

BREADTH

ENCOURAGING PATIENTS TO BE THEIR OWN ADVOCATES

Michelle Fleshner, MD, MPH

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As I enter the room, my 3:00 patient props herself up with her cane so she can stand and shake my hand. “Doc, I’ve been doing real good with my sugars, so I knew it was time to come in.”

Charlene was probably the most difficult patient I had intern year, but she has grown on me in many ways over the past year. She’s 54 and lives alone on the south side of Pittsburgh. She once told me a story about how, on the bus ride to the hospital, the driver got in a screaming match with one of the passengers and that made her late to her appointment. I forgave her in that particular instance. Unfortunately, she misses or reschedules about half of her appointments. Struggling with obesity, chronic pain, and severe anxiety, she often has trouble making the journey in. When she does make it, she often looks at me skeptically and says, “But, doc, I have to keep eating even when I’m not hungry, you know, to feed my insulin.” It is difficult for Charlene to grasp the concept that she doesn’t need to constantly eat to prevent hypoglycemia.

Charlene normally attends our appointments in dark-colored sweat suits, waiting at least five minutes before she actually makes eye contact with me. Today, she presents herself in a colorful dress and a smile on her face. She immediately makes eye contact with me. Reviewing her chart, I notice that she had followed up with her endocrinologist as well as our diabetic educator.

“I know I have a ways to go, but I’m feelin’ good. I’m even feeding my insulin less, and I think that’s helping.”

These are big steps. I congratulate her, and together we review her glucose logs, meticulously making changes to her already-complex insulin regimen.

I ask next about her anxiety.

“I’ve been going to my women’s group every week, but, doc, I’m still worried all the time. What if I lose my insurance?”

To this, I don’t have a good answer. I can’t solve this problem as I can with her insulin. All I can do is validate her concerns.

Charlene is on Medicaid, as are about half of my patients, and she is currently on disability. As generalists, we have to accept that the greatest determinants of our patients’ health lie outside of what we were taught in medical school. Charlene’s obesity and poor control of her diabetes all stem from significant generalized anxiety disorder, limited health literacy, and difficulty physically making it to clinic. Over the past year, she has been treated medically for anxiety, enrolled in a support group, and provided with biweekly diabetic education. She has also received transportation to clinic paid for by her insurance, which has significantly increased her attendance. By and large, our interventions are not medical; rather, they target a much broader psychosocial context. We are able to provide these interventions in Charlene’s case because of her insurance’s ability to afford them. She happens to have Medicaid, but a large portion of our patients have insurance through the Affordable Care Act (ACA).

With the ACA constantly being threatened, the need for physician advocacy has become more immediate. I shared Charlene’s story with my state senators in hopes that this will personalize that which has become so political. I also encouraged Charlene to write to them as well.

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WE HAVE SO MUCH WORK TO DO

Joseph Conigliaro, Editor in Chief, *SGIM Forum*

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Tonight, my associate chiefs and I had a meeting with several faculty in my division to discuss recent concerns over productivity targets and how to improve the current low morale in one of the largest practices in our health system. We sat and listened, and I worked hard to give people the time to vent their frustrations without interruptions or getting defensive. “What do you mean I didn’t communicate the rationale behind the RVU targets?” “Of course we value the academic non-clinical work that you are doing.” They needed to be heard and they were right.

So much of what we heard during that meeting has been echoed over and over again over several years in the *Forum*, at national meetings, and other venues; it is directly related to the overwork, under appreciation, and lack of compensation that is the plight of academic general internists. I work with some of the best physicians, educators, and researchers in my 30-year career. They weren’t complaining for themselves but in defense of an ideal, academic general medicine environment—one that meets the patients’ needs, trains students and residents, and is rewarding for faculty.

In the April *Forum*, some concerns are discussed and a few answers are proposed. Dr. Maria (Gaby) Frank describes that hospitalists who decide to admit their patients under Medicare’s definition of *observation care over inpatient* may be imposing major financial hardships on them. These regulations can strain the patient-physician relationship and affect the recommendation for post-acute care services. Dr. Marcie Levine and colleagues describe how their program benefited from the expansion of the role of the medical assistant to more of a care coordinator to achieve the quadruple aim-enhancing patient experience, improving population health, reducing costs, and improving the work life of health care providers, including clinicians and staff. Dr. Lauren Block and her colleagues describe their interprofessional collaborative practice training program, the IMPACcT program, that also makes use of medical assistants as key members of the team.

This month’s *Forum* also touches upon several important issues that are not only facing generalist physicians but also the country. Dr. Keith vom Eigen describes the impact of the new tax law on health care, and it’s not pretty, as it relates to health care access and affordability. Dr. Michelle Fleshner describes the rewarding practice of physician as advocate.

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SGIM AND THE NEWTONIAN SOLUTION

Thomas H. Gallagher, MD, SGIM President, and Giselle Corbie-Smith, MD, SGIM President-elect

As we transition to the Corbie-Smith presidency, the next year will involve significant attention to strategic planning and focusing our priorities as an organization. These priorities will inform work on long-term financial planning for the organization and increased attention to fiscal stability. We will be implementing recommendations from the Communication Audit to improve internal and external communications. And there will be continued attention to organizational efficiency in order to stimulate innovation and focus on emerging issues facing our members.



As it turns out, Sir Isaac Newton was on to something. Newton's First Law is a statement of inertia, highlighting that objects will remain in their state of motion unless a force acts to change that motion. Almost 100 years after Newton's death, mathematician Lazare Carnot published the first description of what is now understood as entropy, the notion that within any closed system, the random and disordered interaction of moving parts represents a waste of energy. This definition was later expanded to include the understanding that entropy naturally increases. SGIM, as an organization of energetic generalists, has many pieces in motion, some of which need redirection, a few at rest that need to move forward, and all at risk of organizational entropy. Conscious effort will be required to harness and leverage that energy into coordinated and focused forward movement, since none of us have extra human or material resources.

SGIM as an organization is currently doing many

great things, but is overcommitted and lacks a stable structure to support all of the important work in which our members are engaged, resulting in outstanding staff being stretched to the limit. This year, Council decided to take a look at our overall structure in order to focus the energy of volunteer members and staff, and to ensure we are organized in a way that provides appropriate support for all important ongoing work. What we saw was a complex mixture of Committees, Task Forces, and Interest Groups, all doing important things, but some more aligned with our strategic priorities than others, and overall insufficient coordination that has led to duplication of effort with a strain on human resources.

Of particular interest during this review was the role of Task Forces in our organization, a topic that was examined 10 years ago by the Council. The resultant 2008 report articulates how Task Forces can best serve the organization. Their recommendations, adopted by Council, emphasize that Task Forces are intended to be time-limited groups that address topics of importance to

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DESIGNING AN INTERPROFESSIONAL TRAINING PROGRAM AND TEAM-BASED PRACTICE AROUND PCMH PRINCIPLES

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Patient Centered Medical Home (PCMH) principles have guided primary care redesign for the past decade¹. Many ambulatory educational redesign efforts are based on applying patient-centered principles to residency practices². Training in collaborative care models has been accepted as a goal by most major accreditation organizations, including the AAMC and the ACGME³. Despite evidence that training in interprofessional models improves outcomes for providers, trainees and patients, few longitudinal interprofessional training programs exist^{4,5}. With funding from the Human Resources Services Administration we conceived and built a longitudinal interprofessional training program with three goals: improving interprofessional education, creating a resident-led collaborative care practice, and increasing the primary care workforce through role modeling and mentoring. In this report we describe how our training program, the Improving Access, Care, and cost through Training (IMPACcT) practice, promotes realization of PCMH principles of team-based care, care coordination, quality and safety emphasis, improved access and continuity, and a whole person orientation.

Team-based care in our practice begins with a structured team-based huddle prior to each half-day clinical session. The huddle is designed to enhance the efficiency of each visit by assigning care team members to specific roles in pre-visit planning, allowing each to work to the top of their license. Team members “scrub” charts to prepare for the huddle, which is led by the medical office assistant (MOA). Residents introduce patients indicating key tests to be done by MOAs. Pharmacy students identify medication-related problems (polypharmacy, medication interactions) as well as needed vaccinations based on the patient’s age and risk factors. Physician Assistant (PA) students note recommended preventive healthcare and cancer screening modalities. Psychology team members highlight behavioral health needs and recommend strategies to optimize patient adherence. Finally, the structure of the patient visit is ascertained, assigning appropriate

team members (including trainees) roles in the allotted visit time to maximize visit efficiency. Care coordination is primarily facilitated by colocation of a patient access coordinator in the team office and inclusion of the coordinator in all clinical activities including the huddle. The coordinator serves as scheduling navigator for patients, calling to remind patients of upcoming visits, and addressing scheduling and insurance barriers to facilitate appointments. The coordinator participates in the huddle as well as more detailed clinical discussions to meet patient care needs. As a participant in the clinical discussion, the patient access coordinator schedules follow up visits (primary, specialty, and testing) at the time of the visit, balancing timely access, continuity, and coordination across care transitions.

To capitalize on the talents of our interprofessional trainees, we have developed a quality and safety initiative focused on collaborative medication reconciliation. Team medication reconciliation begins with pharmacy team members identifying patients with complex medication regimens (e.g., polypharmacy, recent discharge, adherence barriers, high-risk medications) and then completes medication reconciliation for identified patients and with the support of other team members as needed (e.g., with the psychology student to help address adherence issues). Medication discrepancies, recommendations addressing medication-related problems, reported side effects, or adherence problems are discussed with the team and a revised medication plan is developed and reviewed with the patient. Given the evolving importance of avoiding polypharmacy, a proton pump inhibitor deprescribing initiative was started in the last year, supported by the Institute for Healthcare Improvement⁶. All patients taking proton pump inhibitors are identified by the pharmacy student during the huddle. If the patient meets safety criteria for potential de-escalation or deprescribing, options are discussed with the patient and clinical team until a mutually agreeable plan is reached. To date,

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WILL GRADUATE MEDICAL EDUCATION AT VA HOSPITALS SURVIVE THE CHOICE ACT?

Rebecca Shunk, MD, Sarah G. Candler, MD, MPH, Mark Liebow, MD, MPH

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Since its initial partnership with academic medicine after World War II, the Department of Veterans Affairs (VA) has trained many of the health care providers of the future. Over the last few years under the Veterans Access, Choice and Accountability Act of 2014 (Choice Act) there has been an even greater expansion of primary care with approximately 350 new GME FTE positions primarily in internal medicine. These increased numbers of VA trainee positions are needed to care for veterans and the increasing demands on the healthcare workforce particularly in primary care training.¹

The initial affiliations served two purposes: to train healthcare providers and start a pipeline for potential future VA staff. Today's programs continue both missions. However, recent efforts to outsource veteran care while expanding training programs create uncertainty about the future of the VA as a health care provider and leader in education.

Sixty percent of all practicing physicians in the United States received some of their training at a VA². As part of the largest integrated health network in the United States, trainees learn skills in resource utilization, interdisciplinary communication, and care for a medically and psychosocially complex patient population—skills that are widely applicable in practice.

Current funds, managed by the VA's Office of Academic Affiliation (OAA), support the "largest education and training effort" in the United States for health professionals. The VA partners with 112 LCME-accredited and 35 AOA-accredited medical schools, providing educational support and collaboration³; OAA will fund 11,000 graduate medical positions in 2018. Of those positions, approximately 3,200 are in internal medicine, representing a significant proportion of all internal medicine positions in the country.⁴

In response to concerns of insufficient access to care, the Veterans Access, Choice and Accountability Act of 2014 (Choice Act) began paying for non-VA providers to serve veterans who cannot otherwise be seen in a timely manner. However, the academic community became worried that expansion of this program would decrease both opportunity and funding for trainees at

the VA as patients and payments are diverted elsewhere. The Choice Act also provided funding for approximately 350 new GME full-time equivalent (FTE) positions, primarily in internal medicine.

Several bills are currently in Congress that impact the VA. The Caring for Our Veterans Act of 2017 (S. 2193) reaffirms the VA-academic affiliations and provides further increases to VA graduate medical education (GME) funds while sunseting the Choice program. It has passed out of committee and is pending before the full Senate. However, the Care Veterans Deserve Act

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(H.R. 1152) would make the Choice program permanent and does not create new GME slots. It has not yet been considered in committee.

The Senate bill has a clause (Section 211) mandating a service commitment to the VA in exchange for funding 1,500 new residency positions, which could be in Federal programs other than the VA. The VA has already invested in pilot programs, explicitly built to develop its own workforce in both primary and specialty care. These Centers of Excellence (CoEs) are designed to prepare interprofessional teams of trainees to provide high-quality, coordinated care to veterans, and each site is tasked with measuring not only the standard effectiveness of curricula but also the rate at which trainees remain in the VA system after graduation⁵. However, these programs' participants are self-selected and the hope for post-training service is not a mandatory commitment. The proposed legislation indicated that any trainee funded in a program created by S. 2193 would be required to complete a VA service commitment of as many years as the years of support received, a model

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HOW WILL FEDERAL TAX “REFORM” AFFECT HEALTH CARE?

Keith vom Eigen, MD, PhD, MPH

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Good news, your taxes are going down! Uh oh, you’re losing your health insurance! Depending on your perspective, the recent federal tax overhaul may be the greatest tax reform of recent years, with tax cuts for all, paid for by supercharged economic growth. Or, it may be the worst tax policy of modern times, with a budget-busting giveaway to the wealthy that will cause millions to lose social services and health insurance.

The Tax Cuts and Jobs Act (TCJA) of 2017 is likely to have far-reaching and long-lasting effects on the national economy, business environment, state and local budgets, and individual finances. It is also the most important healthcare legislation passed by the federal government since the ACA. It will impact the healthcare system at multiple levels, and the ripple effects could dramatically alter the healthcare landscape for years to come.

Whatever your opinion of this complex bill, known unofficially as the Tax Cuts and Jobs Act (TCJA) of 2017¹, it is likely to have far-reaching and long-lasting effects on the national economy, business environment, state and local budgets, and individual finances. It is also the most important healthcare legislation passed by the federal government since the Affordable Care Act (ACA) of 2010. It will impact the healthcare system at multiple levels, and the ripple effects could dramatically alter the healthcare landscape for years to come. As it rolls out over the next decade, and beyond, we can expect to see significant effects on health insurance availability, access to care, and healthcare costs.

The provision that will have the most obvious and direct impact on health care is the elimination of the ACA tax penalty for individuals not covered by a qualified health insurance plan. The “individual mandate” was included in the ACA to counterbalance the requirement that insurers sell coverage to anyone, regardless of their health status. With elimination of this penalty, many individuals, especially those who are younger and healthier than average, may decide not to

buy health insurance, driving up premiums for the older and sicker population left behind. This could potentially send health insurance exchanges into a “death spiral,” with rising costs driving out more and more people until insurance becomes unaffordable for most. But the Congressional Budget Office (CBO) expects the exchanges to stabilize, albeit with 13 million more Americans uninsured by 2027, and with premiums rising 10% annually above baseline projections. CBO projects that with fewer buying insurance plans on the exchanges, federal subsidies will be reduced by \$338 billion over 10 years.² However, this does not account for the costs of uncompensated care shifted onto hospitals, providers, and other payers, the societal costs of worse health outcomes, or the increased costs of caring for a population with less access to care.

A less direct, but potentially even more important, effect of the TCJA is its overall impact on the federal budget and the growing national debt. While proponents argue that it will pay for itself by stimulating growth, most economists feel this is unlikely. CBO projects it will add about \$1.4 trillion to the debt over 10 years, adjusted down to about \$1 trillion after accounting for additional growth. Other analyses, however, suggest it could add more than \$2 trillion to the debt.³ Budget deficits could get even worse if there is a downturn in the economy. The reality is that over the foreseeable future, Congress will face rising deficits and growing pressure to cut spending, especially on domestic non-defense programs, such as Medicare, Medicaid, and Social Security. Congressional leaders have already indicated their intention to target these programs for cost reductions, and the current administration seems eager to support this.

Cuts to Medicare and other federal health programs are likely to fall heavily on hospitals and providers, and could have far-reaching effects on access to health care, especially for the most vulnerable Americans. Changes are already being proposed for Medicaid, such as work requirements and paperwork obstacles, which seem intended to reduce costs by limiting access. While “reforms” to popular social programs could carry sig-

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TRANSFORMING MEDICAL ASSISTANT TO CARE COORDINATOR TO ACHIEVE THE QUADRUPLE AIM

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Many healthcare institutions are transforming their delivery of primary care due to workforce shortages, increasing medical complexity of patients, an aging population, escalating costs, and pressures to provide better quality and more efficient care.¹⁻³ Primary care redesign often involves shifting from the traditional physician-centric model towards care delivered by teams, allowing each member of the health care team to practice at the level commensurate with their training, skill, and knowledge. One member of the team has emerged as increasingly important, the medical assistant. Previously the scope of the medical assistant was limited to the role of placing a patient in the exam room and obtaining vital signs (“rooming”). The role is now expanding to encompass functions such as health coach, care coordinator, scribe, phlebotomist, and preceptor.³⁻⁴ More meaningful contributions of the medical assistant in team-based primary care may lead to benefits across all domains of the quadruple aim: patient experience, cost savings, quality of care, and physician and staff satisfaction.⁴

In the Ten Building Blocks of High Performing Primary Care, a framework for robust primary care articulated by the University of California San Francisco’s (UCSF) Center for Excellence in Primary Care (CEPC), one of the foundational blocks is Team-Based care.⁵ In the CEPC teamlet model, the medical assistant plays an integral role on the team and carries out a number of higher level functions within his/her scope of practice. This expanded medical assistant role in the teamlet, referred to as Care Coordinator, further evolved at Stanford Primary Care. The role was first implemented at Stanford Coordinated Care, a clinic founded in 2012 to drive down the cost of care for the most medically complex patients by providing comprehensive, team-based primary care. Supported by other team members,

the Care Coordinator is the patient’s main contact with the clinic. They are present and take notes during visits, provide health coaching and care navigation to patients as well as support population health management: activities expected to positively impact patient experience, cost, and quality of care. Each Care Coordinator has a panel of about 125 patients in this low volume, high touch practice for the highest utilizers of health care. Stanford Coordinated Care was designed to promote patient activation, developing the patient’s capacity for behavior change and improve self-management skills in the context of a trusting relationship between the them and their health care team; the medical assistant plays the key role in cementing that relationship.

Expanding the role of the medical assistant to care coordinator has led to improvements in team cohesion, meaningfulness of clinic work, patient trust, and population health measures. Factors leading to the success of the Care Coordinator role underscore the importance of putting systems into place that facilitate professional fulfillment and joy of practice for all team members (i.e. the fourth quadruple aim).

In 2015, Stanford Primary Care adapted the Care Coordinator role when initiating a broad-based practice redesign effort, Stanford Primary Care 2.0. Based on the experience of Stanford Coordinated Care and research from UCSF’s CEPC, Care Coordinators in Stanford Primary Care 2.0 have responsibilities that include expanded rooming tasks, scribing, health coaching, previsit planning, and in-basket management. Within a team-based practice model, Care Coordinators work directly with patients during the primary care visit and

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UNDER A HOSPITAL'S MOON: A TALE OF OBSERVATION CARE

Maria (Gaby) Frank, MD, FACP, FHM

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As a hospitalist, I have dealt with inpatient and observation care issues for many years. Because hospitalists' patients are outpatient generalists' patients, these issues encompass the spectrum of patients cared for by SGIM members. Using two short clinical scenarios, I will highlight the daily concerns that hospitalists and their patients face; from financial burden, patient-physician relationship strain, readmission, to the safe recommendation of post-acute services.

Mr. DES and Mr. BMS are 68-year-old twin brothers. They have no significant past medical history—they exercise regularly and report remote nicotine use (1 pack per day x 15 years). They presented to the ED for Chest Pain and were admitted for further work up. Work up for both included a left-heart catheterization that revealed a 90% LAD obstruction, and each received a stent. They were discharged within 48 hours. Mr. DES, however, was admitted under INPATIENT STATUS, yet Mr. BMS was admitted under OBSERVATION CARE, paying \$817 out of pocket more than his sibling.

In brief, according to Centers for Medicare & Medicaid Services (CMS), observation care is a subset of outpatient services status, and is defined as the following:

“A well-defined set of specific, clinically appropriate services, which include treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital ... and in the majority of cases the decision ... can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do outpatient observation services span more than 48 hours.”¹

For those needing a quick review of how Medicare is structured, we can summarize it as four parts. Medicare Part A covers inpatient services and usually has a fixed annual deductible. Part B covers outpatient services, and usually carries a deductible and 80/20 cost sharing per service (80% CMS, 20% beneficiary); it does not cover pharmaceutical drugs and has no Skilled Nursing Facilities benefits. Part C, or Advantage, refers to supplemental insurance plans and varies between different private insurers. Part D, or Medicare prescription drug benefit, is also considered supplemental insurance and subsidizes the cost of prescription medications and pre-

scription drug insurance premiums for Medicare beneficiaries. Observation care is a subset of Outpatient status, hence covered by Medicare Part B; conversely leading to a highly variable financial liability to the beneficiary, particularly depending on services provided during hospitalization. The financial burden for the patient will vary based on plan and whatever supplemental insurance the patient may have; however, using the 80/20 example above a patient may receive a bill for 20% of all hospitalization cost plus 100% of medications.

Therefore, when a patient presenting to a hospital or clinic needs to be admitted, the provider decides if this should be as Inpatient (Medicare Part A) or Outpatient/Observation care (Medicare Part B). Nevertheless, in most hospitals the determination is made not by the provider, as stipulated in CMS guidelines, but by a review group including utilization management, social work, physician advisor, etc. In some cases up to 35% of instances, determination will mismatch a provider's clinical prediction. Several medical necessity screening tools (i.e., Milliman Care Guidelines^R [MCG]) are available for CMS and its contractors, who occasionally use a tool that may not coincide with the one used by the admitting facility. Most tools include a combination of intensity and severity of illness as well as medical necessity documentation. Different jurisdictions, even within one hospital, may use different tools.

Based on a Medicare Payment Advisory Commission (MedPAC) report, outpatient services have increased by 47.4% in a 10 year-period (2006-2015) and inpatient discharges have decreased by 19.5% in the same time period. In 2013, in an effort to decrease prolonged outpatient hospital stays, CMS finalized the “2-midnights” rule, which was to be fully imposed by audits, and enforced by CMS, as of October 2015. This rule proposed that patients, expected to require at least 2 midnights (each Diagnosis Related Group [DRG] has a known mean Length Of Stay [LOS]) of medically necessary care while in the hospital, be classified as inpatient; while those below that timeline be categorized as observation. This rule however failed to achieve the goal of reducing prolonged observation stays. This failure may be in part due to the audit and recovery process, which is outsourced by CMS to external contractors. The Medicare's Recovery Audit Contractors (RACs) are in charge of

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auditing and enforcing suitability of payment. The RAC's payment incentives are based on amount of money recovered to CMS, in many opportunities by declining inpatient status claims and denying reimbursement for services provided. Recently CMS has replaced RACs by Quality Improvement Organizations (QIO), as of today; there is no available data to assess the outcome of this change.

In August 2015, the Notification of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act, PL 114-42) was signed into law by President Obama; and was implemented, after bipartisan and bicameral support, in March 2017. The law requires that hospitals inform patients hospitalized under Observation Care, for 24 or more hours, about their status and the financial implications. Hospitals must obtain a signature from the patient on the Medicare Outpatient Observation Notice (MOON) form within 36 hours of applicable hospitalization. After recent media attention, families and beneficiaries have begun to contest their status; which is understandable, particularly because physicians make no obvious distinction, based on status, when they provide medical care. These situations are an added emotional load to patients during an already stressful situation and damage physician-patient relationship and trust.

Mrs. SNF and Mrs. LTC are 93-year-old twin sisters. They have been living independently for the last 25 years. Their family is worried about their ability to perform their activities but want to respect their autonomy. They have been seen in the ED on multiple occasions for falls and were admitted for failure to thrive. They underwent a complete work up which was non-contributory. During their three-day (midnights) hospital stay, Physical and Occupational Therapy recommended discharge to a Skilled Nursing facility (SNF). Mrs. SNF had been admitted under INPATIENT STATUS and was discharged to the

SNF of her and her family's choice. All her SNF costs were covered by Medicare. Mrs. LTC on the other hand had been admitted under OBSERVATION CARE, which resulted in her facility costs not being covered under Medicare.

This is yet another downside of Observation status. At least three days of an acute inpatient stay are necessary, under Medicare rules, for a beneficiary to qualify for post-acute services such as a SNF. Outpatient stays do not count towards the three-days rule, henceforth placing the patients at risk for high out-of-pocket payments, and/or the choice to opt out of those necessary services placing them at risk for injuries and readmissions. In 2015, MedPAC recommended that CMS revise the 3-day rule for SNF placement and count "any" hospital day (inpatient or observation) towards the "3-days" requirement. Currently, this rule adds significant barriers for patients to access essential post-acute care. The Improving Access to Medicare Coverage Act of 2017 (S. 568/H.R. 1421), also known as the Courtney-Thompson Bill, is a bipartisan, bicameral bill introduced to Congress in an attempt to provide a permanent solution to the "three-days" issue. This bill states that beneficiaries who spend three days in the hospital, regardless of the inpatient/observation classification, would be eligible for Medicare SNF benefits.

Many patient advocacy groups are actively working on the Improving Access to Medicare Coverage Act^{2,3}, and other professional societies⁴ have made Observation as their main advocacy imperative. I invite you to review the Society of Hospital Medicine White paper on Observation Stays⁴ to further your understanding of the topic. The media⁵ have been interested in the topic as well. Observation care can affect many of our elder relatives and the most fragile General Internal Medicine patients, and it is our duty to advocate for them.

In summary, observation stays for hospitalized patients:

- **Originally instituted as a means to decrease number of unnecessary admissions**
- **Count as Outpatient status, hence covered by Medicare Part B**
- **Do not count towards "readmissions" and therefore there are an incentive for hospitals to improve quality performance scores**
- **Carry a highly variable financial liability to the beneficiary and/or hospitals. Some beneficiaries are unable to cover the cost of their observation bills leaving the hospital responsible.**
- **Currently under the "two-midnights" rule**
- **Require an extra administrative burden related to Utilization Management determination of "admission status", and collection of signature on MOON form**
- **Use many severity tools for status determination, leading to inconsistency about how CMS rules are implemented and audited by QIOs (former RACs)**
- **Application of NOTICE and MOON form add emotional burden and stress to patients and families and may damage physician-patient relationships and trust**
- **Three-day inpatient stays (not observation days) are required to qualify for Medicare SNF coverage**
- **93% of hospitalists rated observation policy as a critical advocacy issue for them and their patients**

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the Society that cut across multiple Committees, produce specific deliverables, and are reviewed for continuation every three years. Sensing that the current state of our Task Forces might not be aligned with this policy, Council decided to undertake an in-depth review focused specifically on the role of Task Forces within the organization.

This review process, led by Council members Eva Aagaard, April Fitzgerald, and Luci Leykum, was intensive and far-reaching, involving numerous conversations with SGIM staff, listening calls with Task Force and Committee chairs, and study of multiple documents, including the original charge documents for each Task Force, as well as their current annual and mid-year reports. Council also devoted a significant portion of the December in-person retreat to this topic.

Several conclusions emerged from this in-depth review of the current state. First, Council applauded the outstanding work that the current group of Task Forces is doing and wanted to ensure that this work has an enduring structure, as these accomplishments have greatly benefited the Society. Nonetheless, there was considerable misalignment between Task Forces and their envisioned role in the 2008 policy. Council concluded that this misalignment has occurred gradually but steadily over time and stemmed largely from the lack of triennial re-

view of each Task Force called for in the 2008 report. This created several entropic challenges, including:

- **Opportunity cost: our staff capacity to support Task Forces has been stretched to the point where adding new Task Forces to address emerging issues is very difficult;**
- **Inefficiency: due to drift of the goals and activities of Task Forces over time relative to SGIM's strategic priorities, as well as redundancies between the activities of Task Forces and Committees;**
- **Communication problems: information flow is not optimized between SGIM staff, Committees, Task Forces, Interest Groups, Work Groups, and Council; and**
- **Inconsistency in composition: wide variation in the size, membership, governance, and scope of work of Task Forces.**

Council considered two possible root causes for the gap between policy and practice related to our Task Forces—first, the possibility that the policy itself was fundamentally flawed; second, if the policy was sound, the difficulty likely arose from misapplication of the policy. After careful consideration, Council unanimously affirmed that the policy articulated in the 2008 Report on Task Forces was sound and should guide the organization going for-

ward. Therefore, drawing again from Newton, the solution called for the application of energy to redirect the motion of our organization related to its Task Forces. This process is ongoing and has evolved in several steps.

- **Step 1: define organizational structures and associated staff support. Council and SGIM staff worked closely on articulating our organizational structures and associated staff support. Part of this work involved the creation of a new organizational unit known as *Commissions*. Commissions are groups addressing topics of enduring importance to the Society that require considerable coordination with multiple Committees or other units. Commissions are expected to achieve specific deliverables consistent with the Council's strategic priorities and be reviewed biannually. The degree of staff support associated with each group is important, as one distinguishing factor between the different organizational units is the degree of staff support provided to each. A document describing each of these organizational units and associated staff support was distributed to the leaders of Committees and Task Forces, and is available to members on request. The document also clearly identi-**

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BREADTH (continued from page 1)

“Now that you mention it, we were talking about writing to them at my women's group and we might do just that.”

My residency program has established a group of residents who are all starting to incorporate patient advocacy into their practice. We meet once per month and learn about how to advocate for our patients, whether it be through story telling or trips to Harrisburg

to lobby for bills. By attacking this larger context, we hope to affect the medicine as well.

Charlene is finally making progress. Medicaid has allowed her to receive appropriate treatment, and it has given us as generalists the opportunity to improve her health outcome. The current political climate has created a unique opportunity—it has given rise to a new generation of physicians and

patients who have become inspired to advocate for health care.

As the appointment is ending, Charlene's Hemoglobin A1C result comes back and has come down from 8.8 to 7.6—she has not been below 8 in years.

She cheers loudly and we high five. “Doc, I am so excited!”

Acknowledgements: Dr. Gaetan Sgro for his thoughts and edits on this piece.

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fies those activities within the organization that are intended to be time-limited and the process for oversight and review of each organizational unit.

- **Step 2: reorganization of all current Task Forces.** On February 1st of this year, each Task Force was notified of Council's proposed disposition for their group, which involved every Task Force being transitioned into either an Interest Group, Commission, being integrated into an existing Committee. These proposed dispositions also included transfer of some Task Force activities (such as programming for the Annual Meeting or development of mentoring programs) into the relevant Committee, with the remainder of that Task Force's portfolio continuing via an Interest Group. Each Task Force was given six weeks to respond to Council's proposal, after which Council will make and communicate its final decision in advance of the upcoming Annual Meeting so that each of these groups can incorporate this decision into their planning for the next year.
- **Step 3: peeling the onion.** Anytime a reorganization of this magnitude is undertaken, an initial change precipitates the need for further reorganization. An important finding that emerged from Council's review of organizational structures was

the presence of inefficiencies and some duplication related to developing programming for the Annual Meeting and creating high-functioning mentoring and career development programs. The next step in this process will involve reshaping how the organization approaches the Annual Meeting Program Committee, as well as our career development and mentoring initiatives. This process has also stimulated the Task Forces to take a fresh look at their priorities and initiatives, with new ideas emerging. We anticipate issuing a call for new Task Forces with a special focus on topics that are forward-looking and innovative. Throughout, a continuous improvement framework will guide Council as we implement these changes and refine our approach going forward.

Newton didn't stop with just one fundamental law of motion. His third law notes that every action leads to a reaction. Council is acutely aware that making changes of this magnitude can be difficult under the best of circumstances, and that some of the decisions have caused discomfort and disappointment to members who have volunteered their time, making outstanding contributions over many years. It is our strong belief that taking these active steps to reshape our organizational structure is critical to avoiding further increas-

es in organizational entropy and additional challenges down the road. However, these long-term benefits certainly do not ease the short-term discomfort. Council hopes that the membership can engage constructively in our shared goals of a high-functioning learning organization that has the structures and bandwidth to address the issues we all care about.

As we transition to the Giselle Corbie-Smith presidency, the next year will involve significant attention to strategic planning and focusing our priorities as an organization. These priorities will inform work on long-term financial planning for the organization and increased attention to fiscal stability. We will be implementing recommendations from the Communication Audit to improve internal and external communications. And there will be continued attention to organizational efficiency in order to stimulate innovation and focus on emerging issues facing our members.

Council's intention as we undertake this far-reaching reorganization has been to take action that brings all of our motion into closer alignment with our goals and reduces entropy. Physicist Marie Curie, the first female Nobel Prize winner, noted that "I was taught that the way of progress was neither swift nor easy." We welcome your thoughts about how best to move together down this important path.

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FROM THE EDITOR (cont. from p 2)

Finally, I want to give a shout out to SGIM members who will be starting their LEAD, TEACH, and LEAHP scholar's programs at this upcoming national meeting. Their respective journeys in those programs will likely leave indelible marks on their careers, and I believe the work they do will provide the answers for the issues brought up by my faculty at our faculty meeting.

Happy Spring!!

SGIM

32 of 63 patients screened have had proton pump inhibitors deprescribed, a total decrease from 10.2% to 8.1% of the practice population.

Improved access in the IMPACcT program is facilitated through practice redesign. Extended hours are available one evening a week. Attending physicians have open hours to allow continued patient access during those times that residents are unavailable to support pre-visit planning and care coordination. Previsit confirmation calls by the patient access coordinator allow timely cancellation of appointments that are no longer needed, decreasing the “no-show” rate and thus enhancing appointment access. As follow up appointments are scheduled by a team member involved in clinical discussions, physician continuity is enhanced significantly compared with the conventional “front desk” scheduling model utilized in our traditional resident practice.

An orientation to comprehensive care is achieved through the clinical huddle and the “clinic-within-a-clinic” structure which allows all team members to gain familiarity with the patient panel. Patient needs are anticipated based on past visits and the patient’s history, and visits are arranged to meet these needs. For instance, a patient with a complex medication history receives extended medication management with the pharmacy faculty. A patient with depression may be scheduled to see the psychologist and the physician in a joint visit. A PA or

medical student will see patients for annual physicals and focus on preventive health needs as well as any acute problems or concerns. Social workers and case managers are engaged during the huddle to plan an approach to the visit before the patient arrives to the office. Given the resident practice operates in a 4+1 model of inpatient and outpatient responsibilities, patient needs which extend beyond the visit are discussed at the end of the week during a team sign-out, so that any unresolved issues and questions can be passed along to incoming team members the following week.

The collaborative care model in the IMPACcT practice was built by embedding PCMH principles into the structure of our team and approach. A creative approach to utilizing the available space, deploying team members, scheduling practice visits, has allowed us to weave care coordination and access into the fabric of our practice. Designing our huddle and team signout with specific roles for trainees from various professions creates an inclusive yet structured approach to team-based care and allows for attention to the whole patient. Capitalizing on the strength of the pharmacy team allows focus on medication reconciliation and deprescribing as key safety and quality initiatives. Our goal is to inspire trainee graduates grounded in interprofessional education and high-functioning collaborative care to pursue careers as leaders in primary care redesign.

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CLINICAL UPDATE: PART II

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continue with the inter-visit work of health coaching, care coordination, and population health management. Early outcome trends from the model include improvements in meaningfulness of clinic work (which may be protective against burnout) and lower provider and staff burnout.⁶ A formal evaluation is forthcoming, but early data have also highlighted positive movement in team cohesion, patient satisfaction, and population health measures such as A1C testing and control (unpublished data). Interviews with our Care Coordinators highlight their increased sense of empowerment: “I love being able to have more control. I feel more respected in this position because they trust me to do all these extra things.”

Factors leading to the success of the Stanford Coordinated Care and Primary Care 2.0 models underscore the importance of putting systems into place that facilitate professional fulfillment and joy of practice for all team members (i.e. the fourth quadruple aim). These factors include:

1. *Adequate tools and training.* A robust scribing and health coaching training program, using a flipped classroom approach, has been developed and implemented. Training is provided in an interprofessional education setting that includes Care Coordinators, physicians, and other team members to promote collegiality, mutual respect, and trust.
2. *Team building.* Weekly 1-hour case conferences include the entire team in discussion of patient care and quality improvement projects.
3. *Recognition.* The creation of step advancements with pay differentials based on skills within the Medical Assistant job category (MA I, MA II, etc.) has been crucial for engagement. Responsibilities warranting an initial wage increase include population health outreach, schedule management, precepting

of new Care Coordinators, and medical social work tasks. Care Coordinators providing health coaching, in-visit clinical documentation, and clinic-level leadership are able to progress further along the advancement ladder.

To sustain this model and optimize Care Coordinators’ interest and engagement through the organization, future plans include:

1. *Care Coordinator Academy.* Developing a Stanford Primary Care ‘Care Coordinator’ training program will ensure standardized onboarding, work expectations, opportunities for expanded training, and continuous education of all medical assistants. Training in advanced skills such as health coaching and scribing will be included in the curriculum.
2. *Professional Development in Quality Improvement.* Care Coordinators will be invited to participate in a rolling training for coaching and mentorship in implementing a quality improvement project that is available for all primary care team members. Skills training in quality improvement and project management will support their progression through the career ladder.
3. *Pipeline Development.* Stanford Health Care affiliates with a medical assistant certification program to provide intern placements, which helps identify and recruit talent into primary care clinics, while introducing them to in the culture and workflows prior to hiring.

The Stanford Coordinated Care and Primary Care 2.0 experience have demonstrated the ability of people trained as medical assistants to successfully expand their responsibilities to develop critical trusting relationships with patients as Care Coordinators. Patients who have received care through Stanford

Coordinated Care and Primary Care 2.0 report very high levels of satisfaction and appreciation for “their” Care Coordinator while Care Coordinators experience much increased levels of meaning in their work and integration into the team. This expanded role of the medical assistant has valuable potential for achieving the quadruple aim.

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nificant political risks in an election year, it fits with Republicans' long-term goals of reducing spending on social programs and shrinking the federal government.

Budget effects at the state level could be just as problematic for healthcare spending. The tax changes will have different effects across the various states, but some may face significant budget shortfalls as a result. Changes to the deductibility of state and local taxes, and limitations on mortgage deductions, will raise the cost of living in high cost states, putting a burden on housing markets and local budgets, while incentivizing high earners to move to low tax states. States already facing tight budgets could see revenues drop while the costs of Medicaid and other state funded social programs continue to rise. This could limit states' ability to fund Medicaid as well as other important programs addressing mental health, addiction treatment, and family support, at a time when demand for these services is rising. We may see states adopt some creative strategies to mitigate the effects of the tax bill, but significant disruptions are likely.

Hospitals, providers, and healthcare companies will also be affected. The most dramatic change is the permanent reduction of the corporate tax rate from 35% to 21%. While many businesses are already paying less than the standard rate due to deductions and other mechanisms, pharmaceutical companies, insurers, and other for-profit health related businesses could benefit substantially. How these gains will be reinvested or passed on to owners, investors, workers, or consumers remains to be seen. But non-profit entities such as hospitals and health systems with tax-free status may find it more difficult to compete against for-profit entities. At the same time, more patients will lose their insurance and fall back on the safety net system, causing an increased burden of uncompensated care. The corporate tax

changes could also have substantial effects on productivity, employment, investment, interest rates, inflation, movement of capital, trade deficits, and many other aspects of the business environment. Supporters are optimistic these effects will be positive, but much uncertainty remains.

The effects on individuals will vary considerably depending on income level, current deductions, family circumstances, location and many other factors. Most taxpayers are expected to see tax reductions for the first 10 years, but after that, more than half will actually see an increase compared to current rates. Lower-income individuals will see the least tax benefits, and will experience overall losses due to more expensive health insurance and cuts in social programs. After 2026, only corporations and the highest income individuals are expected to continue to benefit.

As for physicians, highly paid sub-specialists will likely benefit most from tax rate reductions, potentially exacerbating already extreme pay differentials among specialties. This could create further incentives for trainees to avoid careers in primary care. Physicians whose practices are set up as "pass-through entities" may see substantial tax benefits, and there may be incentives for others to reorganize along these lines. While the individual tax changes are set to expire in 2026, proponents are hopeful they will be extended beyond this. But such an extension has not been figured into revenue projections, and would produce even higher federal deficits than currently expected.

From a social perspective, one of the most important effects of the tax changes will be exacerbation of already historically high levels of inequality in wealth and income. Because the bulk of the tax benefit will go to high earners, the overall result will be to further concentrate wealth and increase inequality. Rather than mitigating the long-term trend towards greater

inequality, the TCJA will actually accelerate it. Aside from the negative effects this will have on health insurance access and affordability of care for the disadvantaged segments of the population, there is evidence that social inequality itself can have negative health effects by worsening health outcomes and raising costs.⁴

Although polls show the TJCA is unpopular with the public, it is unclear how its passage will affect future elections. Proponents are optimistic that support for the tax bill will increase as it translates into bigger paychecks, higher employment, and lower taxes. Opponents are hopeful it will energize the opposition and lead to Democratic gains, and eventually further healthcare reform. But even if Congress shifts to Democratic control, substantial changes are unlikely while we have a Republican president. The work to repair the damage to healthcare access and affordability will be an uphill struggle, at best.

So enjoy your tax cut... while you can!

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MEDICAL EDUCATION: PART II (continued from page 5)

akin to National Health Service Corps (NHSC) grants. It is not clear if and how those positions would be offered through the National Residency Matching Program as students matched in this fashion are then legally obligated to join a program requiring a payback. If and when the positions could be offered, it is unclear if they would fill.

While expansion of GME within the VA is an attractive idea, especially when lifting Medicare's cap on funded positions seems unlikely, practice changes driven by Congress by linking these positions to the Choice program could threaten the benefit of these expansions. The Choice program has been a significant strain on the VA budget and Congress has had to appropriate supplementary funding to the VA to keep it afloat⁶. There are concerns that if the program continues indefinitely, it will put pressure on the money available to the VA in general and could compromise the amounts available for spending on GME programs. Continuing the program also means the loss of patients to outside

providers, leaving fewer patients for VA trainees to see, potentially compromising the attractiveness—and some fear accreditation—of GME programs. It remains to be seen how these changes would impact the training of our future workforce and the care of our veterans.

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