



## Now, Where Was That Article that I Read? New Internet Sites for Finding Medical Articles

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The following is an article that appeared in the October 1997 issue of the *Forum* with an up-to-date table.

For years, we have exclusively used MEDLINE to locate articles to guide our clinical practice. While MEDLINE remains the most thorough way to find articles, new alternative sites address MEDLINE's deficiencies. Have you every searched MEDLINE for an article that you know was recently published, but it wasn't on MEDLINE? Unfortunately, there is a delay between an article's publication and its inclusion in MEDLINE. Vice President Al Gore recently announced the free availability of PubMed. Like MEDLINE, PubMed is produced by the National Library of Medicine. Unlike MEDLINE, PubMed is very up to- date and may have articles published the current week.

Many clinicians use secondary publications such as *Journal Watch* or *ACP Journal Club* to "keep up" with medical advances. If you've ever found yourself at the hospital or clinic wanting to use an article that was abstracted in one of these publications but you could not remember when you read the abstract, both *Journal Watch* and *ACP Journal Club* can be accessed on the Internet and allow searching across back issues. Soon, both sites will require passwords. Avoid losing access because of password problems. Be consistent on your capitalization and consider ending your passwords with a number to facilitate updating.

Lastly, when you do use MEDLINE, strongly consider starting your searches by using "hedges" (presaved expert searches). As compared to medical librarians, clinicians find only half of the articles relevant to their clinical question.<sup>1</sup> Hedges, which have been carefully developed, quickly

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## Improving Access: Team-based Primary Care via Telehealth in the VA

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#### Introduction

In the United States, access to quality healthcare is an ongoing problem and a “substantial and growing concern” in rural communities.<sup>1</sup> Projections estimate a need for 52,000 additional primary care providers (PCP) by 2025.<sup>2</sup> The Department of Veterans Affairs (VA) is one of the largest healthcare systems in the world and faces similar challenges. When asked how the VA will increase its presence in rural communities and address the provider shortage, the current secretary of the U.S. Department of Veterans Affairs, David Shulkin, MD, described the need to “use technology in areas where we are not able

to recruit all the health care professionals we need”.<sup>3</sup> To this end, our local Boise VA has implemented a new model of interprofessional care called the Virtual Integrated Multisite Patient Aligned Care Team (V-IMPACT) which utilizes video telehealth technology to provide access to care in rural and underserved communities having difficulty recruiting or retaining providers. This paper describes this innovation in the field of primary care.

#### Background

Within the VA, the United States and territories are divided into 18 Veterans Integrated Service Networks (VISNs): Each VISN is comprised of numerous VA facilities. The VISN 20 serves Alaska, Oregon, Washington, most of Idaho, northern California, and the northwestern tip of Montana. (As of fiscal year 2016, 39% of active patients in VISN 20 live in rural areas compared to 33% veterans nationally). With the challenges of recruiting PCPs to rural areas, the V-IMPACT program was created within VISN 20 to honor America’s veterans by using emerging technologies to meet their primary care access needs through an integrated, team-based approach. Utilizing the framework of the Patient Aligned Care Team (PACT), similar to the Patient Centered Medical Home

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## Something I Need to Tell You: Improvement and Openness

Thomas H. Gallagher, MD, President, SGIM

Even though being open doesn't come naturally to us, it's critical that we learn to get better at it, both as individuals and as an organization. A culture of continuous improvement hinges on openness. Being open is also an essential element of high trust relationships. And health care clearly is moving towards greater transparency on a variety of fronts.



Several of my past presidential columns focused on the issue of culture. Culture can best be thought of as "the way we do things around here;" a collection of customs and norms, both written and unwritten. SGIM members who are interested in promoting change would be well served to become experts in understanding how cultures develop and evolve. And while we traditionally think of cultures as they relate to groups of individuals and organizations, a willingness to examine culture is equally important for changing our own behaviors.

Last month's column focused on the importance of adopting a culture of continuous improvement, both as individuals and for our Society. Early on in any journey of continuous improvement, one is forced to confront the habits and reflexes that develop over time and drive our current behavior. These habits and reflexes, both as individuals and organizations, represent the status quo. It is essential to recognize that the status quo does not develop by accident. They serve our interests through promoting positive effects but also by avoiding negative or noxious consequences. But over time these ingrained habits often inhibit our progress.

For example, the junior faculty member who reflexively says "yes" to every request to participate in a project may benefit early on from a reputation as a valued team player,

but ultimately will suffer from over-commitment and decreased productivity related to his personal projects. Ideally, if this faculty member were committed to continuous improvement, he would actively seek out feedback from mentors and peers about his current performance, recognize this over-commitment as an area for improvement, and develop strategies to say "yes" to requests more selectively. But for many of us, this commitment to continuous improvement does not come naturally. Continuous improvement can be difficult on our self-image, a particular challenge for physicians who tend towards perfectionism, coupled with patients' and society's extremely high expectations of us.

A critical ingredient in a culture of continuous improvement is a strong commitment to openness. Much of my career has involved studying and trying to improve how we respond to problems in health care, an area where openness is essential. This work has led me to understand how from an early age we develop reflexes that limit our openness, especially if it involves something that has gone wrong. Think about a time when you have made a mistake in your personal or professional life that has caused significant harm. Sometimes it's a mistake that is readily apparent for all to see, and not being open about what happened is not a viable option. But other times, especially for prob-

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lems that may not be obvious to others, our tendency to keep what happened to ourselves is overwhelming. We think to ourselves, "Maybe if I just lay low, everything will blow over." And sometimes it appears that this approach works—No one is the wiser about what happened, and we go about our lives thankful that our mistake did not come to light. The root causes of a lack of transparency are multiple, but generally involve a fear of punitive consequences, shame and embarrassment, or uncertainty about how to talk with others about mistakes.

Openness about mistakes includes two major components. The first is information sharing, conveying  
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## Personalized Wellness for Women Physicians

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**“Ginger Rogers did everything Fred Astaire did, except backwards and in high heels.”**

—Bob Thaves, 1982, *Frank and Ernest* (cartoon)

**P**ersonalized medicine aims to tailor care to diverse patient populations by implementing decisions, practices, and interventions that are customized to the specific needs and preferences of each patient to achieve a positive outcome. Personalized wellness should aim, like personalized medicine, to treat physician subpopulations, using interventions that are adapted to clinical specialty, local culture, or other characteristics.

Recent approaches in optimizing physician wellness implement interventions for individual clinicians, but newer approaches are also a part of more comprehensive interventions that address external factors contributing to burnout, many of which are organizational and systemic in nature. One major subpopulation primed for personalized wellness interventions is women physicians. Cultural and policy changes towards increased inclusivity are achievable because much is already known about gender-related differences in the occupational experience of medicine for women physicians.

### The Disproportionate Burden of Burnout among Women Physicians

Women make up 46% of U.S. physicians in training, and more than half of practicing physicians in specialties like pediatrics and obstetrics/gynecology.<sup>1</sup> As a historically male-dominated profession, these numbers indicate cultural shifts in the demographics of medicine, both in the United States and abroad. However, women physicians remain

disproportionately affected when achieving wellness.

Female physicians are twice as likely to experience burnout compared to their male counterparts.<sup>2</sup> The incidence of physician suicide is higher than the general population, and depression and suicide are up to four times higher in women physicians compared to the general population.<sup>3</sup> These statistics are both alarming and distressing. Women physicians also experience greater barriers to academic and professional advancement, more difficulty achieving professional satisfaction at all life stages, and a persistent lack of pay parity.

Women physicians may be more likely to experience nonlinear career paths and have less access to role models, resources, and leadership positions. In the United States, women make up only 38% of faculty, 21% of full professors, and 16% of deans.<sup>4</sup> Although the number of women at all levels of academic medicine has increased,<sup>5</sup> maintaining an academic career and raising a family is hard work, particularly for female physician scientists and researchers.<sup>6</sup> Also, along the pipeline, women tend to negotiate less aggressively and with less confidence than men, which has significant financial implications over the course of their career.<sup>7</sup> Women overall are estimated to achieve equal pay in 2059; however, for black and Hispanic women to achieve pay equality is impossible within one working lifetime.<sup>8</sup> Among physicians, men are paid more than women by an aver-

age 16% more in primary care specialties and 37% more in other medical specialties.<sup>1</sup>

Traditional gender roles may reduce time available for building a career. Women physicians still bear a disproportionate expectation of family and caregiving responsibilities, while also fulfilling professional responsibilities. A study of dual-physician marriages reported that 87% of women and 59% of men arrange their work schedule to accommodate child care.<sup>9</sup> Outside of dual-physician marriages, mothers are more likely to interrupt their careers to attend to family needs. Working mothers with children under 18 years devote more time to child care (10.7 hours v. 7.2 hours per week) and household needs (14.2 hours v. 8.6 hours per week) than do fathers.<sup>10</sup> Maintaining well-being and sustaining self-care are challenging when competing responsibilities vie for finite time and energy.

Additionally, women physicians perceive work as less family-friendly, even discriminatory towards working mothers,<sup>11</sup> and compared with men, women experience a lower sense of belonging in the workplace, less self-efficacy regarding advancement, and perceived less alignment between individual and organizational values.<sup>12</sup> Women may be hired based on merit and past performance rather than potential as is more typical of men in professional work;<sup>13</sup> when promoted, they may find themselves facing “sticky floor” (stuck in a middle management position) or “glass cliff” sit-

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## The Obesity Epidemic and Potential Interventions

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**O**besity is a growing public health problem that leads to multiple comorbidities and mortality. The health-care-related cost of overweight and obesity in the United States is estimated at \$270 billion yearly and is expected to increase to \$500-800 billion in 2030, if unchanged. Despite being one of the fastest growing health problems, obesity is often unrecognized by healthcare providers and the public. There is wide heterogeneity in the causes and manifestations of obesity that leads to wide patient-to-patient variability in the response to anti-obesity therapies. In this article, we discuss underlying causes of obesity, how to address the complex issues of obesity using a team-based approach, potential medical and surgical treatments, and emerging therapies.

The prevalence of obesity has significantly increased worldwide over the past three decades, creating a global public health crisis. Based on data from the National Health and Nutrition Examination Surveys (NHANES), approximately 68% of adults in the United States are overweight and 35% are obese. It is projected that between 2010 and 2030, the incidence of obesity will rise from 35% to 50%.

The cause of obesity is multifactorial. Although genetically influenced, obesity is not a simple Mendelian trait disease. As of October 2005, only 176 different human obesity cases due to single gene defects were found. Cultural and society factors play an important role in obesity prevalence. Adipose tissue itself is an endocrine organ, which can become dysfunctional in obesity and contribute to systemic metabolic disease. In 2012, the American Association of Clinical Endocrinologists (AACE) published a position statement designating obesity as a disease. Other organizations such as the American Heart Association, the

American College of Cardiology, The Obesity Society, the Obesity Medical Association, and the Endocrine Society have also developed obesity care guidelines and algorithms incorporating care plan of a complications-centric approach. These guideline developments accelerate further scientific study of obesity and demand for obesity management. It is expected that general internists and primary care providers be at the front line of screening, prevention, diagnosis, and treatment for patients with obesity and its related complications.

In recent years, many new modalities have emerged to treat obesity, although lifestyle and behavioral interventions do remain the mainstay of treatment. The U.S. Food and Drug Administration (FDA) has approved five weight-loss medications for long-term management of obesity. The following medications target different neurochemical and hormonal pathways to promote satiety, reduce hunger, and decrease energy intake:

- Orlistat (Xenical or Alli) works by inhibiting enzyme lipase at the intestinal brush border that in turn causes fat malabsorption and decreased energy intake.
- Lorcaserine (Belviq) is a selective serotonin receptor agonist (5HT<sub>2c</sub>) which promotes satiety and appetite control.
- Phentermine/Topiramate ER (Qsymia) is a combination of sympathomimetic and anti-seizure medication that affects appetite control and satiety.
- Naltrexone/Bupropion (Contrave) is a combination of an opioid receptor antagonist and a norepinephrine-dopamine reuptake inhibitor that works at neurotransmitters in the brain to control appetite and promote satiety.
- Liraglutide (Saxenda) is a glucagon-like peptide-1 receptor

agonist, also known as GLP-1 receptor agonist or incretin mimetic. This class of drugs includes exenatide (Byetta/Bydureon), albiglutide (Tanzeum), and dulaglutide (Trulicity) which are used for treatment of type 2 diabetes as they increase insulin secretion. However, most of them have additional effects on appetite, satiety, and gastric emptying which promote weight loss. Nevertheless, Saxenda is the only one in its class that is approved for weight loss treatment.

Providers need to monitor patient's response and side effects closely in order to appropriately titrate treatment regimen. To choose the proper treatment regimen, a good understanding of the mechanism of action and side effects of each medication is required. Primary care providers need to gain experience and develop expertise in obesity treatment to use these medications effectively and comfortably.

In addition, surgical treatment for weight loss has been developed and refined with significantly lower morbidity and mortality. The two most common surgical procedures include laparoscopic sleeve gastrectomy and roux-en-Y gastric bypass, which usually lead to 50-55% and 60-70% of excess weight loss, respectively. Both procedures promote significant weight loss and improve various metabolic parameters through restrictive and malabsorptive effects. A proper evaluation by bariatric team members is crucial and usually requires a comprehensive psychiatric and medical evaluation. Other emerging procedures include endoscopically implant intra-gastric balloons, bypass liners or endo-barriers, aspiration therapy using gastronomy  
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## Why SGIM Supports Health Professions Pipeline Programs

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### The Importance of Pipeline Programs

Racial and ethnic minorities continue to be underrepresented in the health professions. African Americans, Hispanics, and Native Americans represent 30% of the combined US population, but only account for 11.5% of physicians, 11.2% of registered nurses, 10.1% of pharmacists, and 9.4% of dentists.<sup>1</sup> While the proportion of minorities in the U.S. population continues to grow, the health workforce distribution is not keeping pace. Beyond the equity problem this poses, health outcomes for minority patients improve when providers share racial/ethnic backgrounds, and providers from underserved backgrounds are more likely to serve the populations with the greatest health disparities and provider shortages: rural, urban underserved, and minority communities.<sup>2</sup>

Pipeline programs work to break down academic, financial, and social barriers for disadvantaged and underrepresented groups within the educational pipeline to healthcare professions. The goal of these programs is to increase matriculation and completion of health professional training for minority and economically disadvantaged potential physicians, advanced practice providers, dentists, nurses, and pharmacists. According to the Institute of Medicine and the Sullivan Commission on Diversity in the Healthcare Workforce, the failure of primary education in meeting the educational needs of minority and low-income students in kindergarten through grade twelve (K-12) is the single biggest barrier to greater diversity in the health professions.<sup>3</sup> Further, among this demographic of college and graduate students, those involved in pipeline

programs have higher matriculation into medical school.<sup>3</sup> Based on current knowledge, these pipeline program interventions are the highest-yield, short-term strategy for increasing diversity in the health professions.<sup>3</sup>

### Government Funding for Pipeline Programs

The Federal Government is the single biggest funder of pipeline programs.<sup>3</sup> The Health Resources and Services Administration (HRSA) Health Workforce provides funding for the Centers of Excellence (COE) and the Health Careers Opportunity Programs (HCOP). According to the Association of American Medical Colleges (AAMC), at least half a million individuals have participated in HCOP and COE programs, including over 400,000 underrepresented minorities and nearly 700,000 educationally and economically disadvantaged individuals. Mentorship programs through COE serve to recruit, train, and retain underrepresented minority students and faculty at health professions schools. As outlined on the Health Resources and Services Administration (HRSA) Health Workforce website, HCOP supports the recruitment of K-12 and college students from disadvantaged backgrounds into health professions programs and improves retention and admission rates of qualified students by means of tailored pipeline programs. In addition, HCOP provides opportunities for community-based health career training, specifically in underserved communities. In a 2012 AAMC survey of COE and HCOP directors, approximately half of HCOP respondents offer direct academic, test, and application preparation for their participants and 32% provide career

guidance through shadowing, mentorship, and advising. Twenty three percent (23%) of COE respondents provide leadership and development training opportunities for diverse faculty as well as cultural competence training.

Despite the ongoing need for diversification of the workforce, since its initial authorization in 1972, HCOP has repeatedly come under threat of defunding. In 2006 the federal budget for HCOP decreased by 89% and COE by 65%.<sup>3</sup> In recent years, the House and Senate have frequently cut or completely defunded these programs in their initial proposed budgets.

### Proposed Pipeline Budget Cuts

As part of its fiscal year 2018 budget proposal to Congress, the Trump administration recommended that the COE program, currently funded at \$21.7 million, be terminated. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals. Similarly, the administration's budget calls for elimination of the HCOP program, which is currently funded at \$14.2 million, citing as justification, "This program focuses its activities on entry points early in the health careers pipeline and does not have a broad enough reach to have a significant impact on the health workforce." While the congressional appropriations process is still in its early stages, the House Appropriations Committee voted on July 24, 2017, to decrease funding from \$21.7 million to \$9.7 million for COE and completely eliminate fund-

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## TECHNOLOGY UPDATE

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(PCMH) widely utilized outside the VA, the V-IMPACT model works to provide accessible, coordinated, comprehensive, and patient-driven care to underserved areas.<sup>4</sup>

### V-IMPACT Model

The V-IMPACT Telehealth Hub model uses a wheel analogy of a hub and spoke to define the locations of where staff and Veterans are located in the care provision process (see the figure). A Hub (provider site) is a facility that houses clinical staff members, including PCPs, clinical pharmacy specialists, and mental-health staff. As an interprofessional team, the clinical Hub staff members are allocated to sites in need to provide primary care services via telehealth technology and assume care of a patient panel. Spokes (patient sites) are the local sites receiving this care with the help of the local registered nurse care manager, nursing-associate, and clerk assigned to this patient panel working in partnership with the Hub staff as a team (see the figure). This team-based care serves as gap coverage allowing Veterans to be seen in their usual clinic, often with the same nursing staff, while Spoke sites are recruiting provider position(s). The interprofessional team members from both the Hub and Spoke sites meet briefly, virtually, on a regularly scheduled basis to prepare for upcoming patient appointments and determine collaboratively how to best address any patient needs. A typical telehealth appointment consists of the patient arriving at their usual clinic and being taken to an exam room equipped with secure telehealth technology that allows for a video-call between the provider and patient. Such appointments are called Clinical Video Telehealth (CVT) appointments. All providers obtain verbal informed consent from Veterans to be seen via telehealth. Nursing staff assist the provider in completing a physical exam by utilizing an adapted auscultation device, high-definition camera, otoscope, and other equipment. This equipment synchronously transfers

clear images and sounds to the PCP at the Hub. PCPs also conduct quarterly Spoke Site visits to allow the provider to see Veterans who may benefit from or prefer an in-person appointment including for procedures (i.e., pelvic-exams, skin procedures). The V-IMPACT model incorporates an extended telehealth team which provides integrated mental-health and clinical pharmacy services within primary care. Integrated mental-health team members provide brief assessment/interventions when behaviors, stressors, or emotional concerns are interfering with a Veteran's physical/psychological well-being. Clinical pharmacy specialists work with Veterans to prescribe/modify medications to treat disease states and serve as a medication information resource. Any team member can request ser-



**Virtual Integrated Multisite Patient Aligned Care Team (V-IMPACT) Hub Site provides interprofessional teams via telehealth technology to align with team members at Spoke Sites to provide primary care access to Veterans in their familiar local clinic. Nursing Assoc. (Nursing Associate); CM Nurse (Chronic [Disease]) Management Registered Nurse; PCPs (Primary Care Providers).**

clear images and sounds to the PCP at the Hub. PCPs also conduct quarterly Spoke Site visits to allow the provider to see Veterans who may benefit from or prefer an in-person appointment including for procedures (i.e., pelvic-exams, skin procedures).

The V-IMPACT model incorporates an extended telehealth team which provides integrated mental-health and clinical pharmacy services within primary care. Integrated mental-health team members provide brief assessment/interventions when behaviors, stressors, or emotional concerns are interfering with a Veteran's physical/psychological well-being. Clinical pharmacy specialists work with Veterans to prescribe/modify medications to treat disease states and serve as a medication information resource. Any team member can request ser-

vices from the extended team. In an effort to provide same day access to care, these team members can also meet with Veterans immediately after their PCP appointment in what is called a virtual warm handoff. During a CVT appointment, a PCP can add a team member to the same video-call, allowing the patient to communicate with both PCP and team member simultaneously for introductions. The PCP may exit the call allowing the other team member to continue same day care, or the interaction may continue in an adjacent room depending on the clinic flow and room availability. The real-time interaction between the team members can help transfer and retain rapport.

Consistent with PACT principles,  
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## PRESIDENT'S COLUMN

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the essential facts about what happened, its causes and consequences, and ideas about preventing recurrences. A second, and generally much more complicated component of being open, involves addressing emotions. As physicians, we often assume that dealing with emotional conversations is something we are relatively good at. However, having observed hundreds of conversations between patients and providers about care breakdowns, I can report that it turns out we are not nearly as good at dealing with patients' emotions as we think we are. Especially intimidating are situations where we worry that the patient will be angry at us. Responding to patients who are angry at us can flummox even the most experienced communicator, which may relate to our obsession with perfection as noted above.

Even though being open doesn't come naturally to us, it's critical that we learn to get better at it, both as individuals and as an organization. A culture of continuous improvement hinges on openness. Being open is also an essential element of high trust relationships. And health care clearly is moving towards greater transparency on a variety of fronts. Patients have open access to their medical records, work pioneered by SGIM leaders. Individual providers' performance data, along with detail patient ratings of their provider, are now just a click away. Whereas a patient may have been hesitant to share concerns with his/her doctor about the care provided during a face-to-face encounter, he/she may be less inhibited about posting critical comments about a provider online. These examples also highlight how transparency is much broader than the issue of being open when something has not gone well (though our willingness to be open about breakdowns is an outstanding litmus test of transparency generally).

Transparency should not be seen as a good, in and of itself, but rather as an important tool to achieving more important outcomes, such as improving healthcare quality or pro-

moting trusting relationships. As such, there are critical boundaries to transparency. A robust debate occurred within the bioethics community two decades ago regarding whether HIV-positive providers needed to disclose their HIV status to patients prior to performing invasive procedures. Ultimately, it was decided that such disclosure was not required and that the harms of sharing this information would outweigh any benefits. Similarly, details about personnel changes that occur at SGIM, information that might be of interest to members, is generally not shared outside a very limited leadership circle to protect the privacy of those involved. Yet, while keeping these limits to transparency in mind, generally speaking when faced with a dilemma, the more open and transparent path should be pursued.

Transparency involves not only being open about things that have taken place in the past, but has crucial prospective as a dimension as well. Through my participation in the leadership coaching process I described in last month's column, I have come to appreciate the importance of being open and explicit about our intentions. Intentions can best be understood as "a plan of action that we chose and commit to in pursuit of a goal." Making our intentions explicit is a critical element of creating shared mental models within a group for what we are trying to accomplish, why the goal matters, and how we plan to achieve that goal. No one can read your mind. So whether that group is just you and a coworker or a 3,000-member Society, articulating your intentions helps avoid an information vacuum that others naturally fill with their own version of what is going on or why a specific path is being pursued. Council developed a set of intentions for how we plan to behave, which was published in last month's *Forum*.

A particularly valuable aspect of being open about intentions, especially in larger groups, involves setting and articulating policies. Though

only one element of an organizational improvement strategy, a policy is both an explicit statement of intentions and a means to enhance quality through standardizing processes and minimizing variation. A few years ago, I attended a session about solving challenging dilemmas related to medical staff. The speaker kept returning to the simple, two-step approach to almost every complex situation the audience threw his way—step 1: Develop a policy, step 2: Follow the policy. Setting and articulating policies not only make an organization's intentions explicit to its members but also help ensure consistency and fairness over time, so that decisions are predictable and principled. But just as transparency does not always come naturally to us, there is an understandable reluctance some have to adopting policies, instead preferring to maintain maximal flexibility to respond to situations as they arise. However, especially for an organization such as SGIM, where elected leadership turns over quickly, increasing our use of formal policies can support organizational improvement.

Council recently put several of these principles related to adopting greater transparency and strengthening our policies into action during the review of Committee and Task Force budget requests for the upcoming year. Each Committee and Task Force can request both financial and staff resources for projects they would like to undertake. Typically, Council's decisions related to a specific Committee or Task Force's request would be communicated back just to that group, and the reasoning behind the decision (especially when a request was denied) could be difficult for the requestor to fathom. This year, we decided to more clearly articulate the principles we were using to make decisions, including: 1) Committees and Task Forces with remaining balances in their budgets should use these funds before requesting additional resources; 2) request for Visiting Professors would

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## FLASHBACK 40: PART I

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retrieve over 90% of relevant citations.<sup>2</sup> When searching questions with many relevant studies, consider starting with the hedge for systematic reviews or meta-analyses. More information about hedges is located in a series of editorials in the *ACP Journal Club* (search ACP online for the title word “harness”) or at the

Internet sites in the table. Ask your medical librarian for help in using hedges at your institution.

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**Table. New Internet Resources for Locating Recent Medical Articles**

Site	URL	Comments 1997	Comments 2017
PubMed	<a href="http://pubmed.gov">http://pubmed.gov</a>	Free and up-to-date!	Consider free MyNCBI account to allow: custom clinical filters, save citations, create alerts. Additional clinical filters at <a href="http://sumsearch.org/searching/1-prepare.shtml">http://sumsearch.org/searching/1-prepare.shtml</a>
Journal Watch	<a href="http://jwatch.org">http://jwatch.org</a>	Password soon to be required.	Still recommended!
ACP Journal Club	<a href="http://annals.org/aim/journal-club">http://annals.org/aim/journal-club</a> <a href="https://journalwise.acponline.org/">https://journalwise.acponline.org/</a>	Search “full site” at ACP Online to access both ACP Journal Club and Best Evidence. Password required.	Also consider ACP JournalWise. Compared to Journal Club does not have commentaries, but has customizable topics, declarative titles, and recent citations.
Zotero	<a href="https://www.zotero.org/">https://www.zotero.org/</a>		Free reference management software. Although not intuitive to use, works with Google Drive. *
Information about “hedges”	<a href="https://hiru.mcmaster.ca/hiru/HIRU_Hedges_home.aspx">https://hiru.mcmaster.ca/hiru/HIRU_Hedges_home.aspx</a>		

**Note for the year 2037:**  
\* If PubMed, Google Scholar, and the International Committee of Medical Journal editors all agree to replace numeric footnotes with “author, year citations” and agree to a common citation format, then no bibliographic software is needed.



## FLASHBACK 40: PART II

# Back to the Future: Medical Literature Review through SGIM’s History

Avital Y. O’Glasser, MD, FACP

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In last month’s *Forum*, Dr. Conigliaro debuted the “Flashback 40” feature as part of *Forum*’s 40<sup>th</sup>-anniversary celebrations for SGIM. The inaugural #FBF piece was a 2002 article presciently addressing burnout before it was “vogue” with an updated reflection by the piece’s author, past SGIM president Dr. Kurt Kroenke.

In my search for a “Flashback 40” piece, I first came across a new *Forum* feature in January 2008: “That Was Then in JGIM”. The feature’s inaugural piece was written by Dr. Adam Gordon—“How Things Change: A Reflection of JGIM 10 Years Ago.”<sup>1</sup> In jumping back 10 years in time to look at this issue of

JGIM (which contained four original articles, several perspectives, and editorials), Dr. Gordon posited:

*“Travelling down memory lane provides some insight into how the practice of medicine and investigative activities has evolved over time.*

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## FLASHBACK 40: PART II

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*It is clear that the content of JGIM 10 years ago...are as relevant today as they were 10 years ago. External forces have changed how we do things, and the science of medicine has evolved. Time will tell if JGIM's content in 2008 will be relevant in 2018."*

I was then inspired not only to continue to comb the *Forum* vaults but also to set the time machine clock to the same month, some multiple of 5 or 10 years in the past. My time-space-continuum travels took me 20 years into the past, to the October 1997 issue. Dr. Bob Badgett's piece "Now, Where Was that Article I Read? New Internet Sites for Finding Medical Articles" caught my attention.<sup>2</sup> As you can read in the piece, republished in this month's *Forum*, Dr. Badgett looks beyond MEDLINE to additional Internet-based research and publication search engines.

My goodness, how far we have come in 20 years with electronic technologies informing and contributing to our practice of medicine! I do not have the word-space or personal stamina to attempt an analysis of the electronic-health record in this essay; so, I will focus briefly on internet-based technologies.

I personally remember discovering and learning how to use Internet-based search engines the same year—I was in high school and struggling to find material to support an assigned position for my "country" on the Model United Nations team. I recall the tedious process of trying to access the internet through my family's AOL connection, with

the ever Pavlovian sounds of the dialing and successful "ping" of connecting. Now, if I am searching for an article, I can open any Web browser on any computer and quickly type pubmed.com. Google Scholar or sometimes a simple Google search gets me to the desired article. Journal Web sites themselves have robust search functions. Additionally, while dozens of journals continue to be published in hard-copy form, many have "Web only" content, as JGIM does, and many newer journals only publish online or electronically.

What else has changed for SGIM in terms of electronic and internet-based technologies in the past two decades? A small advertisement in the same *Forum* issue as Dr. Badgett's piece encouraged the reader to visit the SGIM Web site, with "World-Wide Website" fully spelled out. The cover article in the December 2006 *Forum* informed me that the Society's home page debuted in October 1996 with a new "Uniform Resource Locator" following a year-long existence of a proto-type Web site at a different address.<sup>3</sup> It is remarkable to see terms and Web site features that I take for granted specifically spelled out, such as *homepage*, *links*, and *hyperlinks*. The piece shared that all SGIM *Forum* articles since April 1996 were available "in an electronic document format known as PDF. Some members may prefer printing the *Forum* and reading it offline." This factoid is then followed by a specific introduction to Adobe Acrobat and instructions on how to download it. While SGIM *Forum* is still archived online as far

back as 1996 (see <http://www.sgim.org/publications/sgim-forum/past-issues>), I was surprised yet impressed that this content was available online from the Web site's inception.

SGIM's Web site has dramatically evolved since then, and SGIM's Web-based presence has since been joined by the creation of the Twitter account (@SocietyGIM) in August 2009 and a Facebook page in July 2009. Twitter guru Dr. Vinny Arora penned the November 2009 piece introducing Twitter and the Society's new Twitter account to *Forum* readers.<sup>4</sup>

As a still early-career physician who started medical school when many of these Internet-based technologies had already been implemented, I find it fascinating to jump 20 years back in time. Learning the historical context of technologies and Web sites I take for granted provides an increased sense of appreciation. Thanks to this #FBF, I look forward to the next 40 years.

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## PRESIDENT'S COLUMN

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not be funded out of SGIM's operating expenses; and, 3) requests needed to be fully aligned with SGIM's strategic priorities, and benefit a substantial segment of the membership. In addition, a full list of all requests, Council's decision, and the rationale was provided back to all the Committee and Task Forces, allowing everyone to see the decisions that were being made. I hope

that this increased reliance on principles to guide funding decisions, along with greater transparency about those decisions, will promote a stronger shared mental model between the membership and leadership about these important issues.

Continuous improvement, whether at the individual or organizational level, is critically dependent on openness. But being open,

whether in regards to a problem that has happened or our intentions going forward, does not come naturally to us. Yet with commitment to these principles and with practice, we can rewire these natural reflexes to keep things to ourselves and create high-trust relationships and teams, promoting individuals and organizational improvement.

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## SIGN OF THE TIMES

continued from page 4

uations (thrust into a leadership role during a chaotic time, expected to lead through a crisis with diminished chance for success and less likelihood of being given a second chance if failure occurs).<sup>14</sup> Burnout often begins first with emotional exhaustion for women, and ends with a progressive reduced sense of accomplishment, whereas men experience depersonalization first with a preserved sense of accomplishment, regardless of burnout status.<sup>15</sup>

Finally, sexual harassment and sexism also add to the burden of unwellness for women physicians. Sexual harassment is defined as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature."<sup>16</sup> Approximately 30% of surveyed women clinician-researchers reported having experienced sexual harassment during their careers, and that it negatively affected their confidence and career advancement.<sup>17</sup> The innocuous assumption that women are not competent physicians is also demoralizing. Recent high-profile anecdotes of women physicians barred from or even punished for being good samaritans in emergency situations highlight this persistent false belief.<sup>18</sup>

Despite these challenges, such findings highlight important opportunities to improve women physicians' wellness on a system level. Also, women physicians appear to be a

great return on the investment. Patient outcomes, such as hospital readmission and 30-day mortality, appear to be better for patients receiving care from a female physician.<sup>19</sup> Women physicians differ in practice style, for example, they are more likely to attend to the psychosocial needs of their patients<sup>20-23</sup> and are more likely to practice communication styles that improve health outcomes for their patients.<sup>24,25</sup> Women as leaders also excel in general leadership competencies, such as taking initiative and driving for results, embodying more than solely the "nurturing" competencies, such as developing others.<sup>26</sup>

### Call to Action: A Personalized Wellness Plan for Women Physicians

Personalized wellness for women physicians is achievable by acting on what we already know. These insights have tremendous potential to improve women physicians' wellness, potentially shifting work culture towards positive and synergistic win-win solutions. Here, we recommend five initial steps for healthcare leaders of any gender to design and implement personalized wellness plans for women physicians at all professional and life stages.

#### 1. Design scheduling policies that are flexible for family care.

Offering work scheduling flexibility offers both a supportive

work culture and directly promotes wellness,<sup>27</sup> especially for women, because of the ability to better balance time spent providing patient care versus child or elder care. The most highly ranked need, a flexible work environment and destigmatization of reliance on flexibility in timing and location of work can help improve the well-being and career success of women physicians.<sup>28,29</sup>

#### 2. Adopt best practices to support the hiring, recruitment and advancement of women physicians.

Two major women emergency medicine physician organizations issued recommendations in 2016 to encourage health organizations' adoption of gender-equitable recruitment and advancement policies.<sup>30</sup> For example, policies from (1) may already exist in an organization but are insufficiently advertised to hirees, which can be an attractive feature of a recruitment opportunity for women. Considering the improved patient outcomes and patient experience associated with care provided by women physicians, what is there to lose?

#### 3. Encourage men to engage in these conversations and in equitable mentoring.

Both men and women are majorities among physicians, and successful efforts

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## SIGN OF THE TIMES

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to reduce gender-related disparities in the profession necessarily involve both subgroups. Being open to long-term as well as spot mentoring,<sup>31</sup> leaders can develop at all stages for physicians of all genders. In addition to supporting professional growth and satisfaction, developing supportive, empathic communities can also promote women physicians' wellness. More specific training methods to develop such communities could involve role playing or even virtual reality to battle implicit stereotypes.<sup>32</sup>

**4. Collaborate within and with broad communities of influence and thought leadership.** Human and social connection benefits physicians' wellness, especially women. This can be technology-based, like the Physician Moms Group that started as a Facebook group initially in 2014, or even sub-communities within larger organizations, like SGIM and the American College of Physicians.

Alternatively, an in-person community like the Women In Medicine group at Southern Illinois University's Department of Medicine, can create a community of women physicians to achieve a "seat at the table."<sup>33</sup> Group advocacy can powerfully and collectively advance important agendas such as promoting women physicians' wellness.

**5. Create safe and open cultures for dialogue.** Decreasing subconscious gender bias and stereotyping among all genders is a necessary step towards challenging learned beliefs and values that support implicit gender stereotypes.<sup>31,34</sup> Directly confronting the discomfort and even fear of having these difficult conversations is needed to build lasting policy and cultural changes. Tackling gender bias and inequality requires gender intelligence<sup>35</sup> and providing opportunities where stories can be shared openly and without judgment is crucial to improving

wellness.<sup>36</sup> This increases access to resources that build confidence, sharpen negotiation and emotional intelligence skills, develop leadership traits early, and provide continuing support and mentorship.

Systemic and cultural changes are initial steps towards multi-faceted solutions to personalize wellness for women physicians. While the focus here is on women physicians' wellness, we understand that physicians who are men or who have alternative gender identities and orientations may also experience unique gender-related wellness challenges. As we advance our knowledge collectively of these challenges, personalized wellness for every physician will become feasible. We welcome SGIM members to share their personalized wellness success stories with us and the SGIM community.

The full reference list of this article may be found here: <https://tinyurl.com/y7sccfen>.

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## TECHNOLOGY UPDATE

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all staff members perform at the top of their licenses, to include nurse care managers at the Spoke Site providing face-to-face chronic care nursing visits under guidance from the provider. Because this is an integrated care team and not just one provider, there are opportunities for better access to comprehensive care. The team provides diversity and resources integral to comprehensive care provision and access, while technology fosters coordination and supports integrated roles and responsibilities.

### Discussion

Since its implementation in FY14 through FY16, the V-IMPACT program has completed over 16,000 patient encounters according to the report generated from the electronic

health record. Such encounters could represent Veterans who may have gone without care or received services outside their usual health-care facility, resulting in potential lack of continuity of care. Using telehealth technology, the V-IMPACT model enables interprofessional care beyond traditional appointments and can be utilized to complete shared medical appointments, group visits, and team meetings. Additionally, by working together at the top of their licenses, the team can focus on individual and population health management with the help of clinical registries available in the VA system. These benefits and the success of the VISN20 V-IMPACT Hub have led the way for the model to be adapted in other VISNs to improve access

and care continuity.

Potential limitations of this model include inefficient workflow due to Spoke Site nursing staff operating the equipment during portions of the appointments. Additionally, on occasion the physical exam via CVT is not conclusive due to technological limitations, body-habitus or both. While VISN20 providers anecdotally indicate they may be ordering additional testing to address this limitation, no current data is available to address this possibility at the time of this writing. Finally, the use of the technology requires investment for its purchase, training, maintenance and support thereafter.

With this investment and commitment, the V-IMPACT model deliv-  
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## CLINICAL UPDATE

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tubes, etc. There is no adequate study and outcome data to support their uses at this time.

How we approach the complex issues of obesity requires a comprehensive and team-based approach that is applicable to real-world patient care. Having a good understanding of pathophysiology of obesity can help us manage patients appropriately. Obesity is a complex and multifactorial disease with multiple signals and hormones influencing the brain and appetite. Diet and lifestyle intervention only works for certain levels of weight loss. The human body fights against weight loss by disproportionate response in energy expenditure, appetite regulation and gut hormone adaptations. Therefore, treatment with anti-obesity medications and/or surgical weight loss may be required for selected population to achieve the goal.

Regulation of obesity and energy balance is much more complex and comprise of physiology involving multiple signaling and homeostasis rather than just the physics of calories in and calories out. Reducing total caloric intake is still the main component of any weight loss intervention. There is no specific diet that provides highest weight loss. The key to success is an adherence to an individualized low calorie diet. Aerobic physical activity should be prescribed for patients as a component to lifestyle intervention. Progressive increase in the volume and intensity of exercise may be needed

with an ultimate goal of moderate exercise of more than 150 minutes per week.

General internists should work as a team with endocrinologists, nutritionists, exercise physiologists, behavioral health providers, midlevel providers, and bariatric surgeons to elaborate a care plan for obese patients. Rather than focusing on a preset decline in body weight, the primary therapeutic endpoint for patient's health and quality of life. Data shows that approximately 10% weight loss from baseline body weight improves obesity-related health conditions, such as hypertension, type 2 diabetes, coronary artery disease, obstructive sleep apnea, infertility, osteoarthritis, and chronic pain.

Weight maintenance is the most difficult aspect of a weight-loss journey. After a successful weight loss, primary care providers are vital in the transition process for surveillance and follow-up. A good long-term relationship with patients is pivotal in the continuum of care to prevent weight regain. Patients with obesity generally have poor access to health care. Providers are also less likely to build emotional rapport with obese patients. Treating the patient, not just the condition, is critical and providers should approach patients in a confident, supportive and non-judgmental fashion.

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## TECHNOLOGY UPDATE

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ers team-based, gap coverage for primary care at Spoke Sites allowing for provision of care within the Veterans' clinic location with familiar on-site staff. Its implementation keeps clinics operational during times of attrition, promotes stabilization of workforce within a VISN, and

reinforces interprofessional care. This interprofessional model of care also allows for access to extended team members whose skills can be immediately leveraged.

### Conclusion

The V-IMPACT program represents

an initiative involving telehealth technology that can be utilized to provide team-based, primary care services to veterans in rural and underserved areas. The model allows veterans to receive services from multiple professionals during one

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## HEALTH POLICY CORNER

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ing for HCOP. (H.R. 3358; House Report #115-244) Despite two-thirds of HCOP and COE programs accessing non-federal funds, 90% of COE programs and 78% of HCOPs indicate that they cannot continue without federal support in the recent AAMC survey. Decreased funding for these vital programs will have damaging consequences for the healthcare workforce as well as the diverse communities they serve. The cuts jeopardize minority and disadvantaged student recruitment and retention, clinical experiences for pre-health students, and opportunities for cultural competency initiatives needed to create a healthcare system and workforce capable of providing universal quality care regardless of race, ethnicity, culture, or language proficiency.<sup>4</sup> Given evidence that racial and ethnic minority health care providers are more likely to work in medically underserved communities, cutting pipeline programs geared towards increasing diversity in the health professions also threatens to increase already prominent health care disparities.<sup>5</sup> State and private funding, not to mention institutional culture and legislative barriers and facilitators, are essential to improving health workforce diversity and equity: However, federal funding for these essential programs is currently at risk for fiscal year

2018, and the Health Policy Committee's Education Subcommittee is concerned about the effect this will have on our future health workforce.

While budget cuts to COE and HCOP threaten the sustainability and growth of health professions pipeline programs, the \$403 million budget cut from HRSA workforce programs proposed by the Trump administration also includes Primary Care Medicine, Area Health Education Centers (AHECs), geriatric programs, and HRSA funding from the Behavioral Health Workforce Education and Training (BHWET) program. Although these programs are not within the scope of this article, government funding for all of these programs is critical providing healthcare to rural and other underserved communities around the country and merits the attention of the SGIM community.

### Conclusion

Pipeline programs play an integral role in preparing students for the healthcare workforce, diversifying our medical community, and improving access to and quality of care for underserved and minority populations. Continued adequate government funding for pipeline programs is critical to the growth and sustainability of these programs and providing comprehensive care to all of the populations that we serve.

*Note:* Final congressional action on health workforce appropriations will not occur until this fall or winter (after the August 15 deadline and before the piece would be published in the *Forum*). Given this, the authors would like to make an addendum to keep it relevant for our readers prior to publication.

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## TECHNOLOGY UPDATE

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visit while being seen in their local clinic location. Despite limitations, the potential benefits of improved access and continuity of care have allowed the interprofessional VISN20 V-IMPACT model to be expanded nationally. This model may prove to be useful for other non-VA healthcare systems.

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