“Chaos: a state of total confusion with no order”.1

The practice of medicine traditionally comprised an encounter between a physician and a patient. That practice now occurs within healthcare systems which offer a wide range of diagnosis and care options, delivered in different settings by multidisciplinary teams. Healthcare systems are now considered “complex adaptive systems,” and with that increasing complexity comes the threat of chaos.

Chaos, Work Environment, and Burnout

Many aspects of work conditions in health care have been linked to physician burnout and patient care outcomes.2,3 Given the complex and unpredictable work environments4, it is not surprising that chaos is remarkably common in day-to-day medical practice. As examples, an ambulatory care clinic’s reliance on efficiency through tightly scheduled visits is easily derailed by a sicker-than-expected patient; anticipated emergency room flow is disrupted and overburdened during influenza season; and a glitch in the electronic health record system can paralyze care delivery. Recent research by the authors specifically supports an emerging link between chaos in medical practice and burnout.5,6

An ethnographic study of almost 100 hours of in-hospital observations of internal medicine specialists provides detailed descriptions of chaos in medical practice.4 Physicians in this setting faced heavy workloads with intense intellectual, emotional, and physical work. Their work was frequently interrupted with waits and delays, unpredictability, and urgency; their team members had different skill sets, levels of experience, and schedules; and team members changed frequently. The physical spaces were, at times, noisy and frenzied. There were occasions of disorganized or absent medical supplies and poorly functioning computer systems. The system was ripe for episodic failures.

A study of ambulatory healthcare settings showed that almost 40% of all participating primary care sites reported hectic or chaotic environments, with significant impacts on the physicians working there.6 Causes of chaos included short doctor-patient visits, a poor sense of control for the physician, and bottlenecks to patient flow for office check-in and check-out. Physicians working in these chaotic clinics were prone to stress, burnout, and leaving their practice.6

Dealing with Chaos

Chaos can be addressed or buffered to some extent. In the hospital-based study described above, a surprising result was the degree to which physicians worked to dampen the effect of chaos on their patients’ quality of care and to keep the system going. The physician participants demonstrated flexibility, adaptability, and creativity in...
FROM THE EDITOR

SCHMOOZING, MENTORING, AND THE “BUMP”

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

If I did this right and I stuck to the deadlines put out by Forum’s managing editor, Frank Darmstadt, then the timing of this editorial should coincide with the start of the annual meeting in Washington, DC. I hope that you downloaded this latest issue of Forum, stuffed it in your carry on, read it cover to cover on the way to DC, and got into the zone for the meeting. I know I’ve said it numerous times in these pages, but will say it again: I love the SGIM Annual Meeting!! Where else can I spend 4 days with more than 2,000 of my best friends? I literally spend hours catching up with so many colleagues, talking about the work we do, our families, and the latest crazy twist that our careers in general internal medicine have taken us.

When I started to attend professional meetings as a fellow, my mentors stressed the importance of “networking.” Merriam-Webster defines networking as “the exchange of information or services among individuals, groups, or institutions specifically: the cultivation of productive relationships for employment or business.”¹ In New York, we always called that schmoozing. The practice has become so important that books have been written about it and Web sites dedicated to the art.² I’m not going to repeat many of the great practices nor provide any more tips, but, suffice it to say, the SGIM Annual Meeting is the single most important place for an academic general internist—e.g., an educator, researcher, administrator, or whatever—to learn, teach, and share the work that they do. It is where we go to hear many of the thought leaders in our profession as well as others outside who influence our work. For many of us over the years, it has also been a social event on a national scale where we caught up with old friends and colleagues, watched our children grow, and missed those who could no longer attend.

One great way to take advantage of the expertise at the meeting is to sign up for the one-on-one mentoring. I have been both a mentee and a mentor and still find time to meet up with past mentors and mentees to continue the process of advising. These days, I seem to be benefiting more from the advice I get from my former mentees than they benefit from what I’ve been providing them. Full circle!!

The meeting also reminds us of the breadth of work that we do. Last month’s Forum was dedicated to the meeting theme of equity, engagement, and advocacy, and continued on page 5
SGIM has long been my professional home as a vital source of support and inspiration for me throughout my career. My career, ethos, and values have been shaped by the many mentors and peers whom I have met through SGIM. I knew from the moment I walked in to a workshop on running resident continuity clinics at the Southern Regional meeting that this was where I belonged and that these were my people. My experiences with SGIM and its members these last 20 years have reinforced my belief that this is an organization whose members have a relentless focus to put patients and communities first, innovate to bring the best care and health outcomes to patients, and work collaboratively with other professionals and sectors. We are shaping the future of health!

In this, my first column, I will share with you where I believe our leadership is needed to advance health for our patients and communities, my own experience in doing that in New Orleans, and describe how we will spotlight exemplars from the SGIM family in future President’s columns and at our national meeting in May 2020. I will also share some of the organizational priorities we have for the year.

There has never been a more important time for our work in this country. The United States spends twice as much as our global peers without much to show for it. We rank poorly in many areas but our big dot indicator—life expectancy—has been diverging from our peers for years; now, for 3 years running, the United States is declining in life expectancy. Every dollar we spend on health care is one we do not spend on the other important drivers of health, such as education, community infrastructure, and quality housing. This decline in life expectancy is not because of a new virus but from broader social drivers, such as social isolation, lack of economic, or educational opportunity. These “Deaths of Despair” manifest as suicide, homicide, alcoholic liver disease, and opioid overdose. Continued on page 5.
Literature suggests the majority of medical students feel they are not appropriately educated in health policy, yet there are currently no mandatory health policy curricula in medical schools. Healthcare reform training has been shown to help prepare medical students for the growing role of advocacy in the medical profession. To address this lack of training, the concept for a health policy and advocacy curriculum was developed by a current fourth-year medical student during his first year at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell (Zucker SOM). The curriculum was formatted as a four-week, student-run, fourth-year elective designed to improve students’ knowledge and skills in policy and advocacy. While medical education has shifted from traditional didactic-style learning to peer teaching and near-peer teaching models, there is a dearth of literature regarding student-run medical curricula. This article addresses both of these gaps in medical education by discussing the impact of a health policy and advocacy elective on student learners’ and student coordinators’ knowledge of these topics in addition to exploring the experiences of the student coordinators.

Prior to designing the elective, existing curricular models related to health policy or advocacy among medical schools in the United States were reviewed. Physicians and public health professionals were consulted to assess the lack of and demand for a health policy and health advocacy curriculum for medical students, as well as the most valuable objectives to meet any identified needs. The four-week elective involved a longitudinal independent advocacy initiative and structured group curriculum based on weekly policy themes. Students coordinated their own advocacy-based research initiatives with a faculty mentor of their choosing. Each of these research initiatives were based on each individual students’ existing research. Weekly themes were supported by foundational readings and a student-led journal club incorporating current literature. Daily small group discussions and workshops to advance practical advocacy skills were led by faculty with policy experience. Weekly debrief sessions with student coordinators included updates on independent initiatives and verbal feedback on each week’s sessions. Additionally, students participated in a policy debate with Internal Medicine residents, audited a class at the School of Public Health, met with their local assemblyman, and showcased their independent initiatives with final presentations. The elective was designed, coordinated, and executed by a third-year medical student with second- and first-year medical students in order to establish a sustainable lineage for future student leadership, with faculty adviser oversight.

Learners (n=3) completed a survey before and after participating in the elective. All three learners reported increased knowledge of both health policy and health advocacy, including improved knowledge of healthcare reform, healthcare structure, and improved skills in lobbying and grant writing. Additionally, all learners reported that pre-elective planning and communication as comparable or more organized compared to other electives, and selected that they would strongly recommend the elective to future students, rating it as excellent in overall quality.

In order to test the hypothesis that planning the elective might increase student coordinator knowledge and skills, student coordinators (n=3) completed a survey after coordinating the elective. All student coordinators reported a moderate or marked improvement in knowledge of health policy, health advocacy, and medical education, with reported skill attainments in curriculum development, educational evaluation, leadership, and program planning.

Based on data collected and informal retrospective feedback from the first iteration of the elective, a number of changes have been made to the curriculum for its second iteration. Due to the limited time frame of one month, the students’ longitudinal advocacy initiative was shifted from an advocacy-based research project to preparation for a formally evaluated mock lobbying experience. While the main health policy textbooks utilized for the course were well-received by learners and will remain central to the curriculum, the journal club continued on page 5.
articles have been revisited to better reflect the weekly themes. Based on the desire for more advocacy training in the daily curriculum, weekly skills workshops were introduced, including conflict resolution and resolution writing.

These results demonstrate that the elective was successful in increasing student learners’ and student coordinators’ knowledge of health policy and advocacy, illustrating that the course successfully addressed medical students’ desire for more training in these topics. Additionally, the improved confidence in lobbying and grant writing demonstrates that student learners gained practical skills related to these domains and have a better foundation that can enhance their roles as future physician advocates for their patients. The student coordinators’ increased knowledge in these subject areas highlights how a course that incorporates peer-teaching educates learners as well as coordinators. This demonstrates that executing the elective offered student coordinators a unique exposure to education program development while also advancing their knowledge of the elective subject matter. In addition, a student-designed and student-run elective created a comfortable learning environment that addressed topics specifically at a medical student level. Finally, the overall quality rating of excellent and strong recommendation of the course to fellow students shows this was a well-received model. Overall, this student-run elective provided immersive and practical training in health policy and advocacy that extends beyond the traditional offerings of a medical school curriculum.

References

FROM THE EDITOR
(continued from page 2)

you’ll notice that the May issue has that same theme due to an overwhelming number of outstanding articles received in response. The subject is so important to our work that we will continue to publish several more articles on this theme in future issues. This issue also includes the first president’s column from our new president, Dr. Karen DeSalvo, who now begins to lay the foundation of her year as president. No small task, following in the footsteps of Dr. Giselle Corbie-Smith!

Speaking of articles, another thing I love about the meeting is the famous annual meeting “bump” during which a Forum editor happily sees an increase in the number of articles submitted immediately following the meeting. Yes, I’m talking to you. If I or one of Forum’s associate editors do not come up to you at your poster, after an oral presentation, or workshop and say “We’d love to see something about that in an upcoming issue of Forum!,” then please approach us. We want to help you disseminate your work, ideas, and interests throughout the Society. Contact us!!

References

PRESIDENT’S COLUMN
(continued from page 3)

To address this challenge of high cost and poor health, the nation has been focused on improving the healthcare system. We often use the framework of the Triple Aim: Better care, lower cost, better population health. SGIM and its members have been leaders in the work to develop care and payment models that focus on providing the best value and most person-centered care. SGIM members are also leading in the development of a workforce skilled to thrive in the future healthcare world based on value.

While clinical excellence is necessary, it is not sufficient to bring affordable health care to all. For real success in value-based care, and for meaningful success in improving the population’s health, we will need to address factors beyond clinical excellence. The social, environmental, and behavioral factors that drive health, called the social determinants of health, account for 60% of our health outcomes. These determine are the root cause of health inequities and include an array of domains

continued on page 15
POLITICS IN THE EXAM ROOM: HOW OUR CURRENT POLITICAL CLIMATE IS AFFECTING THE MOST VULNERABLE PATIENTS

Katherine C. McKenzie, MD; Sarah Kimball, MD; Carolyn H. Kreinsen, MD, MSc; P. Preston Reynolds, MD, PhD, MACP

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In recent years, healthcare providers dedicated to social justice have seen their values challenged as offensive political rhetoric becomes common and legal precedents are attacked, sometimes on a daily basis. Physicians caring for immigrant populations are especially aware of the increasing hardships faced by individuals fleeing from conflict zones or human rights abuses. They have watched with dismay as changes in policies create misery and uncertainty for patients pursuing better health and a life protected from persecution.

The tradition of offering safety to refugees and asylum seekers, established in the aftermath of World War II, embodies some of the most important tenets for which this country stands: respect for human rights and opportunity for individuals to build new lives free of the fear of violence and death. Implicit within that has been our national willingness to welcome and shelter less fortunate newcomers to this country. Obstacles to the collective acceptance of these individuals and integration of them into our heterogeneous society have been mounting. Simultaneously, widespread persecution of large populations has been forcing fear-based and trauma-induced flight and migration of greater numbers of people, resulting in a record number of refugees and asylum seekers worldwide. The subsector of those individuals “fortunate” enough to enter the United States while waiting for adjudication of their asylum cases encounter more delay in the process, often resulting in longer periods of time spent in bleak and dangerous detention facilities.

Physicians possess the unique skill sets, values and expertise to impart genuine positive impact for these marginalized populations. Medical evaluation of an asylum applicant, performed and documented by a trained examiner, significantly increases the likelihood that asylum will be granted. A larger number of trained medical evaluators could facilitate this process. In addition to seeking medical care, asylum seekers also present to physicians for difficult examinations of the physical and psychological scars that resulted from their prior persecution to create legal documentation in support of their asylum claim. While traumatized by the events that they have experienced, these individuals are also hopeful that the United States will offer security and new positive prospects. With extra training that builds upon skills physicians already possess, they can make a unique and substantial contribution to the legal appeal necessary for asylum seekers.

Refugees are on a pathway to citizenship when they arrive in the United States. Because of this, they do not have the same legal needs as asylum seekers do. Nonetheless, they have unique health concerns and require specific assessments when entering the United States to meet State Department requirements and to establish care as new members of society. They benefit from trauma-informed care to address ongoing medical problems as well as those illnesses seen more commonly in patients who have been persecuted, such as post-traumatic stress disorder, functional abdominal pain, and headaches. They are frequently adapting to lifestyles that are dramatically different from their home country, attempting to learn a new language, restarting professional identities, and learning how to operate in a new social system. With attunement to these needs, internists are well suited to care for this population and to assist as refugees become integrated into American life. On an individual basis, physicians often serve as trusted and stable contacts for refugees and asylum seekers within their new communities. These therapeutic relationships are critical. Sequelae of trauma, especially when not addressed, can continue to affect not only victims of atrocities but also subsequent generations of families and communities.

Whether it involves care in the exam room or physician advocacy, medicine as a profession possesses the unique combination of knowledge, authority, and stature to influence individual lives, public opinion, and policy in continued on page 7
ways that carry important societal gravitas. It is time for us to mobilize individually and as a profession to employ our clinical acumen and public influence to impact lawmakers. We need to use our medical skills and empathy for these marginalized individuals to advocate on their behalf to members of society with the power to foster the political changes necessary for a lasting impact. Our country and our patients will benefit from action in these problematic times.

The medical profession currently faces an evolving and growing challenge. There is a great need for increased capacity among physicians to be able to evaluate asylum seekers and to care for refugees. Likewise, there is a substantial need for physicians to recognize patients within their respective practices who have endured past trauma and who may be suffering from ongoing adverse ramifications of those experiences. Medicine historically has demonstrated the ability to adapt appropriately to the changing healthcare horizon, most importantly to the diverse patients and populations for whom we care. SGIM represents an ideal vehicle for all members to promote information dissemination, academic and professional collaboration, and future consultation. It provides an effective environment for connecting like-minded individuals and for creating a supportive network and community for ongoing efforts. The existing healthcare and political obstacles confronting refugees and asylum seekers are daunting, but certainly not insurmountable.

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It began in July 2016 when an anonymous medical student tweeted about a first date. Other women in medicine on Twitter responded to the post, first with the phrase “girl med Twitter” and then with #girlmedtwitter. From there, other Twitter users liked, retweeted, commented, and began using the hashtag for their own posts pertaining to life as a woman in medicine. In the ensuing months, #girlmedtwitter became a mainstay of women physicians and medical students on social media, generating thousands of tweets and millions of impressions and linking women in medicine around the world through shared experiences. The conversations ranged from the basic (what shoes were stylish but able to withstand hours of rounding on an inpatient medicine rotation) to the career focused (how do you find a mentor) to the difficult (how do you respond to sexual harassment from a supervisor).

As this online community grew, participants saw the strength of women supporting women, and wondered if there was a way to translate this network from the realm of social media into real life action to advance women in medicine. Five women came together and formed Girl Med Media Inc., a 501(c)(3) non-profit whose mission is to promote mentorship, provide education, and support the advancement of women in all fields of medicine. These founding board members saw the power of what was happening online and asked the question, what could happen if we got this community together in person? The short answer is, a lot. A study of 2,600 women who attended Conferences for Women found that of those women who had attended a conference 15% of them received a greater than 10% pay raise as compared with just 5% of women who had signed up for but not yet attended one of these conferences. In addition, 42% of attendees were promoted during the study period as compared with 18% who had not attended a Conference for Women. For the founders of Girl Med Media Inc. the achievements women were sharing through #girlmedtwitter revealed the tangible effects of the support, resources, encouragement, and relationships forged online. It was time to bring that energy to a live event.

That is how #GirlMedLive2018 came to be. The Girl Med Media board set the mission “to bring together all of the wonderful women (and men!) who believe in promoting and supporting women, discussing issues affecting women in healthcare, and making sure we all have a seat at the table”. The organization raised more than $5,000 from dozens of supporters to make this event happen, and solicited volunteers via social media to join the CME planning committee. Four of us responded and under the leadership of Joannie Yeh, MD, chief education officer of Girl Med Media Inc, we spent the next several months putting together a 12 credit CME program. We determined our areas of interest to include identifying and addressing gender gaps in medicine, negotiating career advancement, communicating more effectively, and determining adaptive strategies for coping with stress and rekindling the joy of practicing medicine. Our learning objectives were very much in line with the American College of Physicians position paper on achieving gender equity in physician compensation and career advancement. Then we opened a call for speakers. The response was overwhelming. We had submissions from phenomenal women in medicine, some of whom were seasoned, professional speakers and coaches, and some of whom were new to conference speaking, but through #girlmedtwitter had realized they had something important to say.

Over the course of a balmy fall weekend in Dallas, approximately 50 women and men from all facets of medicine came together for two and a half days of learning, networking, and empowerment. #GirlMedLive2018 generated more than 2,000 tweets and more than 8 million impressions. Not bad for such an intimate group. More importantly, participants left the conference having made new connections with peers and mentors and having learned strategies to further their career.

#GirlMedLive2018 captured the magic of the medical Twitter community and proved that these connections formed behind the keyboard are real and can affect change in our individual careers and in the culture of medicine. There are many great things to come from Girl Med Media Inc. including the return of #GirlMedLive May 1-3, 2020.

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1. Student Dr. Meow, //lifeofamedstudent.com/2017/01/06/surgery-lipstick-and-the-rise-of-continued on page 9
overcoming road blocks to care within complex, unpredictable systems. They did so by engaging in deep and intense relationships with their co-workers, learners, and patients, generating an extended teamwork approach to making the system work. They promoted positivity and wellness behaviors such as using humor to diffuse stress.

In the ambulatory care setting, the Provider Wellness Committee and Office of Professional Worklife at Hennepin Healthcare in Minneapolis, MN, have identified specific, positive workplace factors that were linked with lower burnout rates even when chaos was present. These included a combination of successful teamwork and a high degree of alignment of physicians’ values with that of leadership within their respective departments. (Unpublished data, Linzer et al)

**Chaos and Patients**
How patients feel specifically about chaos and inefficiencies in the healthcare system is less well known, but we do find that patients are affected. In the study of chaos in the clinic described above, the patients from the chaotic clinics were more likely to experience medical errors and missed opportunities for preventative health care. Chaos may drive burnout in physicians, and physicians who are burned out are at risk for providing poorer patient care. Results of a qualitative study exploring what patients think of physician wellness exposed links between patients’ perceptions of their physician’s wellness, the care they received, and the chaos in medical practice. For example, patients judged physicians to be unwell if the physicians appeared to be pressured, tense, or working at a hectic pace. Even if the patients’ judgments were inaccurate, their perceptions affected the doctor-patient relationship. For example, they were less likely to trust a physician they viewed as unwell. Patients also felt that their care may be compromised if the physician’s office appeared disorganized and cluttered. The patients in this study also identified the chaotic work context and inefficient systems as contributing to physician burnout.

**Chaos and Healthcare Systems**
Healthcare systems may also suffer when their patient care settings are chaotic. Many physicians, driven by burnout and frustration from flawed working environments that do not support the patient-doctor relationship, leave their practice at an enormous cost to healthcare systems ($250,000 to $500,000 per physician). Frustrated patients offer feedback (online and otherwise) about chaotic experiences and interruptions in the continuity of care—and in some cases, may seek care elsewhere.

**Addressing the Problem of Chaos in Medical Practice**
Chaos-inducing events may make physicians vulnerable to burnout, patients susceptible to lower quality care, and healthcare systems less effective in providing compassionate, safe, high-quality care. While some aspects of chaos are unavoidable, there is room for improvement.

Complexity theory suggests that being “on the edge of chaos” may promote innovation and creativity if the individuals working within the system and the system itself have the resilience to adapt. This further supports the need to buffer physicians and other healthcare providers from work-related hazards, such as burnout, so they can be innovative and creative in their solution-building efforts. Individuals do find ways to work around the chaos and mitigate the stressful effects of chaos on doctors and patients, but the following true system-level reforms are imperative:

1. **formally address gaps in medical education where learners are not suitably taught that context affects our work, nor provided with skills to negotiate this complex, dynamic work environment.** If we teach learners these skills, they may also be better able to identify chaotic elements that can be remediated in the system.
2. **task physicians, patients, and healthcare leadership with identifying disruptions and inefficiencies within healthcare systems and give them the necessary leverage to address those findings.**
3. **apply these interventions and track our successes in reducing chaos in the clinical environment.**

While chaos is prevalent, it is not universal; this suggests that how work is organized can potentially address chaos and reduce it. Further...
The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) led to the creation of the Quality Payment Program (QPP) to adjust physician payments based on “value” over volume. Defining value remains challenging and subjective. Most Medicare physicians receive traditional fee-for-service (FFS) payments and are thus subject to value as defined by the Merit Based Incentive Payment System (MIPS) arm of QPP, which will increase or decrease physician payments based on their performance in four categories: quality, cost, use of certified electronic health records systems, and participation in performance improvement activities.

QPP has been criticized as a flawed system, most notably by the Medicare Payment Advisory Commission (MedPAC) who officially recommended scrapping the QPP and starting over, before it became entrenched. However, short of new congressional legislative action, The Centers for Medicare and Medicaid Services (CMS) is mandated by MACRA to implement the QPP based on the agency’s best interpretation of value. QPP is not going anywhere, but it can be altered in CMS’ annual rulemaking process. The recently released data on the first year (2019) of payment adjustments reaffirms the numerous concerns about the direction of the program. Based on year one QPP data and on the history of Medicare physician payments, three concerning themes relevant to SGIM members and our patients emerge:

1. There are systematic winners (large, urban medical centers) and losers (practices that care for socially and medically complex patients, small and rural practices).
2. The magnitude of these payment adjustments will become meaningful starting in 2021, as CMS “ramps up” the program. If your practice is not paying attention, now is the time (actually it’s already late—payments in 2021 are based off performance in 2019).
3. SGIM members have always cared and advocated for socially and medically complex patients, and for underserved patients broadly, including those in rural areas. Now is the time for our membership to be informed and advocate for change in MIPS/QPP, before systems become fully entrenched, payments to providers who care for these populations go down, and access for these patients worsen.

History Teaches Us Not to Be Complacent
The Physician Fee Schedule (PFS) was introduced in 1992, worsening the existing undervaluation of cognitive/non-procedural evaluation and management (E/M) services (especially for complex care). Significant but insufficient E/M revisions occurred in 1995 and 1997 with no further major adjustments for more than 20 years, and the issue continues to hinder SGIM members and our patients today. The Sustainable Growth Rate (SGR) was created by the 1997 Balanced Budget Act to control growth in Medicare spending on physician services. The SGR model did not adequately incorporate the aging Medicare demographic and the expanding repertoire of interventions and therapeutics. It’s potential cuts to physician payments flew under the radar until 2002, when a 4.8% reduction in payments across the board “snuck up” on physicians. Many professional societies welcomed MACRA in 2015, which ended the SGR. However, history is now set to repeat itself, as MACRA/QPP negative payment adjustments remain minor during this ramp up phase and may yet again fly under the radar. By full ramp-up in 2023, when negative payment adjustments will reach -9%, the status quo will be well entrenched and meaningful change perhaps decades away.

What Should SGIMers Know about MIPS Structure and Pitfalls?
Most physicians are reimbursed through FFS Medicare payments, and thus fall under the MIPS arm of QPP. Two significant MIPS structural challenges are worth noting:

1. MIPS reporting is burdensome and complex. This is one primary reason cited by MedPAC to scrap MIPS and start over. There are 4 domains (3 of which are legacy CMS programs repackaged) in which providers/practices must report data and are scored: quality

continued on page 11
to the MACRA mandate for budget neutrality, the low number and magnitude of negative adjustments in 2019 means that the high number of positive performers will only see very small benefits (maximum 1.88% in 2019). By 2021, the magnitude of positive payment adjustments is expected to reach 5%, and in future years is expected to reach double digits, with a theoretical maximum of 37%.3

MIPS Is a High-Stakes Game, Losers Could Just Vanish

The structure of MIPS is such that certain groups of providers/practices face a disadvantage out of the gate. SGIM draws from the following two most notable groups:

1. Small and rural practices. These practices have historically scored worse on legacy programs such as PQRS.3 Year 1 QPP data released by CMS confirms the continuation of this trend, with large practices achieving a median CPS score of 90 (of 100 possible) points, 75 for rural practices, and 38 for small practices.1 The burden of MIPS reporting and the resource constraints faced by small practices contribute significantly. CMS grants some leniency, including a five-point small practice bonus to the CPS score in year 1 (which clearly did not close the 52-point gap) and other provisions. The 2019 final rulemaking alters and shrinks the overall small practice bonus, and CMS explicitly states that the small practice bonus is meant to be temporary.1 One could read that CMS is determined to force all independent physicians into larger enterprises.

2. Complex patients. Data are not available to compare scores for practices that preferentially care for socially or medically complex patients, but there is significant concern that MIPS scoring methodology does not adequately account for these factors. CMS has finalized its plan to continue a maximum 5-point complex patient bonus, based on Hierarchical Condition Category (HCC) scores (CMS’s measure of medical complexity), and Medicaid dual eligible status. CMS states the ongoing need to identify better ways to risk adjust for socially and medically complex patients but chose not to alter their methodology for 2019. While it is not clear how best to account for these factors, what is clear is that the current policy puts providers caring for these patients at a disadvantage. For example, by only using Medicaid dual eligible status to

continued on page 14
WHAT’S IN A NAME?: RESPECT AND IDENTITY IN TRANSGENDER CARE
Aliza Norwood, MD

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This month, the Society of General Internal Medicine will hold its 2019 Annual Meeting, with a particular focus on advocacy and equity. Although the transgender community has received more societal awareness in recent years they have still not achieved equity in health care, as demonstrated by well-documented health disparities between cis and transgender patients. The American Academy of Pediatrics found that 30% of male-to-female transgender adolescents and 51% of female-to-male transgender teens report having attempted suicide.1 As adults, transgender patients are less likely than cisgender patients to have routine care and have higher rates of cardiovascular disease, psychiatric disorders, substance abuse, and suicide.2,3 These disparities are worsened by transphobic systems and providers. A 2012 study revealed that 1 in 5 transgender people postponed or did not try to get health care because of fear of discrimination.4 In contrast, transgender patients report positive healthcare experiences when their providers create an inclusive, safe space.5 This article will highlight an example of how a simple patient-centered intervention strengthened the therapeutic alliance between a transgender patient and their provider and provide tips to increase trust in this underserved community.

The following story is about a young transgender man named Ethan and his account of a particularly meaningful moment he had with his provider. Ethan was born biologically female but suffered from intensely painful gender dysphoria and depression from a young age. With each step of his medical transition that dysphoria seemed to lighten, like a cloud lifting. He first started testosterone which gave him secondary sex characteristics that eased his transition including bulk, a beard, and male-pattern baldness. He had a mastectomy, relieving him of the daily task of tightly binding his breasts which had caused back spasms and breathing problems. These changes made him feel more normal, more like himself.

He decided to have a hysterectomy which required that he go to frequent gynecology visits. He told me about the experience of being a man sitting in a gynecology waiting room, surrounded by staring women. He brought his wife along for support and to deflect those stares. During these visits he had to talk about personal feminine body parts which triggered his gender dysphoria in a very intense way. These visits were extremely uncomfortable for him, so one day his wife had a strange but thoughtful idea. She renamed his feminine parts with masculine names. Instead of talking about his uterus, she referred to his duderus. His fallopian tubes were fellow-pian tubes, ovaries became bro-varies, and his cervix was a Sir-vix. It was ridiculous but it was a way to inject humor into a painful situation and it did make him feel better. Ethan and his wife joked about this during a gynecology appointment, and he told me that the doctor did something in that moment that completely changed the dynamic of their visits. She looked at him and asked, “Would you like me to refer to them with those names?”

When Ethan reached this part of his story, I could see in his eyes that this simple act changed the way he saw his doctor. It showed a level of respect and a willingness to adapt in order to make him as comfortable as possible. And it worked. He felt more cared for, and he trusted her in a deeper way.

On the surface, this story is about a provider who listened to her patient and offered a simple concession. But on a deeper level, she recognized these names were part of a new identity and they made Ethan feel safe and in control. This story also reminds me of watershed moments I’ve had with my own primary care patients. Those moments have invariably occurred when I’ve taken the time to ask some version of ‘What is important to you?’ As the medical community embraces patient-centered care, we should strive to apply that focus to our interactions with patients from historically underserved communities, including transgender patients. Medical providers have a certain amount of authority both in the clinic and in society. We can use that power to not only affirm a patient’s gender, but to affirm that they are worth our respect. The positive ripples from that kind of interaction can travel beyond the clinical space and provide another layer of strength and protection to transgender people.

In clinical practice, providing patient-centered care for transgender patients, referred to as gender-affirming care, means creating safe and inclusive spaces for patients. A few examples of how to create an inclusive space include
providing gender-neutral bathrooms in the clinic, creating medical records that record gender-affirming names and pronouns, dedicated training for staff and providers, and universally asking patients what they preferred to be called. Cisgender patients may not understand the question, “what are your preferred pronouns,” but asking the question “what do you prefer to be called” to all patients is a way to universally screen for gender identity and is a clear opportunity for transgender individuals to provide preferred name and pronouns. Regarding staff training, evidence shows that holding open forums with staff to discuss transgender biases can allow for targeted education. There are high-quality free resources available to help with provider and staff education. The UCSF Center of Excellence for Transgender Health has an online Transgender Health Learning Center with helpful resources for healthcare providers, researchers, and the public. Fenway Health also has a thorough Web site with helpful information on gender-affirming care and support resources. GLAAD, an organization that advocates for LGBTQ inclusivity in media, has a great tipsheet for transgender allies that can be accessed at www.glaad.org/transgender/allies. At an academic level, medical students and residents should receive training so that more providers are willing and able to provide quality gender-affirming care, easing transgender patients’ burden of teaching their providers. Finally, physician advocacy regarding discriminatory policies such as the military transgender ban and anti-transgender bathroom bills can help highlight how such policies create structural barriers to well-being for transgender people.

As medical providers, we took an oath to serve all patients to the best of our ability and to do no harm. Just as we practice universal precautions for infection control, so should we practice universal respect. One of the simplest things we can ask a patient is, “What do you want to be called?”. When we ask patients what their pronouns are it isn’t a silly exercise in semantics. A name is an identity. It carries with it a personal story, self-worth, and, in this case, a commitment to live an authentic life despite real risks of danger and bigotry.

Ethan’s story is a reminder of how providers can empower their patients and create safe spaces by listening and asking, ‘What is important to you?’.

References
research is needed in this area. When present, chaos may result in consequences that are common, important, and at times dangerous. Creative and innovative solutions should be encouraged so that physicians can work efficiently for their patients and thrive in healthy work environments, patients can receive better care, and healthcare systems can run more smoothly. Everyone’s health may depend upon it.

References

The Call to Action for SGIM Members
QPP and MIPS will profoundly influence primary care practice for the foreseeable future. There will be winners and losers. Some of this is already apparent but there will likely be other currently unrecognized unintended consequences. For the sake of our patients, especially those most disadvantaged and vulnerable, and the financial viability of our primary care practices which care for them, SGIM members need to maintain heightened attentiveness to CMS’s implementation strategy. Specifically, our researchers, advocates and activists must investigate, monitor and report the adverse consequences of MACRA’s QPP. Our members have repeatedly demonstrated expertise in teasing out the failures and harms caused by national policies. CMS is very mindful of the published literature. It is not their intention to harm. Like all systems, they need a feedback mechanism.

If nothing changes from the status quo, the cognitively sophisticated clinical care we provide for medically and socially complex patients will take a double hit—from the distortions in the existing Physician Fee Schedule and from the inadequacies of the Quality Payment Program. Access to care for these patients has always been a challenge and will only get worse if reimbursement for providers caring for these populations continues to decline. SGIM members can be a catalyst for change in MACRA’s QPP. The time is now to pay attention, ask the tough questions, design the studies, disseminate the results, and advocate for the change needed to protect access to care for our most complex and vulnerable patients.

References
and drivers such as housing and food insecurity, social isolation, racism, environmental exposures and lack of economic opportunity to name a few.1

The nation is entering a highly active phase for research, development of care models, and experiments in financing and policy to address these social determinants. I believe that this national awakening about the social determinants of health is medicine coming full circle. This approach to care is what I hear in William Osler’s words: “The good physician treats the disease; the great physician treats the patient who has the disease.”2

The social determinants of health are more than a set of facts or abstract concepts. As do many of you, I think about the countless patients whose social circumstances, community context, and life experiences represent barriers to achieving optimal health and wellness. But the importance of these social determinants of health was never clearer than after Hurricane Katrina in 2005. The destruction of the infrastructure and social fabric of our community in New Orleans laid bare the challenges our patients were facing, often unseen by us in the clinical setting. The experience drove the greater New Orleans community to build a successful care model that could address health beyond health care.3,4 We also paid attention to strengthening the sectors impacting the social determinants of health, such as housing, public health, and education.

During my term as president, I want to see that the excellent science, practice, educational, and policy expertise of this organization and our members are recognized by key national thought leaders and leveraged to bring about a more accessible, affordable, and just health system for all—one in which we address all drivers of health, including the social determinants of health.5 Over the course of the year, I will use this column to spotlight the work of our members and their organizations who are working to advance the model of addressing the social determinants of health. We will cover the many efforts and dimensions addressing the determinants, including:

- medical education opportunities
- clinical practice innovation
- payment models
- measurement and evaluation
- research advances and gaps
- approaches leveraging multi-sectoral partnerships
- data and technology demands, and
- public and private sector policy needed to support sustained models.

I also welcome suggestions for models and people who may be “flying under the radar” but whose innovations should be more broadly known so we may spread and scale their efforts.

The theme of our 2020 Annual Meeting in Birmingham, Alabama, will focus on how general internists can inform and advance efforts aimed at addressing the social determinants of health. Eric Rosenberg has agreed to chair the meeting and the team at the University of Alabama at Birmingham are thrilled to be the local hosts. I encourage you all to start now to think about your submissions to the meeting that will inform the science, practice, education, and policy around the social determinants of health. I am anticipating content that not only spotlights our leadership in this area but also shapes the future of this essential work.

Though thematically I will focus on the social determinants of health in the coming year, I want to assure the membership that I will not lose sight of our core mission and goals in partnership with SGIM staff, council, committees, and commissions. Over the coming year, SGIM will continue to strengthen its core so that we can be a strong partner and advocate for our patients, trainees, and communities. We will build Web site functionality that better supports the members and our work, build upon the strategic planning work and define our metrics and targets, act on some of the recommendations from the finance planning work to further strengthen our financial standing, encourage cross-cutting efforts, such as an evaluation process, for our enhanced career development efforts, and enhance partnerships where we have mission alignment to make an impact.

Thank you all for the work you do every day to create a just system of care in which all people can achieve optimal health, including attention to the social determinants of health. I could not be prouder than to serve as president of this extraordinary organization in the coming year and look forward to what we will be able to achieve together.

References
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