and time consuming. We need to spend more effort on research—discovery, implementation science, and the randomized controlled trials that

many want to see before changing clinical practice. We need to advocate for funding for such research. We need to continue the good work being done in personalized cancer care. And we need to increase our efforts to educate and keep all of our clinicians up to date on the latest that genomics has to offer, including developing an increased understanding of when these tests are useful. There is much to be done, and I continue to hope that genomics and a better understanding of FHH risk will allow patients to be healthier for longer periods of time. In the meantime, I urge clinicians to keep abreast of current research in this field and seek opportunities to learn how genomics may influence an individual's risk for disease and response to therapies. We should re-dedicate our efforts toward accurate FHH collection and use of FHH for risk prediction. As for me, it is clear that genomics and FHH are important ingredients, but they are just one portion of our overall ability to provide personalized care. Personalized health care will require a convergence of biology and science; community and individual health and wellness; patient engagement; and coordinated, team-based, accessible health care. Some call this popula-

tion health; some call this value-based care. Regardless of the name, we need to move together as a team of clinicians, scientists, teachers, patient advocates, and innovators so that we can achieve the goal of better health for our patients and communities and the vision of the *right* care for the *right* patient.

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SGIM

cians would take care of the most complex patients, while more straightforward patients would be cared for by nurse practitioners and physician assistants. Medical assistants and licensed practical nurses would play increased roles in care management as well.

I was jolted by Bill's talk, as this was not the common thinking at that time. If we consider the current health policy and market landscapes, Bill's ideas sound strikingly similar to concepts of population health management, including risk stratifying the overall patient population and directing patients into different care pathways that vary in intensity depending upon the complexity and needs of the patients. I first met Bill through the Midwest SGIM One-on-One Mentoring Program. He has consistently provided wise advice and insights based on outstanding judgment shaped by extensive front-line experience.

A major focus for improving the physician's work and practice environments involves creating systems that enable physicians to succeed in caring for diverse patient panels. Mark Linzer has identified autonomy as critical for a physician's sense of well-being. I don't think he means autonomy in the sense of the lone wolf doing it on his/her own but working in a system that doesn't overwhelm the doctor and in which the physician feels he/she can easily mobilize the people and resources necessary to give that patient the best possible care. Clinical operations should be efficient, and teams and clinics should be structured in ways that enable seamless patient care across the continuum of home self-care, outpatient, and inpatient care. Autonomy also means the provider can control workload and thus manage work-life balance.

Imagine, for example, a health information technology system that risk stratifies patients, identifies the key medical and social problems of a given patient, provides decision support to facilitate the provision of key clinical processes of care, and links patients to the community resources they need to thrive at home and in their neighborhoods. Imagine that high-risk patients with chronic disease are routinely monitored and contacted between visits by nurses and medical assistants to help them do well at home and detect early exacerbations of disease and prevent hospitalizations.

SGIM has several initiatives to improve work and practice environments for general internists. The theme of the 2016 annual meeting is population health, which will address many relevant health care delivery issues. SGIM has been developing collaborations on population health with the family medicine and general pediatric societies and will participate in a joint meeting with them in the spring that will focus on population health and other topics. The Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) has a work wellness program in progress that involves surveying clinicians at partici-pating institutions about their well-being and helping to design and implement interventions to improve physician wellness.

The SGIM Clinical Practice Committee recently held a retreat to consider how it can build upon its current efforts and improve the practice environment. As noted in a recent *Forum* column by Jim Bailey and Martin Arron who chair the Clinical Practice Committee Practice Management Subcommittee, the Committee is beginning a number of initiatives including enhancing practice improvement resources on SGIM's website, increasing practice management workshop offerings at the regional and national meetings, writing a regular "Improving Care" column in *Forum*, and exploring a potential SGIM-American Medical Association STEPS Forward collaboration around free practice transformation toolkits (www.stepsforward.org). Improving work and practice environments was a key issue discussed at the December 2015 SGIM and ACLGIM retreats. In addition, plans are underway to coordinate and synergize efforts of pertinent groups such as the SGIM Clinical Practice Committee, ACLGIM, and the Academic Hospitalist Task Force.

The challenge of improving work and practice environments draws upon some of the best of SGIM—our skills in developing innovative care delivery systems and delivering truly patient-centered care. We can do much to improve care and our work environment.   *SGIM*

writing) you'd like feedback on.

7. *Ask for explanation.* If your attending comes up with a recommendation you hadn't considered, ask about the decision-making process. If you're discussing a topic you don't know much about, request suggestions regarding guidelines or articles that might help you better understand the issue.

8. *Communicate with other team members regarding significant issues, preferably face to face.* Request that team members cosign or alert you to notes on shared patients to highlight important events. This conveys to them both your interest in their ongoing participation and your clinical concerns. It will also clarify what you need from them in terms of follow-up.   *SGIM*

Table 1. Disagreement with New 2014 MOC Requirement	
New 2014 MOC Requirement	**% of respondents who disagree/strongly disagree**
The new MOC requirement of some MOC activity every two years (instead of 100 points every 10 years) is a positive change.	59%
The new MOC requirement of 100 points of MOC every five years (instead of 100 points every 10 years) is a positive change.	73%
The new MOC Patient Survey (now called "Patient Voice") requirement is a positive change.	79%

Table 2. Respondent Scores for Medical Knowledge Modules	
Medical Knowledge Module	**Average score** *1 = strongly not recommend* *3 = neutral* *5 = strongly recommend*
ACP MKSAP 15	4.0
ACP MKSAP 16	4.0
ACP Online High Value Care Cases	3.9
ABIM 2012-14 Update in Hospital Medicine	3.7
ABIM 2011-14 Update in Internal Medicine	3.7
NEJM Interactive Medical Cases	3.7
ABIM 2012-14 Update in Geriatric Medicine	3.6
ABIM 2011 Update in Hospice and Palliative Medicine	3.6
NEJM Knowledge+ Internal Medicine Review 1-8	3.6
SGIM: Cultural Competence and Disparities in Health/Healthcare	3.5

Table 3. Respondent Scores for Practice Assessment Modules	
Practice Assessment Module	**Average score** *1 = strongly not recommend* *3 = neutral* *5 = strongly recommend*
CDC: STEADI Fall Prevention Quality Improvement Program	4.3
ABIM Clinical Supervision Practice Improvement Module (PIM)	4.0
ABIM Completed Project PIM	3.7
ABIM Palliative Care for Primary Care & Subspecialist Physicians PIM	3.7
ABIM Cancer Screening PIM	3.5

education activities to count for MOC, however, will certainly make reaching these point totals much easier for diplomates.

Although there will now be many more ways to accumulate MOC points, we were interested in learning which medical knowledge and practice assessment modules were the most popular among SGIM members. Using a five-point scale, the medical knowledge modules that respondents would most strongly recommend to a colleague are presented in Table 2.

Nonetheless, even the highest-ranked modules may not be viewed as very valuable since 47% of respondents disagreed/strongly disagreed with the statement that the medical knowledge modules "…are an accurate test of my medical knowledge" and another 41% were neutral about this statement. It remains to be seen whether activities that have traditionally counted for CME credit will be seen as accurate assessments of medical knowledge.

Also using a five-point scale, the practice assessment modules respondents would most strongly recommend to a colleague are included in Table 3.

A full 73% of respondents disagreed/strongly disagreed with the statement: "The current MOC practice assessment products are a useful way to measure quality in my practice." As noted above, the ABIM has currently suspended all practice assessment requirements through December 31, 2018.

The majority of the free text comments expressed negative opinions about MOC, including concerns about high costs, lack of relevance to daily practice, the limited value of doing "busy work," difficulty for researchers or others to fulfill certain requirements, and requests to have access to clinical resources during the secure exam. Some representative comments included:

- "MOC feels like busy work."
- "The primary problem with MOC is that questions are often too academic—not covering the 'meat-and-potatoes' concepts that practicing internists in the community deal with on a daily basis."
- "CME should be counted toward MOC. Most of the courses I take or teach are much more pertinent to my practice than MOC materials."
- "Verification of competency by

13

periodic testing is not a valid approach."

- "The exam questions did not reflect the way I practice general internal medicine.… Other board groups allow their members to take exam questions from their office or home, look up the answers for self-directed learning, and then submit their answers for certification. This is something the board should consider."
- "I do not think I will take the exam 10 years from now—too much time, money, and effort."

A number of the changes implemented and planned by the ABIM address the issues above, including revising the blueprint for the secure exam, allowing CME to count for MOC, and potentially doing away with the 10-year secure exam altogether.

There were also a few respondents who noted that MOC is an important professional responsibility as reflected in these comments:

- "I am generally in favor of requiring some sort of meaningful, relevant continuing education for physicians..."
- "While a bit inconvenient, I think that there is a social contract between the profession/GIM specialty to stay ahead of evidence, promote safety, promote hi [sic] value care, promote the preservation of Medicare, teach trainees in a high-quality effective way…. The MOC requirements are just a way to keep us honest. It's not too tough on me to meet the obligations of the program because I'm simultaneously doing it and teaching it..."
- "MOC is an important concept and a good idea..."

Overall, the ABIM is moving in a direction concordant with the views expressed in this survey of SGIM members. Although MOC 2.0 only went into effect at the beginning of 2014, since then we have seen a rapid change in course by the ABIM. We also see the recommendations of the 2020 task force as a very forward-thinking approach to the concerns about MOC and will be very interested in possible implementation solutions to making MOC "work" for the physicians enrolled.

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ESSAY

Table 1. Home Health Care Oversight Billing			
	Recertification # G0179 Billed	Certification # G0180 Billed	Total
June-July 2014	33	3	36
August-September 2014	91	19	110
October-November 2014	100	37	137
December-January 14/15	113	33	146
February-March 2015	144	25	169
Total	481	117	598

Our solution to these problems was to develop a process that allows all members of the clinic to know the completion status of the documents at any given time. Additionally, with revenue generated from improved HHC billing, we were able to justify assigning a member of the clinic staff to assist in overseeing this administrative process. When a 485 comes into the office, it is first passed to the clinic staff member. This person is assigned to monitor the completion status of the forms and is also responsible for ensuring that the HHC agency listed on the 485 is the correct agency based on our records. Checking to make sure that the form is not a duplicate and identifying the last office visit in which HHC services were addressed are key functions of this individual. If it has been greater than six months since the last office visit, a note is sent to a medical assistant to schedule an appointment for the patient. The staff member then creates a note in the EHR that includes this information and passes the EHR note (electronically) and the 485 (paper mailbox) to the resident. As personnel complete their work on the HHC document, they update the EHR note and pass the 485s to the next member of the team. A complete cycle includes the note and the 485 passing from the staff member to the resident, to the attending, to the staff member, and finally to the clinic manager for billing. The EHR notes are viewable by all members of the clinic, thus allowing others to know the completion status of the documents at any time. This process has cut down on duplicate work and the game of phone

tag that often occurred when HHC agencies inquired about the completion status of these forms

In order to help residents understand how to best utilize HHC services and how the HHC workflows can help them monitor the services their patients are receiving, we have developed an HHC curriculum that is delivered annually through didactic sessions. In these sessions, we review how the HHC can be used to help patients, the structure of 485s and the information included in them, documentation required to receive HHC services, signs of fraud when reviewing HHC services (i.e. changes in start of care dates, unexpected changes in HHC agencies, documentation of services provided for conditions that have resolved, and unexpected changes in diagnoses that could justify prolonged services), and understanding the basics of HHC waiver programs. Waiver programs often provide patients with a greater intensity of service than would be typically allowed or provide services to patients who would not qualify for HHC services based on typical requirements (i.e. need to be homebound or need for skilled services).

After implementing this workflow and the educational programming, 85% of residents stated that they felt more confident in monitoring and managing HHC services. Additionally, 100% of faculty stated that they were aware that they could bill for HHC oversight services, and 92% of faculty stated that they billed for these services regularly. Our clinic staff member tasked with overseeing this workflow states that the process is easy to follow. Call center staff state that they are able to more easily handle queries from HHC agencies asking for updates on form completion and can avoid sending messages to residents.

Oversight of HHC services is complex and time consuming, yet the inappropriate utilization of HHC services is costly, and inadequate oversight can lead to poor patient care. In a large practice with many new physician learners who are caring for a highly complex population, creating a standardized process that allows for maintenance of learner autonomy and preceptor supervision, safe patient care, and decreased clinical resource utilization is important. We have described one model for managing oversight of HHC services that has been well accepted by physicians and staff and has resulted in positive financial gains.

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Senate bill is expected to be released and discussed this year. Although the legislation was reportedly on a "parallel track" with the House bill, the Senate bill will likely be different. Senate Republicans have expressed a preference for funding that remains discretionary instead of mandatory. They are also sure to be examining the language addressing regulation closely. Moreover, in light of the recent budget deal passed in December 2015, which provides a $2 billion (6.6%) increase in NIH funding, the Senate may feel less urgency to push forward legislation whose primary aim is to increase NIH funding.

There are certainly things to like about 21st Century Cures legislation, particularly the promise of direct funding to the NIH that is not subject to appropriations. That said, it is not yet clear if this funding will focus solely on drug discovery or if it may also be used to fund health care delivery research. The expansion of de-identified health data also holds great promise for SGIM researchers, as does expanded loan repayment programs, but concerns about other provisions remain. The Health Policy Committee Research Subcommittee will be watching closely as the Senate crafts and deliberates its legislation in the coming year.

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Call for Authors

The Society of General Internal Medicine (SGIM) *Forum* seeks articles for our Morning Report column. SGIM Forum offers articles, essays, thought-pieces and editorials that reflect on health care trends, report on Society activities, and air important issues in general internal medicine and the health care system at large.

Morning Report articles are short clinical cases (750-1,000 words with less than six references) with clear learning points.

- Choose a case that will engage the audience (either because it is common, scary, or interesting).

- Use a presenter and discussant format with discussant typically in italic.

- Aim for up 750-1,000 words with less than six references.

- Feel free to use poetic license in recreating the case in order to make the details of the case more or less cumbersome for your audience. Given our limited amount of space, it is best to emphasize a particular part of the patient encounter—either the history-taking, physical exam, work-up, or treatment.

- Early on, create a prioritized differential by the discussant. Emphasize the differential diagnosis, discuss all possibilities, and then sort the diagnoses emphasizing what is thought to be most likely and which diagnoses should not be missed.

- Focus on some aspect of the case in the didactic portion (i.e. the presenting signs and symptoms, physical exam, differential, work-up, or treatment). Don't try to present the whole topic...just one area in better detail.

- End with summary including two to three teaching points.

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