Prescribing pharmaceuticals for patients is one major way that internists heal patients, making the cost of those drugs—purchased through mail-order, health plans, or directly from pharmacies—a growing issue in primary care. Since candidate Donald Trump first departed from the Republican Party line by promising to reduce drug prices, the health policy world wondered how. On Friday May 11, 2018, the Trump Administration communicated a plan through a policy speech delivered in the Rose Garden at 2:00 PM, formally announcing many of the components of American Patients First.¹

There is general bipartisan agreement that government intervention is needed to lower pharmaceutical prices with a 2018 poll finding 90% of Democrats and Republicans favoring federal negotiation with pharmaceutical companies.² National Health Expenditure data shows growth in pharmaceutical spending exceeds growth in other healthcare spending. According to the National Health Expenditure analysis from the CMS Office of the Actuary, the cost of pharmaceuticals as a percentage of overall health care costs has increased from 6.3% of healthcare expenditures in 1996 to 9.8% of overall health care spending 2016 and the compound annual growth rate of pharmaceutical spending was 8.2% during that period, in excess of overall medical spending growth during this time of 5.8%.

Simultaneously, High Deductible Health Plans (HDHPs) have grown rapidly for people with commercial coverage. Drug prices have become more visible because total drug spending has grown and high deductible plans that expose patients to drug costs more directly have become increasingly common.

The most striking part of American Patients First was the decision not to negotiate directly for drugs as was promised during the campaign.³ The absence of direct drug price negotiation in the policy proposal resulted in an increase pharmaceutical stock prices after the speech. While a controversial tool due to the potential impact on innovation, it is the policy option most likely to have a tangible and prompt impact on drug prices.

Overall, four major issues were discussed in the proposal:

1. **International Drug Pricing.** Canada, France, Japan, and the United Kingdom use their full negotiating power to negotiate lower drug prices for their healthcare systems. The Trump Administration plans to target the low-hanging fruit in the pharmaceutical industry by eliminating many of the most egregious pricing practices.

² Overall, the Trump Administration plans to target the low-hanging fruit in the pharmaceutical industry by eliminating many of the most egregious pricing practices.
A YEAR OF WORDS

Joseph Conigliaro, MD, MPH, Editor in Chief, SGIM Forum

“Either write something worth reading or do something worth writing.”
—Benjamin Franklin

 This month’s Forum marks the second year of my tenure as Editor in Chief. I know it’s a cliche but where did the time go? I cannot believe that a year has gone by since I took the reins from Dr. Karen Horowitz. With the help of Forum’s outstanding group of associate editors, SGIM Communications Director Francine Jetton, the SGIM staff in Alexandria, Managing Editor Frank Darmstadt, and Graphic Designer Howard Petlack, I made it through my first year. From July 2017 through June 2018, SGIM members and other colleagues wrote nearly 100 articles for Forum. During the past year we heard from you through our reader survey—we changed the look of Forum, tweaked a few things, and kept the things you liked to make a great publication even better. As part of our 40th-anniversary year, we introduced “Flashback40” and revisited articles from the Forum archives with a fresh perspective.

As we embark on the coming year, there are a few acknowledgements and reflections I’d like to share:

1. SGIM members are gifted writers with a broad range of expertise and ability to write about diverse topics. The quote above by Benjamin Franklin is appropriate for SGIM members as they do both. Over the last year, they provided articles on the role of the environment on health, health policy, issues of equity, improving care and the practice of medicine, and medical education to name a few. Keep it coming and continue to engage in areas not typically covered in traditional journals.

2. Never underestimate the capacity of your associate editors. There have been many times Forum associate editors have come through with outstanding copy from a diverse group of colleagues or wrote the copy themselves. A big shout out to Avi O’Gasser, where did the time go? I cannot believe that a year has gone by since I took the reins from Dr. Karen Horowitz. With the help of Forum’s outstanding group of associate editors, SGIM Communications Director Francine Jetton, the SGIM staff in Alexandria, Managing Editor Frank Darmstadt, and Graphic Designer Howard Petlack, I made it through my first year. From July 2017 through June 2018, SGIM members and other colleagues wrote nearly 100 articles for Forum. During the past year we heard from you through our reader survey—we changed the look of Forum, tweaked a few things, and kept the things you liked to make a great publication even better. As part of our 40th-anniversary year, we introduced “Flashback40” and revisited articles from the Forum archives with a fresh perspective.

As we embark on the coming year, there are a few acknowledgements and reflections I’d like to share:

1. SGIM members are gifted writers with a broad range of expertise and ability to write about diverse topics. The quote above by Benjamin Franklin is appropriate for SGIM members as they do both. Over the last year, they provided articles on the role of the environment on health, health policy, issues of equity, improving care and the practice of medicine, and medical education to name a few. Keep it coming and continue to engage in areas not typically covered in traditional journals.

2. Never underestimate the capacity of your associate editors. There have been many times Forum associate editors have come through with outstanding copy from a diverse group of colleagues or wrote the copy themselves. A big shout out to Avi O’Gasser, who took “Flashback40,” the special feature for SGIM’s anniversary year, and ran with it.

3. Always appreciate the work of your Managing Editor and graphic designer. Frank Darmstadt and Howard Petlack are the people behind the scenes that make it happen. Patiently waiting for copy and then turning a diverse collection of articles into a well-crafted issue. Thank you!!

Looking back on this first year, I can say that it’s been a little challenging and a little nerve wracking, espe-
PRESIDENT’S COLUMN

LET’S TALK ABOUT EQUITY
Giselle Corbie-Smith, MD, MSC, President, SGIM

For some time, our larger profession has embraced a focus on equity, as have other groups across the United States. However, in these turbulent and rapidly changing times, I fear our core value of equity may seem at odds with the current perspectives of some stakeholders and policymakers.

Equity has long been one of the defining values for this organization. In fact, the clear and unapologetic focus on ensuring health for all people is one of the reasons that SGIM has been my professional home since 1995. SGIM researchers, educators, and clinicians have led the field in the evolution from a focus on health disparities, describing differences in health by race and ethnicity, to a focus on health equity, developing interventions within systems of care to ensure all groups have the chance to live a healthy life. Our members have often been at the vanguard of helping communities leverage their strengths to address health issues of concern to patients and promoting equitable health for all people in all settings.

For some time, our larger profession has embraced a focus on equity, as have other groups across the United States. However, in these turbulent and rapidly changing times, I fear our core value of equity may seem at odds with the current perspectives of some stakeholders and policymakers. This difference in world view and emphasis could potentially compromise the impact of our dedication to improving the health of all people in all settings. How do we have an engaged conversation with those whose world views may be at odds with our own? What are the values that underlie many of the current conversations about health? What consistent messages regarding health equity can each of us incorporate in our interactions with our patients and others in our spheres of influence? I offer the work of the Robert Wood Johnson Foundation (RWJF) and some work we are doing in the Clinical Scholars Program, that I have the privilege of co-directing, as ways to help provide a focal point for these types of conversations.

In the RWJF Clinical Scholars Program, Drs. Carolyn Crump and Jim Emery from UNC Chapel Hill work with our fellows around stakeholder analysis and messaging to ensure their work is supported and accessible to the full range of stakeholders. They describe the values that underlie many messages about health: efficiency, effectiveness, and workplace environment.

...continued on page 7
COPING WITH HARASSMENT AND DISCRIMINATION IN HEALTH CARE: A PRIMER FOR LEADERSHIP

Quratulain Syed, MD; Nicole Redmond, MD, PhD, MPH, FACP; Jada Bussey-Jones, MD, FACP; Eboni Price-Haywood MD, MPH, FACP; Inginia Genao, M.D.

Dr. Syed (quratulain.syed@emory.edu; @anniesyed3), assistant professor of medicine, Division of General Medicine and Geriatrics, Emory University School of Medicine. Dr. Redmond (Nicole.Redmond@nih.gov), medical officer, National Heart, Lung, and Blood Institute, National Institutes of Health. Dr. Bussey-Jones (jcbusse@emory.edu), professor of medicine, chief, Grady Section General Medicine and Geriatrics, co-director, Urban Health Initiative, Division of General Medicine and Geriatrics, Emory University School of Medicine. Dr. Price-Haywood (eboni.pricehaywood@ochsner.org), director, Center for Applied Health Services Research Ochsner Health System. Dr. Genao (inginia.genao@yale.edu), associate chair, Diversity and Inclusion, Department of Medicine, associate professor, Yale University School of Medicine.

Introduction

Discrimination and harassment in the workplace are not rare phenomena in the U.S. healthcare industry where more than 60% of the surveyed physicians (primarily women, racial minorities, and international medical graduates) report experiencing workplace discrimination1. For example, 33% of female clinician researchers report sexual harassment at work2, 15% of LGBTQ physicians report harassment by colleagues and denial of patient referrals3 and more than 25% of physicians (mostly belonging to racial minorities) report quitting at least one job during their careers due to workplace discrimination4. Statistics in other healthcare professions are not encouraging either, with at least 50% of nurses reporting verbal abuse from co-workers5. In this article, we review definitions of commonly used terms, current laws, and recommendations for healthcare leaders to effectively manage incidents of peer discrimination and harassment and promote a culture of collegiality and healthy workplace.

Commonly Used Terms in This Article

1. Workplace violence: Any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at work. Worker-on-worker violence includes violence by coworkers, and includes bullying (repeated, health-harming mistreatment of a person); verbal or emotional abuse; and physical violence (including homicide). (The Centers for Disease Control and Prevention and the Occupational Safety Health administration).

2. Disruptive behavior (by Physicians): A style of interaction with others, including hospital personnel, patients, and family members, that interferes with patient care or adversely affects the health care team’s ability to work effectively (American Medical Association).

3. Workplace discrimination: Any workplace action, such as hiring, firing, demoting, and promoting based on a prejudice of some kind that results in the unfair treatment of employees (HR Hero).

4. Harassment: A form of workplace discrimination, which includes an unwelcome conduct based on race, color, religion, sex (including pregnancy), sexual/gender identity, national origin, culture, age, disability, or genetic information. It may include verbal comments or other verbal or physical conduct; or written content as workplace graffiti; posting, e-mailing, or circulating demeaning or offensive pictures, cartoons or other materials in the workplace. (The Equal Employment Opportunity Commission [EEOC])

5. Sexual harassment: A form of harassment based on sex, which includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature. (EEOC)

Legal Challenges

Workplace discrimination and harassment violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Americans with Disabilities Act of 1990, and the Immigration Reform and Control Act of 1986. However, victims of such incidents face many legal challenges. For example, an employer may not be covered by EEOC laws in cases where the victim is an independent contractor (locum physician) or in a solo/small group practice (based on total number of employees). Also despite the EEOC interpretation of the Title VII of the Civil Rights Act of 1964 to cover sexual orientation and gender identity-based employment discrimination, there is no federal statute that explicitly addresses employment discrimination based on sexual orientation or gender identity. Only 20 states have statutes that protect against discrimination based on both sexual orientation and gender identity.

continued on page 5
in employment, and only 3 states have laws on workplace bullying. Individual state medical boards have variable definitions of unprofessional conduct, and may therefore not be able to entertain complaints other than those of sexual misconduct or practicing under influence (alcohol, drugs).

Scenario
An openly gay physician has been working in a multi-specialty group practice for more than a year. He gets along well with his colleagues. However, he has noted that one of his colleagues who generally shares jokes in the lunch room, has been telling crude jokes targeting the LGBTQ community when he walks into the lunch room.

How Administration Should Respond to This Situation
Employers are legally required to look into complaints of workplace harassment/discrimination and engage in a prompt and thorough investigation. A few tips for the administration, compiled from guidelines by Society of Human Resource Management, U.S. Department of Labor, and HR Hero, include the following:

1. Be familiar with EEOC guidelines;
2. Develop adequate documentation of the events;
3. If you are a supervisor who gets a report of an incident of harassment or discrimination, do not begin the investigation unless you are designated to do so by your employer. Report the incident immediately to the human resources department (HR) or the person assigned to investigate such complaints;
4. Interview the victim, respondent (perpetrator) and all potential witnesses (bystanders);
5. Explain the seriousness of the complaint, the employer’s sexual harassment policy and investigation procedures to the complainant and the respondent;
6. Notify the police if criminal activities are alleged;
7. Take interim remedial measures during the investigation;
8. Take steps to avoid retaliation;
9. Explain to the victim that full confidentiality may not be feasible during an investigation, assure of the policy prohibiting retaliation and advise to report any retaliation to a supervisor or HR;
10. Avoid prejudging complaints;
11. Submit a written report summarizing the results of the investigation and making recommendations to designated company officials;
12. Notify the complainant and the respondent of any corrective actions planned; and
13. Develop a standardized process to ensure that like cases are treated alike, regardless of the relative stature of the parties involved.

How the Leadership Should Respond to Avoid Such Situations in Future
The following tips have been compiled from Employer’s Guide: Move Beyond Compliance, published by the AAUW:

1. Solicit input from a diverse and an inter-professional team to create well-defined policies that include examples of the prohibited behaviors, reduce fear of retaliation and explain disciplinary actions. Incorporate these into the employee handbook, and regularly train employees with the content using different methods.
2. Create a complaint procedure that identifies HR professionals designated to document and investigate complaints including harassment and bullying. Explain the investigation process and offer examples of proportionate corrective actions that may result at the conclusion of an investigation.
3. Conduct regular, anonymous climate surveys to ascertain the existing climate of inclusion and identify potential areas for growth.
4. Empower bystanders by providing trainings that impart skills needed to intervene and report harassing behavior.
5. Require leadership at all levels to exemplify a culture that is inclusive and values employees.
6. Educate all team members on appropriate professional behaviors consistent with the organization’s code of conduct, and hold them accountable for modeling the desirable behaviors.

Conclusion
Workplace harassment and violence are fairly prevalent in the healthcare industry, and can impact the overall health and wellbeing of healthcare providers, leading to low job satisfaction and increased job turnover. While victims and witnesses of such incidents need to be empowered to facilitate reporting of these events, leadership at healthcare organizations should work with their employees to adopt policies indicating that such behaviors are unacceptable. In the next article in the series, we will discuss resources and best practices for healthcare providers who are victims of harassment and discrimination by co-workers at workplace.

** Dr. Redmond contributed to this article as the chairperson for the SGIM Disparities Task Force. The views expressed in this manuscript are those of the author and do not necessarily represent the views of the National Heart, Lung, and Blood Institute; the National Institutes of Health; or the U.S. Department of Health and Human Services.

References
2. Jagsi R, Griffith KA, Jones R, continued on page 7
October 26, 2017, President Trump declared the opioid crisis a public health emergency. According to the CDC, 91 Americans die every day from an opioid overdose and, since 1999, the number of overdose deaths involving opioids including prescription opioids and heroin has quadrupled. The administration’s plan to combat the opioid epidemic builds on previous efforts, including education, availability of reversal agents, such as Narcan, and continued funding for substance abuse treatment programs. As internists, we must ask ourselves what else we can be doing. From 2000-10, approximately 20.7% of ambulatory visits were associated with a primary symptom or diagnosis of pain. Together, family practice, internal medicine, and general practice accounted for nearly half (44.5%) of all dispensed opioid prescriptions in 2012. How do we ensure safe opioid prescribing for our patients without impeding physician workflow?

Prescription drug monitoring programs (PDMPs) play a crucial role in combating the opioid epidemic and enhancing safe prescribing. PDMPs are electronic databases that record when a controlled substance is dispensed to a patient. This data helps physicians ensure there is no duplicity prior to prescribing a controlled substance for a patient. Several states, including Ohio, Kentucky, New York, and Tennessee, have passed state legislation mandating that clinicians review PDMP data prior to prescribing a controlled substance. Following implementation of this legislation, Ohio and Kentucky saw the morphine milligram equivalence per capita decrease in most of their counties from 2010-15. In New York, a 75% drop in patients seeing multiple prescribers for the same drugs was observed following mandated PDMP review legislation. In Tennessee, a 36% decline in patients seeing multiple prescribers for the same drugs was seen. Evidence is beginning to suggest that when provided controlled substance dispensing information, prescribers initiate safer prescribing behaviors thus enhancing patient safety. Yet, several challenges with PDMPs remain.

PDMPs are managed at the state level and various roadblocks to seamless usage for physicians exist, including variable integration into electronic medical records, non-standardized pharmacy reporting practices (ranging from real time or batched monthly), and lack of interoperability between states. Physicians practicing in towns near state borders need access to neighboring state PDMP data, but data is not always shared between state databases. For example, Ohio shares and receives PDMP data from 17 states, and West Virginia shares and receives data from 10 states. Florida, while it receives data from other states, does not yet share PDMP data. However, Florida HB 21, effective July 1, 2018, authorizes the Department of Health to share and exchange PDMP data with other states provided certain provisions are met. A congressional briefing September 8, 2017, reviewed successes of PDMP implementation and Electronic Health Record integration featuring reports from three different states. This report highlighted that each state has differing legislation mandating PDMP use, variable PDMP database EHR integration, and variability in interstate PDMP data sharing.

The successes reported from usage of PDMPs are promising and highlight a need to move in a national direction to ensure all states are adhering to the same high standard to protect patients from harm. In addition to increasing available data, a national PDMP database, or national standards for the use and interoperability of PDMP databases, would likely increase physician usage of PDMPs by streamlining the process for PDMP access. Currently, states differ in their requirements that prescribers utilize PDMP databases. States also differ in what clinical team members are granted access to PDMP databases. Increased access to these databases by standardizing PDMP access to medical assistants, physician assistants, nurse practitioners will also increase utilization of PDMPs and encourage incorporation into clinical workflow. A national PDMP database could also leverage EHR vendors to provide seamless integration into their products.

It is evident that PDMPs are proven and effective
cientcy (how does money or time play a part in this problem), liberty (how is your freedom and choice affected), equity (what seems unfair about this problem), and security (what about this problem leaves you feeling less safe, healthy or secure in life).

The RWJF itself spent a considerable amount of time and resources researching the best ways to talk about equity and the social determinants of health. The Foundation focused on message framing to ensure the important work being done by its grantees was available and accessible not just for those of us in the field and committed to the work but also for people to guide and help them talk about health equity in a way that does not align with any particular political perspective and is inclusive of a variety of world views.

The Foundation’s research resulted in six messages around the social determinants of health and health equity that tested well as ways to describe this work (our work). The following statements use simple language, familiar references, focus on solutions rather than problems, and incorporate notions of personal responsibility allowing the statements to resonate with a broad audience regardless of political ideology:

1. Health starts long before illness in our home, schools, and jobs.
2. All Americans should have the opportunity to make the choices that allow them to live a long healthy life regardless of their income, education, or ethnic background.
3. Your neighborhood or job should not be hazardous to your health.
4. Your opportunity for health starts long before you need medical care.
5. Health begins where you live, learn, work, and play.
6. The opportunity for health begins in our families, neighborhood, schools, and jobs.

I ask you to reflect on the values described by Drs. Crump and Evans, and to think deeply about the above six RWJF statements. Then, consider your own thoughts on health equity and how you frame your messages.

Do the values and messages as stated by RWJF mesh with your own? If so, how can you incorporate them in your day-to-day work and life? If not, where do you differ? What are opportunities you can create to engage others in meaningful conversations around health equity and social determinants of health? These are just two examples for us to consider as we continue to advocate—through research, education, and policy—for all people to live their healthiest life. Please share other ways that you have incorporated messaging around equity in your work as generalists so it is accessible to the broadest audience.

References

HEALTH POLICY: PART II (continued from page 6)

tools in combating the opioid epidemic. The time is now for general internists to work with professional organizations to advocate for a national PDMP database that would provide a valuable tool for clinicians at the point of care to enhance patient safety and encourage prudent prescribing.

References
A CASE OF TESTICULAR CANCER IDENTIFIED IN A FREE CLINIC: OVERCOMING BARRIERS TO CARE FOR UNINSURED PATIENTS

Steven Fox, MD; Maggie Benson, MD, MS; Thuy Bui, MD

Dr. Fox (foxsw@upmc.edu) is a PGY3 resident in Internal Medicine (Global Health/Underserved Populations Track) at University of Pittsburgh Medical Center. Dr. Benson (bensonmk@upmc.edu) is assistant professor of medicine in the Internal Medicine Residency and medical director for the Program for Health Care to Underserved Populations at the University of Pittsburgh. Dr. Bui (buit@upmc.edu) is associate professor of medicine and the director of the Global Health/Underserved Populations Track in the Internal Medicine Residency at the University of Pittsburgh Medical Center.

Introduction

Uninsured men with germ cell tumors (GCTs) are more likely to be diagnosed with advanced disease, and have an 88% greater likelihood of dying from GCTs than men with traditional health insurance. Here we present the case of an uninsured man with a GCT, and discuss perspectives related to navigating the care of uninsured patients with serious health concerns.

The Case

Mr. K. is a 28-year-old man who presented to the Birmingham Free Clinic in Pittsburgh, Pennsylvania, reporting a painless left testicular lump that he first noticed four weeks prior. His exam revealed firmness to the posterosuperior portion of the left testis. In young men presenting with a testicular mass, guidelines recommend testicular ultrasonography, serum tumor markers and referral to urology to facilitate timely diagnosis and treatment of possible testicular cancer. Limited point of care ultrasonography of the scrotum was performed in clinic by the Internal Medicine resident and attending. This revealed a hypoechoic mass in the posterosuperior portion of the left testis measuring 1.8 cm.

The attending physician contacted a urologist who has previously provided care for uninsured patients referred from the clinic. The Birmingham Free Clinic (BFC) provides free acute and preventive medical care to uninsured patients in the Pittsburgh Community. It serves as a continuity clinic site for Internal Medicine Residents in the Global Health Underserved Populations Track at the University of Pittsburgh Medical Center. Health navigation services are emphasized to enhance access to insurance and to other medical services. After referral and after being seen by the specialist, ongoing

Discussion

**The Importance of Early Diagnosis in GCTs.** Testicular cancer is the most common malignancy in men between the ages of 15 and 34. Early diagnosis and treatment is critical. The doubling time of a GCT is approximately 10 to 30 days. In patients with a testicular mass, ultrasound accurately distinguishes intratesticular from extratesticular pathology. Radical orchiectomy is the first step for both treatment and definitive diagnosis. Diagnostic delay, defined as delay from initial identification of symptoms to radical orchiectomy, can be substantial. Patients with a diagnostic delay of less than three months have less advanced disease, and better survival than those with longer diagnostic delay. Uninsured patients have been shown to have higher mortality rates from GCTs. In Mr. K.’s case, the time from presentation at primary care to radical orchiectomy was just 5 days, which is extremely rapid, even for a patient with insurance. We will now discuss factors involved in this case that enabled Mr. K. to receive care in such an expeditious fashion.

**Access to Primary Care**

Mr. K. identified the testicular mass and sought medical attention, which was fortunately available at the Birmingham Free Clinic. The Birmingham Free Clinic (BFC) provides free acute and preventive medical care to uninsured patients in the Pittsburgh Community. It serves as a continuity clinic site for Internal Medicine Residents in the Global Health Underserved Populations Track at the University of Pittsburgh Medical Center. Health navigation services are emphasized to enhance access to insurance and to other medical services. After referral and after being seen by the specialist, ongoing
active follow-up by free clinic staff is important to ensure continued follow-up care in a population at high risk for falling between the cracks of our complex health system. This case emphasized the critical safety net role of free clinics and community health centers.

**Point of Care Ultrasonography (POCUS) in the Free Clinic Setting**

POCUS can be an important tool in aiding diagnosis and management particularly in resource limited settings. In this case, the internal medicine resident and attending had training in ultrasonography, but had limited experience performing scrotal ultrasound. Even still, the presence of a left intratesticular mass was clear. The role of ultrasound in this case was to clarify the physical exam finding, making certain the presence of an intratesticular mass that confirmed the sense of urgency for referral. A negative study would not have provided adequate evidence to rule out a testicular tumor.

This demonstrates a few points related to the use of POCUS in clinic:

1. **Lack of extensive experience in a particular ultrasound study does not mean it should not be performed; however, the results must be interpreted with caution. In particular, high stakes studies requiring high sensitivity must be done only with very high standards. Markedly positive findings, such as those seen in this case, can be useful.**
2. **Images should be stored in the patient record for view by other providers and for quality assurance through independent corroboration. In this case, images were placed into the note in the medical record, and emailed to the urologist.**
3. **Residency training programs, particularly those geared toward global health and underserved populations, should include training in ultrasonography.**

**The Medical Neighborhood**

This case demonstrates the importance of a referral network, which we will refer to as a medical neighborhood. The medical neighborhood includes healthcare providers of several disciplines who work together to fill gaps in the medical system to provide care for vulnerable patients. In this case, the attending physician has cultivated relationships with several specialists, and directly contacted a urologist via e-mail to request assistance. From our experience making referrals from a free clinic to specialist physicians, we have observed the following:

1. Cultivating a shared mission, nurturing teamwork, and building relationships are key in developing a medical neighborhood.
2. Direct communication (ex: email, phone) leads to more effective coordination of care than working through traditional means of calling the office staff or placing a consult in the electronic medical record. Warm handoffs, with direct communication between physicians, is ideal for patient care and for cultivating relationships within the medical neighborhood.
3. Cases should be appropriately selected for referral. A non-urgent, or non-serious case could be deferred, to avoid overburdening specialists.

**The Importance of Specialists Familiar with the Care of Uninsured Patients**

Characteristics of specialist physicians and their offices beneficial for care of uninsured patient include:

1. Willingness to see patients in non-standard scheduling spots (for example, on lunch break or between cases). If flexibility is required, it is reasonable to ask a patient to wait in the office longer than usual, when services are provided for free.
2. Involvement of the office staff in coordination of care—sometimes a patient may call a doctor’s office and be told that without insurance they cannot schedule an appointment. Involving clinic staff including appointment schedulers, secretaries, and nurses in the referral process can help to ensure smooth coordination of care and allow additional flexibility that may be necessary for uninsured patients.

3. **Understanding that the patient should not be billed in the same manner as most insured patients. If there will be a cost to the patient, this should be discussed with the patient prior to proceeding. To recoup costs to the organization, the patient may be able to obtain medical assistance or emergency medical assistance and gain retroactive coverage, or access charity care programs. The physicians (primary care and specialist) can assist this process through providing a letter stating that the patient would have death or disability if diagnosis and treatment were not provided. Involving specialized insurance navigators can be particularly useful in complex cases.**

**Conclusion**

In this case, the delay from presentation at primary care to definitive diagnosis was a mere five days. In alternative scenarios using traditional models of care, the delay could have been much longer (on the order of several months), and the disease may have become more advanced at diagnosis, leading to additional costs, complications, or death. This case demonstrates how non-traditional methods, including access to a free clinic with associated health navigation resources, use of point of care ultrasound, development of a medical neighborhood, and specialist physicians accustomed to caring for uninsured patients can promote the provision of high quality, expeditious care for uninsured patients.

*continued on page 15*
Over the last 18 months, SGIM has been selecting a vendor to undertake an exciting member database transition. Our new database, MemberSuite, was chosen after a careful review of SGIM business practices, member needs, and a competitive selection process. We are excited to begin sharing these improvements and new features with our members.

Beginning in July 2018, members will have the opportunity to login into their secure SGIM/ACLGIM member account at www.sgim.org and explore the new user interface. Over the coming months, there will be ongoing improvements and enhancements of database features and member account capability. We appreciate your understanding and patience as we continue to improve our infrastructure and the member experience! This system will not replace the use of GIM Connect as our online community and we encourage you to continue networking with your colleagues through communities on GIM Connect.

Top Three Upcoming Features of MemberSuite.
1. Redesigned Member Profile: Member profile will include detailed questions regarding personal and professional background, career trajectory, and opportunities for engagement. Member profile information allows SGIM to understand your role in GIM and better serve as your “professional home”.
2. Upgraded Member Portal: Improved centralized location for all member-related activities (memberships, meeting registrations, CME, MOC, donations, etc.).
3. Improved Data Analysis: Updated member data will allow SGIM to further understand the current membership composition, help foster program enhancement/creation, and better target organizationwide networking for members.

Stay tuned for this exciting transition this summer and please contact the SGIM National office at info@sgim.org with any questions.
SGIM members have always been finely attuned to the importance of health policy and advocacy work to advance the field of general internal medicine. In fact, SGIM maintains an annual advocacy agenda that is essential to accomplishing SGIM’s health policy mission. Members like you help SGIM advocate for important priorities that include ensuring healthcare reform efforts to maximize the opportunities for all patients to lead a healthy life, maintaining access to health care as a fundamental right, right-sizing compensation for providers, aligning graduate medical education (GME) policy with U.S. workforce needs, and expanding funding for health services research. Our ability to have a positive impact in these areas depends on the work of our Health Policy Committee, SGIM leadership, an informed and engaged membership and staff, and other partners.

In support of these activities, SGIM initiated an Advocacy Education Campaign in 2017. Since then, we have seen 100% participation by SGIM’s Council and generosity from many members—netting us an impressive $43,000 to continue the work of educating members about important advocacy issues. We thank our members and partners for their generous donations to this campaign (see donor list below). Their support enhances our ability to engage members in pursuing SGIM’s ambitious mission, to educate members about key issues affecting healthcare, and to give members opportunities for career development around health policy.

But we are only halfway to our goal. Won’t you pledge your ongoing support to help us reach our target of $75,000 in advocacy education funds by April 2019? To donate, please go to www.sgim.org/donate.

The funds that members have already contributed have enabled us to enrich the education of our members in the importance of advocacy. The Health Policy Committee provides a variety of educational services to members, including:

1. Leadership in Health Policy Program (LEAHP).
   SGIM’s Leadership in Health Policy Program (LEAHP) is a yearlong career development program that aims to develop members to become effective health policy advocates and local health policy experts, leaders, and teachers. The LEAHP program is a pipeline that is expanding a national cadre of knowledgeable advocates for SGIM’s priorities. Launched at the 2017 annual meeting, the LEAHP program has graduated its first cohort of 19 scholars, whose achievements include: developing health policy curricula; leading several policy workshops at regional and national SGIM meetings; publishing several health policy articles in SGIM’s Forum and in academic journals; and rising to leadership positions within the Health Policy Committee and Council. The second cohort of LEAHP scholars began their journey at the 2018 annual meeting and we look forward to their contributions.

2. SGIM Forum Articles.
   Member of the SGIM Health Policy committee and others frequently submit articles to SGIM Forum in order to inform members about issues in Washington, DC. Some recent articles include:

continued on page 12
The Health Policy Committee and other member leaders maintain partnerships with other SGIM committees and commissions to lead health policy related workshops at SGIM’s regional and national meetings. SGIM wouldn’t be able to continue all of these projects without your help. We encourage you to get involved in advocacy education and we thank all those leaders and members who have donated to this campaign thus far:

<table>
<thead>
<tr>
<th>LEADERSHIP CIRCLE ($1,000 or more)</th>
<th>OTHER CONTRIBUTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eric Bass</td>
<td>Eva Aagaard</td>
</tr>
<tr>
<td>Ruscio and Dennis Cavarocchi</td>
<td>Bradley Benson</td>
</tr>
<tr>
<td>Marshall Chin</td>
<td>Nina Bickell</td>
</tr>
<tr>
<td>Mark Earnest</td>
<td>Dolores Buscemi</td>
</tr>
<tr>
<td>Joseph and Rosemarie Conigliaro</td>
<td>Jada Bussey-Jones</td>
</tr>
<tr>
<td>Giselle Corbie-Smith</td>
<td>Sarah Candler</td>
</tr>
<tr>
<td>Mitchell Feldman and Jane Kramer</td>
<td>Cynthia Chuang</td>
</tr>
<tr>
<td>April Fitzgerald</td>
<td>Carolyn Clancy</td>
</tr>
<tr>
<td>Robert and Suzanne Fletcher</td>
<td>Jeanne Clark</td>
</tr>
<tr>
<td>William Moran</td>
<td>Shadia Constantine</td>
</tr>
<tr>
<td>Eugene Rich</td>
<td>Bradley Crotty</td>
</tr>
<tr>
<td>Steven Schroeder</td>
<td>Susan Day</td>
</tr>
<tr>
<td>Mark Schwartz and Adina Kaler</td>
<td>David Dugdale</td>
</tr>
<tr>
<td>Harry Selker</td>
<td>Joslyn Fisher</td>
</tr>
<tr>
<td>Barbara Turner</td>
<td>Marshall Fleurant</td>
</tr>
<tr>
<td>Sankey Williams</td>
<td>Thomas Gallagher</td>
</tr>
<tr>
<td>Richard Gitomer</td>
<td>Lauren Alise Peccoralo</td>
</tr>
<tr>
<td>Eric Green</td>
<td>Monica Peek</td>
</tr>
<tr>
<td>Ryan Greysen</td>
<td>Eboni Price-Haywood</td>
</tr>
<tr>
<td>Brooke Herndon</td>
<td>Allan Prochazka</td>
</tr>
<tr>
<td>Eric Holmboe</td>
<td>Eileen Reynolds</td>
</tr>
<tr>
<td>Anne Katherine Hust</td>
<td>P. Preston Reynolds</td>
</tr>
<tr>
<td>Thomas and Nancy Inui</td>
<td>Theresa Rohr-Kirchgraber</td>
</tr>
</tbody>
</table>

FROM THE SOCIETY: PART II (continued from page 11)
leverage and their citizens pay lower prices for drugs than Americans pay as a result. The Trump Administration proposes to use international trade negotiations to pressure other countries to increase prices for pharmaceuticals. The implication is if the United States can successfully cause other countries to raise pharmaceutical prices, pharmaceutical manufacturers would voluntarily lower prices in the United States. Economics, however, predicts that prices in Europe and in the United States are independent. Pharmaceutical companies are profit maximizers and a pharmaceutical company’s fiduciary responsibility to its shareholders is to maximize its overall profits across all markets. If the price of a drug were $50 in the United States and $30 in the United Kingdom, any method of forcing the latter to raise the price from $30 to $40 would not according to economic theory result in the pharmaceutical company reducing its U.S. price. Therefore, if this policy is effectuated there is no reason to believe that it will result in tangible pharmaceutical savings to American patients.

There were three policy ideas that could result in modest savings to U.S. patients.

2. Dropping the Pharmacist Gag Rule. A USC study found that in 23% of transactions (2.2M claims of 9.5M transactions reviewed) at the pharmacy counter, the cost of the drug is actually lower than the copayment. This means that an antibiotic prescription may cost $5 at the pharmacy, but if the patient presents an insurance card requiring a $15 copayment, the pharmacist collects $15 on behalf of the insurer, the insurer pays the pharmaceutical company $5 and keeps the remaining $10. Meanwhile, if the insured patient did not use insurance the drug cost would have been $5, not $15. In addition, the pharmacist often understands this differential and wants to assist the patient in minimizing costs but is banned by state laws often called “gag rules” from informing the patient. The Trump Administration proposed banning these state laws and permitting pharmacists to assist patients in purchasing the drugs their physicians prescribe at the lowest price.

3. Regulating Rebates. Drug rebates are a concept that the Trump Administration has single-handedly brought into the public eye. In short, when an insured individual purchases a drug for $1,000 per month through their insurer, and the insurer receives a $250 rebate from the pharmaceutical manufacturer, the patient pays $1,000 and receives no rebate. Pharmaceutical spending was $329B in 2016 and of this there were $89B in rebates disbursed, a whopping 27% of total spending. While many economists believe that these rebates, which incentivize insurer brand loyalty are passed back to the patient in terms of lower premiums, the pathway by which the rebates reach the patient is indirect and may result in inefficiencies. The Trump Administration seeks to simplify this process and streamline the path of the rebate to the drug purchaser. If successful and the size of rebate was reduced, or if rebates were required to be passed directly to the patient, the result would be lower drug costs to those purchasing drugs.

4. Clearing Generic Drug Roadblocks. The third area that the Trump Administration pledged to improve was clearing the pathway for generic competition by reducing the ability of pharmaceutical companies to use frivolous litigation and obscure patent protection clauses to delay generic market competition. For example the administration plans to prevent generic manufacturers that are the first to market from “parking” their patent to permit the brand drug to continue to have exclusivity while preventing any other generic from entering the market. Success in this arena could streamline generic entrance, resulting in additional savings, primarily during the initial six month period when generic alternatives are first permitted to enter the market.

Overall, the Trump Administration plans to target the low hanging fruit in the pharmaceutical industry by eliminating many of the most egregious pricing practices. These proposals will mostly require no major legislative change, will reduce pharmaceutical spending, and speed generics to market, all of which will improve patient access. Because the American Patients First scope is narrow, expected reductions in pharmaceutical prices and spending are expected to be small, the speech resulted in an increase in pharmaceutical stock prices immediately after the speech. The industry had been fearful of a heavier hand in pharmaceutical price control and in spite of some discussion during the 2016 campaign, the Trump Administration has proposed an approach that the pharmaceutical industry favors, is achievable and will have at most a moderate impact on the growth in pharmaceutical costs. Overall, internists who do much of the prescribing in the United States will not find many changes to their daily practice as a result of the proposal.

References
FROM THE EDITOR (continued from page 2)

cially when a deadline is approaching and articles are still coming but always enjoyable and rewarding. I’ve appreciated the feedback I’ve gotten via e-mails, and in person about what you liked and what you didn’t. Moving forward, we are looking for more articles related to the diverse research programs pursued by the members of the Society. In addition, we hope to decrease the time to publication for select articles that we feel need to be released sooner for their time-sensitive subjects by exploring e-pubs ahead of publication. Look for some more theme issues. And, following the example from the 2018 National Meeting, look for a new feature, where we hear from the voice of the patient.

This month, we also welcome several new associate editors to the Forum Editorial Board: Drs. Jorge Rodriguez, Justin Roesch, Irene Alexandraki, Elisa Sottile, Ricardo Correa, Yousaf Ali, and Megan McNamara. Our new associate editors give us representation in medical education, hospital medicine, women’s health, and the VA. Geographically, they come from Arizona, Florida, Massachusetts, New Mexico, New York, and Ohio. Be sure to reach out to them as well as the rest of the existing Editorial Board for questions about submitting article to Forum and any ideas to make the publication better. Their contact information can be found on the SGIM Forum Web site as well as on the masthead of the printed version.

This month’s Forum, as always, features a breadth of work by SGIM members:

- Economist Dr. Adam Block from New York Medical College
- School of Health Sciences and Practice breaks down the American Patients First Act, The Trump Administration’s Strategy to Lower Drug Prices.
- Drs. Dianne Goede and Scott Joy provide the rationale for a national consolidated prescription drug-monitoring program to aid in combating the opioid epidemic.
- Dr. Quratulain Syed and her colleagues give recommendations for healthcare leadership to promote a culture of collegiality and healthy work environment, and to manage incidents of peer discrimination and harassment in the workplace.
- Dr. Steven Fox and colleagues provide a clinical example of how to provide care for the uninsured.
- Finally, some updates and acknowledgements from the Society round out the issue.

Happy reading!!

**SGIM**

---

**UNIVERSITY OF KENTUCKY**

**Chief, Division of General Internal Medicine**

The Department of Internal Medicine at the University of Kentucky seeks candidates for the position of Chief of the Division of General Internal Medicine. The division is poised to achieve regional and national recognition in clinical care delivery and medical education with opportunity to build a robust research program focused on the care of medically complex patients. Our department benefits from serving an integral role in a vibrant and robust health care enterprise, UK HealthCare, which brings state-of-the-art facilities and technology to our Lexington, Kentucky campus as we move toward our goal of becoming a top 20 medical center. UK HealthCare ranks in the top quartile of academic medical centers with service volume per year greater than 1 million outpatient visits and more than 40,000 hospital discharges with an annual operating budget of approximately $2 billion. Lexington, Horse Capitol of the world, is located in the beautiful Bluegrass Region of Kentucky.

Responsibilities of the chief include a combination of administrative, clinical, research, and educational duties pertinent to background and experience. Applicants must have an MD or equivalent degree and have demonstrated excellent qualifications in education and research. Additional training with a master’s degree in public health, research, education, health administration, or business is desired, but not required.

It is anticipated that the successful candidate will be appointed as an associate or full professor.

The Division of General Internal Medicine must lead our growing robust outpatient academic practice and promote the development of expertise in medical education, complex care, quality and safety, and health services research. Candidates should have excellent skills and experience in leadership, education and research to further advance the success of our clinical and academic programs.

We seek candidates who exemplify the Living DIReCT values of UK HealthCare – Diversity, Innovation, Respect, Compassion, and Teamwork.

Applicants should submit a cover letter, curriculum vitae, and names of three references to:

Mark V. Williams, MD
Chair, Search Committee for Chief of General Internal Medicine
Professor & Vice Chair
Department of Internal Medicine
University of Kentucky
740 South Limestone Street
Room J525, Kentucky Clinic
Lexington, KY 40536
mark.williams@uky.edu

The University of Kentucky is an equal opportunity employer and encourages applications from minorities and women. Upon offer of employment, successful applicants must pass a pre-employment drug screen and undergo a national background check as required by University of Kentucky Human Resources.
HEALTH POLICY: PART I (continued from page 13)


References


