

FROM THE SOCIETY

## Taking a Risk to Lead

Eric B. Bass, MD, MPH, FACP



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**A**fter working at the Johns Hopkins University for 30 years, I've learned how to thrive in a stressful but stimulating academic environment. Why take the risk of making a big change in my career now? The answer is that I felt called to serve the organization that supported and inspired my career development, dating back to the 1987 meeting of SGIM's predecessor, the Society for Research and Education in Primary Care Internal Medicine. I was also looking for a new challenge. As Tom Staiger, chair of SGIM's Health Policy Committee, put it when he saw the announcement that mentioned my experience as a scoutmaster, "I was pleased to see you have the leadership expertise in keeping adolescent boys from injuring themselves in risky environments, ...those leadership skills could be generalizable to other high-risk situations."

On September 11, 2017, I became SGIM's first physician Chief Executive Officer (CEO). I'm extremely excited about this extraordinary opportunity. I am honored to serve an organization that has a noble mission and its amazing members who share a passionate commitment to their core values. Those values are more important than ever in a healthcare environment full of risks to patients and vulnerable populations.

In this position, I have 4 major priorities:

1. Strengthen SGIM's relationships with other organizations in order to enhance our voice and influence;
2. Revamp SGIM's financial development activities to bring in more support for our ambitious agenda, while continuing to respect SGIM's ethical standards;
3. Modernize communication within the organization and with external entities to enhance effectiveness and efficiency; and

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## Saving the World

Joseph Conigliaro, MD, MPH

Editor in Chief, SGIM Forum

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The great thing about being general internists is that we can adopt, advocate, or study almost anything that affects health and health care. We have been among the leaders in advocating and addressing problems not directly linked to the delivery of medical care to adults, such as studying and addressing social determinants of health, health care reform, gun control, and climate change. Generalists are philosophically well suited to tackle these issues. Many of these causes are often orphaned by others as they do not fit into the prevailing model of specialized care. They are broad in nature and more often indirectly affect health and health care so anyone or no one can be concerned about it. If anyone can do it, then often no one does. So is the case for climate change.

On August 21, 2017, many in the United States witnessed a full solar eclipse. The event was anticipated for some time, with the media counting down to the last minute before the eclipse took place all over the world. In ancient times, when eclipses were not well understood, they were met with dread and superstition by humankind. Through scientific study over the centuries,

eclipses are now celebrated with awe and turned into media events. They show us the immensity and power of the universe and the world in which we live. The thorough understanding and the predictability of an event like an eclipse is so mundane as to have become one of the routine contributions of science.

Since early September, Eastern Texas, the Caribbean, Florida, and Puerto Rico have been hit by three devastatingly powerful hurricanes: Harvey, Irma, and Maria. Science and technology helped us track and prepare the areas where they eventually made landfall. As we look at the devastation of these storms, it's important to note that over the last 40 years many in the scientific community have articulated a strong argument that humankind, through rising CO<sub>2</sub> concentrations, has had a profound influence on climate, the environment, and weather. Yet despite the evidence, there continues to be skepticism and too few policy efforts to enact climate change.

A recent report<sup>1</sup> by scientists from 13 federal agencies concluded that there is likely a link from climate change to existing weather patterns, droughts, and the environment. As of the writing of this column in September, this report, released in June 2017, had not been addressed by the current administration in Washington, DC. It still remains unclear how the report will affect any climate change policy.<sup>2</sup>

Unfortunately, the administration's previous approach to science and the scientific community has been to question data that might lead to further regulation. This issue of *Forum* includes a report by Dr. Elizabeth Gillespie on the convening of a group of likeminded physicians who are creating a voice within the medical community to speak out on the health effects of climate change. In

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## Exciting Transition, Communication Challenges

Thomas H. Gallagher, MD, President, SGIM

Communications is the way members can connect with each other, and is the mechanism by which critical information can flow between Council, Committees/Task Forces/Interest Groups, and membership. Communications is also how the Society relates to those outside the organization, be it individuals who are curious about the Society and what we do or large external entities with whom SGIM seeks to partner.



SGIM faces a time of unprecedented opportunity and challenges. As our membership grows, so do our aspirations for the organization. Two executive directors, Elnora Rhodes and David Karlson, guided SGIM for virtually all of its existence. After careful deliberation, Council decided that the surest path to take SGIM to the next level was hiring Dr. Eric Bass, a physician-CEO, who began his tenure as SGIM's CEO in early September. This month's column will discuss why Council made this major shift in our staff structure, why we chose Eric to be our CEO, and touch briefly on one of the primary domains we have asked Eric to focus on: communication.

Our movement towards a physician CEO began in earnest with a report released in June 2014 by our Ad Hoc Executive Director Search committee (AHEDS), a group chaired by Barbara Turner. Assembled in anticipation of David Karlson's retirement, AHEDS conducted a wide-ranging environmental scan examining how other voluntary medical membership societies were organized as well as conducting a host of stakeholder interviews. While acknowledging that effective senior staff leaders can come from a variety of backgrounds, the report noted the potential advantages of having a physician in the role of senior executive. The fact that SGIM seeks to have a major influence on academic medicine and

healthcare delivery, while a relatively small organization, suggests that close partnerships with other stakeholders is key to accomplishing this vision. And having a physician as the senior staff leader for SGIM was thought to possibly give SGIM a more influential seat at the table. After careful deliberation, Council approved a model in which a half-time physician CEO would partner with a full-time deputy CEO in the leadership of the Society's staff, and created a search committee to identify the ideal physician-CEO.

The search process was extensive, and I was thrilled when Dr. Eric Bass accepted our offer to become SGIM's first physician-CEO. In his application cover letter, Eric noted that this was a *"Fabulous opportunity to serve the amazingly talented and dedicated members of SGIM...I cherish the values of SGIM...the organization that has always been my professional home"*. One of Eric's references noted, *"Eric's quiet determination has made him an exceptional leader. He is a top-notch communicator and leader, and will work well with stakeholders (they will love him) over his tenure. (He) wins people over with his thorough and thoughtful approach, and by doing things well."* Eric provides some details of his vision in his companion article in this issue of the *Forum*. We were equally thrilled when Kay Ovington, on whose shoul-

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ders and selfless dedication SGIM's success over the last several years has largely rested, agreed to serve as Deputy CEO. I anticipate Eric and Kay will make a superb team, guiding the staff to support SGIM in achieving our lofty ambitions.

Eric's job description has four key elements, as he outlined in his column: 1) Stakeholder engagement, 2) Development; 3) Strengthening and supporting our staff; and 4) Enhancing communication, both internally and externally. While each is critical, the area that would be most visible to the membership is communications. Communications is the way that members can connect with each other, and is the mechanism by

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## Proposing a Climate Action Plan for General Internal Medicine

Beth Gillespie, MD

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This January, I was selected by SGIM's Health Policy Committee to serve on the steering committee for the Medical Society Consortium on Climate and Health. I am grateful for this opportunity to inform SGIM as well as the general public about the health effects of climate change and the benefits of prioritizing clean air and energy practices.

Our nation has recently witnessed the costly effects of extreme weather, which is one of the many health effects of human-driven global warming, along with emerging vector-borne diseases, food and water-borne disease, air pollution, food security, extreme temperatures, drought, as well as mental health disorders. Tropical storms Harvey and Irma together tally 126 deaths at the time of this edition September 19<sup>1,2</sup>, and the flooding has displaced whole communities from their physical homes, medical homes, and regular medication. Hurricane Harvey alone has projected economic costs of anywhere from \$70-90 billion<sup>3</sup> to \$190 billion<sup>4</sup>, depending on the analysis. Conservative estimates account for direct costs of wind, storm surge, and inland flooding, while the higher range considers "total negative impact to the economy", according to J Myers of Accuweather<sup>4</sup>. As is true with most instances of extreme weather, the recent hurricanes have adversely impacted a disproportionate number of people with low socioeconomic status: people in poverty, the homeless, the elderly and disabled, and those with chronic medical conditions.

Climate science is complex, with interrelated waves of cause and effect that are oftentimes politicized and negated in our society. That being said, 99% of climate scientists internationally believe climate change is real. Health effects of our changing

climate can be devastating. Since the majority of these effects are known to be human-caused, we as physician leaders have great potential to lead by example in our lifestyle, education, and advocacy efforts. By prioritizing clean air and energy practices, we can help reduce projected global temperature and sea level rise, and therefore improve health outcomes for ourselves, for our families, for our patients and for future generations.

As SGIM's representative, I want to update fellow members on the Consortium's launch in March, propose several action items for moving forward, and encourage members to join the Environmental Health Interest Group.

### The Consortium's Launch

In March 2017 in Washington, DC, the Medical Society Consortium for Climate and Health launched its first press release with its first report: *Medical Alert! Climate Change is Harming Our Health*. This was the culmination of months of research and outreach by Consortium Program Director and Founder Dr. Mona Sarfaty and her staff at George Mason's Center for Climate Communications. The event began with an informative six-hour meeting among steering committee members from the following medical societies: American Academy of Asthma, Allergy, and Immunology, American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), American College of Preventative Medicine, American Podiatric Medical Association, and National Medical Association (NMA). We brainstormed about how to engage respective society members; heard from a lobbyist

and former self-proclaimed "climate-denier" on how to frame climate adaptation and mitigation messages to more conservative lawmakers; and learned how other major stakeholders are tackling climate change within their organizations, which included the American Lung Association, the American Public Health Association (which has named 2017 the "Year of Action on Health and Climate"), the Ohio Clinicians for Climate Action, and Healthcare Without Harm.

The following day, a group of other steering committee members, society leaders, and affiliate organizations (e.g., APHA and Kaiser Permanente Total Health) assembled for a live press conference hosted in the Washington, DC, office of the Kaiser Permanente Center for Total Health. Dr. Sarfaty headed the panel, which also included two medical society presidents—Dr. Gellhaus of ACOG and Dr. Dahmle of ACP, Dr. Patz from UW Madison Global Health Institute, a pediatrician, an internist, and a representative from a parents' organization on climate justice. After a brief Q and A session, the Steering Committee walked to the Capitol to disseminate copies of the *Medical Alert* to members of Congress. I visited a staffer for Senator Michael Bennett (D-CO), who has demonstrated a favorable voting record toward clean air and energy issues throughout his seven years in office.

The public launch of the Consortium in March was well attended, both in-person and virtually via wide news coverage of the event. Some main news outlets covering the event included CBS, NBC, *USA Today*, and *Voice of America*. It was also widely covered by medical media outlets such as *AMA Morning Rounds*, the *AAP Smart Brief*, *AAP*

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# An Advocacy Guide for Government Employees: Understanding Federal and State Ethics Rules

Amy Baughman, MD

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Physician advocacy is essential to improve patient care, protect essential funding for research and public programs, and maintain our medical profession. SGIM encourages all members to participate in advocacy efforts.

Many medical centers across the nation are affiliated with public organizations, such as state universities and government organizations like the Veterans Association (VA). The VA is the largest healthcare system in the United States and employs approximately 25,000 physicians. According to a 2014 membership survey, 11% of SGIM members report affiliation with VA medical centers. As executive branch employees of the federal government, VA physicians have special regulations for how to engage in advocacy work. Physician employees of public universities also have specific restrictions based on local state regulations.

Clinicians who have chosen to work for a federal or state entity have volunteered for more responsibilities to the public and consequently have more restrictions. Understanding the rules of engagement for advocacy work, in particular for these federal and state government employees, can be challenging. This article addresses common questions and concerns for government employees interested in participating in advocacy efforts.

## 1) Can I participate in Lobby Day or SGIM Hill Day activities?

Yes, you can, and we encourage you to attend SGIM Hill Day in Washington, DC on March 14, 2018! Federal and state employees still have a constitutional right to lobby and do advocacy work, but only in their personal capacity. In addition, there are important restrictions for federal employees:

- You cannot use federal time or resources; e.g. you cannot engage in activities on your tour of duty or using federal property such as your work computer, e-mail servers, copiers, fax machines, telephones, and Internet.
- You cannot use your federal title or position to represent you or your organization's viewpoint in conversation or written communication. You do not need to conceal this information; however, if your federal employment comes up in conversation, you must provide a disclaimer, e.g. "While I work at the VA, I am here today representing my own personal view and in no way represent the views of the VA or federal government."
- You cannot wear your federal government uniform or white coat.
- You cannot give out your federal government business card (even if you have paid for it yourself) or use your government work e-mail to communicate with legislative staff.

Doing any of the above items is considered using your federal official position to endorse an outside non-government activity, and this is against the law! [*Standards of Ethical Conduct for Employees*, 5 C.F.R § 2635.702(b) and (c)].

## 2) Can I write an op-ed or public opinion piece in the media or public press as a government employee?

Yes, you may write op-eds or publish opinion pieces in the media. However, you cannot mention that you work for the VA or federal government in the body of the text. Regarding your signature, you cannot

include your federal employment if you are only allowed to include one identifier. However, if you can include several identifiers, then you may include your official federal title or position so long as it is given no more prominence than any other identifiers. You should also include a disclaimer stating that the views expressed do not necessarily represent the views of the VA or the United States government. It is recommended that you contact your local Federal Ethics Officials to review before publication. [*Standards of Ethical Conduct for Employees*, 5 C.F.R § 2635.807(b)(2), and 5 C.F.R § 2635.807(b)(1)]

## 3) Can I advocate on an issue directly with a Federal Agency, (e.g., could I advocate for reallocation of Medicaid funding to the Centers for Medicare and Medicaid Services [CMMS])?

You may advocate only as an individual with your opinions, on your own behalf, as a federal employee to a federal agency such as CMMS or a federal court. You may not advocate to a federal agency while representing a third party, such as a person (including patients) or organization (such as SGIM). Thus, if you work for the VA, you would not be able to advocate to CMMS on behalf of SGIM for reallocation of Medicaid funding. This is an important law to understand because it is a criminal statute which means violation can result in criminal prosecution. [18 U.S.C §§ 203 and 205]

## 4) Can I participate in a political campaign as a government employee?

Yes, you mostly likely can, but there are several specific rules that you should understand beforehand. To ensure that the federal workforce is free from partisan polit-

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## Description and Patient Perspectives of the UPMC Enhanced Care Program for Super Utilizers

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**F**ive percent of patients use over 50% of healthcare dollars.<sup>1</sup> Termed *super utilizers*, these patients receive lower quality of care despite frequent visits to the emergency department (ED) and admissions to the hospital.<sup>2</sup> Super utilizers have difficulty navigating the healthcare system and suffer from untreated mental illness, financial difficulties, and comorbid medical illnesses.<sup>3,4</sup>

In July 2014, the University of Pittsburgh Medical Center Health Plan (UPMC HP) and UPMC General Internal Medicine practice in Oakland (GIMO) partnered to create the Enhanced Care Program (ECP) to address the needs of super utilizers. The goals of the program are to provide high-quality care and decrease health care utilization. Patients are asked to join the program if they have gone to the ED five times or more over the past year. Each patient has an initial interview where they share their story, with an emphasis on the barriers to wellness they have encountered. Many have faced significant physical and emotional trauma. Others struggle with access to care because of poverty, lack of social support, or low health literacy. Following the initial interview, a plan

for wellness is developed to address the full spectrum of physical, mental, financial, vocational, environmental, and spiritual health.

ECP's approach is based on Maslow's hierarchy of needs, and seeks to address the social determinants of health first so a patient can then work on managing other aspects of his wellness.<sup>5</sup> A medical doctor, nurse care manager, and social worker become the patient's "team" to help guide him to achieve individualized goals for wellness. Patients can call their team 24/7, make same-day appointments, and receive home visits. Prepackaged, home-delivered medications help ECP patients follow prescribing recommendations and provide a mechanism for monitoring adherence. The ECP team meets daily to discuss relevant events and patient needs over the past 24 hours to develop updated treatment plans.

Now in its third year, the ECP has enrolled 240 patients and shown improvements in both quality metrics—hemoglobin A1c, retinal exams, blood pressure measurements, and cancer screenings—and in connecting patients to mental health care.<sup>6</sup> In addition, ECP has shown a significant reduction in all unplanned care

(ED visits, acute inpatient admits via the ED, and urgent care center visits) (unpublished data).

Structured interviews with six ECP patients helped us understand the patient experience as one with 1) improved patient-provider communication, 2) high-quality, streamlined care, and 3) treatment as a whole person in a non-judgmental environment. ECP patients shared their personal stories about their health and healthcare experiences through the MyPaTH Story Booth project, which aims to facilitate patient engagement in research for improving health or health care (University of Pittsburgh IRB PRO15100466). Our analysis team reviewed their audiorecorded stories for insight into features of healthcare delivery that can help patients with complicated medical histories better achieve their health goals.

### Improved Patient-Provider Communication

One of the primary themes patients spoke of was the improved communication with their healthcare providers. One patient shared an experience prior to ECP with another physician, saying "They wouldn't listen. I would come in with lists and journals about what was going on. And they wouldn't look at it. So I started to feel like it didn't even matter. It was like, here's your injection, go away." Whereas in the ECP, the patient stated, "[ECP provider] listens, it feels like I'm talking to someone who gets it. Everyone listens to everything I have to say. And that's amazing. I've never had that before with doctors, or a medical team, at all."

The ECP has improved quality of care, reduced unplanned healthcare utilization, increased patients' trust in their care team, and empowered patients to better manage their health. Barriers for implementation of super utilizer programs include securing funding, maintaining patient engagement, and avoiding staff burnout.

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## Transforming Care for High Cost, High Needs Patients to Improve Experience, Quality, and Spending

Ania Wajnberg, MD, and Jeremy Long, MD, MPH

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As health systems move towards value-based models of care and focus on reducing healthcare spending, there is growing interest in improving the care of high-need, high-cost patients, sometimes referred to as “super utilizers” or “frequent fliers.” These patients account for a high proportion of overall health care utilization and spending, receive more fragmented care, require more intense coordination, and often have worse health quality and outcomes.<sup>1,2</sup> Health systems across the country are scrambling to intervene on the utilization patterns of these patients. The impact of care models targeting these groups has been mixed, but heterogeneity of patient populations and intervention strategies have made it challenging to draw firm conclusions. Nevertheless, there are various clinical models, including many academic medical centers, which specialize in the care of these patients, building innovative primary or transitional care programs for them.

In general, incentives in our largely fee-for-service health systems are not well-aligned with the care needs of these patients. High-risk patients require longer outpatient visits

due to their complexity, intensive within-visit coordination, and transportation or navigation services that are not easily obtainable. Consequently, 9-1-1 becomes an easier so-called one-stop-shop, even though preventing avoidable emergency visits and hospitalizations is ideal. Models that provide interdisciplinary, high-touch, and sometimes home-based services that are needed to fully address patients' barriers to care, are not properly compensated under current billing codes, thereby reducing sustainability. Thus, until incentives shift across healthcare settings, it will be difficult for such models to move beyond pilots or grant-funded projects towards integrated components of our health system. As groups move towards shared savings, accountable care organizations, and value-based care, the incentives to provide such care are growing rapidly.

One challenge to implement new care models successfully is the need to define and identify patients most in need of high-intensity services. Early efforts focused on patients with high prior spending, but a major limitation of this strategy is related to

high variability of patient expenditures over time—even those in the top 5% of spending in one year do not tend to incur that same level of spending in the following year. A few years ago, “hot spotting”—using claims data to guide clinical interventions—was an acceptable method for predicting future risk and cost, but further analysis of large claims datasets has revealed that most patients have short periods of high need and high cost, then return to their baseline levels of spending. Although variable across different populations, in general only about 10-30% of patients will remain high-utilizers for more than one year<sup>3</sup>; rates may be lower in Medicare or commercial populations. These patterns also raise methodological issues when assessing the effectiveness of new models, as decreases in health expenditures of patients enrolled in high-risk care models may be related to regression to the mean and not hold up in randomized trials. In our conversations with emerging programs across the country, this is a major factor in their development: claiming regression to the mean as a success leads to initial favorable outcomes followed by an almost inevitable plateau in financial performance.

Similarly, identifying the set of patients about to enter this high-risk, high-cost pool using claims or automated data has not been particularly fruitful. While many commercial algorithms are available and plans have proprietary risk scores, studies have found that these models have a positive predictive value of only 10-15%.<sup>4</sup> The relatively poor perfor-

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Our experience overseeing clinical programs for high-risk patients at urban academic medical centers has shown us that one of the most valuable metrics in working with high-cost, high-need patients is patient satisfaction. This becomes obvious during the transition for such patients when their situation has stabilized and they are returning to traditional primary care settings.

## An Open Letter to the SGIM Community

The recent SGIM annual meeting focused on physician burnout, an important issue for generalist physicians. Yet, few of the sessions addressed the complex, inequitable, and wasteful healthcare financing system that frustrates clinicians, poorly serves patients, and is a root cause of burnout.

Over the years, few plenary or other featured sessions at annual meetings have explored the option of fundamental health care reforms. The current political and health crises in the United States lend special salience to such issues. There is a “burning platform” for advancing important policy changes that SGIM members have long supported.

We urge the SGIM leadership and meeting chairs to take several actions to ensure that our society plays an active role in addressing the needs of our patients and the policy milieu that profoundly influences the everyday lives of clinicians. We propose that SGIM forthrightly advocates for a single-payer national health insurance program in the United States that covers all our patients and ensures that the 2018 annual meeting includes ample (and prominent) space for discussion of healthcare reform and other efforts on behalf of social justice. The particular steps we recommend include the following:

1. Passage of a clear, unequivocal resolution indicating that the SGIM endorses a national single-

payer health insurance program in the United States. We note that a 1992 SGIM resolution endorsed “universal access” to health care. This resolution also called for “simplicity” in the design of this system, a “common financing system throughout the United States” and minimization of “administrative costs.” The resolution was passed following SGIM member surveys showing broad support for these principles among society members. A subsequent 2005 member survey reaffirmed these principles, and it found that 87.9% of SGIM members believed in “a single consolidated health care financing mechanism throughout the United States.” It is time to codify this sentiment with an updated, unequivocal SGIM resolution endorsing a national single-payer health insurance program in the United States. Members of the “Single Payer Interest Group” would be happy to assist in drafting such a resolution.

2. Following consideration (and hopefully passage) of a clear single-payer resolution by SGIM, we propose a society-led lobbying initiative advocating that Congress enact single-payer legislation. Given the current political climate, we suspect that many SGIM members would embrace the chance to participate in such an effort. With guidance and support from the SGIM leadership, such advocacy could have great impact.

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

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

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

*Director, Center for Behavioral Health and Smart Technology*

Division of General Internal Medicine

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

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

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## PERSPECTIVE

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3. Inclusion of major sessions and plenary speakers that address healthcare reform—particularly single payer—in the 2018 national meeting. Unfortunately, past meetings have rarely featured such presentations, although many have been proposed.
4. Sessions and speakers at the 2018 national meeting that situate the grave problems in health IT in the influence of market models and business interests of health care institutions and IT vendors that are driven by the perverse incentives of our health care financing and quality monitoring systems. While attention to the technical and practice design issues surrounding health IT is important, our discussions should also encompass and focus on analyses of

why and how defective systems that greatly contribute to dysfunctional workflows and burnout have characterized the IT landscape.

Many SGIM members are passionate advocates, and leading teachers and researchers on the broad policy issues that shape the future of our work and profession. Yet, too often, discourse within SGIM has neglected these topics. With existing health care and other social programs under grave threat—even as 28 million remain uninsured and physicians are increasingly alienated and unhappy—it is essential that SGIM's leadership and members engage in vigorous discussion of (and action on) these issues.

Sincerely,

Gene Bishop, MD. Pennsylvania Hospital, Philadelphia, PA

David Bor, MD. Cambridge Health Alliance, Harvard Medical School, Boston, MA

Olveen Carrasquillo, MD. University of Miami, FL

Oliver Fein, MD. Weill Cornell Medicine, New York, NY

Aaron D. Fox, MD. AECOM, Montefiore Hospital, Bronx, NY

Maura George, MD. Emory University, Atlanta, GA

Erin Goss, MD. University of San Diego Health, La Jolla, CA

Bruce Gould, MD. University of Connecticut, Farmington, CT

Maria E. Hamm De Miguel, MD. Columbia P&S, New York, NY

Magni Hamso, MD. Saint Alphonsus Health Alliance, Boise, ID

Iman Hassan, MD. AECOM, Montefiore Hospital, Bronx, NY

David Himmelstein, MD. AECOM and Hunter College, New York, NY

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Danny McCormick, MD. Cambridge Health Alliance, Harvard Medical School, Boston, MA

Susana Morales, MD. Weill Cornell Medicine, New York, NY

Brianna Norton, MD. Albert Einstein College of Medicine, Bronx, NY

Barbara Ogur, MD. Cambridge Health Alliance, Harvard Medical School, Boston, MA

Viraj Patel, MD. AECOM, Montefiore Hospital, Bronx, NY

Richard Pels, MD. Harvard Medical School, Boston

Gordon Schiff, MD. Brigham and Women's Hospital, Harvard Medical School, Boston, MA

Martin Shapiro, MD. formerly: UCLA, currently: Weill Cornell Medicine, New York, NY

George Shelton, Jr. MD. Ben Taub General Hospital, Houston, TX

Leigh Simmons, MD. Massachusetts General Hospital, Harvard Medical School, Boston, MA

Deborah Swiderski, MD. AECOM, Montefiore Hospital, Bronx, NY

Lello Tesema, MD. University of California, Los Angeles, CA

Theresa Townley, MD. Creighton University Medical Center, Omaha, NE

Liz Tung, MD. University of Chicago Medical School, Chicago, IL

Keith A. von Eigen, MD. Saint Francis Hospital and Medical Center, Hartford, CT

William Weppner, MD. University of Washington, Seattle, WA

Leah Wolfe, MD. Johns Hopkins School of Medicine, Baltimore, MD

Christopher Wong, MD. University of Washington, Seattle, WA

Stephanie Woolhandler, MD. AECOM and Hunter College, New York, NY

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## FROM THE SOCIETY

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4. Build and nurture the strongest possible team to support our mission and members.

I pledge to be a strong and consistent advocate for the policies and decisions made by SGIM's elected leaders, and will encourage SGIM to tackle challenging issues related to our mission.

Fortunately, SGIM has a superb Health Policy Committee that works hard to engage members in addressing issues. I urge members to communicate with the committee when they have concerns about health policy. When SGIM wrestles with controversial topics, I will see to it as my responsibility to remind the Council that some members may not share the views of the majority. I want to hear from anyone who may disagree with what seems to be a prevailing point of view.

I want to honor the spirit of SGIM's first Executive Director, Elnora Rhodes, by making every member feel at home in the organization. In recognition of what I learned from SGIM's second Executive Director, David Karlson, I will do my best to bring a business-savvy approach to leadership while also respecting SGIM's high ethical standards. As a long-time member of SGIM, I plan to use my intimate knowledge of the organization to prod the leaders and every member to reach higher in pursuit of our mission—to lead excellence, change, and innovation in clinical care, education, and research in general internal medicine.

SGIM's vision, approved by the Council in 2012, calls for healthcare delivery that is as follows:

- comprehensive, technologically advanced, and individualized;

- instilled within a culture of respect;
- efficient in the use of time, people, and resources;
- organized and financed to achieve optimal outcomes;
- equitable; and.
- continually learning and adapting.

My own version of the mission focuses on improving the quality, efficiency, and equity of health care with an emphasis on team-based relationship-centered care through innovative work as educators and researchers.

Thank you for giving me this fabulous opportunity to serve the mission and members of SGIM! Please feel free to reach out to me with any questions, suggestions, or concerns you have about our Society at [basse@sgim.org](mailto:basse@sgim.org). I look forward to working with all of you! **SGIM**

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## SIGN OF THE TIMES

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mance of claims-based algorithms is probably related to the lack of information about the most important drivers of cost, such as social determinants of health, health behaviors, social support, trust in the health care system, and patient activation. Growing care management systems should focus on these underlying issues and add them to risk stratification algorithms, supplementing the diagnostically-focused claims-based models currently available.

Even for those who have invested in care models for high-risk, high-cost patients, programs adopt widely variable staffing models that limit scope and generalizability. Early programs and some health plans often use telephone-based support models that have not shown consistent impact on outcomes. Even more expensive and resource-heavy programs target broad groups of high-utilizers, most of whom have multiple comorbidities. The complexity required for managing multiple diseases and polypharmacy is poorly

met by the disease-specific care protocols usually included in traditional care models. Furthermore, patients in this group are clinically heterogeneous (e.g., patients in the last year of life, patients on disability, patients with active substance abuse) requiring very different clinical skills and care coordination modalities, depending on the factors that lead to their high service utilization. Most programs are built to serve one type of patient population and may not be flexible enough to respond to the various needs of high-risk patients. Learning more about this population will be key to understanding different clinical cost drivers and to creating programs and linkages that can respond to them, even if these are varied or require different approaches.

Our experience overseeing clinical programs for high-risk patients at urban academic medical centers has shown us that one of the most valuable metrics in working with high-cost, high-need patients is patient satisfaction. This becomes obvious

during the transition for such patients when their situation has stabilized and they are returning to traditional primary care settings. Patients are quite reluctant to leave their interdisciplinary team, easy access to team members, and abundant available resources. We have adopted more patient engagement efforts so that our initial enablement of newly enrolled patients can pivot more toward empowerment efforts, increased activation, health literacy, and motivation.

Nationally, there is tremendous interest in rapidly identifying and managing the care of high-cost, high-need patients. As we gain experience, more payers pilot these models, and more research is conducted, we can share best practices to optimize patient selection and intervention models to improve the health and quality of care for the most vulnerable populations. Despite the great deal of heterogeneity discussed above, some best practices are emerging, especially for high-risk   
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## PRESIDENT'S COLUMN

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which critical information can flow between Council, Committees/Task Forces/Interest Groups, and membership. Communications is also how the Society relates to those outside the organization, be it individuals who are curious about the Society and what we do or large external entities with whom SGIM seeks to partner. An amazingly capable and dedicated group of staff supports our communications and marketing efforts, but this is a domain in which our aspirations far outpace the available resources. Council has identified enhancing communications as a major strategic priority, and to do so is partnering with Pyramid Communications to conduct an "audit" of our current communications practices and recommend opportunities to take our communications work to the next level.

Many of our members place great value on SGIM's ability to communicate externally by taking public positions on issues of importance. Examples of highly visible issues, on which members have requested the organization take a public position, include Single Payer (see "An Open Letter to the SGIM Community" on this topic in the November *Forum*), DACA, and the devastation wrought by recent natural disasters. Less visible issues on which SGIM has devoted considerable attention from its active Health Policy Committee include providing detailed, formal written feedback on proposed new rules from CMS for MACRA. SGIM has also signed on to multiple statements from other organizations on various efforts to repeal the ACA and other health policy issues. While pro-

viding timely public comment on such issues is challenging at any time, the pace with which items come up that require the Society's attention during the current political climate is truly unprecedented.

The following are three important points to bring to our members' attention regarding how the Society approaches requests to take public positions on time-sensitive issues:

### 1. **The speed of the Society's response does not reflect how deeply we care about the issue at hand.**

Most members are involved with multiple voluntary membership organizations, many of which have a dedicated multi-person communications team. In addition, other organizations often have a much more staff-driven model than SGIM. These factors allow other organizations to release public positions with 24-48 hour turnaround. SGIM at present does not have the staff capacity to release external communications on such a rapid timeline. In addition, our member-driven focus involves ensuring that relevant Committees, Task Forces, and Interest Groups have had the opportunity to provide feedback on a proposed public position. The communications audit that I mentioned above will be exploring opportunities for streamlining this process. But even in situations where the Society does not have the capacity to respond publicly as quickly as we would like, the issues at hand are still ones that SGIM cares deeply about.

### 2. **Embrace the diversity of our members' views.**

As an organization of generalists, we have an amazing diversity of interests. And while we share a set of core principles as articulated in our Society's vision, it is reasonable to assume that there is more diversity in our members' attitudes and beliefs about many of the issues in the news. We should embrace this diversity, and not assume (no matter how strongly you hold a particular view) that the same opinion is shared by every other member. While we don't want to limit the organization to making public statements to those issues on which we have complete consensus among our members, our decision-making process for issuing public statements needs to reflect the range of opinions our members have on most issues.

### 3. **Use our established process.**

SGIM has established a process for submitting requests for the organization, and I would strongly encourage members who would like SGIM to take a public position on an issue to use this process. More information can be found at: <http://www.sgim.org/File%20Library/SGIM/About%20Us/Policies/HPC-policy-pathways.pdf>

I hope you join me in welcoming Eric to his role as our first physician-CEO, and engage with us as we work to strengthen our organization's communication capabilities.

SGIM

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**SGIM**  
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## FROM THE EDITOR

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last month's *Forum*, SGIM President Tom Gallagher, talked about openness for individuals as well as organizations. Tom particularly spoke about how polices are important in revealing an organization's intentions.

The work of the climate science group can, quite literally, save the world. The November *Forum* also introduces our new CEO, Eric Bass, advocacy guide for federal employees,

and identifying and managing the care of high-cost, high-need patients.

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SGIM

## HEALTH POLICY CORNER: PART I

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*News, ACP in the News, Scientific American, and Medscape*. Since March, the George Mason Center for Climate Communications continues to issue its monthly newsletters and the Medical Society Consortium issues periodic letters to Congress and the President on climate-related issues. We also have phone meetings where we can brainstorm further ways we as leaders can promote the Consortium's mission:

*To inform the public and policymakers about the harmful health effects of climate change on Americans, and about the immediate and long-term health benefits associated with greenhouse gas emissions ... and other preventative and protective measures.*

Several medical societies have already issued formal statements on the health effects of climate change. Others educate their members and the public on the medical arguments behind clean energy and lowered carbon emissions. To highlight examples of different societies and their climate change infrastructure, the ACP issued a position paper in 2016 along with a "climate change toolbox": a list of climate action items, fact sheets, and educational slides for its members. In 2015, ACOG also issued a position statement on climate change and maternal/fetal health. Through their government affairs committee, ACOG also keeps a

scorecard on the various legislators, rating them, among other things, by their stance for/against toxic prenatal exposures. The NMA has a health and equity curriculum. The AAFP has a commission for health and climate policy. Multiple societies include presentations on climate at their national meetings. Since the 1950s, the AAP has had a council on environmental health, which holds various workshops and training sessions for their members.

### Action Items for Moving Forward

To build on the momentum of this event and to increase awareness among SGIM of the health effects of climate change, a small group of like-minded individuals met in Washington, DC, at the SGIM 2017 National Meeting to brainstorm ways to achieve our goals. At the meeting we discussed our vision for climate change action and environmental health as a broader issue within our medical society: to exist in the form of a committee or subcommittee, generating advocacy resources (a "tool kit") for members, and serving as an official forum to issue real-time commentary on current events with environmental health impacts. We see ourselves creating both standard and CME-eligible educational materials. As one informational tool for gauging SGIM members' interest, Professor Ed Maibach at George Mason's Center for Climate Change Education has offered the use of his

survey on climate change and health, which we will circulate soon among SGIM members. The NMA surveyed its members with Dr. Maibach's tool and found the feedback very helpful.

*The Lancet*, in a recent article, proclaimed climate change the "biggest health threat of the 21<sup>st</sup> century"<sup>5</sup>. The APHA is running a monthly education campaign throughout 2017 labeled the Year of Climate Change and Health. Recent extreme weather events have shown that this is as an important time as any for climate awareness and action.

### SGIM's Environmental Health Interest Group

Individual SGIM members are engaged in environmental health issues through the Environmental Health Interest Group. Last January GIM members predating this interest group helped publish an entire issue of the *Forum* dedicated to the topic. This is an opportune time to organize our efforts. I invite you to join the environmental health interest group, which is expanding its efforts, and to complete the online climate and health survey later this year.

Please feel free to contact me at [elizabeth.gillespie@dhha.org](mailto:elizabeth.gillespie@dhha.org) with any comments or questions.

To learn more about the Consortium, or to read its report, *Medical Alert!* go to <https://medsocietiesforclimatehealth.org/reports/medical-alert/>.

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## HEALTH POLICY CORNER: PART I

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## SIGN OF THE TIMES

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Medicare and Medicaid populations<sup>5</sup> and summarized as follows:

1. Super utilizer status is dynamic, and patients may move in and out of this category over time.
  2. Supporting and strengthening primary care structures is key to engaging and retaining patients.
  3. Integrating behavioral health care into high-risk programs should be a priority.
  4. Face-to-face interventions are more successful than telephonic ones.
  5. Home-based assessments can improve engagement and understanding of patient barriers.
  6. Training health professionals further in prognosis and goal setting and in palliative care communication is very beneficial.
  7. Programs that are adapted to the needs of the local population are more successful. These needs should drive team composition (e.g., pharmacist, health coaches, nurse care managers, social workers, etc.).
  8. Identifying social needs and incorporating social services is important to address barriers for high-risk patients, especially when there is cross-agency collaboration.
  9. Close relationships with certain subspecialty providers may be beneficial, as their expertise may be crucial for subgroups (e.g., congestive heart failure, chronic obstructive pulmonary disease, or palliative care).
  10. Staff dedication, mission and flexibility are key to success.
  11. Access to real-time data sharing across health systems allows for more effective patient outreach and engagement into high risk models.
- Building scalable programs that are appropriately staffed and well incentivized to provide care for medically and psychosocially complex vulnerable patients will improve our health system and improve patients' outcomes. As incentives shift and primary care develops in this direction, we need to learn from one another and commit to the study of this field. We need to work together to collect best practices and rapidly implement them into our population health systems to achieve our goals of patient-centered care, improved quality, and lower costs.

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## HEALTH POLICY CORNER: PART II

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ical influence, a federal law known as the Hatch Act of 1939 [*Political Activities*, 5 U.S.C. §§ 7321-7326] was established. In 1940, the law was expanded to include state and local employees [*Political Activity of Certain State and Local Employees*, 5 U.S.C. §§ 1501-1508] whose positions are funded by federal funds or programs. While healthcare advocacy issues may be in theory non-partisan, many current issues, such as the Affordable Care Act, have become divided along political party lines and, thus, it is important to understand the law. For example:

- You may donate to a candidate or political fundraiser event, but you cannot use email or social media to solicit other donations.
- You can attend a political fundraiser but you may not host one or invite other guests.
- When engaging in political activity or event, you may not use federal or VA resources (see above lobbying restrictions)

An important exception is that certain federal employees may not participate in partisan political cam-

paigns, such as Career Senior Executive Service employees in the civil service. These more strict regulations, however, do not pertain to a physician who works for Federal health systems including the VA. "A Guide to the Hatch Act for Federal Employees" is an excellent summary with additional information that can be found at: <https://osc.gov/Resources/HA%20Pamphlet%20Sept%202014.pdf>.

**5) What restrictions do I have if I am affiliated with a state government (e.g., a public or state university medical school)?** Each state has its own definitions of lobbying and rules defining what kind of lobbying and campaigning activities in which state employees may and may not participate. In general, many restrictions are similar to those for federal employees, but you should confirm this by reviewing local regulations which are easily searchable on the internet. Many states have lobbying guides and manuals available online.

Universities may additionally have academic ethics rules, but these are often generally less re-

strictive than Government Ethical Standards. This discrepancy can be problematic for clinicians with both university appointments and federal employment. In this case, observing the stricter rules is a safer bet. Before making a public statement or taking a public position that may reflect on your organization, it is prudent to check with your organization's public relations (PR) and/or Ethics Officials.

**6) Whom do I contact for additional questions related to being a federal employee?** You are encouraged to reach out to your local Ethics Officers with specific questions or concerns. The VA Ethics officials are extremely accessible and can be easily reached by e-mail via [https://www.va.gov/OGC/docs/Ethics/VA\\_Ethics\\_Officials\\_Contacts.pdf](https://www.va.gov/OGC/docs/Ethics/VA_Ethics_Officials_Contacts.pdf):

- VA Central Office (VACO): GovernmentEthics@va.gov
- Outside VACO: OGCNorthAtlanticEthics@va.gov  
OGCMidwestEthics@va.gov  
OGCContinentalEthics@va.gov  
OGCPacificEthics@va.gov

SGIM

## BEST PRACTICES

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### Treatment as a Whole Person in a Non-judgmental Environment

In the ECP, patients felt respected and treated as a whole person. According to one patient:

*"She [ECP physician] has a relationship with my psychiatrist as well so there's all this communication across everyone which is what I've always needed but I didn't understand when it wasn't there. So I feel like she treats me like a person and not just another number." Another noted, "She [ECP physician] looks over my whole body...I mean, they give me a body makeover. And I didn't have that before."*

In addition, patients felt safe from judgment. One patient explained:

*"Some doctors I believe have this idea of, 'Oh, if we tell them this' or a fear tactic that they try to use. That's not always works with every patient. I'm not scared of nothing. And sometimes they feel like, 'Oh, if you do it our way it's better', and that's not always the case. I feel like you have to meet people where they're at sometimes and granted you may not agree with what they're doing or their behaviors, but you talk with them as people and some doctors don't talk to you as a person. They talk to you as if you're your illness."*

The patient continued by saying:

*"They [ECP] see you when you're doing good and they see you when*

*you're doing bad... I get to be part of making the decision. It ain't like people just make decisions and you gotta go with it."*

A different patient shared about the importance of not feeling judged:

*"They all know that I smoke weed on occasion, but they don't hold it against me. They try working with me. They don't just sit there and tell me 'this is how it is and that's it'. They break it down and work with me."*

### High-quality, Streamlined Care

Each of our patients shared in a unique way their appreciation for

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## BEST PRACTICES

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high-quality and streamlined care. When asked what has helped better manage health, one patient said “I guess the detail working with me. More specific. They are not overwhelming.” Later the patient said that ECP “got me to start working on things one at a time, ‘cuz I had a lot of different problems.” When discussing managing his/her problems before the program, another patient said:

*“I had so much medical going on I sort of like given up worrying about anything. And here they break it up. They take baby steps one thing at a time.”*

In summary, the ECP has improved quality of care, reduced unplanned healthcare utilization, increased patients’ trust in their care team, and empowered patients to better manage their health. Barriers for implementation of super utilizer programs include securing funding, maintaining patient engagement, and avoiding staff burnout. Partnership and funding from UPMC Health Plan was critical in implementation of our program; however, use of shared savings arrangements and case management fees may be promising to secure funding. Showing a return of investment to funders may not be evident in the start-up period. Increased medication adherence and diagnosis and treatment of previously undiagnosed conditions such as cancers, hepatitis C, and autoimmune disease may lead to initially increased pharma-

ceutical and medical costs respectively. Furthermore, success is often by a patient-by-patient basis. Readiness to change may vary and changing a patient’s interaction with the health care system takes time. The clinic has instituted walk-in hours and waived co-pays for appointments; however, many patients still feel they are better served in the ED as more tests are performed and it is easily accessible. This perception may change with continued rapport and trust building with our team. In addition, maintaining a healthy team is essential. ECP providers have seen patients go through horrific tragedies; murder of their children, death by suicide, rape, and abuse. It is difficult to leave this at the office, especially when such deep patient-provider relationships have been formed. Leaving time for reflection, rest, and teambuilding is a way the program has worked to avoid staff burn out in order to continue to serve this patient population. We are hopeful that our experiences and successes presented here will promote the expansion of super utilizer programs.

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James Schuster, MD, William Shrank, MD, and Donald Yoder.

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