

ANNUAL MEETING UPDATE

Resilience and Grit: Pursuing Organizational Change and Preventing Burnout

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As the autumn leaves withered and the first snow fell from Vermont to Washington State, the SGIM 2017 program committee designed a spring renewal cherry blossom meeting at the Washington, DC, Hilton Hotel (April 19-22). Our theme—*Resilience and Grit: Pursuing Organizational Change and Preventing Burnout*—inspired a program poised to change how we think, feel, and act, as we go forward to face a new era of health care transformation and political uncertainty.

For SGIM members, the annual meeting is a chance to come together to celebrate our shared mission of patient care, medical education, health care advocacy, and leadership. In response to the high level of member engagement at the 2016 annual meeting, our Program Committee redesigned the 2017 meeting schedule so that all sessions are one hour long; thus, substantially increasing the number of scheduled sessions. As you read this, SGIM members across the country and around the globe are busily reviewing abstracts, vignettes, and innovations in anticipation of a great event to come.

Resilience and Grit: Pursuing Organizational Change and Preventing Burnout is a timely theme that captures several content areas of leadership in cutting-edge issues. Our Web site reflects both our diversity and our opportunities as we engage in this most critical “generational” conversation, writ broad.¹ We aim to reenergize and appreciate our senior members as we bring on new members, and also develop our younger members by offering them mentoring opportunities, viable skills, and a sense of belonging in our “academic home.”

The 2017 Peterson Lecturer, Vivian S. Lee, MD, PhD, MBA, will provide a perspective on her leadership while serving as the CEO of University of Utah Health Care in Salt Lake City, dean of the University of Utah School of Medicine, and senior vice president for Health Sciences at University of Utah. Dr. Lee is known for her work on increasing efficiency in health care that culminated in The LEAN Management and Value-Driven Outcomes initiative, a model program that lead to streamlined processes

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Now What? Postelection Reflections from Millennials

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Like many Society of General Internal Medicine (SGIM) Associate (trainee) members, I was a medical student when the Affordable Care Act (ACA) was signed into law. In the last six years, 20 million people gained health insurance, Medicaid expanded significantly, adults with pre-existing health conditions were covered, and young adults were allowed to stay on their parent's health insurance plans.^{1,2}

As a primary care resident in New York City, I saw the effects of the ACA firsthand. My panel and my colleagues' panels of patients became increasingly populated by people who had health care for the first time or regained access to health care after a very long time without it. From preventative services and contraception to the management of complex chronic conditions, my colleagues and I addressed the medical and psychosocial needs of these patients. As residency came to a close, I felt I had made a difference as a primary care doctor.

Now, six months into a health services research fellowship, a very dif-

ferent feeling washes over me when I see my clinic patients.

I am fearful.

For many physicians, the days and weeks following the election have been a time of serious reflection. And while most of us have been affected in some way by the divisive rhetoric of the 2016 presidential campaign, it is our patients—the chronically ill and the poor—who remain the most vulnerable.

The loss of the ACA would have an enormous and detrimental impact on the lives of these Americans. And, based on recent events, the ACA may soon be repealed. The nomination of Dr. Tom Price as secretary of health and human services (HHS) is particularly alarming for those of us who support the ACA. Not only does Dr. Price intend to repeal it but also he advocates rolling back the expansion of Medicaid and supports the privatization of Medicare. Taken together, these positions would dismantle safety nets for the poorest Americans (including children) and leave seniors particularly vulnerable.

These concerns are widely shared by my peers. "I worry most about my Medicaid patients losing their health insurance," says Dr. Meredith Niess, an assistant professor at Oregon Health and Science University. "I was a resident at the University of Colorado when the ACA was passed. I remember there were patients of mine with diabetes and hypertension, who could afford medications for the first time. I also remember patients who died because of lack of insurance and health care access. Unfortunately, I think it will be those who have benefited the most from the Medicaid expansion and the Ex-

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Choosing Most Wisely

Eileen E. Reynolds, MD

Our Evidence-Based Medicine Task Force has worked hard to combine the reality of the evidence, the lack of evidence, and feedback from SGIM members. Reading the fine print is essential to understanding the nuances of the recommendation.



Tomorrow morning I'll be seeing patients in my primary care practice. I have 10 patients scheduled—nine of my own and one urgent care visit of a colleague's patient. The scheduled patients range in age from 48 (the urgent care patient) to 94; in addition to the 94-year-old, four are in their 80s (87, 85, 83, 81), two in their 70s, and one more youngster of 51.

The 94-year-old, Ms. T, is actually the healthiest. She has incredibly stable hypothyroidism and some osteoarthritis but is otherwise remarkably well. Ms. T has few relatives, lives alone, takes one medication, and declines all preventive health options, except the flu shot. She is upbeat, energetic, involved in the lives of her neighbors. She bristles at her protective, condescending niece.

I've known Ms. T for 16 years; I've met her landlord who is her healthcare proxy, have talked with her about her dying brother, and know a lot about her end-of-life preferences. How often do I need to see her? What is the value of our regular visits—on top of the every-once-in-a-while TSH check to prove she should remain on the same replacement dose? Should she have an annual visit? She doesn't want preventive measures. She doesn't have much in the way of medical problems. Her last visit was 6 months ago; at that time her TSH was normal. I suggested hearing aids. She is scheduled for a "check up" tomorrow morning.

The 51-year-old is a nurse manager, Ms. M. She has hypothyroidism as her only real medical problem and takes one medication. I've known her for about a decade and a half. Some years she sees me and some years

she doesn't, mostly depending on how busy her life is. I know about her kids, her ex-husband's tragic death, and her concern about living a long life to be there for her children. Ms. M. is completely up to date with her preventive measures and has had the flu shot, but she is scheduled to see me for an annual physical tomorrow.

Does either of these patients need a "check up" tomorrow? Well, it depends on what you mean by a check up.

SGIM has a love-hate relationship with the annual physical. In 2013, the Evidence Based Medicine Task Force (EBMTF) agreed to create five "Choosing Wisely" recommendations for the ABIMF Foundation (ABIMF). Choosing Wisely is an effort to control utilization. Launched in 2012, Choosing Wisely® aims to advance a national conversation about avoiding wasteful or unnecessary medical tests, treatments, and procedures. More than 70 medical societies have joined the movement and have identified things that "providers and patients should question"¹

The ABIMF required that the recommendations be highly structured—SGIM was to present them as negatives (things *not* to do) with a bolded sentence leading a very short initial paragraph. After a work group drafted the five recommendations, SGIM's council voted to approve, and the recommendations were published on the Choosing Wisely Web site. Four were very straightforward (don't use urinary catheters for provider or patient convenience; don't screen for cancer in patients who have short life expectancy; don't do pre-operative testing before low

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risk procedures, don't use finger stick monitoring in Type II diabetes).²

The fifth reads "**Don't perform routine general health checks for asymptomatic adults**" in the bolded first line. The fine print summarizes the available evidence that routine checks and screening (annual physical examination and blood tests) have not been shown to reduce mortality, morbidity, or hospitalizations, and that they may increase the potential for harm from unnecessary testing.

Although the evidence-based recommendation garnered substantial positive public attention, was lauded by Consumer Reports, and reported in the *NEJM*, the recommendation didn't sit well with a sizable group of SGIM's members.^{3,4} Then-President Eric Bass summarized initial reac-

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Caring for the Emerging Young Adult: The Role of the General Internist

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In daily clinical practice, general internists encounter an increasing number of young adults with chronic conditions originating in childhood. This population includes patients with a wide range of diagnoses—from cerebral palsy to congenital heart disease—who may have both physical and mental challenges. General internists are increasingly faced with trying to meet the unique health care needs of this diverse group of young adult patients. To do so, physicians and other health care professionals must develop the knowledge and skills required to provide high quality, developmentally appropriate health care to this population.

Each year, nearly half a million children with chronic conditions enter adulthood, and it is estimated that 20 percent of young adults in the United States have a chronic condition.¹ As children, these patients are often referred to as children or youth with special health care needs (CYSHCN). The U.S. Health Resources and Services Administration Maternal and Child Health Bureau (MCHB) defines CYSHCN as “children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require more than routine health and related services.”²

As these patients with childhood-onset conditions “age out” from pediatric practice, increasing attention has been paid to the importance of transition from pediatric to adult care. In 2002, the American Academy of Pediatrics (AAP), American Academy of Family Physicians

(AAFP), and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) released a consensus statement recognizing the need for improved transition services.³ In 2011, the AAP, AAFP, and ACP published guidelines on implementation of a successful medical home transition.¹ The Maternal and Child Health Bureau (MCHB)-funded Center for Health Care Transition Improvement (Got Transition) is a valuable resource for both pediatric and adult providers.

General internists play a critical role in the life trajectory of young adults with special health care needs by providing both primary and secondary preventive care as well as chronic disease management. Only recently has there been an increasing awareness of young adults with chronic conditions of childhood onset within the general internal medicine community. In March and April 2013, two special theme issues of the SGIM *Forum* focused on the transition and care of young adults with special health care needs.^{4,5} In September 2013, the Adults with Complex Conditions Originating in Childhood (ACCOC) Task Force was formed.

The goal of this task force is to improve the care of all adults with disabilities and complex conditions originating in childhood, with the following specifically stated objectives:

1. Increasing awareness and education of SGIM membership regarding issues related to the care of this high-risk population,

which faces well-established health care disparities;

2. Collaborating within SGIM to ensure issues related to this patient population are incorporated into ongoing SGIM initiatives in practice redesign, education, health care payment reform, and health policy;
3. Promoting needed research and scholarship in this area; and
4. Partnering with other organizations to increase SGIM’s role in national efforts to improve care and draw attention to the needs of these patients during their adult lives.⁶

With the support of members of Council and the SGIM staff, the task force has been actively involved in achieving these objectives through a range of endeavors. For example, members of the task force serve on the Got Transition Advisory Committee and the Health Care Transition Research Consortium. The task force has also partnered with the Kaiser Foundation and Physician Parent Caregivers in an effort to develop and promote a policy agenda that will positively impact this vulnerable patient population. Education on issues relevant to this diverse group of patients has been disseminated by the task force members to other members of SGIM through workshops, symposia, and poster presentations at both regional and national society meetings. These sessions and projects have focused on a broad scope of issues including, but not limited to, the clinical care of spe-

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Risk Adjustment in Medicare Advantage Plans

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Introduction

The rapid adoption of new payment models across the United States health care system presents profound challenges and opportunities for primary care. The success of this transformation requires highly committed, well informed, and engaged primary care providers that effectively embrace the underlying principles of population health. One opportunity for primary care providers to enhance their performance involves the accuracy of the risk adjustment that applies to their patients. Over the past 15 years, there has been rapid growth in the number of Americans enrolled in health plans that incorporate risk adjustment into their payment methodologies, including Medicare, Medicaid, state and federal Health Insurance Exchange products, and commercial health plans.¹ In addition, risk adjustment will play an important role in the quality and cost measures used by Medicare as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

This article focuses on the risk adjustment methodology used by Medicare Advantage (MA) plans, which are private insurance options offered under Medicare Part C. This is important for primary care providers for several reasons. First, enrollment in Medicare Advantage plans has tripled to 17.6 million beneficiaries from 2004 to 2016.² Approximately 31% of all Medicare beneficiaries are enrolled in one of these plans. These plans receive monthly, capitated, risk-adjusted payments from Medicare based on Hierarchical Condition Category (HCC) codes.³ These codes, which represent a select group of almost 9,000 ICD 10 diagnoses, estimate the likelihood of patients utilizing health care resources in the future.

The HCC codes are given different numerical weights, with higher values indicating greater illness complexity. These codes are also used to severity adjust CMS's quality and cost measures, making accurate risk adjustment a prerequisite for proper outcome measurement.

The majority of these HCC codes are submitted by primary care providers, and must be submitted once each calendar year, based on face-face encounters between patients and either physicians or a limited number of other care providers, such as nurse practitioners and physician assistants. The visits may occur in the outpatient office, the emergency department, or during an inpatient stay. Each HCC code must be supported by a specific diagnosis and its associated status and plan both clearly documented in the medical record. Several sources can be used to complete the proper clinical documentation for this coding model. These include hospital data (inpatient and outpatient services), diagnostic reports, as well as records from other medical services (physical therapy, occupational therapy and pathology).

Each Medicare beneficiary is assigned a total Risk Adjustment Factor (RAF) score that is comprised of a demographic RAF and an HCC RAF. The demographic RAF is based on age, gender, and a limited number of other factors, such as Medicaid enrollment and the presence of disability. The HCC RAF is the numerical sum of the individual RAF assigned to select acute and chronic medical conditions they experience. The total RAF from one year determines the payment made by Medicare during the subsequent year. Improvements in the accuracy of HCC coding can lead to large increases in HCC RAF scores that greatly influence reimbursement

and the accuracy of risk adjustment. The accompanying table demonstrates the significant impact of more specific and comprehensive coding on the total RAF, using a patient with type 2 diabetes mellitus and common comorbid disorders as an example.^{4,5,6} Prior experience indicates that certain disease categories represent more frequent opportunities to improve coding, including cardiovascular, pulmonary, endocrine, renal, hematologic, oncologic, nutritional, and behavioral health disorders.

A variety of approaches are used by payers and providers to improve their HCC coding. For example, health plans often hire intermediaries to analyze claims and clinical data in order to identify patients with significant coding opportunities and perform outreach to physicians to get them to submit the desired documentation. In some instances, payers are reaching out to patients directly, including arranging home visits to address potential coding opportunities. Medical groups can utilize information provided by payers or derived from their electronic medical records and practice management systems to identify coding opportunities. These can be converted into patient-specific coding alerts that offer guidance to physicians at the point of care. Some electronic medical records have embedded processes that facilitate accurate HCC coding. Provider groups have also hired personnel with expertise in coding to assist physicians and numerous companies offer coding services to assist practices in these efforts. Performance measures related to clinical documentation quality improvement can be used to measure and track improvements over time. Some payers and provider organizations pro-

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Substance Abuse and Mental Health Services Administration Rule on Confidentiality of Substance Use Disorders Patient Records

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Health Policy Research Subcommittee

One role of the SGIM's advocacy efforts in research and health policy involves closely following legislation and federal rules that impact SGIM researchers. In recent years, we have been following the Substance Abuse and Mental Health Services Administration (SAMHSA) rule about access to substance use data in Medicare and Medicaid files.

In 2013, the Centers for Medicare and Medicaid Services (CMS) began to withhold any claim with a substance use disorder diagnosis or related procedure code from Medicare or Medicaid research data sets in response to concerns about protection of patient privacy. This data suppression is estimated to affect about 4.5% of all inpatient Medicare claims and 8% of inpatient Medicaid claims, and it seriously impedes the ability of researchers to study care for millions of Americans with substance use disorders.¹ At a time when our country is facing a critical opioid crisis and attempting to improve care for individuals with mental illness and substance abuse, as well as hepatitis C and HIV/AIDS—which are associated with substance abuse—substantial concern has arisen regarding our ability to identify gaps in the actual care of these populations.

The original privacy regulations date back to 1975. These rules were written in a way that authorizes providers of care to disclose data on substance-use disorders for research purposes, but prohibits third party payers (including CMS) from doing so.¹ In 2013, SAMHSA required CMS to suppress substance use information to comply with the regulations.

This recommendation was surprising to many, especially as the law on which the original regulations were based stated that identifiable data on substance-use disorders “may be disclosed” even without patient consent “to qualified personnel for the purpose of conducting scientific research.” Since late 2013, Medicare and Medicaid claims data used for research have omitted any claim with a primary or secondary diagnosis code for substance use disorder.

In February 2016, responding to concerns about this change in policy, SAMHSA released a proposed rule for comment that would restore access to Medicare and Medicaid claims involving substance use disorder. The proposed rule would expand the definition of “providers” who may legally share these data with researchers to anyone who is a “lawful holder” of data, including third-party payers. This goes a long way toward addressing the problems, by restoring to CMS the authority to include identifiable substance use records in Medicare and Medicaid data and allowing private employers and insurers to do the same.

In April, members of the SGIM Health Policy Research Subcommittee (some of whom also participated in similar efforts by Academy Health) sent letters strongly supporting SAMHSA's proposed rule, while also making additional recommendations. Specifically, we commented on two aspects of the proposed rule that would benefit from more clarification. First, we shared concerns about the aspect that addressed data linking. Language of the proposed rule could be interpreted to suggest that *only* the federal government can imple-

ment linkages between datasets that contain substance abuse data. Our hope is that the intent of this part of the rule will enable both the federal government *and* other entities (with the proper data security) to create such linkages. It would be unnecessary, impractical, and costly for the federal government to do all data linkages. Many researchers have tremendous expertise with such linkage processes, and have been making these linkages safely and confidentially for years.

The second point involved data intermediaries. The proposed rule was somewhat unclear about what parties qualify as “lawful data holders.” There are a number of non-federal entities that are very important data intermediaries, including state entities that administer All-Payer Claims Datasets (APCDs) and private entities that hold and analyze data. Such non-federal entities are increasingly important sources of data for improving the quality and value of care provided to patients with substance abuse disorders. We believe that the regulation should clarify that non-federal entities could qualify as “lawful data holders.”

As this article goes to press, the final regulation has not been released. The SGIM Health Policy Research Subcommittee will continue to follow this issue closely with the hope that the rule will be revised to address these remaining concerns.

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An Unusual Case of Bleeding

Lauren Mechanic, MD, and Michele Fang, MD (discussant in italic)

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A 64-year-old man presents to his primary care physician for evaluation of prolonged bleeding and a rash. He states that his symptoms started approximately 5 days prior to this presentation; he noticed a small amount of bleeding after blowing his nose. In addition, he developed a hematoma after accidentally biting his lip. He also reports that a scratch on his face took approximately 1 hour to stop bleeding. The following day he noticed a rash that looked like pin-point red spots on his ankles that over the next 2-3 days spread to involve his lower legs and forearms, prompting him to seek care. He denies joint pain or swelling, melena, hematuria, or gingival bleeding with brushing his teeth. Additionally, he denies fevers, chest pain, dyspnea, rashes, or abdominal symptoms.

The clinical evaluation of bleeding involves a careful history as it reflects a disorder of hemostasis (involving platelet number and function, vascular integrity, coagulation factors, and fibrinolysis). Establishing an accurate history of bleeding can be difficult as there is great variability in patients' perceptions of bleeding given the lack of a uniform clinical measure of bleeding severity.¹ The patient's description of rash is characteristic of a petechial rash, characterized by hemorrhage of small capillaries. Petechiae characteristically develop in crops in areas of increased venous pressure. Thus, they are most dense on the feet and ankle and less on the legs (as in our patient). Petechiae are not palpable and are typically asymptomatic. Petechiae usually reflect disorders in platelet number and/or function.

In contrast, coagulation disorders typically manifest with large palpable ecchymoses and deep, soft tissue hematomas. Hemarthroses usually indicate a severe inherited coagulation disorder such as hemophilia. Thus, we are most likely deal-

ing with a case of low platelet count or low platelet function. Questions about liver disease and medications will be important as both can lead to thrombocytopenia.

His medical history is significant for Barrett's Esophagus, for which he undergoes regular endoscopies with radiofrequency ablation, and seasonal allergies. He drinks 1-2 glasses of wine nightly and does not smoke nor use illicit substances. His medications include esomeprazole twice daily, fluticasone nasal spray, cetirizine as needed for allergies, ibuprofen as needed, and a multivitamin. Three weeks prior to presentation, he started taking multiple supplements including fish oil, chlorella, resveratrol, alpha lipoic acid, 5-HTP, and turmeric to help with memory.

In addition to antiplatelet agents, NSAIDs, anticoagulants, medications (such as beta-lactam antibiotics), and selective serotonin reuptake inhibitors, many herbal medications can potentiate bleeding by inducing thrombocytopenia, platelet dysfunction, aplastic anemia, or induce or exacerbate a coagulation disorder. In the United States, 7.8% of adults take fish oil that has been linked to increased bleeding time and a reduction of ADP and platelet aggregation. Ibuprofen, a nonselective NSAID, has also been linked to increased risk of ulcers and GI bleeding.^{2,3}

The patient's physical exam is notable for the absence of conjunctival pallor and a normal cardiopulmonary exam. His abdominal exam is negative for hepatosplenomegaly. He has a small 1cm x 1cm hematoma on the lower lip in addition to a petechial rash on his lower legs and wrists. His neurologic exam is within normal limits.

To further investigate our hypothesis that the patient's petechial rash is concerning for a disorder of platelets, it will be important to get an accurate platelet count and peripheral smear. In addition, coagula-

tion factors, such as prothrombin time, bleeding time, and activated partial thromboplastin time, will be important to rule out coagulopathies. Liver function tests will also be important as chronic liver disease with splenomegaly can commonly also cause thrombocytopenia.

Initial laboratory studies show a white blood cell count of 8.6 THO/ μ L, hemoglobin of 14.5 g/dL, and a platelet count of 8 THO/ μ L. A comprehensive metabolic panel is normal. Coagulation studies are notable for INR of 1.1 and a PTT of 30.6 seconds. LDH is mildly elevated at 268 U/L with normal haptoglobin, D-dimer, and fibrinogen. The peripheral smear is notable for the absence of platelet clumping or schistocytes. Additional laboratory studies including HIV, EBV, CMV, and HCV are later found to be negative. Of note, the patient had a normal platelet count of 210 THO/ μ L 10 months prior to this presentation.

The differential diagnosis for isolated thrombocytopenia includes Idiopathic Thrombocytopenic Purpura (ITP), drug reaction and infection (HIV, HCV). We can rule out other causes, such as chronic liver disease with normal liver function tests. Additionally, other infections, including babesia or malaria, are less likely with normal hemoglobin, and factor deficiencies or inhibitors are unlikely in the presence of normal coagulation studies. Thrombotic thrombocytopenic Purpura (TTP) is unlikely in a patient with normal renal function, absence of anemia, and absence of schistocytes on peripheral smear. In this patient, the diagnosis of ITP is highly likely, but this is a diagnosis of exclusion.

In light of this history and laboratory data, the differential diagnosis is now either medication-related thrombocytopenia or ITP. The patient's supplements are discontinued and as a result 48 hours later his platelet count rises to 48 THO/ μ L. A follow-

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Tool Kit for High Value Care Coordination

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Ms. M. had waited 2 months for her appointment with Surgeon Z. regarding surgery for a newly diagnosed eye problem. However, as the surgeon perused her records for the first time after coming into the room, he abruptly commented “I do not perform that surgery; you will need to go to XXX Clinic to get that done.”

Mr. J. made an appointment for the endocrinologist as his PCP had asked him to do. After waiting 3 months for the appointment and taking the day off of work for the two-hour drive, the endocrinologist was upset that he did not know why he had been referred. She reported that she had received no records from his PCP before the appointment and that they had just called the PCP but the office was closed that day.

None of us relish this fragmented, disconnected care, but we do not have a widely disseminated system or established template of expectations to guide us in care coordination. (Nor were we trained in communication and care coordination.) The development of the Patient-Centered Medical Home model has done much to help improve care delivery within primary care practice, but without improved connections to the medical neighborhood, the medical home is just a better functioning silo of care.

In January 2013 the American College of Physicians High Value Care Coordination Work Group convened representatives from specialty and primary care organizations and clinicians (including a strong SGIM presence) to develop a High Value Care Coordination (HVCC) Tool Kit and corresponding training curriculum. This effort, enhanced by the participation of patient and family advocates, sought to optimize interdisciplinary communication within the medical neighborhood.

The resulting tool kit includes components designed to ensure a

high value referral request and consultant response. Beyond the requisite demographic information, the tool kit includes recommendations for a well formulated clinical question or a summary of the reason for referral along with adequate and pertinent data to support the referral and reduce duplication of testing and other efforts. The latter “Pertinent Data Sets (PDS)” were actually the main focus of the HVCC workgroup efforts, with each specialty society creating one or more such PDS around commonly referred conditions. The selection of what information is needed as preparation for referral for each condition was intended to allow the specialists to do the following:

1. determine if the referral is to the appropriate specialty;
2. triage the urgency of the referral (in essence, to risk stratify the referral needs); and
3. enable the specialist to do something at the first visit whenever possible.

These sets also indicate specific testing that is not necessary or even not recommended (with a link to Choosing Wisely guidelines) along with links to educational items for the patient regarding the referred condition and/or specialty and links to good resources on the condition for the referring physician.

Additional steps to ensure that the referral is patient-centered include: confirmation that the patient and/or their caregiver understands and agrees with the goal of the referral; provision of information to the specialty practice regarding any special needs or requirements for the patient such as visual, hearing or cognitive impairment; and provision of contact information for patients and their surrogates (such as e-mail address) to facilitate scheduling the

appointment and/or helping with pre-appointment forms.

Having the needed information in advance of the referral appointment allows the specialist/specialty practice to more appropriately tailor the consultation in order to meet the needs of the patient. This information also allows referring provider and consultant to evaluate the urgency for the referral and the role to be played by the specialist.

Referral needs can be triaged or “risk stratified” into urgent, subacute/intermediate or routine. This can be specified by the requesting practitioner, however review by the specialist or his/her representative can help ensure appropriate timing of the consultation. Pre-consultation review can serve to ensure that the referral is appropriate, and, if not, allow the referral to be redirected to a more suitable consultant. It can also help ensure that the supporting data is complete and if not, facilitate completion of recommended testing prior to the appointment. Pre-consultation review can open up the lines of communication and collaboration around the referral process, with the requesting clinician and specialist enabled to have an iterative exchange (such as “is this referral appropriate for your specialty?” or “what testing would you like done before the appointment?”). In some health care systems, well developed “virtual consults” or “e-consults” serve this function.

The type of referral determines the role of specialist. Depending on the practice, this can be determined by the referring provider, the consultant or a care management coordinator. A cognitive consultation provides advice around diagnosis and/or management and usually requires only one or two visits to the specialist. A procedural consultation provides assessment of the need for a diagnostic, therapeutic

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or palliative procedure and if needed, provision of the procedure.

Co-management of a condition or set of conditions can be *shared* by the specialist and primary care clinician, with the primary care clinician taking lead and “first call” but assisted by the specialist as needed. Alternatively, the specialist can provide care for a condition or set of conditions, taking first call around any related issues. The role of the specialist in meeting the needs of the patient is fluid, depending on changes in the condition and/or the patient. This allows for patients with stabilized conditions to be graduated out of specialty co-management and back to management by primary care, opening up specialty care for new patient referrals with greater needs.

Expectations for the consultant include a detailed answer to the clinical question addressing the reason for the referral, and including discussion of the specialist’s thought

process. Clarity should also be provided regarding the anticipated next steps for the specialist, the patient and the referring clinician including any recommended follow up.

These items, and more, can be agreed upon in a formal or informal care coordination agreement devised by the primary care practice and the specialty practices that they work with. A template of such an agreement is detailed in the online tool kit as well.

The medical neighborhood is built around a patient-centered model of care, with the primary care medical home providing the hub of care around the patient and specialty (and ancillary) care as an extension of care or helping with care when and as needed. Those referral needs can be better and more expeditiously met with appropriate information sharing, communication and collaboration connecting the care process for the patients.

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SGIM

MEDICAL EDUCATION: PART B

AMA and SGIM Partner in Creation of Online Learning Modules to Improve Workflow and Reduce Burnout

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Would you like to learn how to hold a daily huddle? Improve transitions of care? Advance Choosing Wisely in your organization? Implement health coaching? Integrate behavioral health into primary care? Listen more empathically? Measure and reduce burnout?

Created by the American Medical Association in conjunction with other societies and organizations, there are currently 44 *free* practice transformation tool kits at www.stepsforward.org that cover these topics.¹ Tool kits with practical, actionable guidance are available to help a practice tackle nitty-gritty details in areas such as improving workflow, supporting professional

well-being, improving patient care, and leading change.

The tool kits are approved for CME and also qualify as Improvement Activities (IA) within the new MACRA legislation. Many tool kits have quality improvement metrics built in, and, in 2017, will be approved for part IV maintenance of certification credit.

In order to make these “one-stop shopping” resources, the tool kits contain sample checklists, policies, teaching curricula, and calculators that allow you to enter practice variables and estimate how much time or money you may save with an innovation. We went around the country obtaining video of best

practices and included clips of the innovations in action in many of the tool kits.

Why is the AMA involved in improving professional satisfaction and practice sustainability with work such as the Steps Forward™ tool kits? Approximately five years ago all of the work at the AMA was reoriented around three strategic priorities:

1. Better health for patients;
2. Improved education for medical students; and
3. Thriving practices for physicians.

Many SGIM members may be familiar with the consortium of
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tions in two *Forum* columns, one of which was accompanied by Letters to the Editor.^{5,6,7,8} One letter, signed by 27 SGIM members, spoke of the value of relationship-building in regular visits, independent of improvements in morbidity and mortality:

“Time spent getting to know patients as human beings may not yield readily measurable improvements in disease outcome but is essential to the art of healing”.⁷ Many members felt that SGIM was holding the core of its interactions with our patients—to build relationships and develop regular opportunities to communicate about health—to an impossible standard of evidence for benefit. Based on old studies that often did not reflect modern practice, the evidence base for or against “general health checks” is of poor quality and those studies typically do not gauge harder-to-measure outcomes, such as trust, communication, and behavior. After a well-attended, passionate, and somewhat acrimonious town hall event at the Annual Meeting that year, the SGIM council voted not to rescind the recommendation.

Fast forward to 2016 (and, by the time of this publication, 2017). This year, SGIM is required to “update” our original five recommendations. The EBMTF updated the literature reviews, made a few improvements to the non-controversial four other recommendations, and tackled the white elephant in the room—general check ups. The EBMTF process has been very thoughtful, incorporated multiple rounds of revision, and included an e-mail to the entire membership soliciting input.

First, the EBMTF presented its new draft to the Executive Committee of Council: The officers gave feedback, and, as a result, a second version was presented to the full Council a few weeks later. More active discussion ensued. Marshall Chin, Immediate Past President, collected this second, extensive set of comments and summarized it for the EBMTF to consider. The EBMTF approached the ABIMF to ask whether the word count and other parts of the

required structure could be flexible. Then, yet a third draft was shared on GIM Connect in late September, inviting all SGIM members to reply to the post with comments. At least 18 members commented, and again the passion of our members about the importance of regular visits as opportunities for relationship-building with patients was palpable. Finally, the EBMTF incorporated the comments from GIM connect into one final version and presented it to Council for approval at our recent winter retreat.

Council approved the final version unanimously, and it has gone to the ABIMF for final approval. There is a chance that ABIMF will ask us to shorten the initial sentence and paragraph or make other edits, so I don't want to promise final wording; however, the bolded first sentence we submitted reads:

For asymptomatic adults without a chronic medical condition, mental health problem, or other health concern, don't routinely perform annual general health checks that include a comprehensive physical examination and lab testing. Adults should talk with a trusted doctor about how often they should be seen to maintain an effective doctor-patient relationship, attend to preventive care, and facilitate timely recognition of new problems.

I hope you will read the fine print of the entire recommendation when it becomes finalized and posted. Our Evidence-Based Medicine Task Force has worked hard to combine the reality of the evidence, the lack of evidence, and feedback from SGIM members. Reading the fine print is essential to understanding the nuances of the recommendation.

What will I do for Ms. T. and Ms. M.? For Ms. T., the 94-year-old with hypothyroidism, I'll assess her housing, social connections, cognition, fall risks, and reassess her end-of-life care preferences. I'll do a very limited physical examination—vital signs, mental status, and a get-up-and-go test. I'll check her TSH but no other blood work, unless directed by symptoms

and signs. For Ms. T., I am abiding by the Choosing Wisely recommendation—I'm not doing an annual general health check with lab tests. And I do always discuss with her when she should come to see me next. I err on the side of suggesting regular visits despite any medical problems besides hypothyroidism. I can't measure the value of those regular visits nor really support them based on her medical history, but I do believe that they have value to her health *and* to my own satisfaction as her doctor.

For Ms. M., the 51-year-old with hypothyroidism, I probably won't be strictly abiding by the recommendation. She is due for cervical cancer screening, so I'll have her get fully undressed and do a pretty complete physical examination. She does need a pap smear, but doesn't really need me to feel her lymph nodes or listen to her heart and lungs (assuming she is asymptomatic). I'll order her TSH but also cholesterol and glucose tests (when she doesn't strictly meet criteria for screening for diabetes) since I'm drawing blood. But, at the end of the visit, when it's time to decide when her next appointment should be, I'll engage her in the conversation and tell her that I don't know the right answer—but that probably she doesn't need this all over again in just one year.

I'll keep trying to Choose Most Wisely, just like SGIM's EBMTF.

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ANNUAL MEETING UPDATE

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of care and increased efficiency at her institution and revolutionized the way we talk about the value and cost of medical care.

This year we are piloting a new format for Clinical Updates: SGIM-MED Talks. These sessions will feature two or three 15-minute TED-style talks on topics of interest—including diabetes and wellness promotion—to our members and meeting attendees. In these sessions, each of the dynamic speakers will combine evidence and experience into a thoughtful discussion of one aspect of the session topic. Our goal for this new format is to deliver impactful information in concise, engaging bursts.

The Saturday morning Armchair Discussion format that began in 2016 will continue with “Tales from the Trenches: Housing and Health.” We

invited Washington-based national gurus, Tom O’Toole and Erika Poethig, to speak on efforts to increase housing security as a social determinant of health. On the more personal, but evidence-based front, Dr. Aviad Haramati will later discuss the physiology of stress and how meditation can mediate those changes.

My own burnout prevention efforts continue as I engage in music, exercise, and mindfulness. Since “connectedness” is a powerful mediator of wellness and career satisfaction, lunch times will be kept open for networking. Several innovative wellness activities and a “Celebrating Our Humanities” session are being developed—stay tuned for updates!

The SGIM annual meeting is always an inspiring occasion to learn and enhance our effectiveness as

leaders, teachers, and advocates for GIM; celebrate our diversity and our united mission; and network with colleagues.

We are honored to lead the program committee, which is working tirelessly on enhancements to the annual meeting. We anticipate it will be an inspiring event for all who attend. Register now for SGIM 2017 at <http://connect.sгим.org/sgim17/register>.

We look forward to seeing you in April in Washington, DC!

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changes, who have the most to lose if the ACA is repealed.” Dr. Mannik Chhabra, a Robert Wood Johnson (RWJ) Clinical Scholar at the University of Pennsylvania, echoes these sentiments with “The policy changes that are being proposed are going to hit certain patients the hardest. Those with an already tenuous social and financial safety net will not be able to sustain the changes ahead.”

As we look to the future, many of us struggle with the same questions: What now for our patients? For primary care? For health services research? What will happen to the Veterans Administration (VA), the Agency for Healthcare Research and Quality (AHRQ), and the Center for Medicare and Medicaid Innovation (CMMI)?

Over the past few months, our members, notably many trainees, have already begun to address these issues. Drs. Jane Zhu, Manik Chhabra, and Navin Vij—all RWJ Scholars at the University of Pennsylvania and SGIM members—launched the Clinician Action Network (CAN) that intends “to challenge proposed

policies that hurt our patients, to defend good ones, and to motivate other clinicians to step into vocal, public advocacy roles on behalf of their patients.”³ Dr. Zhu emphasizes the profound impact that physicians can have in that “We have a unique voice. CAN encourages physicians to use these voices when they are outside of the exam room or hospital.” In December, CAN launched a national “Speak Up” campaign that aims to publish physician-written commentaries on how an ACA repeal would affect patients and the profession in local and regional newspapers across the country.

In addition to CAN, several other physician groups that focus on advocating for vulnerable populations are intensifying their efforts in the post-election period. One example is the New York City Coalition to Dismantle Racism in the Health System (NYC-DRHS), founded by Kamini Doobay, a fourth-year medical student at the Icahn Mount Sinai School of Medicine. The organization is a multidisciplinary collaboration among the medical and public health communi-

ties and community-based organizations that seeks to address structural health inequities in the United States.

As social media outlets played an unprecedented role in the 2016 election, they are also having a profound impact in shaping post-election advocacy efforts by young physicians. Similar to Occupy Wall Street and #Black Lives Matter movements, millennial physicians have taken to social media platforms to start discussions and inspire action.⁴ Facebook groups, such as Progressive Doctors, with nearly 3,500 members, blogs, tool kits, including the “UCSF Advocacy for the ACA,” online petitions, and phone banking, are effective avenues for young physicians to engage in a number of grass-root advocacy efforts.⁵

Certain physician-provider groups have come together to publish online petitions and letters that opposed Dr. Price’s nomination and its endorsement by the American Medical Association’s (AMA).⁶ To date, the organizations that have spoken out include the following:

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- CAN, which published “The AMA Does Not Speak for Us”;
- National Physicians Alliance (NPA);
- Doctors for America;
- Physicians for Reproductive Health; and
- American Medical Student Association (AMSA).

In addition to organizing petitions, many of these organizations send members weekly “Action items” scripts before important votes or legislative hearings that explain how to call members of Congress. In the future, SGIM might consider this strategy to update the members in events and engage them in advocacy efforts.

Physicians are becoming increasingly involved with policy debates at the national level, a development welcomed—and often spearheaded—by millennial doctors. Jamie Jarmul, an MD/PhD student from the University of North Carolina at Chapel Hill, states that “Advocacy from the medical community, especially the primary care community—whether that is practicing clinicians, educators, health services researchers or trainees—is going to be imperative in the coming years.”

Yet, as many millennial medical students and young physicians recognize, undergraduate and graduate medical education programs have only just started to integrate health policy curriculum and advocacy training.⁷ While some practicing physicians feel comfortable with advocacy, the majority do not. In fact, most physicians have not had formalized career development in this domain.⁸ SGIM understands this and has launched a new year-long course called Leadership in Health Policy (LEAHP), which is the first national health policy career development program. Led by Dr. Thomas Staiger and Dr. Mark D. Schwartz, LEAHP teaches SGIM members to become effective and active health policy advocates, local health policy experts, leaders, and teachers.

In addition to LEAHP, SGIM’s Health Policy Committee is another outlet for physician-led advocacy.

“The HPC has provided a number of opportunities during tumultuous times in healthcare,” says Dr. Tyler Winkelman, a RWJ Clinical Scholar at the University of Michigan. “The policy committee receives frequent updates about important policy proposals and signed legislation at the federal level, so I feel up-to-date on important issues that affect my patients. I’ve also been able to learn effective advocacy strategies and how to navigate complex coalitions from seasoned policy-minded physicians.”

Beyond advocating for an equitable healthcare system, CRD Associates (the HPC and the SGIM’s lobbying firm) is committed to advocating for increased funding to the highest level attainable for the National Institutes of Health (NIH), the Patient-Centered Outcomes Research Institute (PCORI), AHRQ, and Medical Services and Medical Prosthetic Research at the VA. Other organizations, like Academy Health, are also working toward these goals. This funding is critical to advance patient care and health services research.

Due to recent events, we are currently facing an unprecedented level of uncertainty in our field, but we cannot compromise our commitment to and pursuit of high quality, evidence-based care for all patients. SGIM is more than a community of academic general internists who take care of patients. We also teach and conduct research—and we advocate for health equity and social justice. Now, more than ever, we must work together to advance our common values.

Our patients rely on us.

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BEST PRACTICES

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cific conditions, sexual and reproductive health of young adults with chronic health conditions, social and psychological considerations, resources available to assist the adult provider in caring for this patient population, and research identifying potential gaps in educational curricula among trainees in internal medicine programs. Additionally, a Speaker's Bureau has been created to promote (both internally and externally) SGIM members as expert speakers on the topic of the emerging adult and caring for adults with complex conditions originating in childhood. Similarly, the task force website is being modified to serve as a resource for adult medical providers. Finally, two significant collaborations highlight the work being done by the task force to inform and educate adult providers about the importance of being able to provide comprehensive, developmentally appropriate care to this rapidly growing patient population.

First, the ACCOC task force has collaborated with the ACP Council of Subspecialties, Got Transition, and the Society of Adolescent Health and Medicine (SAHM) to lead a project involving more than 25 medical societies and organizations (including most of the internal medicine subspecialty organizations that are members of the ACP's Council of Subspecialties, the AAP, the AAFP, and other interested groups) to expand the ACP's High Value Care Initiative in order to include tools to improve the care of Young Adults with Chronic Conditions. The goals of the project were as follows:

1. Adopt and utilize a tested standardized approach to transitions for all youth moving from pediatric to adult care in both primary care and subspecialty practices;
2. Customize the tools from Got Transition's Six Core Elements to facilitate the implementation of an improved transition experience for young adults with specific

chronic conditions; and

3. Create a process to effectively disseminate the use of this approach among clinical practices.

The tools and results of this collaboration are available for all to use online.⁷

In December 2016, *Care of Adults with Chronic Childhood Conditions: A Practical Guide* was published.⁸ This book was the result of a joint effort between the SGIM ACCOC Task Force and Springer Publishing. It is the *first* published guide on the care of this population intended for adult health care providers, both the generalist and the specialist. The book serves as a timely reference that provides a new framework for thinking about the approach to caring for these young adults and identifying opportunities for positively impacting their health outcomes. The book is divided into five parts:

1. A detailed overview of the health care transition from pediatric to adult medicine;
2. An approach to emerging adulthood and how to provide comprehensive care for this population;
3. Condition-specific chapters for 16 commonly encountered childhood conditions including a case discussion and a chronic condition fact sheet for quick reference;
4. Additional clinical considerations including enteral feeding, respiratory support, and palliative care; and
5. A discussion of important socio-legal issues that arise when caring for adults with childhood conditions.

It is the hope of the ACCOC Task Force that these on-going efforts will enable adult providers to accept and embrace these young adults with chronic conditions originating in childhood and other special health care needs into their care.

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| NON-SPECIFIC CODING | | SPECIFIC CODING | |
|---|--------------|---|--------------|
| ICD 10 Code | RAF* | ICD 10 Code | RAF* |
| Demographic RAF | 0.395 | Demographic RAF | 0.395 |
| E11.9: Type 2 diabetes mellitus without complications | 0.104 | E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease | 0.318 |
| N18.9 Chronic kidney disease, unspecified | 0.000 | N18.4: Chronic kidney disease, stage 4 | 0.237 |
| E66.9: Obesity unspecified | 0.000 | E66.01: Morbid Obesity | 0.273 |
| F32.8: Other depressive episodes | 0.000 | F32.1: Major depressive illness, single episode, moderately severe | 0.395 |
| I25.9 Chronic ischemic heart disease, unspecified | 0.000 | I25.119: Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris | 0.140 |
| Total | 0.499 | Total | 1.758 |
| <i>**Payment Year 2017, Average Total RAF FFS Medicare is 1.000</i> | | | |

vide financial incentives for physicians to submit the more appropriately specific documentation.

Efforts to improve the accuracy of HCC coding and risk adjustment have several potential advantages, including the following:

- an enhancement in the engagement of providers to build comprehensive patient profiles and maintain accurate problem lists;
- an increased physician understanding of risk levels within their medical panels;
- a reduction of diagnostic gaps; and
- an encouragement of regular visits by patients to the medical practice.

These risks scores can identify patients who would benefit from more intensive care management interventions, allowing organizations to proactively plan and deploy the practice resources across different practice sites. More accurate risk adjustment allows medical groups to highlight the quality care they provide and identify opportunities to further improve the services they deliver.

However, on the downside, to improve the specificity and comprehensiveness of coding present challenges for primary care physicians. Identifying the correct code and providing the appropriate documentation requires focused effort by

physicians who may already be beleaguered by other clinical and administrative demands. At times, it may be difficult for primary care physicians to code at the desired degree of specificity, particularly when specialists do not share the same medical record or important elements of care are delivered at other institutions. To avoid creating and perpetuating inaccuracies in the medical record, physicians must only code to the level of specificity that is supported by the available clinical data.

It is important to recognize that primary care providers traditionally have not received sufficient training in past or current health care payment systems. The consequence of this educational gap is that many primary care providers have a limited understanding of coding guidelines and the restrictions placed upon the billing personnel reviewing their medical records. This lack of focus on payment systems and coding creates a significant degree of reluctance among some primary care providers to engage in efforts to improve risk assessment.

Submitting HCC codes with higher value that are not medically appropriate or supported by required clinical documentation violates coding rules and may be considered upcoding. CMS performs Risk Adjustment Data Validation (RADV) audits to confirm the accuracy of coding and to detect fraudulent behavior. The risk scores of patients en-

rolled in Medicare Advantage plans has been estimated to be 6.4% higher than those in traditional Medicare.¹ This likely reflects providers attempting to document more accurately so their risk scores accurately reflect the medical complexity of their patients. Some have viewed this difference as unwarranted upcoding.¹

Conclusion

Primary care physicians are uniquely positioned to drive improvements in risk adjustment. This is a required core competency as our health systems transform and adopt value based payment models. Efforts to educate PCPs about HCC coding and the risk adjustment methods used by other payers should be prioritized and clinicians encouraged to develop improved approaches to accurately capture relevant data using processes that improve care and mitigate bureaucratic busy work. This content should be included in the population health curriculum for medical residents, so they leave residency with the necessary knowledge and experience. Current information technology, data analytic tools, and employees with expertise in risk adjustment must be deployed to assist practices in their efforts to enhance the accuracy of clinical documentation and coding. Engaged and knowledgeable primary care physicians will augment the integrity of the medical

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record and improve the accuracy of risk adjustment leading to more appropriate severity-adjusted reimbursement, more accurate performance results on quality and cost, and more effective outreach to high risk patients who will benefit from more intensive disease management approaches.

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medical schools that is working to create the medical school of the future. Others may be aware of the partnership between the AMA, Johns Hopkins, and the CDC to improve care for patients with hypertension and pre-diabetes.

For the last two years, I have worked in the third strategic focus area as vice president of Professional Satisfaction (my husband calls me the “Veep of Joy”) with a mission to improve the health and well-being of patients by improving the health and well-being of physicians and their practices. The Steps Forward™ tool kits are one product of this work. In addition, we are working with the regulatory community, such as The Joint Commission and CMS, to debunk urban myths and reduce regulatory pain points.

We have also collaborated with the Rand Corporation and Dartmouth on research initiatives related to professional satisfaction. The Rand study looked at drivers of physician career satisfaction and dissatisfaction.² We learned that time spent on EHRs and away from patients was a major driver of professional dissatisfaction. In a follow-up with Dartmouth, we performed a

time-motion study and found that fully half of a physician’s workday is spent on EHR and deskwork.³ Additionally, for every one hour of direct clinical face time with patients, a physician must spend nearly an additional two hours on EHR and deskwork.

As part of this investigation, we recently held a “Joy in Medicine Research Summit” that brought together 35 researchers from the United States, Canada, and Europe to outline a research agenda. The next day we brought together CEOs from 12 of the largest institutions in the country to elevate awareness and action around the critical issue of physician burnout.

Mark Linzer’s work demonstrates that one of the most effective ways to reduce physician burnout is to improve workflow.⁴ I invite you to take a look at the Steps Forward™ practice transformation tool kits, designed to improve workflow, build greater mastery of our craft, and create room for joy in practice. I also invite you to give feedback—what’s working, what’s missing, and how can we make these better.

Ours is such a wonderful profession, inherent with joy, purpose, and

meaning. With more than half of U.S. physicians exhibiting signs of burnout, I believe we have an enormous opportunity to be forces for good, by reengineering the way we do our work, eliminating waste when possible, empowering teams when appropriate, and creating the conditions where physicians can spend the majority of their days doing the work for which we are uniquely trained. This will be a win for the patients, for care teams, and for physicians.

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up CBC obtained one week after discharge is notable for a platelet count of 301 THO/ μ L.

This case highlights the importance of performing a thorough medication reconciliation, including not only prescription medications but also over-the-counter and herbal medications. There are more than 120 conventionally used pharmaceuticals that are directly derived from plant species.² More than 12% of adults in the United States reported taking herbal medications in a 1997 national telephone survey of complementary and alternative medicine.³ Herbal supplement use has increased over the years leading to the creation of the National Institutes of Health (NIH) Office of Alternative Medicine (OAM) in 1992, the NIH Office of Dietary Supplements in 1994, and the National Center for Complementary and Integrative Health (NCCIH) in 1998. In 2007, the

FDA issued new rules requiring Good Manufacturing Practices (GMPs) for dietary supplements that require supplements to be properly labeled, free of adulterants, and manufactured to specified standards for personnel and equipment.⁴ Makers of dietary supplements are not, however, required to prove efficacy, safety, or quality prior to marketing and manufacturers are not obliged to report post-marketing adverse events to the FDA.

In conclusion, here are two important points to keep in mind:

1. A thorough medication history, especially the inclusion of herbal supplements and over-the-counter drugs is important—this includes dosage, timing of administration, and type of medication; and
2. In contrast to coagulopathies, drug-induced thrombocytopenia

can present with petechiae with little overt bleeding.

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