

HEALTH POLICY

ADVOCATING FOR HEALTH SERVICES RESEARCH AND AHRQ

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In 2000, the Institute of Medicine (IOM) released “To Err Is Human,” a report that awoke the medical community and the public to a startling reality: health care too often harms. Eighteen years after this landmark report, there has been evidence of improvement, but one troubling reality remains—we still harm too many patients. This fact is unavoidable. Medical errors continue to be one of the leading causes of death in the United States. A Johns Hopkins study found that medical errors killed 250,000 people in 2013, making it the *third* leading cause of death behind heart disease and cancer.¹ Although the study’s methods may have led to overestimates of the number of deaths caused by medical errors, the estimates are nevertheless alarming. Another startling example of health care’s harm is the opioid epidemic. For decades, physicians uninhibitedly prescribed opioids to their patients with pain. Not too long ago, I was sitting in a medical school lecture given by a renowned professor who explained to a group of attentive medical students that opioids were “not that addictive” and “pain should never go untreated.” Unfortunately, this professor as well as most of the medical community got this wrong. Today, towns throughout the United States are being crippled by the opioid crisis that kills more than 100 lives every day.²

Thus, we arrive at the following question asked after “To Err Is Human” was published—how do we improve our healthcare system so that it does not harm those it intends to heal? An answer to this question will take further investment in health services research; researching how we deliver care, its quality and safety, and evaluating the impact of newly implemented value-based methods.

To the public, *health services research* is an obscure term, but to many clinicians, researchers, and policy makers, it is an essential part of improving our healthcare

system. The Agency for Healthcare Research and Quality (AHRQ) funds a large portion of the health services research in the United States. The importance of the agency’s work is evident. Since 2010 AHRQ-funded research is estimated to have decreased hospital acquired conditions by 21%, prevented 3 million adverse events, and saved 125,000 lives.³

AHRQ has also created the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, the Healthcare Cost and Utilization Project (HCUP) databases, and the Medical Expenditure Panel Survey (MEPS). These publicly available datasets have been invaluable to our understanding of patients’ experiences with care and the delivery and costs of care in the United States and the effects of various health policies on care and outcomes. Primary care research, often underfunded compared with research focused on specialty care, has been another beneficiary of AHRQ. For example, EvidenceNow is a \$112-million-dollar project to fund 1,500 primary care clinics to implement cardiovascular evidence-based care and study how this impacts outcomes.⁴

It may come as a surprise then that AHRQ’s future has been precarious. Proposals for eliminating AHRQ have been brought forth in Congress several times in the recent past. None have succeeded, yet. In February 2018, the President’s FY19 budget proposal was released to Congress, and it recommended a major funding cut to AHRQ from \$322 million to \$256 million, an approximately 20% decrease from FY18 (see figure on page 13).⁵ Beyond the expected budget cuts, the President’s proposal also recommended moving AHRQ from a free-standing agency in the Department of Health and Human Services (HHS) to a component of the National Institutes of

continued on page 13

CONTENTS

1. Health Policy1
2. From the Editor 2
3. President’s Column..... 3
4. Best Practices 4
5. Technology..... 6
6. Perspective: Point/Counterpoint Part I..... 8
7. Perspective: Point/Counterpoint Part II..... 10

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FROM THE EDITOR

TALK AMONGST YOURSELVES

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

As I write this month’s *Forum* editorial, the details and unfortunate controversy surrounding Senator John McCain’s memorial service, and his legacy, are just two days old. When I heard of his passing, I was reminded of his “nay” vote rejecting a scaled-down Republican plan to repeal parts of the Affordable Care Act, after returning to the Senate following a recent diagnosis of brain cancer.¹ Certainly, it was only one of many votes and actions in his remarkable life and career but the one that I, as a general internist, will always remember. The struggle to provide a workable plan that provides every American with affordable healthcare has been long with a profound gap among policy makers and stakeholders as to how it should be accomplished.

This month’s *Forum* highlights a related debate that many of us have joined in in our work institutions, our homes, and, for some of us, in the public arena—the United States adopting a single payer system and whether or not SGIM should advocate for it. Drs. Mark Earnest and Daniel McCormick each respectively make cogent and compelling arguments reflecting their points of view and of those they represent. To be sure, there are many in the organization who would love to see the Society take a definitive stand on this, one way or another. Many in the Society also stress caution, arguing that the Society should continue to take a broader view in this debate and focus our efforts in incremental ways in the discussion of how best to improve the health, and health care of our nation such that it is of the highest quality, and of the greatest value yet fairly and equitably distributed. The debate can be made on moral grounds, economic outlooks, or societal beneficence. Read the articles and make your own conclusion. I welcome reader comments in upcoming issues to keep the discourse going.

Further in this issue, Dr. Giselle Corbie-Smith, in her President’s Column, continues the conversation around SGIM’s sabbatical year. The word *sabbatical* literally means a rest from work, or a break. Many of us in academic medicine know it as any extended absence in your career whereby you achieve something. Dr. Corbie-Smith explains the rationale and the process of our sabbatical year to ensure that SGIM’s organizational structure and focus align with our mission, vision, and values. The long-term effects from this sabbatical year will enable SGIM to play a role in the health care debate by supporting member development, informing the membership and continued advocacy.

continued on page 15

STARTING WITH “WHY?”

Giselle Corbie-Smith, MD, MSC, President, SGIM

Our current political and social landscape is changing quickly and unpredictably, and SGIM needs to focus our activities to address issues at the forefront of our field in the coming years. We want to respond. . . but we do not have the organizational bandwidth to do so. This is why Council and staff are engaged in an indepth strategic planning effort. . . .



Some of you may be familiar with Simon Sinek. His 2009 TED talk (available on YouTube) focused on helping individuals find their why—their purpose, cause, or set of beliefs that inspire them to do what they do. Sinek introduced a model of three concentric circles with WHY at the center, HOW in the middle circle, and WHAT in the outer circle.^{1,2} He calls this the *Golden Circle* and has since applied the same model to organizations. The work our SGIM Council and staff are doing during our “sabbatical year” focus very much on our why, how, and what.

In my first *Forum* column as your president, I spoke of the need for us to have a clear vision as an organization—SGIM’s WHY. Having a well-defined focus will allow us to concentrate our efforts on initiatives we are uniquely positioned to lead successfully and enable us to respond to the important challenges that face us as a profession. SGIM’s reality is that as an organization we have

been stretched too thin and have had many “WHATs” that were not integrated into an organizational strategic plan. Our current political and social landscape is changing quickly and unpredictably, and SGIM needs to focus our activities to be in a better position to address issues at the forefront of our field in the coming years. We want to be able to respond to these types of cutting-edge issues that define who we are as an organization and profession, but we do not have the organizational bandwidth to do so. This is why Council and staff are engaged in an indepth strategic planning effort in this, our “sabbatical year.”

Coming out of the June Council retreat, our commitment as a Council for the coming year is to ensure that SGIM’s organizational structure and focus align with our mission, vision, and values. We took the findings and recommendations from the Pyramid audit of our society’s communications quite seriously—the issues raised in the report were sobering and required what may seem to be drastic action.³

continued on page 12

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The SGIM *Forum*, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the *Forum* is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Howard Petlack.

ACUTE PAIN AND SYMPTOM MANAGEMENT FOR HOSPITALIZED PATIENTS WITH OPIOID-USE DISORDER

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Case Presentation

A 48-year-old woman with a history of intravenous heroin use presents with fevers and worsening lower back pain for two weeks. She has had chronic neck pain for seven years stemming from a motor vehicle accident. Her chronic pain was managed with opioid pain medication for five years through a pain management clinic. Two years ago, she lost her insurance and turned to intravenous heroin. She usually uses five “bags” per day but increased to seven “bags” per day for the last two weeks because of increasing pain.

On examination, she is extremely uncomfortable but neurologically intact. A spine MRI reveals osteomyelitis of the L4 vertebra. Blood cultures are positive with 2/2 bottles growing gram positive cocci. She was initiated on morphine 2 mg IV q4h prn severe pain which she reports is not relieving her pain.

Management of Acute Pain

The opioid epidemic continues to expand in the United States, with increasing numbers of deaths related to opioid use. While the number of prescriptions for opioid pain medication has decreased since 2012, opioid overdose deaths due to heroin and synthetic opioids have continued to increase, as have hospital admissions due to opioid-use related complications.¹ Opioid-dependent patients admitted to the hospital with acute pain have complex pharmacologic needs and require a systematic approach to analgesia. Managing their acute pain is often complicated because of their opioid dependence. Long-term opioid use changes the neurobiology of pain sensation, creating tolerance to opioids.² These patients have a lower pain tolerance than opioid-naïve patients and often require higher doses of opioids for analgesia.²

Physicians may be hindered by biases when caring for patients on long-term opioid therapy or with a history of opioid-use disorder. Physicians have reported anxiety about being manipulated by patients to get opioids that are not medically indicated.² Physicians have also expressed worry that using opioids may induce a relapse of addiction.³ There is no data to suggest that this is true. Several small studies have looked at this and found

no increased risk of relapse.³ Instead, multiple studies have shown that these patients are usually undertreated⁴ and are more likely to have poor outcomes when their acute pain is not well managed.²

There also seems to be a poor understanding of how opioid dependent patients experience pain. Although studies have shown that these patients have less tolerance for pain than opioid-naïve patients, a minority of physicians know that to be true.⁴ This leads to missed opportunities to manage pain. With precise calculations and careful monitoring of symptoms, opioid-dependent patients can have acute pain safely and effectively addressed in the hospital. Table 1 outlines an effective approach to opioid analgesia for this patient with heroin-use disorder who is experiencing severe, acute pain.

Opioid Withdrawal

Opioid withdrawal may occur in hospitalized, opioid-dependent patients who are not receiving adequate opioid therapy. Common symptoms include: diffuse pain, abdominal cramps, nausea, vomiting, diarrhea, yawning, rhinorrhea, lacrimation, with elevations in heart rate and blood pressure seen in more severe cases. There are scoring systems available to help further categorize the severity of withdrawal and guide treatment.² The timing of the onset of symptoms depends upon the opioid used. Acute withdrawal from short-acting opioids begins after 8-12 hours, peaks at 36-72 hours, and lasts 7-10 days while acute withdrawal from long-acting opioids begins at 36-72 hours, peaks at 4-6 days, and lasts 14-21 days.²

Opioid withdrawal is best managed through the administration of opioids in conjunction with symptom-directed therapy. In general, symptom-directed treatment without opioids is not as effective⁵ and should be avoided if possible. For acute opioid withdrawal, you may start methadone or buprenorphine as part of an inpatient detoxification versus initiation with linkage to an outpatient clinic at discharge. When deciding which to start, considerations include cost, access to follow up care (methadone clinic versus any physician with buprenorphine training certification), risk for medication

continued on page 5

Table 1. Acute Pain Management in Heroin-use Disorder

<p>100 mg IV heroin = 15-30 mg IV morphine 15 mg IV morphine = 45 mg PO morphine Ms. Smith has been using ~700 mg IV heroin daily for the last 10 days without adequate analgesia = 105 mg IV morphine</p>
<p>Oral SR opioid for basal with IV or oral short acting opioid for breakthrough</p>
<ol style="list-style-type: none"> 1. Calculate baseline opioid use in oral morphine equivalents (OME) 100 mg IV morphine/24 hours = 300 mg oral morphine/24 hours 2. Reduce dose by ~25-50% to account for incomplete cross tolerance Oral morphine 150 mg/24 hours 3. Convert reduced dose to long acting agent for baseline pain control Morphine SR 45 mg q 8 hour or morphine SR 75 mg q 12 hours 4. Use short acting IV opioid agonist or start opioid PCA for rapid titration to address acute pain
<p>Morphine 5-7.5 mg IV q 3 hours PRN breakthrough</p>
<ul style="list-style-type: none"> • Emphasize non-opioid and non-drug treatments • Convert to oral opioids asap • Opioids will be tapered as acute pain improves • The goal is to effectively treat acute pain, improve function and prevent withdrawal symptoms • Discharge plan: <ul style="list-style-type: none"> • Refer for MAT or initiate in hospital if able Harm-reduction strategies

interactions, patient preference, and whether the patient has a pre-existing prolonged QTc (which would be increased by methadone). Table 2 outlines recommended dosages and schedules for both medications.

Table 2. Buprenorphine and Methadone Tapering Protocols²

<p>Buprenorphine Detoxification Buprenorphine/naloxone 2/0.5 mg SL film or tab:</p> <ul style="list-style-type: none"> • QID x 2 days • then TID x 2 days • then BID x 2 days • then daily x 2 days then stop
<p>Buprenorphine Induction (with planned linkage to outpatient clinic) Buprenorphine/naloxone 8/2mg SL film or tab:</p> <ul style="list-style-type: none"> • Day 1: 1/2 film or tab; reassess 1-2 hours - ? film or tab; repeat until cravings and withdrawal resolve; max dose day 1=8 mg • Day 2: Day one dose + ? film or tab; reassess 1-2 hours; max dose 16 mg * if nauseated only or over sedated, the dose is too high
<p>Methadone</p> <ul style="list-style-type: none"> • DAY 1: Methadone 10 -30 mg; reassess in 2 hours; if patient still having distressing withdrawal symptoms provide a one-time additional dose of 5-10 mg (maximum dose = 40 mg) • Taper by 5-10 mg daily over 10-14 days * check ECG at baseline; avoid in patients with QTc Prolongation

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CLINICAL UPDATE IN CLINICAL INFORMATICS—PART II

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In the August 2018 *SGIM Forum*, we coauthored the first of a series on Clinical Informatics, inspired by a live Clinical Update session at this year's 2018 SGIM Annual Meeting. In brief, each article in this series summarizes key papers in clinical informatics for generalists published within approximately the last year. The complete methods for journal and article selection are described in the August 2018 article.¹

In the previous article, "Clinical Update in Clinical Informatics—Part I," we summarized publications in the year prior the annual meeting that were relevant to a currently popular topic: desktop medicine. In this article, we focus on policy recommendations for electronic health records and health information technology. In the discussion, we highlight real examples of high-level policy changes that impact the health data ecosystem.

Case Vignette

Mr. Shah is a 55-year-old male, with essential hypertension on lisinopril, who moves to Denver, and is experiencing shortness of breath a few times in the past week. He selects a new primary care physician and schedules an appointment. He does not have his medical records from his last physician. He receives a letter in the mail welcoming him to the new practice, containing information about his new doctor and the practice group. Enclosed also is a paper form that has questions about his medical history. He is to complete this and bring it to his upcoming visit.

Policy Recommendations

The vignette describes a common clinical scenario in which a patient and physician express several information needs towards a common task of having an in-person office visit to establish primary care. This vignette is loosely based on one presented in a key paper published by Adler-Milstein et al. in April 2017² that presents high-level policy recommendations as a potential roadmap for health information technology (IT) and electronic health record (EHR) policymaking. The paper is the result of a policy invitation of the American Medical Informatics Association (AMIA), which assembled clinical informat-

ics experts to outline "goals and near-term achievable actions...to enable the health IT ecosystem to meet the acute needs of modern health care delivery."

Adler-Milstein et al. describe the needs of the health IT ecosystem from the perspective of multiple stakeholders: patients, physicians, researchers, and innovators. For example, the authors go beyond identifying gaps in the patient experience, such as having online scheduling capabilities, electronically transmitting personal health records, or collecting health data (patient-generated health data, or PGHD); to enable these types of functionalities, the authors suggest policy updates, such as clarifying HIPAA requirements to ease patient access to their health records or to their PGHD from wearables and apps. In the vignette, supportive IT infrastructure, incentivized by appropriate policy, would facilitate Mr. Shah's access to his health records and their transmission electronically to his new physician; further, he could easily track his own biometric data and provide medication and health status updates electronically to his new physician.

This paper is aligned with but broader in scope than a position paper that the AMIA EHR Task Force published in 2015 describing the current state of EHRs and making five high-level recommendations about the future of EHRs.³ Many of those recommendations, such as those pertaining to a call for simplifying documentation, refocusing regulation of EHRs, ensuring that EHRs support patient-centered care, and other recommendations, have also been reframed in the 2017 paper partly as issues concerning physicians² and discussed in other organizations' position papers.⁴ Concerning researchers and innovators as stakeholders, Adler-Milstein et al. recommend the development of a policy framework that assures that appropriate data is used for appropriate reasons, with appropriate patient consent and agreed upon terms.

Finally, an editorial by Labkoff and Sittig in June 2017 focuses on needed safety surveillance of EHRs and clinical decision support (CDS) knowledge sources by proposing the concept of a Health Information

continued on page 7

Technology Safety Center.⁵ That is, they comment that with the rapid and widespread usage of EHR and CDS systems, a health IT safety center could collect, investigate, and disseminate learnings from challenging EHR-related safety issues.

Discussion

A real-life example of a policy framework relating to appropriate consent for data usage, enacted in May 2018, is the European Union's General Data Protection Regulation (GDPR). The GDPR applies not only to health data but also to all consumer data in the EU—including non-EU organizations who engage in the collection and usage of data from EU-based users. According to the European Commission, with GDPR in place, the general principle is that no data processing is done unless necessary, for example, for reasons of public interest or where the subject has given explicit consent. In practice, this means that companies offering mobile apps, devices, and other healthcare technologies collecting data from EU users must comply with GDPR or risk facing very expensive fines. This includes hospitals and healthcare systems. In the United States, California governor Jerry Brown signed the Consumer Privacy Act, also a digital privacy law, in June 2018; considered a Californian version of GDPR, the law is expected to go into effect in January 2020.

All of these papers touch upon components of a key concept in clinical informatics: the learning health system. According to an Institute of Medicine report on Digital Infrastructure for the Learning Health System, a learning health system is designed to both generate

and apply best evidence in the provision of high-value, patient-centered care, driving scientific discovery as a natural extension of patient care and ensuring innovation, quality and safety in health care. The learning health system should include infrastructure and policies supportive of secondary uses of EHR and other patient data—importantly, with a focus on value for each patient *and* without undue burden on clinicians—such as quality measurement and improvement, safety monitoring, public health surveillance and management, basic and clinical research, and healthcare innovation.

FAIR data principles, published in 2016, can accelerate the achievement of the learning health system. FAIR defines a set of principles to enhance the Findability, Accessibility, Interoperability, and Reusability of all types of digital objects, such as electronic health care records, clinical guidelines, and predictive algorithms.⁶ The FAIR principles suggest, for instance, that such digital resources should have high quality metadata, unambiguous licensing, adhere to data standards, and follow community expectations. The FAIR principles have been widely adopted across global communities, including governments, governing bodies, publishers, and funding bodies. Consequently, these principles offer a sensible framework for the design of digital infrastructures to support the learning health system and its components, towards meeting the data needs of healthcare stakeholders—patients first and foremost, but also healthcare professionals, researchers, and innovators.

The next article in this series will focus on clinical decision support systems and population health.

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SGIM SHOULD SUPPORT A SINGLE-PAYER NATIONAL HEALTH INSURANCE PROGRAM

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Despite improvements in health insurance coverage under the Affordable Care Act (ACA), 29 million Americans remain uninsured and millions with coverage are also unable to afford care. Meanwhile, in our healthcare institutions, the drive for profit increasingly trumps clinical imperatives, and even in not-for-profit organizations, mounting bureaucracy drains both funds and joy from patient care. None of the incremental reforms currently being debated would fix these problems. SGIM has supported the goals of universal access to care and health equity, but has never taken a position on how to achieve these goals. The time has come for our organization to endorse and advocate for the only viable way to ensure universal access to comprehensive care at an affordable price—a single-payer reform.

Current State of Coverage and Access in the USA

The ACA implemented the largest health insurance expansion since the start-up of Medicare and Medicaid in 1966. Since 2013, 15.5 million Americans have gained coverage, with larger gains among the poor, Hispanics and African Americans, although these groups continue to suffer higher-than-average rates of uninsurance.¹ Yet, 9.1% of Americans remain uninsured, and 13.0%—including 16.3% of black and 20.3% of Hispanic people—can't afford a needed physician visit currently.²

But we have likely seen all the coverage gains achievable under the ACA. Unfortunately, the current administration is seeking to undercut the law, implementing policies that will erode existing coverage levels.³ Even without these setbacks, the Congressional Budget Office estimated that no further increases in coverage would occur through 2026.

SGIM's Mission, Previous Work, and Role in Medicine

SGIM is an association of the world's leading academic general internists whose members have expertise in health services and policy research, healthcare administration,

clinical care, and ethics. This allows SGIM to play an important role in guiding the public and policy makers on which specific policy options to select to address key policy problems. Through its committees and the Council, SGIM works hard to advance its mission “to achieve health care delivery that is comprehensive...[and] is organized and financed to achieve optimal health outcomes and maximize equity”. SGIM's stated values include “social responsibility and equity in health and healthcare”. In addition, SGIM's Health Policy Committee affirms a commitment to “universal health care access”.

SGIM regularly supports specific policies, even controversial ones, by issuing white papers or public statements. As an organization, we have taken strong positions against physicians' participation in torture and in support of providing care for undocumented immigrants. However, SGIM has yet to advocate clearly on how to achieve universal and equitable access to care. We believe it should now publicly support a single-payer program for the United States.

Why Should SGIM Support a Single-Payer Healthcare System?

Merits of Single-payer

A single-payer reform would replace the current welter of private and public insurance plans with one public plan covering everyone for all medically necessary care—in essence, an expanded and upgraded version of the traditional Medicare program. The potential health benefits of this approach are substantial. Numerous studies, many from SGIM members, have shown that being uninsured carries mortal consequences. Covering the 29 million Americans who are currently uninsured would likely save many thousands of lives annually, and would reduce the risks borne by many more patients who delay seeking care and skimp on medications to save costs.

The economic case for single-payer reform is also

continued on page 9

compelling. Private insurers' overhead averages 12.4% versus 2.2% in traditional Medicare. Reducing insurance overhead to Medicare's level would save approximately \$220 billion this year. Even larger savings would accrue by sharply reducing provider overhead, including the substantial costs of billing and paperwork required to deal with multiple payers. By paying hospitals lump-sum operating budgets rather than forcing them to bill per patient, Scotland and Canada have held hospital administrative costs to approximately 12% of revenues versus 25.3% in the United States.⁴ Further, a single-payer program could use its bargaining clout to sharply reduce drug prices. Single-payer's savings on bureaucracy and drug profiteering would fully offset the added costs of providing universal, comprehensive first-dollar coverage. Indeed, even critics of single-payer estimate that such reform would cut overall health expenditures by \$2 trillion over a decade.⁵

Single-payer and SGIM's Organizational Objectives

Single-payer aligns well with SGIM's organizational goals. We agree with SGIM's support of the broad principles of access and equity. However, lacking any plan for how these goals can be realized effectively undermines advocacy efforts. SGIM's not providing specific recommendations, leaves the impression that it believes that incremental reform is a plausible way to achieve universal coverage. The evidence does not support this belief.

We are also convinced that single-payer is the best way to address SGIM's mission of "improving the work and practice environment for general internists" and reducing physician burnout. The simplified, uniform billing procedures under a single-payer system would reduce the time and effort physicians currently waste arguing with private, profit-driven insurers and providing documentation that is clinically superfluous but essential to justify payment.

The Moral Argument

Universal access to care is, fundamentally, a moral issue. As scientists, we must be attentive to research evidence, policy details and economic necessities. Ultimately, however, we must be guided by our conscience. Access to health care should not be dependent on one's age, employer, wealth, or zip code; it is a moral failure that we do not guarantee the clear common good that is health care. A strong body of research in the United States and experience in other nations give clear evidence that a single-payer system would dramatically expand access to care, including treatments for millions with chronic illnesses, saving thousands of lives annually. As physicians, we have an obligation to advocate for policies that evidence indicates are in the best interest of the public's health. In light of this, we believe that advocacy for single-payer reform is a professional duty.

Arguments against SGIM's Support for Single-Payer

Some suggest that advocating single-payer reform would commit SGIM to supporting a fringe proposal that would isolate us from the mainstream of political debate. Yet, recent surveys indicate that most Americans favor such reform. Single-payer bills in Congress have gained co-sponsorship from 123 members of the House and 16 in the Senate. All the leading Democratic party contenders for the presidency in 2020 openly call for single-payer reform.

Some may also worry that SGIM support for single-payer could alienate some current or potential members, or isolate us from other physician groups. Yet, as noted above, SGIM has not shied away from taking stands on other controversial and potentially divisive issues when it was clearly in the interest of the public's health. Moreover, past polls of SGIM's membership have found substantial support for "a single, consolidated financing mechanism," and recent surveys indicate that a majority of physicians—and an even

larger proportion of general internists—favor a single-payer system.

Others may view an incremental strategy as a more practical route to universal coverage, citing nations such as Switzerland and Germany that have retained multiple insurers while achieving universal coverage. Yet those nations' insurers are fundamentally different from ours. In Switzerland, for example, only non-profit insurers can offer the tightly regulated mandatory coverage and are required to pay providers identical rates. Transitioning to this or similar models would entail converting our for-profit insurers to heavily-regulated non-profits, a reform that insurers would vehemently oppose. Moreover, both insurance overhead and providers' administrative costs in multi-payer systems are far higher than under single-payer. While the incremental approach may sound appealing, it would sacrifice much of the administrative savings that makes universal coverage under a single-payer system affordable and it would still require a head-on confrontation with America's for-profit insurance giants.

Conclusion

SGIM supports universal access and the elimination of disparities in access to care. The only plausible way to achieve these goals is through adoption of a single-payer national health insurance program. Single-payer would cover 100% of Americans, dramatically expand access to care, and improve access to needed treatments for millions with chronic illnesses, saving thousands of lives annually. Popular and political support for single-payer is growing. SGIM should provide leadership in advocacy for such reform.

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continued on page 14

WHY SGIM SHOULD NOT ADVOCATE FOR SINGLE PAYER

Mark Earnest, MD, PhD

Dr. Earnest (Mark.Earnest@ucdenver.edu) is the GIM division head at the University of Colorado and current chair of SGIM's Health Policy Committee. He is a former Soros Physician Advocacy Fellow and served as the Vice President for the Colorado Coalition for the Medically Underserved for a decade. He is the founding director of the University of Colorado's Student and Resident Program in Leadership and Advocacy (LEADS) and their interprofessional education program.

"Our lives begin to end the day we become silent about things that matter."

—Martin Luther King Jr.

Healthcare reform matters. SGIM should advocate firmly for a just healthcare system that cares equally for everyone as one of our top priorities. Physicians, both individually and collectively through our professional societies, have a critical, public role to play in ensuring that the American healthcare system delivers universal, equitable access. No one else can speak with the same authority and experience of the consequences of our current chaotic and inequitable system. Our deeply flawed healthcare system breeds corruption, forces unethical choices on us daily, and contributes mightily to the growing inequalities that sap our nation's health and vitality. It must change. As a solution to all of these problems, a single payer system is undeniably elegant. Nevertheless, it would be a mistake for SGIM to endorse single payer health reform.

This position is far from where I started. Twenty-five years ago, as a junior faculty member, I delivered my first departmental grand rounds entitled "The Case for Single Payer Health Reform." I was among those loudly calling for SGIM to endorse single payer. In the years since, I've continued to speak on health reform. I've given scores of talks to professional and lay audiences on the topic, but over time, my approach has changed.

The change began with polite questions from physician audiences. "Aren't there health systems that perform well and have private insurance?" Initially, I was completely unprepared to answer the question and left with a sense of discomfort. Reflecting on that moment and those that followed, I realized I was struggling to locate my voice and my role. Was I speaking as a physician in equipoise—like I should at a patient's bedside—or as a citizen-activist with the goal of moving people to my point of view? Which voice should I use and where?

As physicians, we have a great deal of latitude to determine how we speak along a spectrum stretching from our purely professional roles, to our roles as private individuals and citizens. At the bedside we speak as physicians—putting aside our biases and self-interest as best

we can. Our commitment to this ideal lends our voices authority and forms the backbone of our profession. We have more latitude speaking publicly as physicians, but we still carry that authority with us and some expectation that we manage our biases and represent the best interest of others. Speaking as individuals, without the mantle of our profession, our obligations are no different than anyone else.

My solution was to make some distinctions. In front of a grand rounds audience or a classroom, I would speak as a physician and address the problems of access and equity with passion, but would also offer dispassion in evaluating the spectrum of responses. There were viable alternatives. Speaking as a physician, I would respectfully allow for their consideration and enable my audience to make a fully informed decision. I would be less constrained at a backyard barbecue or a party caucus, but speaking in my professional capacity, it was improper to present my preference as if it were the only reasonable choice.

SGIM as a professional society needs to make these same distinctions when we advocate for policy. SGIM can never speak as freely as any of us can as individuals. To maintain our credibility and effectiveness as an organization, we need to stay at the professional end of the spectrum when we speak. We should be absolutely clear about the ends we pursue, but when there are multiple means to achieve a particular end, we should speak as a doctor would. We should rigorously evaluate how well different options would accomplish the goals we have articulated and help policy-makers and the public make an informed decision. We should hold the process accountable to acceptable outcomes, but we should not make the choice for them.

As the gentleman in my grand rounds audience noted, single payer is not the only way. A quick scan of the globe reveals several high performing health systems that deliver universal, equitable, high quality care, through

continued on page 11

models that include private insurers. Among the many examples are Germany, Switzerland, and Japan who all deliver better population outcomes at a fraction of the cost of the United States.

Replacing private insurers with a government program would have been much simpler 40 or 50 years ago when health care as a percent of the economy was still in single digits and most insurers were not-for-profit. It is much more complicated now that nearly 1 dollar out of every 5 that change hands in this country is spent on health care, and a sizeable proportion of that passes through the coffers of U.S. insurance companies. While we can question the value these companies add, the facts remain that they employ hundreds of thousands of people in good paying jobs, and many Americans own a piece of these companies through their retirement plans. There may be many salutary benefits to adopting a single payer system, but we should be clear, there will be side effects. In evaluating the choices we face in health reform, SGIM can highlight the effectiveness and elegance of single payer as a solution and enumerate its many advantages, but we should recognize the consequences and be open to discussing them with the people who worry about them. If we endorse single payer as the model of reform, we imply it is the only model and we compromise our voice and reduce our influence.

Unfortunately, health reform has become highly politicized and partisan and single-payer generates a lot of heat. While single payer's star may be on the rise in this political moment, let's be clear about what that looks like: single payer is red meat for Democrats and kryptonite for Republicans. SGIM cannot as a society adopt active advocacy toward single payer without creating the impression we are a partisan organization. If we appear partisan, we will instantly alienate a majority of current members of the House and Senate (and many of our own mem-

bers). This would reduce our ability to influence their opinions on future health reform proposals and alienate support we will need for other critical items on our advocacy agenda. There are many voices advocating for single payer, but we are almost alone in advocating for academic GIM. Our research, education, and clinical care agendas are vitally important, and we should be very cautious about anything that compromises them.

Our position now will also determine our role in future reform. The ACA passed without a single Republican vote; "repeal and replace" became one of the most potent rallying cries through the last four election cycles. I hope we will have another shot at reform soon.

Health care will be one of the top issues of the 2020 presidential election. Meaningful, durable reforms—that Congress can build and improve upon rather than tear down when another party takes power—will need bipartisan support. Adopting single payer now will reduce our influence on that debate. Perhaps the political landscape will evolve in such a way that single-payer reform is possible. What if it does not? What if the only model that will attract enough support to pass is a bill to fix the ACA? If we are all in on single payer, we are by definition opposed to other options. We might find ourselves on the sidelines with some strange bedfellows, when we could be working to ensure that a compromise proposal meets the critical needs of our nation.

Just because SGIM maintains equipoise doesn't mean our members should. Our membership includes some of the most articulate and effective voices in support of single payer as well as many of the investigators who have developed the evidence for its efficacy. Those voices are important and should be heard. We should all make our votes count. As citizens, we should pressure candidates to commit to support health reform and even pledge in advance to

what policies they will support. We should each support candidates who can move us forward, and oppose those who will undermine reform efforts. Each of us has the opportunity to challenge, engage, educate and reason with our students, residents, colleagues, friends and family. We should be writing editorials and supporting organizations that apply political pressure in ways we agree with.

As a society, we cannot be silent about this thing that matters. SGIM's principles and goals must be firm and clear. Healthcare reform is an urgent national priority. We have an important role to play as a trusted, objective, non-partisan resource in the coming debate. That is how SGIM will move hearts and minds toward the solution we have so long sought and so desperately needed. Perhaps that solution will be a single payer system, but we should be prepared to do all we can to ensure the best outcome, even if it's not.

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SGIM
Society of General Internal Medicine

SGIM Organizational Goals



I want to share with you how the planning efforts are proceeding. During the June retreat, Council and Staff took a considerable amount of time to review and revise the mission and vision statements that I shared with you in my September column. Our next step was to reexamine the strategic goals and priorities for the organization to further identify how we could be most effective in the work we do as an organization and how we can best serve our members.

In developing the strategic plan, we revisited the strategic priorities developed in 2015 and used them as the starting point to develop a set of organizational goals (HOW) and current tactics (WHAT) to achieve these goals.⁴ Below are the current working goals and tactics in the SGIM strategic plan:

Foster the development of future leaders in academic general internal medicine.

- Develop an integrated, comprehensive portfolio of career development initiatives
- Run programs to stimulate interest in careers in general internal medicine
- Offer awards to recognize innovators, scholars, and leaders

in academic general internal medicine

Promote high-value, evidence-based, person-centered, population-oriented approaches to improving health.

- Strengthen and leverage the organizational infrastructure for catalyzing and disseminating evidence-based innovations in clinical practice, research, advocacy, and education

Advocate for our vision of a just health system that brings optimal health for all people.

- Conduct advocacy with an emphasis on vulnerable and underserved patients and communities
- Advocate for policies supporting the ability of general internists to provide optimal care in ambulatory and hospital settings
- Develop advocacy-related education messages to communicate to members

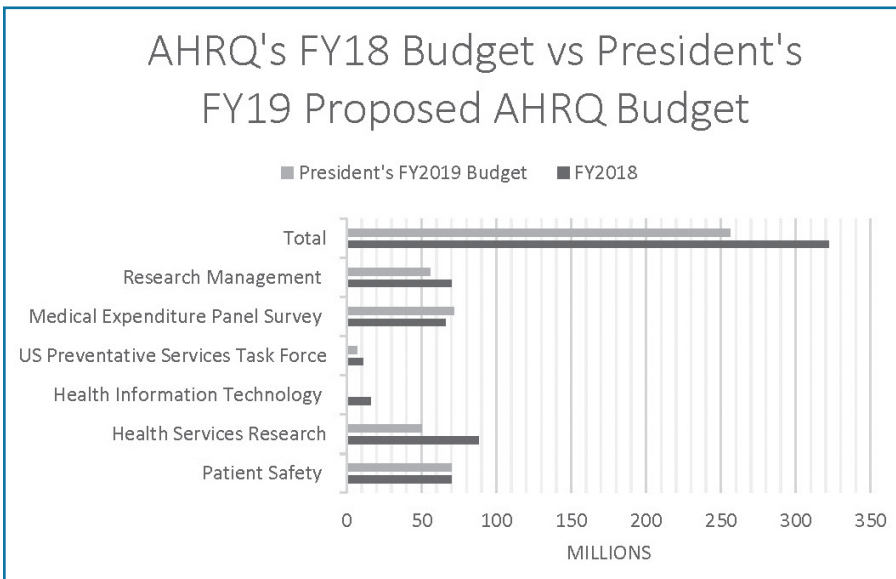
Ensure SGIM financial health and employee satisfaction.

- Align organizational structure and workload to make effective use of resources and foster growth
- Enhance employees' satisfaction and fulfillment with work

I want to commend the Council members and SGIM staff who participated in these discussions—we had very intense and rigorous conversations. These strategic goals will form the backbone for identifying/refining tactics and articulating high level performance metrics for SGIM so we can chart our path as an organization. In service of this strategic planning process, we will tackle four major initiatives in the “sabbatical year” focused on organizational renewal:

1. SGIM leadership will continue to respond to the recommendations from the Pyramid communications audit. An oversight committee chaired by Tom Gallagher has started working on our implementation strategy.
2. The Finance Committee, chaired by Mark Schwartz, has been working on a long-term strategic plan for financial sustainability and growth for SGIM. They are examining and developing targets for all sources of revenue, keeping well within our external funds policy.
3. A steering committee, chaired by Mitch Feldman, will reassess our career development programs in order to develop a more cohesive overall strategy and sustainable business model for these programs. As you may have seen in my message in GIM Connect, SGIM has declared a temporary hold on new enrollments in existing career development programs. We have outstanding content to which many of you have contributed and for which SGIM has become known. We are at a key time-point to ensure coordination and synergy in the pedagogical approaches and logistics of implementing these programs. We will be calling on committees and commissions to help us as we get into the details of this work.

continued on page 14



AHRQ's FY18 budget vs President's proposed FY19 budget. Modified from

<https://www.ahrq.gov/sites/default/files/wysiwyg/cpi/about/mission/budget/2019/NIRSQ.pdf>

Health (NIH) and renaming it the National Institute of Research on Safety and Quality (NIRSQ). The President's FY18 proposed budget also made this recommendation, but it never gained traction.

The FY19 proposals from the House and Senate Appropriations Committees recommend no change in AHRQ's budget compared with FY18, although the funding legislation is still pending at the time of this writing. Looking forward, the President is already threatening a government shutdown by vetoing any spending bill that does not include funds for building his wall. This could once again put AHRQ in danger of funding cuts if the legislation is not passed.

Foreseeing the political battle over the budget and the impact it may have on the future of health services research, it's important to better understand the president's proposal to move AHRQ to the NIH and understand why health services research funding, which is crucial to the success of our healthcare system, continues to be threatened.

I spoke with Dr. Andy Bindman, former AHRQ director under President Obama, to help answer these questions.

Me: What are the benefits of having health services research at the NIH?

Andy Bindman: Right now, the NIH has already been funding tremendous efforts in health services research in projects such as the National Institute of Aging and the National Cancer Institute. Yet, I don't know if their efforts are well coordinated for the larger efforts made in health services research, which AHRQ is very good at. But it's been hard to bridge these efforts with AHRQ being a separate institute. A benefit of having AHRQ at the NIH would be better coordination of health services research between departments in the NIH and a dedicated department where this type of research is the main focus.

Me: Why does health services research, which is so critical to improving our healthcare system, not get the same support as biomedical research?

Andy Bindman: Biomedical research funds projects that are tied with industry and leads to new drugs that go into the market place to be sold... Health services research helps make our healthcare system more intelligent. But most of our incentives in the market place are not geared that way,

towards rewarding value... Nobody at first blush would say they are against value but there are a lot of people who are gaining by working in this current volume-based system, and thus it's hard to find support for increasing incentives towards a value-based care system, and therefore funding health services research.

Me: How can groups like SGIM help support health services research, and make the key stakeholders aware of its value in improving our healthcare system?

Andy Bindman: It's not just about having stakeholders support health services research, it's about having stakeholders seeing health services research as one of its top priorities... When I was first director of AHRQ I went to a meeting at the AAMC [Association of American Medical Colleges], who is a big stakeholder, and they listed their top three priorities for Congress that year. The NIH was on the list, but AHRQ and health services research was not. My goal was to have AHRQ and health services research get on that list. Doing so helps Congress and other stakeholders wake up to the importance of this work. One issue in achieving this goal is that health services researchers often talk amongst themselves but not to the end users... When a drug gets discovered and cures a disease its easy to draw a line from biomedical research to the outcome. This helps emphasize the importance of biomedical research. But when you prevent a medical error or improve the quality of a healthcare treatment, who knows that health services research lead to this outcome? Health services researchers and groups like SGIM need to focus on making stakeholders aware of the impact of health services research, if they want to see continued support and become a top priority among important stakeholders.

The possibility of moving AHRQ to the NIH is uncertain, and would require authorizing legisla-

continued on page 14

4. Council will complete the strategic planning work by identifying tactics and metrics for each strategic goal. As part of this effort, Council will ask committees and commissions to map their current programs and initiatives to this plan, articulating measures that would help us benchmark our progress in meeting these goals.

In the coming months, we will share the outcomes of these four initiatives and continue to share

information about the process the Council is using to do this work. We expect this strategic planning process to strengthen the organization so that it is better able to serve our members and pursue new opportunities to keep SGIM at the cutting edge of issues in general internal medicine.

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SGIM

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SGIM

*A full set of references is available upon request from the authors.

HEALTH POLICY (continued from page 13)

tion, which does not appear likely in the immediate future. However, threats of funding cuts should remind us that health services research is not on the priority list of enough important stakeholders. By following Dr. Bindman's advice, clearly summarizing our successes in health services research and their associations with improved healthcare outcomes, we will better acknowledge its significance. Wanting to end the opioid epidemic or prevent another medical error from taking a life is not a partisan debate; neither should be supporting health services research and AHRQ. The members of groups such as SGIM, who can inform policy makers, need to continue to advocate

for AHRQ and the crucial research it funds.

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SGIM

The rest of this issue is a great example of what and who we are and what we stand for. Dr. Tom Kingsley describes the history around and the role that AHRQ plays in the funding of health services research. Drs. Annie Massart, Theresa Vettese, and Julie Hollberg educate us on the best practices

regarding the difficult topic of providing adequate pain relief to patients that are opioid dependent. Finally, Drs. Tiffany Leung, Jorge Rodriguez, and Stephen Morgan provide us with the second part of their Clinical Update in Clinical Informatics taken from the 2018 Annual Meeting.

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SGIM

Academic Primary Care Positions at Beth Israel Deaconess Medical Center in Boston

The Division of General Medicine and Primary Care at Beth Israel Deaconess Medical Center, a teaching hospital of Harvard Medical School, seeks highly motivated board eligible and certified internists to join our hospital-based, academic primary care practice. We are an NCQA certified level III patient-centered medical home, with a strong track record of high quality, innovative patient care, excellent population-health tools and an abiding commitment to excellence in teaching, research, quality improvement and work-life balance. Our practice delivers team-based care with integrated on-site support from mental

health providers, as well as anticoagulation, HIV, diabetes, hypertension and substance use disorder management services. Residents and Harvard medical students are integrated into the overall practice and team structure, and we have a cutting edge primary care residency program. A Harvard appointment will be offered commensurate with academic qualifications. We offer a highly-competitive salary, incentives closely aligned to the diverse mix of elements required in providing quality care and a generous benefits program.

Candidates should visit <http://www.hmphysicians.org/careers>, create an

account, use the search term "Academic Primary Care Physician," and apply to requisition # 171439. Primary care physicians are employed by Harvard Medical Faculty Physicians (HMFP), the faculty practice plan for all physicians at Beth Israel Deaconess Medical Center, Inc.

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.



Beth Israel Deaconess
Medical Center

Research Faculty Position Division Of General Medicine



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

The Division of General Medicine at Boston's Beth Israel Deaconess Medical Center (BIDMC, major teaching affiliate of Harvard Medical School), seeks junior and mid-career/senior research faculty. The Division is home to the Sections of Primary Care and Hospital Medicine, with research focusing on improving the health of vulnerable populations and those with chronic conditions, fostering patient-centered care, improving clinical decision making, and developing, implementing, and testing innovations in primary care and hospital medicine. Eighteen M.D. and Ph.D. investigators conduct research, seek external funding, and provide mentoring within Harvard's general medicine and integrative medicine fellowships.

JUNIOR POSITION—For junior positions, we seek to grow depth in established research areas as listed above. The Section for Research takes particular pride in our mentoring of junior faculty members; most senior faculty are recipients of individual awards for excellence in mentoring, and our Section has been recognized with Harvard Medical School's Program Award for a Culture of Excellence in Mentoring.

MID-CAREER/SENIOR POSITION—The successful applicant will be prepared to lead a new research program within the Division, garner significant external research funding, and mentor fellows and junior faculty members within his/her area of expertise. Resources will be available to establish a research program, including potential recruitment of additional faculty or fellows. We seek to grow breadth in our present lines of inquiry, and therefore welcome investigators focused on new topics relevant to general medicine. Such topics include (but are not limited to) health disparities, healthcare policy and organization, and substance use disorders.

M.D. and/or Ph.D. required, with general medicine (including hospital medicine) research interests. M.D.s practice in BIDMC's faculty inpatient and outpatient settings. Under-represented minorities, women, and persons with disabilities encouraged to apply. EEO/AA/M/F/Vet/Disability. Please apply by going to <https://hmphysicians.org/>. Please enter 171454 in keyword search to locate the job posting to apply.

**Boston University School of Medicine / Boston Medical Center—
 Medical Director for Primary Care**

The Section of General Internal Medicine at Boston Medical Center and Boston University School of Medicine is seeking an innovative and inspirational faculty leader to serve as Medical Director for Primary Care, providing overall leadership responsibility for Primary Care Operations, Transformation and Innovation.

Working with an Associate Medical Director, Administrative Director and Clinic Operation Managers, the Director has responsibility for Primary Care operations, transformation, and innovation. The Director will have important roles in ensuring the success of our very exciting Medicaid Accountable Care Organization as well leading our primary care clinicians to continue to excel in all aspects of high value, patient-centered care. The primary care practice in the Section of General Internal Medicine has 70 faculty and responsibility for approximate 38,000 patients. In addition, the practice has critically important specialized pro-

grams in Office-Based-Addiction-Treatment (e.g., buprenorphine), Women's Health, Refugee Health, patient navigator programs, Care Coordinator program, Clinical Pharmacist Program, and TOPCARE for safe opioid prescribing.

The Primary Care Medical Director will oversee Practice Team and Leadership Development by creating a culture of continuous performance improvement, responsible stewardship of resources, and career development of our talented clinical faculty. The Director will also have an important role in ensuring that the primary care practice facilitates effective educational environment for our students, residents, and fellows in primary care. The Director will report to the Chief, Section of General Internal Medicine and the Vice Chair for Clinical Affairs in the Department of Medicine, and will be expected to work collaboratively with the BMC leadership team in formulating strategic plans for the practice.

This is an exciting time to join the Section of General Internal Medicine at New England's largest safety-net hospital and make a real impact. The Section is comprised of a diverse, energetic and committed group of Primary Care Faculty Members. Boston Medical Center is committed to growing and strengthening Primary Care, and the Section of General Internal Medicine has embarked on an effort to further transform our NCQA-certified patient centered medical home into a leading primary care practice with a focus on providing high-value, team-based care consistent with our mission for caring for Boston's underserved.

Boston University is an Affirmative Action and Equal Opportunity Employer. Salary and faculty rank will be commensurate with prior experience and qualifications. Interested candidates - please send a cover letter and CV via email to Jeffrey Samet, Section Chief of General Internal Medicine: jsamet@bu.edu

**Boston University School of Medicine / Boston Medical Center—
 Associate Medical Director for Primary Care Transformation and Innovation**

The Section of General Internal Medicine at Boston Medical Center is seeking an innovative and inspirational leader to join the Primary Care Leadership team as the Associate Medical Director for Primary Care Transformation and Innovation. This is a faculty position in the Department of Medicine and the Boston University School of Medicine.

This position will combine direct patient care with significant administrative time to lead change and quality improvement in key priority areas. The Associate Medical Director will work closely with the Medical Director to lead the efforts to drive changes in primary care as the hospital transforms into an Accountable Care Organization for the safety-net population. In partic-

ular, the Associate Medical Director will lead a multidisciplinary team in conceptualizing and implementing a care delivery model for complex and high-risk care management from the ground up. Successful applicants will have experience in change management, project implementation, process improvement, and managing diverse teams. This leader will serve on key quality and strategy committees, interact directly with Hospital and Department of Medicine leadership, and will have leadership development and mentorship opportunities tailored to the applicant's interests. There will be an expectation of teaching and scholarship related to primary care quality and innovation work.

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