ANNUAL MEETING UPDATE: PART I

¡SI SE PUEDE!: YES, WE CAN!
Brita Roy, MD, MPH, MHS, and Lenny Lopez, MD, MPH, MDiv

Dr. Roy (brita.roy@yale.edu) is an assistant professor of medicine and director of population health at Yale School of Medicine and was the chair of the 2019 Annual Meeting. Dr. Lopez (Lenny.Lopez@ucsf.edu) is an associate professor and chief of hospital medicine at University of California, San Francisco VA Medical Center and was co-chair of the 2019 Annual Meeting.

The 2019 Annual Meeting in Washington, DC, shattered prior attendance records with more than 2,700 registrants! As chairs of the 2019 SGIM Annual Meeting, we would like to thank the staff, program committee, and other volunteers, presenters, and attendees who all contributed to its unparalleled success. Most attendees (81%) rated the conference “above average” or higher and almost all (99%) would recommend the conference to others.

The theme of the 2019 Annual Meeting was “Courage to Lead: Equity, Engagement, and Advocacy in Turbulent Times.” To this end, we designed the 2019 SGIM Annual Meeting to be a venue to discuss how generalists can proactively lead collaborative efforts—within our clinics, health systems, classrooms, and communities—to advance health, well-being, and equity. We encouraged all SGIM members to collectively act to achieve equity using their strengths, passions, and expertise in research, medical education, high-quality clinical care, and health system design. Giselle Corbie-Smith reminded us that “if you want to go fast, go alone; if you want to go far, go together,” and Camara Jones supported that when she said, “our power is in collective action.” In this short article, we review some of the meeting highlights in hopes of reinvigorating your commitment to improving equity.

We heard outstanding and engaging talks at each morning’s plenary sessions. In order to reinspire us, we list a few noteworthy quotes from these presentations:

- **Giselle Corbie-Smith**: “The master’s tools will never dismantle the master’s house.” (Audré Lord) “Find your tribe. Find your purpose. Find your tools.”
- **Alicia Fernandez** taught us that justice is the same in every language as we all chanted together “Si Se Puede.”
- **Yvette Roubideaux** shared that it’s essential to know your work is important, even if others don’t and even if the challenge is large.
- **Carl Streed**: “By focusing on transgender health, we can be better doctors for everyone.”
- **Adina Kalet**: “Education is the most powerful weapon with which you can change the world.” (Nelson Mandela)
- **Patrick O’Connor**: “Success is based on outstanding mentorship.”
- **Camara Jones**: “Systems that perpetuate racism have mechanisms that are identifiable and addressable.”
- **Brittany Badesch** emphasized the importance of letting the community lead us in our efforts to end urban gun violence.
- **Sonia Angell**: “We can’t make healthy choices if we don’t have healthy choices,” and “what we don’t measure really does matter.”

The 2019 Annual Meeting had several successful program innovations:

1. **Patient & Community Engagement**: In addition to a pre-course focused on community engaged research, this was the second year we invited patients/community advocates to co-present their work with SGIM members in workshops and abstracts. This innovative engagement was well received by attendees.
2. **Advocacy 2019**: Annual meeting participants had an opportunity to schedule in-person visits with their...
FROM THE EDITOR

HERE WE GO AGAIN!

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

This month’s Forum features the traditional National Meeting recap including three pages of evocative photos, summaries, and perspectives. Drs. Roy and Lopez recap what was an amazing meeting that was true to Giselle Corbie-Smith’s theme of leadership in equity, engagement, and advocacy. It was a great meeting; nothing more to say—records were broken and attendees loved it and were duly inspired. Don’t just take my word for it. Read Dr. Joan Bosco’s take on how her meeting experience can make her a better physician and teacher. Dr. Patricia Harris also interviews Dr. Peter Boling who gave the annual Distinguished Professor in Geriatrics address. He advises young faculty to find a problem that is meaningful to them and to focus on it. Also in this issue, Dr. Karen DeSalvo, SGIM President, highlights the disconnect between the need for social determinants of health (SDOH) data and the technology and processes needed to support it.

Where do we go from here? Well, to Birmingham of course!! Yes, yes, there’s that controversy thing. All I know is that I have faith in SGIM and its members to take controversy and turn it into opportunity. In this recap issue, Drs. Narayana and Snyder give their view of how we should approach next year’s meeting.

What do you think?
PRESIDENT’S COLUMN

HEALTH INFORMATION TECHNOLOGY MEETS THE SOCIAL DETERMINANTS OF HEALTH
Karen DeSalvo, MD, President, SGIM

As the work to liberate healthcare data progresses, a new challenge is already on the horizon: The flurry of activity around addressing the social determinants of health (SDOH) both inside and alongside the healthcare system is creating a demand for a health information technology system to support collecting, storing, and sharing SDOH information.

I have been hesitant to write this article about data and technology as a core component of assessing and addressing the social determinants of health. In the other parts of our lives, technology is an enabler, a helpmeet, a tool that has made our lives more enjoyable in countless ways: movies and music On Demand, recommendations on the best route to take on our drive, a seamless banking experience.

Health care has not been so enjoyable. We are now 10 years out from the start of a journey, laid out first by President Bush and later by President Obama, to implement health information technology in the healthcare sector and digitize the care experience of everyone in the United States. While we have accomplished that goal, it has not been without pain and frustration on the front line. The electronic health record systems that were pushed out following the stimulus funding from the Health Information Technology for Economic and Clinical Health (HITECH) Act were built to enable compliance and billing, not to support clinical care and decision making.

During my tenure as National Coordinator for Health Information Technology in the Obama Administration, we worked on several areas meant to ease the pain and also to make actionable information available. The policy work included slowing the implementation of meaningful use regulations, decreasing expectations such as computerized order entry and working with Congress to gain more flexibility around what would be expected overall from the Meaningful Use regulations.

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The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held May 8-11, 2019, at the Washington Hilton in Washington, DC. SGIM is proud and pleased to announce the recipients by category.

**Recognition Awards**

The Robert J. Glaser Award—Presented to Patrick G. O’Connor, MD, MPH (Yale School of Medicine) for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Herbert W. Nickens Award—Presented to Alicia Fernandez, MD (University of California, San Francisco School of Medicine) for a demonstrated commitment to cultural diversity in medicine.

David R. Calkins Award in Health Policy Advocacy—Presented to Andrew Bindman, MD (University of California, San Francisco School of Medicine) in recognition of his extraordinary commitment to advocating on behalf of SGIM.

ACLGIM Chiefs Recognition Award—Presented to Jeffrey Samet, MD, MA, MPH (Boston University School of Medicine). This award is given annually to the general internal medicine Division Chief who most represents excellence in division leadership.

Lawrence S. Linn Award—Presented to Aroonsiri Sangarlangkarn, MD, MPH (Mayo Clinic, Rochester). This award is presented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

The ACLGIM UNLTD (Unified Leadership Training in Diversity) Award—Recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. The 2019 recipients are Eloho Ufomata, MD, MS (University of Pittsburgh Medical Center) and Raquel Greer, MD, MPH (Johns Hopkins University School of Medicine).

The ACLGIM Leadership Award is given to a member of the ACLGIM who is within the first 10 years of faculty appointment. It recognizes skills in leadership in any number of areas of academic medicine, including clinical, educational, research or administrative efforts. The 2019 recipient of this award is Stacie Schmidt, MD (Emory University School of Medicine).

The Quality and Practice Innovation Award—Recognizes general internists and their organization that have successfully developed and implemented innovative role model systems of practice improvement in ambulatory and/or inpatient clinical practice. The 2019 award was presented to Mount Sinai High Value Care Team, Hyung (Harry) J. Cho, MD.

**Research Awards**

John M. Eisenberg National Award for Career Achievement in Research—Presented to Kevin Volpp, MD, PhD (University of Pennsylvania School of Medicine), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator of the Year—Presented to Shreya Kangovi, MD (University of Pennsylvania School of Medicine) for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research Mentorship Award—Presented to Sonya Borrero, MD (University of Pittsburgh/VA Pittsburgh) in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper of the Year—Presented to Atheendar Venkataramani, MD, PhD (Massachusetts General Hospital) for his 2018 publication “Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study.” This award is offered to help members gain recognition for their papers that have made significant contributions to generalist research.

Founders’ Grant—Presented to Ashley Jenkins, MD (University of Cincinnati Medical Center). The SGIM Founders Award provides $10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to
establish a strong research funding base.

**Clinician-Educator Awards**

*National Award for Career Achievements in Medical Education—*Presented to Adina Kalet, MD, MPH, (New York University School of Medicine) for a lifetime of contributions to medical education.

Frederick L. Brancati

*Mentorship & Leadership Award—*Presented to Alexander Walley, MD, PhD, (Harvard Medical School) for her individual contributions to medical education in one or more of the following categories: Scholarship in Medical Education—The Brancati Award honors an individual at the junior faculty level who inspires and mentors trainees to pursue general internal medicine and lead the transformation of health care through innovations in research, education, and practice.

**National Award for Scholarship in Medical Education—**Presented to Subha Ramani, MBBS, MPH, PhD, (Harvard Medical School) for her individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

**Mid-Career Mentorship in Education Award—**Presented to Donna Windish, MD, MPH (Yale School of Medicine). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician educators.

**Presentation Awards**

Mack Lipkin, Sr. —Associate Member Awards are presented to the scientific presentations considered most outstanding by students, residents and fellows during the 2019 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2019 are as follows:

- **Timothy S. Anderson, MD (University of California, San Francisco School of Medicine)**
  - Intensification of Older Adults Antihypertensives at Hospital Discharge Leads to Serious Adverse Events Without Long-Term Benefit

- **Yu-Tien Hsu, MD, MPH (Massachusetts General Hospital)**
  - “Lifetime Risk of Non-Fatal Firearm-Related Injuries in New York State: Racial and Sex Disparities”

- **Audrey D. Zhang, BA (New York University School of Medicine)**
  - Clinical Trial Evidence Supporting FDA Approval of New Drugs Over Three Decades, 1995-2017”

- **Milton W. Hamolsky—Junior Faculty Awards** are presented to the scientific presentations considered most outstanding by junior faculty during the 2019 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education.

- **Linnaea Schuttner, MD, (VA Puget Sound Health Care System)**
  - “Patient Centered Medical Home Implementation and Chronic Disease Care Quality in Patients with Multimorbidity”

- **Zirui Song, MD, PhD, (Harvard Medical School)**
  - “Changes in Economic and Clinical Outcomes Under CMS Mandatory Bundled Payments for Joint Replacements”

- **Elizabeth L. Tung, MD, (University of Chicago Division of the Biological Science—The Pritzker School of Medicine)**
  - “Social Isolation, Loneliness, and Violence Exposure in Older Adults”

**SGIM Clinical Vignette Oral Presentation Awards—**Recognizes the best presented clinical case by a medical students, internal medicine residents or GIM fellows (not faculty) at the SGIM National Meeting.

- **Ann Wang, MD, (Montefiore Medical Center)**
  - “Diffuse Coronary Artery Ectasia: An Unusual Cause of ST-Elevation Myocardial Infarction”

- **Rebecca Angoff, MD, (Beth Israel Deaconess Medical Center)**
  - “A Case of Recurrent Sinusitis”

**Outstanding Quality & Patient Safety Oral Presentation Award** recognizes the most outstanding oral abstract presentation related to quality assessment, gaps in quality of care, medical errors, quality improvement or patient safety in the inpatient or outpatient setting at the SGIM National meeting. This year’s awardee is Sarah Follman, BA, (University of Chicago Hospitals and Health System) for the abstract, “Low Naloxone Prescriptions among Individuals at High Risk of Opioid-Related Overdose Despite Healthcare Interactions.”

**Distinguish Professor of Women’s Health Best Oral Abstract Award—**Laura Hawks, MD (Harvard Medical School/Cambridge Health Alliance) for the abstract, “#MeToo: A National Study of Forced Sexual Initiation Among US Women.”

**Distinguish Professor of Geriatrics Best Poster Award—**Anna Leone, BA (University of Pittsburgh School of Medicine) for the poster titled “Provider Perspectives on Barriers and Facilitators of Long-Acting Reversible Contraceptive Use in a Large Health System.”

**Distinguish Professor of Geriatrics Best Oral Abstract Award—**Mara Schonberg, MD, MPH, (Beth Israel Deaconess Medical Center) for the abstract, “A Decision Aid on Mammography Screening for Women Aged 75 and Older Reduces Screening.”

**Distinguish Professor of Geriatrics Best Poster Award—**Sachin Shah, MD, MPH, (University of California, San Francisco School continued on page 7
On Tuesday, May 14, 2019, the Alabama State Senate approved a measure to ban abortions in the state, except when the mother’s life is at risk, with no exceptions for rape or incest. Abortion would be considered a crime, thus holding physicians accountable. Since that time, other states have enacted similarly strict abortion laws, many of which would not allow abortion once a fetal heartbeat is detected (as early as six weeks gestation). However, other states are now passing laws that expand or protect access to abortion. Long a hot button political issue, the United States is on the cusp of a major policy shift around abortion.

Legislation around abortion and contraception have real and lasting consequences for our patients. As internists, we often care for women of childbearing age and counsel patients on pregnancy and contraception. Many of us help manage complex medical issues during pregnancy. As members of the Society for General Internal Medicine (SGIM), we pride ourselves in this organization’s core values, to “[lead] the way to better health for everyone” and establish a “just system of care in which all people can achieve optimal health.”1 We are concerned that legislation limiting access to abortion will create inequities and injustices, making it harder for women to receive care they need.

The 2020 SGIM National Meeting is being held in Birmingham, Alabama. The national meeting is designed to promote collaboration, share research and educational successes and failures, and motivate each other to practice the best medicine and provide the best care for all. Every year, we return from this meeting inspired to think more creatively and collaborate more effectively to create the just health-care system our patients deserve.

Hosting our national meeting in the same state that is attempting to eliminate a critical health care option for women is controversial. Some have called for SGIM to consider moving the location of the 2020 meeting away from Alabama, saying this law does not model our professional values.

We are writing today from inside and outside of Alabama to share our perspective on a more meaningful and impactful response. While SGIM leadership has articulated financial reasons for not moving the meeting, the abortion law in and of itself is all the more reason we should go to Alabama in 2020. We can capitalize on our presence in Alabama and the fervor around the abortion law to 1) learn from local and community stakeholders, 2) execute programming around contraception, family planning, and medical abortions, and 3) partner with colleagues in local advocacy—all to ensure we continue to champion women’s health.

The SGIM meeting in Alabama would allow many members to learn from a community quite different from their own. Abortion is an issue around which many have very deeply held beliefs, us included. While bridging differences may sometimes appear intractable, conversation is often a powerful tool to move forward. By engaging with colleagues, trainees, and community stakeholders living and working in Alabama, we may be able to better understand the broader context of the abortion discussion. We can explore the nuances of how we may weigh our underlying values, witness the depth and breadth of our own organization, and ideally find some common ground to promote research, education, and advocacy that can foster informed, civic solutions. These open conversations are challenging but are necessary for SGIM to develop unifying policy statements around women’s health. Some SGIM members do agree that restricting access to abortion is appropriate, whether or not they support the extent to which these recent laws restrict it. SGIM, and Alabama, are not monolithic cultures. There is, and should be, space for many opinions.

As a professional network, SGIM should demonstrate to trainees the importance of engaging in a dialogue with those with contrary opinions, whether it be with patients, colleagues, or policy-makers. We should not abandon institutions just because their state(s) enacted a law many in the medical community oppose. We will continue building academic connections and creating academic projects regardless, and we will be more empowered to study pregnancy, abortion, and family planning needs in our patients, engage in political discourse, and improve women’s health overall, because we faced the issue head on. Even if women in

continued on page 7
Alabama feel abandoned, we have not abandoned them. We will remain their physicians and help them get the health care they deserve.

A unique form of protest would be to capitalize on the dialogue around abortion laws by aligning the meeting programming with the theme of “Transforming the Medical and Social Determinants of Health.” Invited local community practitioners and patients could share their perspectives on delivering and receiving health care in a state that limits healthcare options for women, including obstetric care. Alabama, along with 13 other states, has not yet expanded Medicaid under the Affordable Care Act. In the years since, Alabama’s rural hospitals have struggled to stay open. Currently, fewer than half of the counties in Alabama have a hospital with obstetric services, leaving many Alabamians to drive for hours to find care. Many organizations are learning how to do more with less, a struggle that may sound familiar to internists everywhere.

Workshops teaching practitioners about contraception counseling and medical abortions should be prioritized. We should consider hosting a special symposium on family planning options in the internal medicine setting, especially since primary care may be an optimal avenue for patients to receive this care due to Title X changes. We could add a special oral presentation session specifically highlighting pregnancy-related cases or contraception. A debate on the ethical, legal, and policy issues related to abortion could be a welcome addition to the program. SGIM’s leadership would be wise to take this issue by the horns and make it front and center in the meeting.

Ultimately, the key to broader change is local advocacy. Physicians play an influential role when engaging with policy makers. During a recent advocacy effort in Sacramento, California, physicians testified on the value of stricter vaccine exemption laws. One of the most powerful statements came from a formerly unvaccinated medical student who was now advocating for vaccinations herself. Another student was able to provide language to a junior assemblyman on how to respond to his constituents who were concerned about seizures after vaccinations. We can likewise provide that countervoice for lawmakers in Alabama. Conceptualizing stories and articulating key points are critical for lawmakers when they consider their votes, what bills to prioritize, and how to best influence their colleagues and constituents. As interns, we have the unique ability to catalogue and share the stories of our patients whose lives are affected by pregnancy. SGIM has capitalized on advocacy as a professional responsibility by sponsoring Hill Days and regional events, as well as creating the Leadership in Health Policy and Advocacy (LEAHP) program. SGIM can likewise facilitate meetings with policy-makers in Montgomery and allow members from around the country to partner with those from Alabama to deliver important commentary. Additionally, SGIM should consider forming coalitions with other medical organizations and speak out in favor of women’s health. It is time for SGIM to take a vocal and formal stand.

We have a golden opportunity in 2020 to embolden our role in supporting women’s health. Unifying disparate feelings around health care does not start with sticking to our sides, whether we are a “West Coast liberal elite” or an “Evangelical Southern conservative.” It begins with learning from each other. We cannot learn unless we show up. As a medical society, we need to show up in Alabama. We must talk to our colleagues, people in the community, and policy makers. We must champion the rights of women. We should not be deterred from our mission.

References
Among physicians, it is increasingly common to feel detached from patients and work, with decreasing feelings of motivation, inspiration, or purpose. From day to day, it is sometimes difficult to see the big picture, the *why* rather than the *how or when*. In particular, general internists are at high risk, with 49% of internists who responded to a 2019 Medscape survey reporting having experienced the aforementioned feelings (up from 46% the year prior). The top contributing reasons included “too many bureaucratic tasks, spending too many hours at work, and increased computerization of practice (EHRs).” When feeling overwhelmed or detached, it is easy to function on “autopilot” and miss something unexpected. It is also difficult to creatively problem solve—a skill that is often required when working with medically and/or psychosocially complex patients. The importance of this ability to think outside the box, to expect the unexpected, and to cultivate a strong sense of purpose was consistently emphasized at the 2019 Society for General Medicine (SGIM) Annual Meeting in Washington, DC.

For example, in such a state, it is easy to understand how a physician could potentially miss the reason why his patient, a 34-year-old Salvadoran immigrant, is experiencing weight loss. He may check thyroid function tests or an A1C, rule out infection, and, in the end, chalk it up to stress. However, as eloquently demonstrated in one of the oral clinical vignettes (“Weight Loss in a Salvadoran Woman: Through the Migration Lens”) presented by Dr. Jordana Laks in the “Social Determinants of Health” series at this year’s SGIM National Meeting, probing a bit deeper would uncover the fact that this woman had just recently walked nearly the entire way from El Salvador to the United States in order to escape a violent gang that had killed her brother and niece. During this journey, she had limited access to regular food, hence the weight loss.

Similarly, we have all probably seen a frustrated colleague (or perhaps even ourselves) write off the noncompliant, undomiciled “frequent flier” who has landed on her inpatient service yet again. Likewise, she may become irritated at the “difficult” patient who continuously and without explanation refuses a necessary cardiac MRI. These were two real cases discussed at the “Moving Beyond the ‘Difficult’ Label: Strategies for Caring for Disengaged, Manipulative and Traumatized Patients” workshop at this year’s meeting. With a little patience and effort, the providers involved in the care of these “difficult” patients discovered that their “homeless frequent flier” actually had a stable home, but was constantly labeled as undomiciled due to his disheveled appearance and to incorrect information being copied forward in his EMR. Due to this mislabeling, the patient felt judged and therefore did not engage with his healthcare team. Similarly, the patient constantly refusing a cardiac MRI carried with her a strong history of abuse and crippling claustrophobia after being serially locked in a closet as a child. These cases illustrate the importance of stepping back and reframing, for example, the manipulative patient as resourceful, the obstinate or disengaged patient as misunderstood.

When we are overwhelmed, overworked, fatigued, or distracted, it is harder to come up with novel solutions to problems, either on the level of an individual patient or the system as a whole. Creativity and flexibility are essential when interfacing with complex patients and systems. This was clearly demonstrated by Dr. Alessandra Calvo-Friedman, during the Thursday Plenary Session, who found a man passed out on her clinic’s steps after overdosing on opiates and was able to get him initiated with a buprenorphine program in under an hour (“From Overdose to Buprenorphine Intake in Under One Hour.”) In such a state, it is also difficult to be alert and on the lookout for opportunities to make systematic changes, like Dr. Brittany Badesch did when she noticed an epidemic of young black men in her community being injured or killed from gun violence and seized an opportunity to intervene (“Between the Bullets: A Case of Missed Opportunity in Primary Care”). Additionally, in such a state, it is easier to give up on a ‘noncompliant’ patient with uncontrolled chronic disease rather than think creatively like Dr. Michael Tzeng did, engaging a patient who was terrified of using needles in a multi-disciplinary approach to bringing down her A1C (“Terrified of Insulin: Using a Patient-Center, Multi-Disciplinary Approach to Treat a Severe Case of Type 2 Diabetes”). Among other things, this approach included weekly outpatient dulaglutide...
In the Presidential Address by Dr. Giselle Corbie-Smith during Thursday’s Plenary Session (“Health Equity: Race for the Sure”), the importance of “finding your purpose” was emphasized as a means of staying motivated and dedicated to our work as physicians. However, as exemplified by some later speakers, this won’t always be easy. Your “purpose” will often be tested. This was demonstrated by Dr. Yvette Roubideaux, who, in her lightning talk “American Indian Healthcare: Trying to Heal a Broken Promise,” noted that she was asked by a mentor essentially why she was “wasting” her skills by choosing to work for the Indian Health Service. Additionally, pursuing your “purpose” can be exhausting. As eloquently described by Dr. Carl G. Steed in his lightning talk (“Sustaining a Note”), it is essential to find the “choir” that will help you “sustain a note” when you lack the energy or resources.

I am writing this from the perspective of a new clinician educator, with now almost a year of junior faculty experience under my belt. This is now my third year attending the SGIM national meeting (and my first year participating as an attending physician; I attended last year as a Young Scholar in GIM). More than ever, I found myself appreciating and understanding the importance of such a meeting as a way to step back and reflect, to exchange ideas, to inspire, motivate and re-spark a sense of “purpose.” Although the official theme of the SGIM 2019 Annual Meeting was “Courage to Lead,” an additional theme that I gathered from the various sessions I attended was “be ready for the unexpected.” This could apply to a surprising clinical diagnosis, an unanticipated or initially invisible piece of social history that influences a patient’s physical health, an unusual solution to a complex problem, or, on a state or national level, the unrolling of new legislation that is potentially detrimental to patients’ access to healthcare. I left the meeting feeling empowered and energized to make changes in my own clinical practice as well as in how I teach my residents about social determinants of health, with the confidence that I am supported, through the SGIM network, by thousands of innovative and passionate advocates for social change.

References
AN INTERVIEW WITH DR. PETER BOLING—THE 2019 DISTINGUISHED PROFESSOR OF GERIATRICS

Patricia Harris, MD, MS

Dr. Boling (peter.boling@vcuhealth.org) is professor of medicine and is the Division of Geriatrics chair at Virginia Commonwealth University. In his career, he has focused on improving health and quality of life in individuals with multiple chronic conditions, specifically on home-based health care. He is also dedicated to medical education and uses his platform to bring the needs of this population into focus. Dr. Harris (pfharris@mednet.ucla.edu) is an associate professor and director of the Medical Home Visit Program at UCLA. She incorporates Dr. Boling’s (and some others’) principles into her practice every day.

At the 2019 meeting, Dr. Peter Boling gave the annual Distinguished Professor in Geriatrics (DPG) address. We were treated to the story of his career as a home visit physician and of the development of home-based medical care over his career. The following is a post-DPG interview by Dr. Harris via email, with Dr. Boling.

—What were your favorite aspects of this year’s meeting?
In my career, I have concentrated my efforts in Geriatrics and home care medicine. SGIM is notable for the intellectual rigor and openness that its leaders have always espoused. As for my favorites, I list three things. a) the poster walk-around, that was a successful activity with good group participation and exchange of ideas; b) the opportunity to synthesize some ideas that I have been considering for a long time in preparing for my formal presentation and c) re-connecting with some people at SGIM that I have not seen for several years.

—What are your thoughts regarding the role of the geriatrician at SGIM? Where should geriatricians focus their energy at SGIM?
Academic geriatrics has increasingly large common ground with a few other groups of academic physicians, particularly palliative care, as well as groups that have organized around site-specific delivery models such as home care medicine and nursing home medicine. The aging of our population, and the dearth of professionals trained formally in geriatrics makes these issues more and more salient to General Internal Medicine. SGIM is rich in people who are skilled at measuring treatment safety and effectiveness, an area of Geriatric care that will need continued investment. In our rush to “do something” when older patients present for care, we seem easily to lose track of what treatments are really most effective, and reflexively slip into applying (often mis-applying) regimens developed and tested in younger, healthier populations. Older adults with co-morbidity and frailty will soon be driving half of the health care expenditures in the US; we need to be better informed about what works best and what works less well.

—In what ways do you think SGIM and geriatrics interactions can be strengthened?
I think the current model with the visiting professor is a good idea and should continue, as should inclusion of geriatrics-specific scientific presentations at SGIM wherever possible. Another approach could be to separate the annual meetings a little more in terms of participant interests, I know this is difficult; the planning process has been the subject of much discussion and the problem is not an easy one to solve.

—Will you elaborate on how you chanced into home visits? How can the generalist use that model of care? Or, can the generalist use that model of care?
Happenstance, and in myself, a desire to be a change agent. When I was in training at the Medical College of Virginia (MCV) now Virginia Commonwealth University (VCU), a visionary physician offered me a job to start a home care medicine program; at the time he was primarily thinking of education as the focus. By making home visits to 75 individuals, I soon realized that there was a significant unmet societal health care need. If we believe in patient-centered care as a first principle, the mainstream model, based on “bricks and mortar,” in which we require patients to come to us at our convenience, on our terms and on our schedules, is not something we should espouse for patients who are immobile and burdened by co-morbidity and frailty. Most of their care is clearly better planned and delivered at home. With smart application of technology, with care system and payment re-design, we can give patients and families the care that they need and want. This is care that is overall the most cost-effective. Hospitals, emergency departments, ambulatory treatment centers and physician offices should become adjunct

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Use program. We also worked on a strategy to enhance the availability of useful, actionable information, including defining national standards for data capture and interoperability.

Perhaps most significantly, we set an expectation that electronic health records would open “doorways to the data” through open source application programming interfaces (APIs), a technology ubiquitous in other industries that allows such conveniences as linking our calendar with mapping software. These policy efforts are beginning to manifest in everyday life, such as with the Apple-supported personal health record on our smartphones. The recent regulations from the U.S. Department of Health and Human Services significantly build upon this work and stand to enable a more fluid data environment that will bring actionable information to our fingertips.

As the work to liberate health care data progresses, a new challenge is already on the horizon: The flurry of activity around addressing the social determinants of health (SDOH) both inside and along-side the healthcare system is creating a demand for a health information technology system to support collecting, storing and sharing SDOH information. Examples range from assessing individual SDOH profiles, to care plans, to social program eligibility and enrollment. A significant challenge in addressing SDOH is the fragmented communication and coordination between community-based organizations (CBOs) and health care entities. This impacts health care and social service payers, as well as providers’ ability to coordinate efforts around SDOH, address patient and caregiver needs, and track patient outcomes.

One approach unfolding in the field is building capabilities into the clinical workflow of the electronic health record (EHR). At the University of Miami, SGIM member Ana Palacio and team are collecting SDOH data in a system-wide fashion via the patient portal without disrupting clinical operations. They are linking the patient reported SDOH to census-based and other geocoded variables and to all EHR data. They translate this data into insights on an interactive dashboard that the clinical team can access. The functionality includes the ability to look at cross tabulations for associations between SDOH risk factors and specific outcomes. They see broader uses for this data beyond improving health outcomes, including utility for advancing health equity research (Dr. Ana Palacio, personal communication, June 20, 2019).

Some SGIM members may already work in clinical settings where digitized resource guides like Aunt Bertha make resource information searchable and allow identification of resources tailored to match patient characteristics such as location, language, or access on public transportation.¹

The venture capital and digital world has been active in designing platforms to meet the need of sharing SDOH data between healthcare organizations and CBOs to facilitate care coordination. These software platforms support an array of needs including referrals to appropriate service or resources, coordination between the various health and social care providers and also population level data to understand needs at the community level and the quality of resources.² The good news is that these platforms are using non-proprietary standards that align with those expected of EHRs in the next generation.

These platforms also offer a feature that I consider essential: a shared care plan that includes access to it for the patient and their caregivers. They also provide the additional important feature of letting patients rate the service of the social care providers in a “Yelp-like” fashion. North Carolina (led by a general internist Dr. Mandy Cohen) is currently a national darling, and rightly so, for its unique approach in a statewide, single digital platform funded by the private sector, but required by the state for use by all Medicaid Managed Care companies.

These privately developed digital platforms are not the only pathway under development for supporting referrals and communication between consumers, social care and health care providers. In some communities, the traditional health information exchanges (HIE) built principally to support healthcare provider data exchange are expanding their reach to support sharing of SDOH data. San Diego may have the most maturity in doing this work and serves as a model for others moving down the path. I am happy to see this expanding function for the HIEs given the investments that the taxpayers have already made in them and the potential for a “network of networks” model to dramatically shorten the timeline to interoperability. A good place to track on this progress is through the Strategic Health Information Exchange Collaborative (SHIEC).³

For this activity and excitement around data collection and sharing related to the social determinants of health, there are a host of challenges on the horizon. The following are at the top of my mind:

1. **Weak social services data and digital infrastructure.** The healthcare sector benefited from billions in new dollars to support accelerating uptake of digital technology, but those dollars didn’t extend to the social services sector and in most cases the IT infrastructure of CBOs that provide services is incapable of meeting the data standards, cybersecurity, and other technological needs to build a robust health care and social care data sharing infrastructure.

2. **Privacy and security challenges.** The data used in some models of social care information

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¹ Dr. Ana Palacio, personal communication, June 20, 2019.
² The data used in some models of social care information
³ The venture capital and digital world has been active in designing platforms to meet the need of sharing SDOH data between healthcare organizations and CBOs to facilitate care coordination. These software platforms support an array of needs including referrals to appropriate service or resources, coordination between the various health and social care providers and also population level data to understand needs at the community level and the quality of resources. The good news is that these platforms are using non-proprietary standards that align with those expected of EHRs in the next generation.

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will move between health care systems and social services partners who are unaccustomed to the regulatory expectations included in HIPAA that govern the protection of personally identifiable data.

3. Data and tech skills in the social care workforce. Technology can enable skilled workers to focus on more technically complex activities while expanding access and enhancing operational efficiency, but the social care workforce will need to build skills in using data and technology.

4. Consumer demand and expectations. Early data suggests that consumers will embrace the use of data and technology to support their social care needs; however, some may not want their physician to know whether they receive meals from a food pantry, or how often they sleep in a shelter.

5. Balancing technology and human capital investments. SDOH IT stands to accelerate the care models that can address, and where needed mitigate, social factors that influence health. But data and technology alone are not the solution and the goal should be to augment human capital and processes rather than supplant them.

6. Inequitable access to technology and unintended consequences. There are instances when digitizing the social and health care infrastructure can result in negative consequences and exacerbate disparities.

7. Ethics of social risk profiling. Finally, potentially serious ethical considerations will need to be addressed in the application of artificial intelligence and other modalities in decision-making and resource allocation for integrating social care into health care. There is a risk that these technologies replicate the biases within our social and health care systems that result in disparities in outcomes.

These challenges should not halt our work to leverage data and health information technology to support our patients in addressing their SDOH. But, we should be thoughtful about this work. Healthcare sector adoption of these SDOH technology tools and platforms is accelerating, driven in many ways by policy and payment change like in North Carolina. For all the good it could do, as the social care experiences of our patients are digitized, we should be intentional to not replicate our mistakes from our work to digitize the healthcare experience of our patients. Thus far, the tools being developed are more interoperable, better at respecting privacy and at sharing information with the consumer and are more affordable than the EHRs we implemented. This gives me hope that we will have a national social care information technology platform that is useful for many important purposes beyond clinical care.

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