HEALTH POLICY: PART I

CONSIDERING INNOVATIVE FUNDING FOR GRADUATE MEDICAL EDUCATION: WHAT WE HAVE TO GAIN

Sarah G. Candler, MD, MPH

Dr. Candler (candler@bcm.edu) is assistant professor of medicine, Baylor College of Medicine, Michael E. DeBakey VA Medical Center

Washington is interested in accountability for federal funds. Physicians and academic institutions need funding sources that allow trainees to meet patients where they are—both geographically and by specialty distribution. Hospitals could benefit from diversification of payers and transparency of Graduate Medical Education (GME) funding to ensure sufficient resources are available when and where they are needed, particularly as hospital systems are expanding into the community and outpatient settings. Patients deserve a system that supports health systems, educators, and trainees focused not on hospital throughput, but longitudinal, quality-based, comprehensive care. We get what we pay for, and right now, we all have something to gain from GME funding reform.

If we have learned anything in recent discussions about the Affordable Care Act, it is that policies that take away benefits are much more difficult to move forward than those offering new opportunities or rights. The latest example has been the coverage of people with pre-existing conditions. However, this same concept has been at the root of discussions about GME funding for decades, an issue that is reemerging as the models of care delivery and trainee education continue to shift away from hospital-based, fee-for-service care.

Since its creation in 1965, the Centers for Medicare and Medicaid Services (CMS) has been a primary funder of GME in the United States. Though initially intended to be a temporary investment, the complex mechanisms of their GME support have now been in place for 52 years. As described recently in SGIM Forum (December 2018 issue), this system now accounts for $9.6 billion of our nation’s estimated $15 billion GME budget.¹

It is clear that Graduate Medical Education (GME) funding must adapt as the models of care delivery and trainee education continue to shift away from hospital-based, fee-for-service care, and the question now is how.

Understandably, discussions about changing the way CMS and others determine GME funding are anxiety-producing, opening doors to cuts in seemingly secure sources of income for hospitals and training programs. However, the current allocation of these resources, like the funding, is still based on decades-old algorithms, which may not be as applicable to today’s health care landscape. The status quo may not be as rosy as it seems.

CMS funds are distributed to organizations (usually hospitals) that serve Medicare (and, in some states, Medicaid) patients. These algorithms and the resultant payments are based on data from 1996, which identified how many trainees were present and in what geographic...
THE AUDACITY OF HOPE
Joseph Conigliaro, MD, MPH, Editor in Chief, SGIM Forum

This last January, during Martin Luther King weekend, I attended our medical school’s diversity “second look” weekend where we invited promising resident candidates to return and take a look at several training programs at our medical center. The event focused on underrepresented minorities applying to residencies in medicine, pediatrics, psychiatry, and anesthesia so I was able to talk to candidates interested in careers outside of internal medicine as well.

Like many institutions, we work hard to attract candidates from diverse backgrounds for our training programs. Our trainees care for a diverse patient population with regard to race, ethnicity, gender identity, and socio-demographics so it makes sense to have a training workforce that reflects the population for whom they care. A diverse workforce also makes sense for several other reasons. From the patient perspective, a diverse healthcare workforce can help to increase healthcare access for the underserved because graduates are more likely to work in areas where there is a need. I believe that not only enriching your program with students from diverse backgrounds is the right thing to do for the individual candidates seeking a training position but also the right thing to do for the training programs. For the institution, diverse candidates are likely to pursue research in neglected areas of societal need and, over time, enhance the pool of leaders and policymakers required to meet the needs of a diverse population.

According to Mark A. Nivet, Ed.D., chief diversity officer for the Association of American Medical Colleges’ Diversity Policy and Programs, the goal is not about ensuring compliance with civil rights legislation and affirmative action but the need for teaching hospitals to “better capture, leverage, and respond to the rich diversity of human talents and aptitudes.” “Fundamentally, it requires a mental shift that frames diversity as a means to address quality health outcomes for all, rather than an end goal in and of itself.” In our discussions with the applicants, the faculty present that day admitted that they never considered diversity as a variable in applying to training programs. For today’s applicants and for our current residents it is an important consideration in the rankings. The day’s events and discussion gave me hope that Dr. King’s legacy is still strong even though we are regularly reminded that racism and inequities still exist and those that disseminate it have been emboldened over the last few years. We must continue to work on it and never become complacent.

continued on page 11
As I think about “self-care” and our ability to weather the tumultuous times we’re in as a profession and as professionals, I often think about this phrase. For me, the work we do as generalists requires we’re in it for the long haul, and self-care is a critical component for this “race.” Self-care is important not only for sustaining us in the work we do each day but also for making space for innovation and creativity.

In *Atomic Habits*, James Clear describes the literature on how to support behavior change, information with which many of us are familiar. He describes four “laws” of building better habits: making it obvious, making the habit attractive, making it easy, and making it satisfying. I really like the idea of using the principles of automaticity and habit formation to move closer towards the goal of self-care. Clear also describes the notion of the 1% change—that small changes compounded over time can lead to important dividends. He notes that starting somewhere, anywhere and making “atomic” changes—small, single units that be a source of energy or power—bring us incrementally closer towards our goals.
The year 2019 will be very active for Medicaid as we will see an interesting juxtaposition where some states will be expanding eligibility while other states may withdraw coverage from beneficiaries if they don’t meet new requirements. Through gubernatorial elections, direct ballot initiatives regarding Medicaid expansion and changes in the composition of state legislatures, the midterm elections will affect Medicaid in multiple states. Particularly “hot” topics in the world of Medicaid include Medicaid expansion in states which have not already expanded and the institution of work requirements for Medicaid beneficiaries in various states. In states that had governorship changes which could affect Medicaid expansion or work requirements, the composition of the state legislature is an important consideration as governors in most of these states will need to work with their legislatures in order to adopt changes.

In Idaho, Nebraska, and Utah, voters passed direct ballot initiatives to expand Medicaid to their states through various funding mechanisms. Montana had already expanded Medicaid; however, a ballot initiative to continue funding Montana’s Medicaid expansion beyond June 2019 failed in the midterm elections and thus continued funding for the current expansion is in the hands of the legislature. Maine, Kansas, and Wisconsin saw a flip in their governors from Republican to Democrat and all of the newly elected governors support Medicaid expansion or further expansion (applicable to Wisconsin). In Alaska, the Republican governor elect has criticized the state’s previous Medicaid expansion (under an Independent governor) and favors a review of the program. Although Wisconsin does have a new Democratic governor, further attention will need to be directed to health affairs in this state as the outgoing Republican governor signed multiple bills before leaving office which could stymy the incoming governor’s efforts. As of January 2019, all but 14 states have expanded Medicaid.

Medicaid expansion was but one portion of the Affordable Care Act (ACA); yet, it has had far-reaching consequences for patients. Most recently, researchers have investigated not only the health outcomes associated with Medicaid expansion but also the potential “anti-poverty” effects, suggesting that Medicaid expansion has reduced the nation’s burden of poverty relative to the pre-ACA era. One study has suggested that Medicaid expansion alone has pulled 690,000 Americans out of poverty. The anti-poverty effects were predictably not significantly seen amongst elderly adults (whose eligibility status was not affected by the ACA) but rather amongst nonelderly adults, who were the targets of expansion, through reductions in direct out-of-pocket spending on health care and decreasing the likelihood of incurring medical debt.

While examining the positive effects of Medicaid expansion on health status and/or household finances, another key area to watch will be that of Medicaid work requirements. The Centers for Medicare and Medicaid approved Medicaid work requirement demonstration projects under a Section 1115 Work Requirement Waiver in several states and more states are applying or considering the same. Each state’s proposal has differences in the mandatory work hours required, who may be exempt due to differing definitions of disability, whether volunteer hours count towards the requirement, day-care considerations, and various other factors. The first state to implement a work requirement has been Arkansas, and many policy folks have watched as greater than 16,000 Arkansas Medicaid beneficiaries have lost coverage. While the stakes are high for these individuals, we do not yet know the full consequences on their health or household finances. Additional data is needed.

While SGIM’s health policy efforts have historically focused on national health policy, we know the saying that “all politics is local” and thus we must not lose sight of what our membership is facing at their local level and how these policies ultimately impact our patients.
While SGIM’s health policy efforts have historically focused on national health policy, we have all heard the saying (often ascribed to the former Speaker of the US House of Representatives, Tip O’Neil) that “all politics is local” and thus we must not lose sight of what our membership is facing at their local level and how these policies ultimately impact our patients. It seems then that patient care and healthcare delivery is local to a large degree. The interplay between national and state health policy is fascinating and explains why our SGIM members face different hurdles in different regions.

References


The Diagnostic Trail

The Freedom Trail in Boston, Massachusetts, serves as an epitaph to the birth of America. Walking from one site to the next, tourists are guided through a story that evolves, revealing a series of decisive events that led to a final conclusion—revolution. The Morning Report functions in much the same way. An expert guide solicits information and ushers the learner through a clinical presentation, navigating bifurcations in the decision tree, leading to a final conclusion—diagnosis.

Familiar readers of SGIM Forum will recognize that the Morning Report column has been a long-standing feature of the monthly publication. With a growing excitement for clinical reasoning as well as the book review for Frameworks for Internal Medicine published in this issue of Forum, we felt it was high time to revisit why we solicit and publish such case-based writing.

The “Morning Report” Column

Harken back to the origin of the name—the classic resident morning report or other case-based conference, a fond generative memory from clerkship and residency training for many internists. Ideally, this was a discussion-based, participatory conference where information was presented in a linear fashion, as cases progress in the real world. This intentionally promoted exploration of a differential diagnosis rather than revelation of a “surprise” diagnosis at the end.

Contrast in-person learning discussions to formal case report publications, where rare or unusual entities are detailed—although useful in identifying novel disease, these are often not applicable and can lead one to searching for zebras. A happy medium exists in the form of clinical reasoning publications, which are “constructed in a manner that emphasizes thought process and reasoning as the case unfolds” and “allows the authors to explore a clinical dilemma in greater detail and present the broader set of teaching points”. Much like the Freedom Trail, it is the “journey to the final diagnosis—not the diagnosis itself—that makes for an educational discussion”. The Morning Report column is the perfect forum to showcase the Internists’ forte—clinical reasoning.

Educational Value

The term clinical reasoning describes the process of gathering information as well as generating and testing hypotheses to develop a diagnosis and treatment plan. Physicians often do this subconsciously, but self-improvement and education benefit from a more deliberate and transparent process.

The “Morning Report” column supports a back-and-forth of presentation and discussion aliquots, analyzing information as it is presented. Such a writing style brings us back to Socratic methods. As heralded in the foreword to Frameworks, not only does “the art of Socratic teaching…reveal what is known but, even more clearly, it reveals what is not known. Everybody learns. Students, teachers, and nurses learn…patients learn” [p. vi]). This form of active learning encourages readers to learn not just from the ultimate diagnosis but from the journey of the discovery process itself.

Cases evolve over time, feeding into Bayesian statistics. During his interview on Dr. Vinay Prasad’s “Plenary Session” podcast, Frameworks’ author Dr. André Mansoor talks about the longitudinal nature of diagnostic reasoning and the importance of going back to the patient with new and additional questions rather than relying on the single admission interview as the diagnostic process is not a static process: “heart failure is on the differential, I didn’t ask about orthopnea or weight gain...I didn’t specifically listen for an S3...it’s always going back and forth from your differential back to the patient and extracting more information”. This emphasis on self-regulation is vital to the process of lifelong learning.

Everyone Else Is Doing It

We are excited to see multiple other venues highlighting clinical reasoning as a core internist skill. Frameworks highlights that rather than waiting for someone to “get” the correct diagnosis, it is important to have frameworks continued on page 7
and schemas for tackling difficult cases and building broad differential diagnoses. The objective is then to narrow the differential based on available data that influences pre-test probability. Many internal medicine podcasts or virtual platforms are producing episodes illustrating dynamic clinical reasoning exercises, including “The Curbsters,” “Core IM,” “The Clinical Problem Solvers,” and the Human Diagnosis Project’s “Global Morning Report.” Beyond providing forums for case discussions, these venues also analyze clinical reasoning theories themselves—talking explicitly about the role of illness scripts, problem representations, diagnostic schema, hypothesis driven reasoning versus data driven reasoning, and Dual Process Theory—and even providing the cognitive autopsy on the back end.

Ready, Set, Go
Channel the motivation behind the “Core IM” Hoofbeats segments, which sought the challenge “to solve diagnostically difficult real world cases”. Pulling from the classic medicine adage about looking for zebras versus horses, their title came from “hoping to avoid a trophy hunt for zebras, even though the cases might well be complex and unusual. Instead, what we’re hoping for here is bits of wisdom, be it clinical pearls, reasoning techniques, rules of thumb, diagnostic schema—the cognitive tools that might be helpful for our next patient. We’d like to get ourselves thinking about how we think, keep visible what is so often invisible”. We want to see “how slight refinements of a problem representation can change one’s differential”. Send us your organized, deliberate process, highlighting the nuances of the challenge of clinical reasoning—from the array of inpatient and outpatient cases you encounter. Just as the Freedom Trail helps us understand our history so we can better create our future, it is the duty of the physician to examine our own diagnostic trails, our pitfalls and our learnings so we can better serve our learners, our patients and each other. It doesn’t have to be a zebra diagnosis.

We want to share with the Forum audience how you groom your horses and the journey you take with them.

- Choose a case that will engage the audience (because it is common, scary, or interesting).
- Consider 2-3 learning objectives you hope to impart on the reader from this case, then build the story around that.
- Use poetic license in recreating the case to make the details of the case more or less cumbersome for your audience.
- Consider emphasizing a particular part of the patient encounter—either the history-taking, physical exam, work-up, or treatment.
- Early on, have the discussant create a prioritized differential. After all possibilities are on the board, discuss what the most likely and the cannot-miss diagnoses.
- Provide a brief didactic which focuses on a pivotal aspect of the case (can be the presenting signs/symptoms, physical exam, differential, work-up, or treatment).
- End with Summary with 2-3 teaching points.
- We use a presenter and discussant format with discussant typically in italic.
- We aim for up 1000-1250 words with less than 6 references.

References
A 40-year-old female presents to the emergency department for evaluation of persistent fevers and a rash over one month.

In a young otherwise immunocompetent woman, the subacute onset of rash and fevers raises the possibility of infections, autoimmune conditions, drug induced skin manifestations, or even paraneoplastic conditions. Further history and exam findings will provide additional information to develop the hypothesis.

She described fevers up to 104.5°F for the past five days, noticed a white plaque on her tongue, and a pruritic rash on the face, palms, and soles. Over the last month, she reported generalized fatigue, chills, unintentional weight loss of 12 pounds, and large joint pain in the shoulders and hips that was accompanied by morning stiffness. She denied headache, changes in vision, dyspnea, hemoptysis, abdominal pain, nausea, vomiting, change in bowel movements, back pain, dysuria, and hematuria. She had not been sexually active for several years and had no history of sexually transmitted disease. There was no recent travel. The patient had no family history of autoimmune disorders or cancer. She endorsed a diagnosis of rheumatoid arthritis (RA) in her twenties, although she took no medication and did not follow up for further care. Social history revealed significant intravenous heroin drug use.

The presence of polyarthralgia in the large joints and constitutional symptoms could point towards a serum sickness reaction mediated by toxins from infections, medications or autoimmune conditions, particularly with history of RA. The patient’s history of drug use raises the concern for infectious etiologies such as acute hepatitis B, HIV, and infectious endocarditis, all of which produce a serum sickness reaction.

In the emergency department, the patient had a temperature of 102.6°F, a blood pressure of 94/57 mmHg, pulse of 103/minute, respiratory rate of 24/minute, and oxygen saturation of 100% on room air. She appeared uncomfortable on examination. There were white plaques on the posterior tongue and the patient had a pruritic, faint, erythematous macular rash on the face in a malar distribution, on the palmar and dorsal aspects of the hands, and on the soles of the feet that began to exfoliate and spread centripetally. No joint deformities were noted. Heart and lung exams were unremarkable. Initial labs revealed pancytopenia and 200 mg/dL of protein on urinalysis. The patient was given clotrimazole for oral thrush and an empiric dose of vancomycin and piperacillin-tazobactam.

Common but elusive presentations for the internist, rashes can be appraised when categorized by type and distribution. The accompanying table presents a useful framework for evaluating skin manifestations of systemic infections. The macular rash on face, palms and soles, and systemic compromise in this patient lead us to consider early phase staphylococcal scalded skin syndrome (SSS) and streptococcal/staphylococcal toxic shock syndrome.

Although unusual, if the patient had used cocaine contaminated with levamisole a LINES syndrome (Levamisole Induced Necrosis of the Skin), by causing vasospasm of distal blood vessels, could also have this appearance. Normally one would expect ear and nose involvement. Another possibility is systemic lupus erythematosus flare, although a normal joint exam brings into question the diagnosis of RA, and hence autoimmune disorders.

Blood cultures returned with gram positive cocci in clusters, consistent with staphylococcus aureus. The following morning, a new 3/6 holosystolic murmur at the left lower sternal border was appreciated on examination. Echocardiogram revealed a 0.9 x 1.0 cm vegetation on the tricuspid valve with moderate regurgitation. With return of culture sensitivities, the patient was treated for infective endocarditis with cefazolin.

Remaining labs were negative for HIV, syphilis, Hepatitis B, and Hepatitis C. ANA, rheumatoid factor,

continued on page 9
The diagnosis of infective endocarditis is made by the Modified Duke’s criteria, which requires two out of three major criteria including: two positive blood cultures of typical microorganisms (or one positive with Coxiella burnetti), a new regurgitant valvular murmur, and evidence of endocardial involvement. Diagnosis can also be made with several “minor” criteria, of which three are needed when one major is present and five minor criteria are needed without presence of a major criterion.

Table 1: Rashes in Systemic Infections
Can be generalized in immunocompromised patients

<table>
<thead>
<tr>
<th>Macular</th>
<th>Papular</th>
<th>Vesiculobullous</th>
<th>Pustular</th>
<th>Purpura</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focal</td>
<td>Contact dermatitis</td>
<td>HSV**</td>
<td>Staph/strep folliculitis</td>
<td>Pseudomonas folliculitis</td>
</tr>
<tr>
<td></td>
<td>Rickettsial pox</td>
<td>Disseminated vibrio</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** denotes progression of rash

Generalized uncommonly palm and soles

<table>
<thead>
<tr>
<th>Viral exanthem</th>
<th>Medication</th>
<th>Disseminated gonococcus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Rickettsia</td>
<td>Lupus</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td>Varicella</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Still's disease</td>
</tr>
</tbody>
</table>

Generalized with palms and soles

<table>
<thead>
<tr>
<th>Syphilis</th>
<th>Late stages of rickettsia</th>
<th>Acute meningococcemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand foot mouth (Coxsackie)</td>
<td>Janeway lesions</td>
<td>Purpura fulminans</td>
</tr>
<tr>
<td>Staphylococcal scalded skin syndrome</td>
<td></td>
<td>Viral Hemorrhagic fevers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leucocytoclastic vasculitis</td>
</tr>
</tbody>
</table>

Musculoskeletal symptoms of endocarditis, while underappreciated, are a common manifestation of the condition. One retrospective study found musculoskeletal manifestations in 44% of cases of bacterial endocarditis. These symptoms included arthralgias (most common) as well as arthritis, low back pain, and diffuse myalgias. In more than 25% of these cases, musculoskeletal complaints were the first manifestations of the infection. Clinicians should be aware of the prevalence of these symptoms in endocarditis due to the potential for delayed diagnosis.

anti-CCP, anti-dsDNA, ANCA, anti-Jo1, and cardiolipin Ab were negative, and she did not use cocaine.

Infective endocarditis can present with a wide variety of non-specific signs and symptoms. In a large prospective cohort study the most common finding was fever, which was demonstrated in 96% of patients, however no other symptom was present in more than 50% of patients with the diagnosis. Other widely associated findings of endocarditis such as Janeway lesions and Osler’s nodes were found in five and three percent of patients, respectively.
BOOK REVIEW

BOOK REVIEW: FRAMING WORKS FOR INTERNAL MEDICINE
Avital Y. O’Glasser, MD, FACP, FHM

Dr. O’Glasser (oglassea@ohsu.edu; Twitter, @aoglasser) is a hospitalist at OHSU and an assistant program director for the Internal Medicine Residency Program.

It gives me great excitement to introduce and review the new internal medicine textbook Frameworks for Internal Medicine by Dr. André Mansoor for the SGIM Forum audience. This incredible new book has been published by Wolters Kluwer and is available directly from the publisher as well as other sellers, including Amazon.

In the day and age of a plethora of online-based resources and changes to traditional medical school bookstore structures, why am I recommending a new textbook for you? At this time when digital-based mediums are becoming more prolific, including streaming medical school classes, this book will ground you back to the bedside.

Frameworks for Internal Medicine is a book that is centered around and simultaneously heralding the importance of diagnostic frameworks. In the preface, Dr. Mansoor reflects on learning from building differentials as a medical student, usually waiting for someone to be “right” though hitting moments of impasse when the differential could not be expanded upon. Fondly remembering a Chief Resident’s use of diagnostic frameworks, he highlights their value: “with this framework for approaching weakness, we had achieved what seemed impossible moments before” (p. vii)—permitting us to simultaneously develop broad differentials, hone diagnostic plans based on a schema, and narrow that differential based on pre-test probability. During his own time as a chief resident, he “discovered that the guidance from the framework alone was enough to result in a meaningful teaching session” (p. viii)—and now, six years later, this book is the culmination and assemblage of his desire to teach via frameworks.

The book is incredibly comprehensive, spanning fifty chapters covering the most common internal medicine pathology—structured by symptoms (e.g., dyspnea or chest pain), physical exam findings and vital sign abnormalities (e.g., edema or tachycardia), laboratory abnormalities (e.g., hypo/hyperkalemia), and diagnoses/syndromes (e.g., endocarditis or cholestatic liver injury). Each chapter utilizes flow diagrams to build schemas based on an introductory case example, followed by question-answer pairs. As each chapter progresses through its schema, layers of additional complexity and nuance build on the early framework. If you have any question about depth and breadth of the book, let me inform you that the index alone is 21 pages long.

In the foreword, Dr. Lynn Loriaux, former chair of the Department of Medicine at OHSU, writes, “This book preserves the art of Socratic teaching...not only does the process reveal what is known but, even more clearly, it reveals what is not known” (p. vi). With this emphasis on question-answer formatting, the book will likely conjure memories of Dr. Salvatore Mangione’s great Physical Diagnosis Secrets. In the true spirit of education, the book also includes an Educator’s Appendix reviewing the value of “chalk talks” and how to apply the frameworks system to such.

Now that I am well into this book review, I confess that I must admit my own bias in this piece. I have known André for just over 11 years exactly, when he was that very MS3 on his internal medicine clerkship (as he writes about in the preface) and I was an intern—we worked and learned together on the same general medicine team at the Portland VA. His zeal for internal medicine was infectious then, and to this day, we reminisce about memories from that stretch. I have had the utmost pleasure and privilege of watching his career trajectory take off since then, and I feel the two of us have spanned the arc of medical training experiences together—he continued on page 11
was my intern when I was an R3 on wards, my R3 when I was a still relatively new attending on wards, and we remain colleagues in the same division. When our residency program still had every fifth overnight admitting shifts, who would pop up during daylight hours and on overnight admitting shifts, who would pop up to the white board at the slightest event? It was my intern when I was an R3 on the wards, my R3 when I was a still relatively new attending on wards, and we remain colleagues in the same division. When our residency program still had every fifth overnight admitting shifts, who would pop up during daylight hours and on overnight admitting shifts, who would pop up to the white board at the slightest

**REFERENCES**

ical locations. Even then, these calculations did not fully calculate how much training did or should cost. The current system assumes that the utilization of resources, the geographical distribution, and specialty distribution are unchanged since the original calculations were made. However, the increasing focus on outpatient care as well as urban growth and population redistribution have led many to worry that many populations are underserved due to lack of training in certain specialties or regions based on these outdated funding mechanisms. Additionally, the bookkeeping processes of these funding mechanisms is less than transparent, so much so that a national Institutes of Medicine (now National Academy of Sciences) committee on the subject relied on subjective survey data rather than hard numbers to calculate costs and accountability of services.

Physician and health policy organizations, such as the Society of General Internal Medicine (SGIM), have identified many concerns with the current GME payment structure. The following are common threads in the positions of multiple specialties and stakeholder organizations:

- **Diversify Funders:** Including all payers in contributing to GME funding would help un-couple training from care of only Medicare patients and would (appropriately) revisit the question of whether residency training is a public good that even should be paid for by federal funds.

- **Improve Transparency of the Payment Process:** Many suggest combining IME and DGME or creating a new measure like a National Per Resident Payment (NPRP).

- **The Focus on Inpatient Care Does Not Address Need for Primary Care Workforce:** A growing body of evidence suggests that we are in need of more primary care physicians in the United States, some estimating that “demand for primary care physicians is projected to reach 263,100 FTEs in 2025”.

- **Create Performance-Based GME Metrics:** Standardized and timely metrics would assist with allocation of funds in a way that addresses the needs of the American people and the medical profession.

- **Lift Caps on GME Residency Slots:** the current number of residents and fellows is based on an algorithm that uses data from 1996.

The administration also recognizes these needs. As a result of discussions about shifting resources to meet locations of health care, and calls for transparency of these processes, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) performed an audit of the GME system and found significant variability in hospital reporting of GME funding allocations. In a review of 8 prior audits, OIG discovered that systems to assure accurate counting of residents (for purposes of reimbursement) were lacking. In fact, its review revealed that it was common for multiple hospitals to be reporting (and collecting funds for) the same residents. In response to the report, CMS concurred with the recommendations that their database be updated and better overseen—a positive step towards more effective models for transparent and accountable reimbursement for GME.

Through the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS has started exploring alternative models of payment and delivery for the country’s older and poorer populations, so this would seem to be an opportune time to address other items on the federal agency’s mandatory budget. In June 2018, Senator Cory Gardner (R-CxO) introduced the Rural Physician Workforce Production Act of 2018 in hopes of unifying DGME and IME payments into a single per resident payment to facilitate the training of residents in sites beyond urban inpatient settings (S. 3014). This fall, Senator Mazie Hirono (D-Hawaii) introduced the Health Equity and Accountability Act (HEAA, S. 3660) that aimed to improve care to underserved populations, promote health equity, and eliminate the cap on Medicare GME funding. Both bills were read twice and referred to the Committee on Finance, but never voted on in the Senate. Now that the new Congress has convened, versions of these bills will need to be resubmitted for further action, presenting opportunities for individual and organizational advocacy.

It is hard to turn a ship that has been moving in the same direction for half a century, but with continued support from the educational community, improved oversight and diversification of major funders, restructuring of reimbursement models, and a call for increased government transparency, we may look forward to a different view.

Acknowledgements: this commentary is a summary of discussions among the Society of General Internal Medicine’s (SGIM) Health Policy Committee’s (HPC) subcommittee on Education. Thanks are due to that committee as well as to our chair, Meredith Niess, MD, as well as member, Susan Lane, MD, Jeffrey Jaeger, MD, and policy partner representative, Erika Miller, who were all instrumental in assisting with this summary.

References

ultimately identified the most likely illness scripts (e.g., LINES would findings), noted variance from their B and C, HIV based on her history, a variety of differentials (e.g., Hep presented, the discussant deliberated diagnosis. It is associated with more accurate cal reasoning is important to note as drug-induced. This process of clin - infection, autoimmune disorder, three broad buckets to explore—

Staphylococcal Scalded Skin syndrome (SSS) results in denudation of the skin caused by exotoxin producing strains of the Staphylococcus species, typically from a distant site. Rarely found in adults, it portends 60% mortality mainly due to underlying disease. The associated rash may progress from localized blisters to a diffuse, markedly erythematous rash with significant tenderness, and flaccid blisters and desquamation with a positive Nikolsky’s sign. Patient presentations range from well appearing to fulminant sepsis. A lack of mucous membrane involvement helps differentiate SSS from Toxic Epidermal Necrolysis, which does involve the mucosal surfaces. Early antibiotic therapy is the mainstay of treatment.

After several days of antibiotic therapy, symptoms improved and leukopenia resolved. Her hospital course was complicated by pulmonary septic emboli and a catheter-associated internal jugular vein clot. The patient was discharged with appropriate antibiotics and anticoagulation.

Discussion

Fever and rash as an undifferentiated complaint should be approached as with any other—with a preliminary diagnostic algorithm. In this case, the discussant used semantic qualifiers (young, immunocompetent female, subacute rash) in the initial problem representation to identify three broad buckets to explore—infection, autoimmune disorder, drug-induced. This process of clinical reasoning is important to note as it is associated with more accurate diagnosis.

As additional information was presented, the discussant deliberated a variety of differentials (e.g., Hep B and C, HIV based on her history, staphylococcus based on her exam findings), noted variance from their illness scripts (e.g., LINES would have ear and nose involvement), and ultimately identified the most likely diagnosis from a framework she uses when evaluating rashes in systemic infections (see the table). The testing confirmed her hypothesis of SSS and infective endocarditis.

The association of SSS with infective endocarditis has been described rarely. Both diagnoses carry significant morbidity and mortality risks, and early diagnosis can result in improved outcomes.

References


So, while my self-care practice is definitely a work in progress, I try to be intentional about incorporating as many of the following elements in my day as I can.

**Magic Mornings:** I have always been a morning person and have come to really cherish that time of day when I can incorporate the building blocks of self-care that work for me before I start working on email or checking the news. The literature on productivity has also endorsed the importance of how you start your day. For example, Hal Elrod, author of *The Miracle Morning,* describes how you can build your morning to improve your health and well-being. For me, my morning routine starts the night before. I have always needed more sleep to feel rested, so making sure I get to bed early is critical for me to maximize my day. I try to wake up early enough to incorporate several things (in addition to coffee!).

*Meditation* has been a tough one, but I started with simple goals—practicing meditation during the five minutes it takes for the coffee maker to brew. I now have incorporated using apps for longer guided meditation. **Reading at least 10 pages:** I have always been a reader but as life got busier, I felt I couldn’t fit in reading if it wasn’t work related. I find this simple goal of 10 pages manageable and it allows me to make some headway on the growing stack of books on my bedside table. **Thirty (30) minutes of “work” on personal and professional goals:** In my personal and professional life I have several passion projects that I am trying to accomplish over the coming years that go beyond what I am currently doing at work. I try to use some time in the morning to chip away at some of the reading, researching, or writing I need to do to move toward those goals.

The last thing I am working on is incorporating the **reflective practice of journaling:** I’m not quite there yet but it’s on the list!

**Food and Exercise:** After decades on this earth and lots of experimentation, I have a pretty good idea of what works for me in terms of diet—whole grains, lots and lots of veggies, and plant or fish-based protein at every meal. It’s simple, I eat pretty much the same thing each day, and I enjoy every bite. I started running when I was 12 years old and have only really stopped for injuries. While I still consider myself a runner (even though I’m currently on a several-month hiatus), recently I noticed a shift in the way I approach exercise as a self-care practice. Over the last several years, exercise for me has evolved from a “gotta” for weight control to a “must-have” for some time outside with my thoughts or with a loved one—still consistent but less intense and with a different motivation. For me, the essential food and exercise parts of self-care are all about consistency and simplicity—reducing decision-making about what and when so I ensure I have the building blocks to feel physically, cognitively, and emotionally at my best.

**Connections:** We are social beings and I believe deep, meaningful connections are essential to our well-being. Yet, the world we live and work in often seems at odds with this fundamental part of our humanity. As someone who is more of an “introvert,” my preferences are for connecting one-on-one or in small groups (I often need some down time after our SGIM annual meeting!). In my day-to-day world, I try to be intentional about connecting with those I care about at work and home in some way, such as making space in busy days for tea or coffee with a colleague, thinking about meeting structures that allow for exchange of ideas one-on-one or in small groups, or regular breakfasts with my middle school son on teacher work days.

These are some of the ways in which I try to be intentional about self-care so that I can be at my best for the people and projects in my personal and professional life. How are you taking care of yourself? What resources are you using or could use? Paying attention to and addressing our own physical, emotional, social, and cognitive needs and desires will help each of us be more fulfilled, find space for innovation and sustain us for the long haul.

**References**


Enjoy discounted fees for SGIM19 when you register by Tuesday, April 2, 2019.

Network, learn and advance your career at this premier event for academic general internists and other primary care and specialty physicians interested in medical education, healthcare delivery and policy, and clinical general medicine.

WHY SHOULD YOU ATTEND?

- NEW! Effective Models for Community Engaged Scholarship Pre-Course
- NEW! Forensic Evaluation of Asylum Seekers Pre-Course
- NEW! Buprenorphine Waiver Training
- Networking and Peer-to-Peer Engagement
- One-on-One Mentoring Programs
- Ancillary Career Development Programming Supporting GIM Fellows, Management Training and Leadership


This meeting is jointly sponsored by the University of Alabama School of Medicine (UASOM) Division of Continuing Medical Education and the Society of General Internal Medicine. The UASOM designates this live activity for a maximum of 16.5 AMA PRA Category 1 Credits™ and a maximum of 16.5 MOCA points.

REGISTER AT:
connect.sgim.org/SGIM19/register