

PERSPECTIVE

MEDICARE FOR ALL 2020

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Healthcare reform has historically been an incremental process in the United States. What began nearly 100 years ago as a political slogan as part of President Teddy Roosevelt's unsuccessful run for a third term in 1912 evolved into a program proposed to Congress by President Harry S. Truman in 1945. However, it was not until 1965 that Medicare was signed into law by President Lyndon B. Johnson with former President Harry S. Truman becoming Medicare Member 0001 effective July 1, 1966.

Since 1965, healthcare reform in the United States has continued to move slowly and managed care has been a central and growing part of how health care is delivered. On March 23, 2010, President Barack Obama

signed the Patient Protection and Affordable Care Act (ACA) into law. This reform was largely built off the employer-based system and it reduced, but did not eliminate, the number of uninsured.

On February 27, 2019, Representative Pramila Jayapal (D-WA) introduced H.R. 1384, the Medicare for All Act of 2019 with 117 cosponsors (out of 435 members, or 27% of the entire House of Representatives).¹ This bill was first introduced in 2003 and has been reintroduced many times since then, but never with the degree of support seen today. Simultaneously, the comparatively moderate ACA has declining enrollment paired with another legal challenge destined for the Supreme Court. In spite of challenges, the progressive wing of the Democratic party is supporting a proposal that would radically change how health care is provided in the United States. On April 30, 2019, Medicare for All had its first congressional hearing by the House Rules Committee.

Overview of Major Changes in Medicare for All

Unlike the ACA, where the mantra, "if you like your care, you can keep it," held true, Medicare for All would unapologetically change coverage for the 85% of the country not currently in Medicare plus a third of those enrolled in Medicare.² The major changes include the following:

1. Every U.S. resident (including non-citizens) would be covered.
2. Managed care plans (which cover all of the commercially insured population), 34% of Medicare, and 81% of Medicaid would be eliminated.

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(President Lyndon Johnson signs the Medicare Bill at the Harry S. Truman Library and Museum in Independence, Missouri. LBJ Library photo by unknown, 34897-22. Taken July 30, 1965.)

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FROM THE EDITOR

THE AMERICAN DREAM

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

Last month, my mother, Giuseppina “Pina” Conigliaro, passed away after a short illness, a complication of a condition that she had been dealing with for more than 20 years. She was an amazing woman who lived the American dream—she immigrated to the United States in November 1954 from Ribera, Sicily, at the age of 18 with her mother, older sister, and younger brother. Because of the devastation of World War II and the hard life that followed, she never attended formal school. She arrived in New York, illiterate and unable to speak English. Despite this, she taught herself how to sign her name and do basic arithmetic. She came to a strange country, not knowing the language, with essentially nothing but relying on the kindness of friends and family who made the journey years earlier. I will always be inspired by the courage and perseverance by her and other immigrants who came here seeking a better life for themselves and their families. She continued to speak the Sicilian dialect of Italian as her primary language. One of my earliest exposures to the medical profession was accompanying her as interpreter to the many visits to physicians and hospitals. Like many young women in the late 50s and 60s, she learned how to operate a Singer sewing machine, joined the International Ladies Garment Workers Union, and worked in a factory as a dressmaker with many of her fellow immigrants from Sicily.

Thank you for allowing me to tell her story. I dedicate this editorial to her and to highlight the efforts our President, Dr. Karen DeSalvo, to make the social determinants of health (SDOH) a major theme this year. So much of my mother’s experience in health and health care were linked to the SDOH that Dr. DeSalvo refers to in her current and previous president’s columns.¹ My mother’s access to healthcare was linked to her income and social status, and her status as an immigrant gave her limited access and choices for care. The initial medical conditions were directly related to occupational exposures and the understanding of her disease and her compliance to treatments were exacerbated by a lack of education and literacy. The era and her Sicilian culture colored her attitudes and beliefs regarding healthy behaviors, such as diet and exercise, the lack of which contributed to her later problems. In her advanced years, and after my father passed, her social supports and coping skills became more significant factors regarding her ability to stay healthy and functional.

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SOCIAL DETERMINANTS OF HEALTH: WEIGHING IN ON THE CONSEQUENCES OF ACTION

Karen DeSalvo, MD, President, SGIM

SDOH has been an obsession since Hurricane Katrina where I saw that what my patients needed most was not medical care, but housing, access to food, transportation, schools, and jobs. Over the past 14 years, I have become more convinced that addressing these non-medical needs is where we need to focus our societal energy to drive health for individuals and communities. Though not only the responsibility of the healthcare system to address these non-medical needs, health care is being asked to step up.

“It is easy to say that people should follow a healthier life-style and in a better environment, but can this be achieved? Are the required policies acceptable? How effective would they be? The last of these three questions is substantially scientific, but the others are political, pragmatic, and ethical.”

—Geoffrey Rose



This past summer, my husband and I traveled to Wyoming where we spent the time enjoying nature including some fly fishing and hiking. On our hikes, we saw animal tracks in the soft soil of the forest floor. They were everywhere, especially hoof prints of the abundant moose, deer, and prong horn in the area. For some reason, these hoof prints made me think about the social determinants of health. But then, everything makes me think about the socials determinants of health (SDOH)!

SDOH has been almost an obsession of mine since Hurricane Katrina where I saw firsthand that what my patients needed most was not medical care, but housing, access to food, transportation, schools for their kids, and jobs to come back to. Over these past 14 years, I have become more convinced that addressing these non-medical needs is where we need to focus our societal energy if we really want to drive health for individuals and communities. Though it isn't only the responsibility of the healthcare system to address these non-medical needs, health care is increasingly being asked to step up.

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NALOXONE: A LIFESAVING PLACE TO START

Rebecca Levine, MD

Dr. Levine (rebecca.levine@va.gov), University of Pittsburgh School of Medicine, is an internist practicing hospital medicine at the VA Pittsburgh Health System.

I saw Mr. N, one of my preceptor's patients, in my primary care resident clinic. His PCP had seen him recently and come up with a plan for his uncontrolled diabetes and worsening dyspnea in the setting of extensive cardiac disease. This visit was to follow up on his progress. Unfortunately, he had missed appointments with cardiology and endocrinology. Both his A1c and shortness of breath had worsened. I asked Mr. N how he was doing and his answer surprised me. His daughter, a teacher and a mother, had started using heroin; he and his wife were taking care of their grandchildren. There was lying and stealing, and life was thrown into chaos. He was hurt and angry. More than anything, he was terrified of the possibility of a heroin overdose.

"I can't do anything. This is all I think about, and there's nothing I can do for her," he looked up at the ceiling as he told me this.

Addiction is described by Al-Anon and Nar-Anon as a *family illness*. This nods at its hereditary nature, but it really points at how addiction corrodes the relationships that hold families together and nourish the people in them. Mr. N was not the first patient I had seen in my clinic who did not want to talk about his own health, but about how addiction was wreaking havoc in his life by threatening to take a loved one from them.

"I've tried forcing her to get treated, I even called the cops. They said they couldn't do that- why not? I keep hearing about kids dying of overdoses, what if she's next?" Mr. N, terrified, asked me impossible questions.

Mr. N told me how powerless he felt to help his daughter. I also felt helpless often when facing patients with substance use disorder. In primary care and on the floors, substance use disorder can be challenging to treat. I saw with opioid use disorder that treatment with buprenorphine and methadone has stabilized many patients, moving them into a functional life of recovery. But for those who chose not to go that route, it was hard for me to know where to start. I listened to them. I gave them the option to go to treatment, I talked about mutual support groups. I reassured them that I would be there with them through anything. Still, substance use disorder can fray the relationship between patients and their care team in the same way it disrupts family bonds. I remain hopeful that gradually, over time, I can make inroads.

Fixing the social disaffection, community breakdown, and lack of economic opportunity that this disease

feeds on and then propagates is beyond the scope of an office visit or inpatient encounter. Starting someone on medications for opioid use disorder in the primary care or inpatient setting is still not possible in many places. This is something we as internists, allied with other specialties, are working to change. More and more providers are getting their waivers to prescribe buprenorphine for opioid use disorder, which is crucial to treating this disease. No waiver is needed to give naloxone to everyone at risk of being around an opioid overdose. It is an incredibly easy, no risk measure we can all do right now. It tells patients and their families that we can meet them where they are. This is the cornerstone of harm reduction, and effective medicine.

After discussing the importance of taking care of himself and his health first, Mr. N left our clinic with naloxone kit in hand, the phone numbers for opioid recovery clinics, and a plan to see a cardiologist and our pharmacist for diabetes management. Over the next few weeks, I checked his chart: Mr. N had not responded to numerous calls and letters to schedule his follow-up appointments. He had missed his echo appointment. A month later he did call into clinic though. I read the message in the chart:

Veteran reported that his daughter's friend overdosed and they used Naloxone to successfully revive her. Please mail him another script.

I've tried calling Mr. N multiple times. He hasn't answered or returned my calls. I suspect his daughter's disease is still all he can think about it. I wish I could get her into treatment. I know Mr. N wishes he could get her into treatment. Until then, we can start where she is and make sure the people who love her are equipped with naloxone.

The prevalence of opioid use disorder has risen dramatically, and we see these patients and this disease's sequela frequently in our practice. As internists, the more equipped and proactive we are at treating this disease, the better our patients will do. As the epidemic persists, more advocacy at the state and national level is necessary to secure the resources we will need to treat our patients.

As internists, we can rise to this challenge.

CLINICAL HARM REDUCTION FOR ADDICTION: A STRATEGY INTERNISTS CAN (AND DO) EMBRACE

Dale Terasaki, MD MPH

Dr. Terasaki (djterasaki@gmail.com), a board-certified internist, recently completed an addiction medicine fellowship at the University of Colorado.

With the opioid epidemic raging, there are many calls from advocates and policymakers to expand access to addiction treatment as well as harm reduction services in cities around the United States. Clinicians of all stripes understand the concept of treating a disease. But fewer appreciate how medical practice aligns with the latter endeavor: reducing harm. I posit that practitioners of general internal medicine are already well-acquainted with the philosophical and pragmatic underpinnings of this parallel approach to care.

Harm reduction is a term that conjures images of syringe exchanges and—with growing public attention, supervised use sites—as examples of programs largely administered outside of the traditional medicine sphere. Yet what constitutes harm reduction is not limited to facilities or programs. According to the Harm Reduction Coalition, a national advocacy and capacity-building organization, harm reduction has no universal definition, but “...accepts, for better or worse, that [the disease/behavior] is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them,” “establishes quality of...life and well-being...as the criteria for successful interventions,” and “calls for the non-judgmental, non-coercive provision of services and resources,” among many other guiding principles.¹ Internists share these values, and they already practice harm reduction in managing many chronic diseases.

...with [substance use disorders], what recommendations currently exist for harm reduction—perhaps better received among medical professionals as tertiary prevention—in clinical practice?

Consider atrial fibrillation. How many teaching points occur daily during morning rounds on decisional aids for anticoagulation? Warfarin and apixaban do not directly address the mechanism of disease (i.e., a cardiac conduction abnormality). Rather, they prevent a serious complication prevalent in this population, especially when the underlying pathology is *not* well controlled. Potential harm is reduced in a non-judgmental fashion.

Or consider a more commonly referenced example: type II diabetes. Comprehensive diabetes care includes

early screening for neuropathy, retinopathy, and nephropathy. These interventions do not, of course, affect blood sugar levels directly. But there is an acceptance that, despite our best efforts, not every patient in all circumstances will have adequate blood sugar control. It is still reasonable to detect and reduce the impact of these medical complications; I am not aware of any concerns about *enabling* poor glucose control by doing so.

The American Society of Addiction Medicine (ASAM) now describes addiction as “a primary, chronic disease of brain reward, motivation, memory, and related circuitry.”² And as readers are aware, there are almost too many medical complications of substance use to count. But with this chronic, relapsing and remitting, biopsychosocial disease, what recommendations currently exist for harm reduction—perhaps better received among medical professionals as *tertiary prevention*—in clinical practice? The following are selected examples of clinical harm reduction that may be well-known but not fully recognized as part of substance use disorder (SUD) management.

- The United States Preventive Services Task Force (USPSTF) gives a grade B recommendation to screen men between age 65 and 75 who have ever smoked for abdominal aortic aneurysms.³
- The American Medical Association Opioid Task Force provides guidance on co-prescription of naloxone with opioids for patients at high risk of overdose, and for their family and friends.⁴
- The Advisory Committee on Immunization Practices (ACIP) recommends that people who inject drugs get vaccinated against Hepatitis A and Hepatitis B. Additionally, the Centers for Disease Control & Prevention (CDC) recommends testing anyone who has injected drugs for Hepatitis B and Hepatitis C infections.⁵
- The ACIP lists *alcoholism* and *cigarette smoking* as indications for pneumococcal polysaccharide vaccine (PPSV23) immunization.⁶

These are established guidelines that do not directly address the pathophysiological mechanism of

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AVOID THE PITFALLS OF AGE-BASED PRECONCEPTIONS: SUICIDE ATTEMPT IN A NONAGENARIAN

Seki A. Balogun, MBBS, FACP, AGSF

Dr. Balogun (sab2s@virginia.edu) is the director of the Geriatric Fellowship Program and associate professor of medicine, University of Virginia, Charlottesville, VA.

A 92-year-old Caucasian woman is a resident in a continuing care retirement community and was transferred to the nursing home section after acute hospitalization for recurrent right-sided malignant pleural effusion for which she had a tunnel pleural catheter inserted. Prior to this, she was in the independent living section and was independent of all basic and instrumental activities of daily living. She is now deconditioned, requires a rollator walker for walking around the facility, and needs some assistance with bathing. She also has a complex medical history of non-Hodgkin's lymphoma, bronchiectasis, chronic obstructive pulmonary disease, atrial fibrillation, and coronary artery disease and is being assessed by her geriatrician/primary care physician on nursing home rounds. Medications include: diltiazem, ipratropium/albuterol nebulizer, apixaban, loratadine, furosemide, salmeterol diskus inhaler. She reports severe acute low back pain over the last 24 hours, radiating to right groin. No recent falls reported. Vital signs: BP- 134/65; Pulse: 95/min; Respiratory rate: 16/min; Temp: 98F; Pulse oximetry: 95% on RA. Physical examination normal except for mild tenderness on palpation of right buttock/hip region.

In an older postmenopausal woman with acute onset low back pain, some of the possible differential diagnoses include: vertebral compression fracture with or without a preceding fall or degenerative joint disease of spine. With the

history of non-Hodgkin's lymphoma and malignant pleural effusion, one must also think of possible bony metastases.

She had work up with her oncologist which included the following: CT Abdomen/pelvis notable for 'persistently enlarging multiple ill-defined hypodense hepatic lesions concerning for lymphoma involvement versus metastatic disease from another primary malignancy. PET scan revealed lymph nodes suspicious for lymphomatous involvement in head, neck and hepatic regions. There was interval loss of disc space and para-disc osteolysis at L3-4 with significant FDG uptake concerning for infective spondylitis.

After extensive discussion with the patient, her family and physician care team (oncologist, pulmonologist, palliative care physician, and geriatrician/primary care physician), the patient opts for comfort measures and no invasive treatments. She is commenced on a pain regimen of oxycodone extended release and immediate release and this is titrated to moderate effect. Her family encouraged continued active interventions, but were ultimately advised on the poor prognosis, and therefore comfort measures, in keeping with the patient's wishes. She became progressively weaker over the next several weeks, developed loss of appetite and unable to take her usual walks around the nursing unit.

One morning, her nurse found her to be very somnolent during routine rounds. Vital signs: BP: 153/73, Pulse: 102/min; Respiratory rate: 19/

min; Temp: 97.8F. Her primary care physician had seen her the day before and she was at her baseline cognitive function with good pain control on the oxycodone regimen. At that time, she had also declined all oral foods and many of her medications including oxycodone, stating that she hoped "she would pass away in her sleep."

With the new somnolence or change in mental status in this older woman with advanced lymphoma, one could easily assume that this is due to her overall functional decline and debility or a sign of metastatic brain involvement. Other possibilities to consider would be adverse effect of her narcotic regimen, though her regimen had not been adjusted in several weeks and she had been tolerating this well previously. Delirium due to an infective process such pneumonia, urinary tract infection or bacteremia secondary to infective spondylitis would also be reasonable differential diagnoses.

As she is being assessed, her nurse finds an empty prescription bottle of hydrocodone/acetaminophen on her bedside table. Of note, it is unknown where she got the prescription from as this was not one of her prior or current prescribed medications. Also, the nursing home section, like most nursing home facilities has nurses administering all medications and does not allow medication self-administration by patients. She admits to taking about 10-20 pills the previous night, in the hopes of ending her life quickly as

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her current situation is “no way to live.” She was transferred by EMS to the hospital emergency department and was found to have features of acetaminophen toxicity (level: 42µg/mL normal: 10 -20), new elevations in liver enzymes with AST: 91 U/L (normal: <35) and ALT; 45 U/L (normal: <55). She was treated with N-acetylcysteine nebulizer solution and promptly discharged back to the nursing facility in accordance with her goals of care for comfort measures only. Hospice services were initiated. Her pain regimen was adjusted to symptom control and she died peacefully about a week later surrounded by her family at her bedside.

Discussion

While suicidal attempts tend to be more prevalent in young adults, suicides disproportionately affect older adults with the highest suicide rates in white men 65 years and older.^{1,2} In spite of this, there is a paucity of data in the literature concerning suicides and suicide attempts in older adults, particularly the oldest old (85 years and above) and those in long term care facilities. As a result and due to other multifactorial reasons, suicide ideation/attempts are not usually the first consideration when assessing the oldest old in long term care facilities, who also tend to have a high chronic disease burden with co-existing cognitive and functional deficits.

In recent studies of older adults with suicidal ideations or self-harm, risk factors identified include: chronic pain, multiple comorbidities, presence of depression/anxiety, cognitive impairment, social isolation, history of previous suicide attempt, alcohol/drug use and functional decline with admission/transition to long-term care settings.¹⁻⁴ Patients with cancer are found to have four times the risk of suicide compared to the general population, with cancers of the head/neck, testes, bladder and hodgkin's lymphoma having the highest suicide rates.⁵

Our patient has some of the

above risk factors, such as the presence of multiple comorbidities, cancer, chronic pain, functional loss, loss of autonomy and recent admission to the nursing home section of a continuing care retirement community. Yet, she is atypical in other ways. In particular, her advanced age (over 90 years), no prior suicide attempt, no prior diagnosis of depression, and the presence of good family support, though her family was not initially in complete agreement with her expressed goals and preference of medical care. In addition, suicide attempts in long-term care facilities with drug overdose is of one of the least utilized methods in this setting.⁶ This is likely as a result of supervision by the health team and specific facility regulations which prevent self-administration of medications. The more commonly reported suicide methods in long term care settings include: fall from a long height, hanging or cutting.⁶ This clinical case illustrates the importance of physicians and the whole health team in carefully assessing older adults for signs of suicidal ideation, particularly those with the above risk factors. It is equally important to recognize that some of the signs may be subtle and atypical. This also reinforces the need to support further measures and research that address mental health issues in this subset of older patients.

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FROM THE EDITOR

(continued from page 2)

In her June 2019 *Forum* column, Dr. DeSalvo stated that general internists have an important role in understanding and supporting interventions to address the social needs of their patients.¹ Through her work and others, I have come to understand how my mother's SDOH and the implementation of those interventions or lack thereof had a major impact on her health and care.

I look forward to this year's planning and attendance of the national meeting in Birmingham, Alabama, entitled “Just Care: Addressing the Social Determinants for Better Health.”

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BOOK REVIEW: PRESENTING YOUR CASE: A CONCISE GUIDE FOR MEDICAL STUDENTS

Avital O'Glasser, MD, FACP, FHM

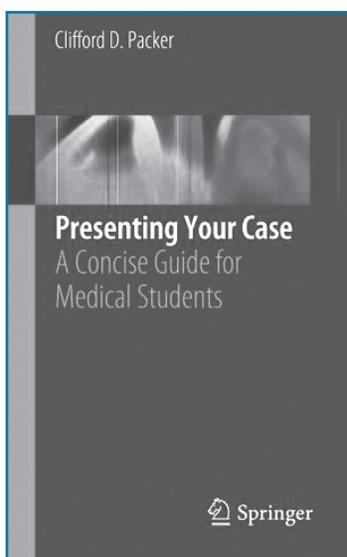
Dr. O'Glasser (oglassea@ohsu.edu, Twitter @aoglasser) is a hospitalist and the medical director of the pre-operative medicine clinic at Oregon Health & Science University.

In the day and age of scrolling rather than flipping, I was excited to recently receive a new medical education book that I anticipate will become a staple on the shelves of internal medicine clinician educators. Dr. Clifford Packer, who has published multiple pieces in *SGIM Forum* about clinical vignette writing and authored a textbook on the subject (*Writing Case Reports: A Practical Guide from Conception through Publication*)¹, just published *Presenting Your Case: A Concise Guide for Medical Students*.² I am excited to review it for the *Forum* audience.

In writing this book, Dr. Packer draws upon his near two decades as an internal medicine clerkship director. Beginning with his preface and arcing through the entire work, Dr. Packer acknowledges and grapples with the weight that has historically been placed on the oral presentation, especially for medical students. Why has the oral presentation become the make-it-or-break-it for the third-year clerkship? Why is it such a challenge for both those on the delivery and the receiving ends of the content? Why is it that “*students who struggle are sometimes viewed as disorganized and lacking in medical knowledge*” (p. vii)? With this book, he aims to “to demystify and deconstruct” (p. viii) this “rite of passage” (p. vii).

Dr. Packer's book is very comprehensive and very well outlined. Just as he encourages the student and the attending to bring structure and form to the entire oral presentation from start to finish, so too is this book organized in manner highly conducive to learning. Dr. Packer addresses each major section of the presentation in stepwise fashion, beginning with dissecting the traditional structure of the H&P from the HPI to the assessment/plan and one's diagnostic reasoning.

Without spoiling the contents (and to encourage you to read it yourselves), I want to highlight some favorite features of the work. I think I stood up and cheered when I read his section that the oral presentation should not be a verbatim regurgitation and recitation of the written notes. I thoroughly appreciated chapter 3, “Variations



on the Oral Presentation,” that provides structure yet flexibility for presentations for night float admissions, transfer admissions, and calling a consultant. I think my #ProudtobeGIM colleagues and clinical educators will also greatly appreciate the section on tailoring the oral presentation to the ambulatory setting in addition to the inpatient setting. Communicating social determinants of health and one's understanding of patients in the context of their illnesses is discussed extensively. High value care, especially as it pertains to discussions of testing and management, is the subject of chapter 10. Chapter 14 incorporates novel technology such as point-of-care ultrasound, and the information it affords us, into oral presentations. Further use of technology, such as using smartphones on rounds to reference the literature in real time, is also discussed.

Dr. Packer argues that the oral presentation is about far more than sharing isolated data point after data point—especially in the day and age of the electronic medical record, where the attending can (and by many accounts should be) accessing and reviewing mounds of data points before teaching rounds. The process, with the ability to recognize and communicate pertinent negatives and positives, must be dynamic and fluid—and he effectively paints the landscape of what that ideally entails. There is a holistic and broader view on the purpose of teaching rounds as a whole—and the emphasis on diagnostic reasoning, the ability to navigate through differential diagnoses, and the importance of maintaining curiosity is deeply appreciated by this reader. Dr. Packer tells the student, “Let us know what you're thinking, then, but show us the evidence. Your assessment is a thesis: it must be argued for and defended” (p. 96). This immediately conjures connections to Dr. Gurpreet Dhaliwal's discussion with *The Curbsiders* that one's assessment and plan should be like a lawyer's closing argument.³

I was also highly impressed and engaged by some of the broad themes that Dr. Packer is able to weave through his piece. The oral presentation is not a static

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event—it is an active process that depends on conversation between the presenter and the attending (this is not to be confused with frequent *interruptions*). There is also a fascinating discussion on the history and role, or lack thereof, for use of the Socratic Method versus “pimping” on rounds. Although I might argue that pimping is never acceptable, Dr. Packer provides an eloquent differentiation between “benign” and “malignant” pimping—focusing on the intent and value of the line of question, rather than the term used to describe it.

Finally, I was also highly impressed by Dr. Packer’s overarching emphasis on the learners and the culture of safety that is essential for the success of the received oral presentation. As stated in the preface, “*I have seen students literally writhing with anxiety as they present their patients*” (p. vii). He is compassionate to the student who might feel that the entire clerkship grade rests

on the evaluation of the presentation, which is only a snapshot of a student’s performance on a rotation. He absolutely respects the learning needs of the students along with the ability for students to be empowered to advocate for their patients and drive their care forward. The tone throughout is respectful and empowering, including creating safe for students to be able to admit and vocalize their uncertainty. The message, in short: “speak up on rounds, engage in discussion, and satisfy your curiosity...stand up for your patients...present your case well, and others will listen” (p.8).

I highly recommend this book to my colleagues in academic internal medicine, and I suspect that clinician educators outside of internal medicine will also find it highly applicable. I think students and residents, especially residents with a keen focus and interest in teaching others, will find this a very worthwhile addition to their personal libraries. It

is informative yet sprinkled with a healthy dose of humor—for example, “adherence to Occam’s Razor is an aspirational goal that is sometimes unattainable” (p.102).

It is a fast, facile, highly informative, and delightfully insightful read.

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IMPROVING CARE (continued from page 5)

SUDs. Yet they can reduce harms that stem from these conditions. Internists should incorporate these recommendations into standard SUD care, and we also need more. What harm reducing strategies besides abstinence-based treatment exist for alcohol-related injuries? Cocaine-induced hypertensive crises? Cannabis-associated hyperemesis? I think many of us have seen and written the *Plan* section of a *SOAP* note that states, “Recommend cessation,” without any other actionable ideas.

I ask the clinical research community to devote more time and resources to tackle not only treatment of addiction but also *prevention* of its medical complications, acknowledging that many will have paroxysmal relapses regardless of an airtight treatment plan. Harm reduction must become part of our lexicon; at least as recognizable as *CHADS₂VASC* and *A1c*.

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MOVING TOWARDS HEALING-CENTERED ENGAGEMENT: WHAT TRAUMA-INFORMED CARE CAN TEACH US ABOUT BURNOUT AND HEALING IN THE WORKPLACE

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Traumatic experiences are common and their effects reverberate within individuals and throughout communities. Much is known now about the neuro-biologic mechanisms and health sequelae of traumatic experiences, and this knowledge offers pathways for understanding and building resilience. For these reasons, trauma-informed care (TIC) seeks to create a framework designed to anticipate, acknowledge, and respond to the effects of trauma on people's lives and, in so doing, mitigate the effects and foster healing.

Healthcare professionals and organizations can respond holistically to trauma by recognizing the interconnectedness between our patients' and our own experience with violence, well-being, and resilience. Thoughtful responses that promote healing and resilience among healthcare workers can reconnect healing professionals to the meaning and purpose that drew them to their work. In so doing, individuals and organizations strengthen their ability to provide trauma-informed care.

The healthcare workforce is not immune to the personal experience of trauma. In fact, healthcare workers are more likely than the population at large to have experienced personal trauma. It is estimated that sixty eight percent of the healthcare workforce have experienced at least one episode of violence, abuse, or neglect.⁴ When compared to their colleagues in other industries, they are also more likely to experience workplace violence. A third, and perhaps more insidious, experience occurs when healthcare professionals develop vicarious, or secondary, traumatization through exposure to their patients' stories of violence and trauma. The manner in which healthcare workers receive and respond to vicarious trauma predicts whether they develop secondary traumatic stress.

In the newly released book *Trauma-Informed Healthcare Approaches: A Guide for Primary Care*, authors Kimberg and Wheeler offer the "4Cs" framework for applying trauma-informed principles in clinical care.

The following is an excerpt from their chapter, "Trauma and Trauma-Informed Care"¹:

Calm: Pay attention to how you are feeling when you are caring for the patient. Breathe deeply and calm yourself to model and promote calmness for the patient, yourself, and your co-workers. Practice calming exercises (deep breathing, grounding) with patients. Cultivate understanding of trauma and its effects to promote a calm, patient attitude toward others (patients and co-workers.)

Contain: Asking the level of detail of trauma history that will allow the patient to maintain emotional and physical safety, respects the timeframe of the healthcare interaction, and allows you to offer the patient important treatment options. Providing education, resources, and referrals to trauma-specific care without requiring disclosure of trauma details facilitates an interaction that does not emotionally overwhelm the provider or the patient.

Care: Practice self-care and compassion for yourself, the patient, and your coworkers. Adopt a compassionate attitude toward oneself and others, sharing messages of support, de-stigmatizing adverse coping behaviors, and adhering to the practice of cultural humility to promote healing.

Cope: Emphasize coping skills, positive relationships, and interventions that build hope and resiliency. Inquire about practices that help the patient feel better. Provide evidence-based treatment for the sequelae of trauma including substance use and mental illness. Celebrate cultural practices that increase well-being and social connection.

Among healthcare workers, as with the population at large, self-efficacy in the face of traumatic events predicts self-growth. Secondary trauma self-efficacy refers to "the

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Fostering Resilience in Patients & Ourselves Toolkit5**

<p>Books</p>	<p>Cope, Stephen. <i>Yoga and the Quest for the True Self</i> Epstein, Ronald. <i>Attending: Medicine, Mindfulness, and Humanity</i> (2017) Hanh, TN. <i>The Miracle of Mindfulness: An Introduction to the Practice of Meditation</i> Kabat-Zinn, Jon. <i>Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life</i> Remen, Rachel Naomi. <i>Kitchen Table Wisdom & My Grandfather’s Blessings</i> Schiffman, Eric. <i>Yoga: The Art of Moving into Stillness</i> Sood, Amit. <i>Train Your Brain...Engage Your Heart... Transform Your Life</i></p>	<p>Apps</p>	<p>Mindfulness Apps: (Number indicates rating by <i>Journal of Medical Internet Research</i> (Mani)) <i>Headspace</i> (Overall Rating 4.0) <i>Smiling Mind</i> (Overall Rating 3.7) <i>Mindfulness</i> (Overall Rating 3.5) <i>Mindfulness Daily</i> (Overall Rating 3.5) Gratitude 365 (gratitude journaling) Exercise/Yoga: Seven minute workout (iphone or android) Office Yoga (or Lite – Free variety)</p>
<p>Websites</p>	<p>American Medical Association Steps Forward: https://edhub.ama-assn.org/steps-forward/module/2702509 American Psychological Association: http://www.apa.org/helpcenter/road-resilience.aspx Office of Cultural Transformation at the Veteran’s Administration: https://www.va.gov/PATIENTCENTERED_CARE/resources/Mobile_Apps_and_Online_Tools.asp Whole Health Library: http://projects.hsl.wisc.edu/SERVICE/curriculum/index.html ACP https://www.acponline.org/practice-resources/physician-well-being-and-professional-satisfaction ACGME: http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being/Resources Substance Abuse and Mental Health Services Administration. SAMSA-HRSA Center for Integrated Health https://www.integration.samhsa.gov/clinical-practice/trauma</p>	<p>Training</p>	<p>Healer’s Art (Naomi Rachel Remen, MD): http://www.rishiprograms.org/educational-programs/ The Center for Mind Body Medicine: https://cmbm.org/trainings/mind-body-medicine/ The Institute for Integrative Health: https://tiih.org/what-we-do/ Center for Mindfulness in Medicine, Health Care and Society: https://www.umassmed.edu/cfm/ Kripalu: https://kripalu.org/ Hakomi Institute: https://www.hakomica.org/ Somatic Experiencing®: https://traumahealing.org/learn-se/#programs The Sensorimotor Psychotherapy Institute (SPI): See http://www.sensorimotorpsychotherapy.org/about.html.</p>

* This toolkit provides examples of available resources and is not meant to be exhaustive.

What can trauma-informed care teach us about burnout and healing in the work place? Check out this fresh perspective on healing centered engagement @meggerber

perceived ability to cope with the challenging demands resulting from work with traumatized clients and the perceived ability to deal with secondary traumatic stress symptoms.”² Individual characteristics (both innate and learned) as well as organizational structures can promote health professionals’ self-efficacy.

The promotion of self-efficacy is a strengths-based approach to trauma-informed care that shifts the paradigm toward “healing-centered engagement”. In his article “The Future of Healing: Shifting from Trauma-Informed Care to Healing-Centered Engagement,” Dr. Shawn Ginwright explains, “A healing-centered approach views trauma not simply as

an individual isolated experience, but rather highlights the ways in which trauma and healing are experienced collectively. The term *healing-centered engagement* expands how we think about responses to trauma and offers a more holistic approach to fostering well-being.”³ For example, humans biologically ‘co-regulate’ with one another, and clinicians can use relaxation of their own bodies and breath to create a calm healing environment for patients and one another.

In summary, healthcare staff are more likely than the general population to have experienced both personal and workplace trauma. Workplace violence includes physical and emotional violence inflicted

by clients and colleagues. In addition, healthcare professionals may be vulnerable to vicarious trauma, which refers to the collective burden of witnessing the suffering of others. By promoting safety and self-efficacy, organizations can reduce the risk of trauma in the workplace. As we look to the future, trauma-informed organizations may help build resilience by proactively supporting the health of their employees. Ideally, they will maintain a sense of readiness to recognize the impact of trauma on the lives of their staff and the clients/patients they serve. Healthcare professionals can work collaboratively with organizations to create environments that are physically and emotionally safe. They can intervene when needed, adapt to the needs and strengths of their workforce, and provide opportunities for individual growth. Collectively, these

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And so, SDOH was on my mind in the woods. I couldn't help but think that these hoof prints, impressions left behind by an event that happened on the trail that I didn't see, were like the many events leaving an impression on the lives of individuals and communities. The forest floor in Wyoming seems resilient and so these hoof prints are largely innocuous, temporary dents in the soft soil, and the forest floor generally rebounds.

On the other hand, the social determinants of health tend to be less innocuous dents and can have a more lasting, and often negative, impact on the health of our patients and communities. Particularly enduring challenges include generational poverty, policies like redlining, and structural racism. Such challenges have been shown to be a constant allostatic load on an individual, causing changes to their physiology and an increase in susceptibility to disease ranging from colds to cardiovascular disease.¹ Just because as doctors we don't see the insults, challenges, and life circumstances, the social determinants are impacting our patients' health in significant ways—pressing into them just like the animal's hooves on the trail.

It is no wonder that public health officials and policy makers are excited about the momentum around the recognition that the social determinants drive the majority of our health outcomes and that the practice and research community are busy understanding what actions can positively address social needs and, as a result, improve health outcomes. For example, if we identify and address food insecurity, we can improve the management of heart failure and reduce unnecessary hospital admissions. These would be the *intended consequences* and a driver behind professional medical societies like the American College of Physicians, American Association of Pediatrics, and the American Association of Family Practice to

put forward position statements and in some cases tools kits to support physicians and healthcare systems in identifying and addressing the social determinants of health.

In February 2018, Congress weighed in by providing additional flexibility for Medicare Advantage to address healthcare-related social needs in beneficiaries, and this regulatory latitude has been acted on by the Trump Administration in their guidance to plans. This policy work isn't limited to the federal government, and states are active in their work to leverage programs like Medicaid to address social determinants of health, such as the Medicaid program in North Carolina where they are engaged in local experiments to address social needs ranging from transportation to intimate partner violence.² Recently, America's Health Insurance Plans made clear that they see the social determinants of health as a strategic priority signaling interest by commercial plans. This interest by public and private payers is a step towards expecting the healthcare system to be accountable for the social determinants of health as well.

While the nation is at work to find ways to impact the social determinants, we should also remember that there may be unintended consequences to our actions. My "watch list" of the unintended consequences of addressing the social determinants of health includes: 1) adding complexity to the health system with new documentation, quality measures and payment rules; 2) harming those we want to help by highlighting their social needs; 3) overwhelming the social care system we are relying on to help our patients and communities; and 4) medicalizing the social determinants of health.

I don't think this is an exhaustive list of unintended consequences by any means. But, I see these as likely to occur if we, as a country, and medicine as a field, are not

intentional about the work we do to address the social determinants of health. The last one, medicalizing the social determinants, may have the most significant consequence and we are on a national pathway to make social needs a medical condition. Some of this involves expecting physicians to code needs like "food insecurity" in to the medical record. Healthcare policy makers are also beginning a journey of building insurance benefits for Medicare and Medicaid populations (and commercial payers won't be far behind) that support healthcare-related social needs. Rather than expecting health care to address social needs, we should be strengthening social systems and services so they can be strong partners with health care in this work.

There are some early signs that the health system and policy-makers are willing to take a pause and consider how the well-intentioned and in some corners aggressive measures we are taking may impact those we want to help most.^{3,4} Others are helping to articulate the important distinction between addressing the health care related social needs of individuals and addressing "upstream determinants" in the community context.⁵ However, the aggressive move to action by payers, policy-makers and some healthcare systems will likely continue given the prevailing thinking that there is a real opportunity to improve health outcomes, improve efficiency, and drive down unnecessary healthcare utilization and cost but making the healthcare system more accountable to the social determinants of health.

And so, I am excited that SGIM is planning to add its voice to the conversation about the social determinants of health over the next year. We bring a special set of experiences, skills, and perspectives to the conversation. We also have significant administrative and educational responsibilities in the U.S. healthcare system. As such, we

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have a responsibility to be educated about the topic and to have a point of view. We weigh in not only about what can be done “downstream” to address healthcare-related social determinants of health but also “upstream” to address the context and community where our patients live, learn, work, and play. In the end, we will have a publicly available position statement on SDOH that provides a broad overview of the role and opportunity for academic general internal medicine to support policy, research, practice, and educational efforts to advance efforts to address all the drivers of health and make recommendations where appropriate. We will also consider the potential unintended consequences of acting on the SDOH.

To do this work, Council has assembled a workgroup to develop a position statement for the society. The group will include SGIM members with expertise in the social determinants of health and/or expertise in areas of import that the medical community should consider including the unintended consequences and the impact on our patients and communities. The goal is to release the paper coinci-

dent with our SGIM 2020 Annual Meeting in Birmingham, Alabama, where the theme will be “Just Care: Addressing the Social Determinants for Health.” I hope that SGIM members who want to engage in the process with suggestions for the position paper and/or are willing to review the draft documents will reach out to me directly so that we may be as inclusive as possible.

Developing a position statement is not a panacea to protecting our patients and communities from the adverse impacts of the social determinants of health. But, it is an important step in the essential work ahead to address health beyond health care. From a public health perspective, it would be ideal if we could create a world where health equity was the norm. Where the countless events that affect the lives of our patients, like the countless hoof prints I saw on the forest floor in Wyoming, did not leave a mark because our patients and communities were resilient. SGIM members have a critical role to play in this dialogue and work, including articulating the intended consequences, and unintended consequences of action.

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BEST PRACTICES

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efforts build resilience. Ultimately, it is through resilient individuals and organizations that trauma-informed care can be sustained and healing-centered engagement achieved.

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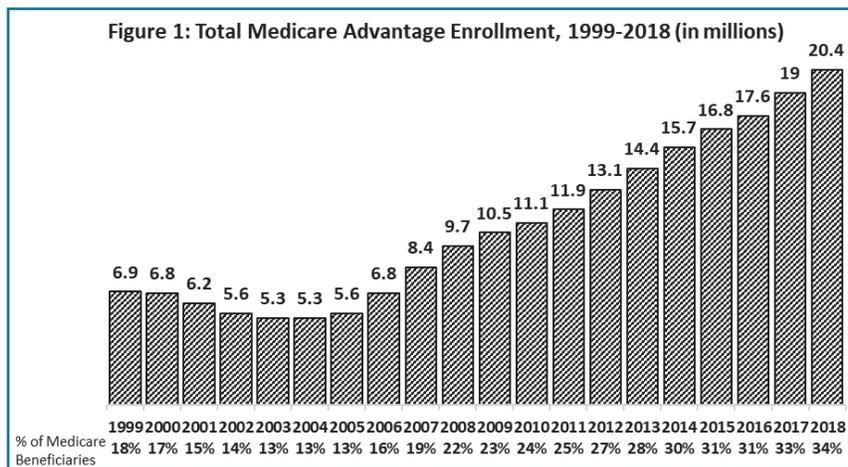


Figure 1: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2018, and MPR, 1999-2007, enrollment numbers from March of the respective year, with the exception of 2006, which is from April. NOTE: Includes cost plans as well as Medicare Advantage plans. About 61 million people are enrolled in Medicare in 2018.

3. Cost sharing, which is 20% in the Medicare program today, would be 0% in Medicare for All.
4. Payment for the Medicare program has not been developed in the bill, but would be funded by Federal revenue, therefore, taxes would need to be raised to fund the coverage expansion.

There are fundamental economic, political, and legal ramifications associated with the extensive changes attendant to enacting H.R. 1384. Here, we limit our scope to consideration of the plausible economic consequences and political importance of H.R. 1384 in the approaching 2020 election. The lack of legal precedent in U.S. history and the ramifications on the employment of hundreds of thousands working in managed care in the workforce will not be addressed in this article.³

Prices

While Medicare and Medicaid currently set prices for all healthcare providers electing to participate in either government program, the coverage of the commercial population through Medicare will use global budgets to pay institutions. This implies the elimination of commercial fees paid to hospitals,

providers, and potentially pharmaceutical companies. There would no longer be “free market” prices—all fees for all providers would be set by the Federal government and, as with current government prices, would be lower than the commercial insurers’ prices today. Additionally, because most physician service costs are salaries, then salaries will go down for all healthcare providers including physicians, nurses, and other clinical and support staff. When salaries decline, the result is a *reduction in the supply* of physicians, nurses, and other clinical and support staff.

Cost Sharing

H.R. 1384 says there will be no cost sharing, meaning \$0 cost at the point of service. While this will have little impact on demand for inelastic services such as brain surgery and dialysis, more elastic services such as physical therapy and outpatient

Medicare for All is supported by 27% of the entire House of Representatives and calls for a revamping of the US healthcare system that will result in reduced physician salaries and shortages of health care.

specialist visits will see large volume increases, thereby increasing *demand*.⁴ Health economics predicts that reducing cost sharing to zero would lead to overutilization of services.⁵ When an increase in demand meets a decrease in supply, there is a shortage, resulting in the longer lines and waiting times that we see for certain services in Canada and the United Kingdom.

Premiums versus Taxes

Many opponents of Medicare for All will decry the multi-trillion dollar estimated costs of the program. However, the costs are misleading because 50% of health care is already paid for by the government via Medicare and Medicaid. And the other 50% is paid by a combination of employer premium contributions, employee premium contributions and to a smaller extent, consumer out of pocket costs. For the working population, both taxes and healthcare premiums are line items deducted from a paycheck—workers never see those dollars in their bank accounts. If premiums are eliminated and absorbed into taxes on average, this makes no difference to the taxpayer. On average, Medicare for All would *not* be a new expense, it would simply be paying the same bill to a different vendor, like switching cell phone companies or electricity providers. However, at the individual level, the wealthy would shoulder a higher percentage of medical costs and lower income persons would pay less. For example, Medicare is paid for with a payroll tax of 1.45% (disregarding the employer portion for simplicity). This means that a family earning \$50,000 in wages pays \$725 towards Medicare per year in taxes. A family earning \$500,000 a year pays \$7,250 per year. The proposal does not identify how the cost burden of the program would be distributed.

Administrative Savings

Estimates of administrative costs due to private insurance vary, but they

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may be as high as 12%, while countries like the United Kingdom and Canada likely have much lower administrative burdens and Medicare's costs are closer to 2%.⁴ Overall administrative costs could theoretically be reduced from the 12% of private insurers to 2% in the Medicare program, at best a 10% point reduction. Still, the administrative savings come at a price, particularly physicians' reduction in reimbursement rates, since historically, government-set fees are lower than commercial fees.

Managed Care Organizations

While many consider managed care organizations a cost driver in the system due to very real, time intensive and frustrating administrative complexities, such as claims denials and pre-authorizations, these organizations have become *more popular*, not less, in the past 15 years as a part of the Medicare program. Nearly 80% of Medicaid beneficiaries and 32% of Medicare beneficiaries were enrolled in an MCO by 2017.⁶ Given the increase in market penetration, it seems unlikely that policymakers would take a popular, voluntary program insuring one-third of Medicare beneficiaries and end it. In addition, no developed country has restricted private insurance in the way that HR 1384 would require.⁷

Next Steps for Medicare for All

Medicare for All as it is currently written in H.R. 1384 will not happen. However, its presence and the mere discussion in the House Rules Committee hearings on April 30th and May 1st forces health policy on the offensive and creates a litmus test for Democrats running for the 2020 nomination to determine whether they are part of the Progressive wing, like Bernie Sanders and Elizabeth Warren who support the bill, or the centrist wing like Joe Biden who opposes it. Expanding health care has proven a reliable source of strength for Democrats; health policy is also a lightning rod, and nobody knows this more than the

current frontrunner, Joe Biden. The political backlash resulted in the loss 63 of 256 Democratically held seats (25% of all House seats held by Democrats) in November 2010, less than 8 months after the passage of the ACA. Therefore, there are a few likely scenarios after the 2020 election and only one of them results in any chance of a serious effort to pass Medicare for All.

What Happens in 2020?

It is understood that Medicare for All cannot move past hearings in the House of Representatives before the 2020 election. After the election there are a limited number of possibilities:

- If Donald Trump is re-elected, we can expect no action on Medicare for All and possibly a renewed legislative effort to overturn the ACA.
- If a centrist Democrat, like Joe Biden, is elected then the health policy focus will be incremental, such as fortifying the strength of the ACA.
- Medicare for All legislation only has a chance at gaining momentum with a strong electoral victory of a Progressive Democratic candidate paired with control of the Senate and elimination of the filibuster. In addition, the new president would have to take this on as the primary legislative task amidst other pressing issues such as income inequality, climate change, tax policy, and others.

These three scenarios show that there is a narrow, winding, but plausible pathway for Medicare for All at the start of the new Presidential term in January 2021. However, Medicare for All, with all of its economic issues, is likely a progressiveness litmus test for Democrats rather than a realistic and viable piece of legislation.

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