

PERSPECTIVE: PART I

THE PATIENT WHO KEEPS CALLING: PERSPECTIVES ON APPROACHES FROM CLINICIANS WHO CARE FOR HIGH-RISK POPULATIONS

Brian Hilgeman, MD; Angela Becker, APSW; Joyce W. Tang, MD, MPH; Nicole Gier, LCSW;
 Anita Leon-Jhong, MD; Bruce Henschen, MD, MPH; Jodie Bryk, MD

Dr. Hilgeman (bhilgeman@mcw.edu) is an assistant professor of medicine in the Division of General Internal Medicine Primary Care at the Medical College of Wisconsin. Ms. Becker (anbecker@mcw.edu) is the social worker for the Enhanced Care Program at Froedtert and The Medical College of Wisconsin. Dr. Tang (jtang@bsd.uchicago.edu) is an assistant professor of medicine in the Section of Hospital Medicine at the University of Chicago. Ms. Gier (ngier@medicine.bsd.uchicago.edu) is manager of social work & behavioral health in the Comprehensive Care Program at the University of Chicago. Dr. Leon-Jhong (lyonsab@upmc.edu) is a clinical assistant professor in the Division of General Internal Medicine at the University of Pittsburgh Medical Center. Dr. Henschen (b-henschen@northwestern.edu) is an assistant professor, Division of General Internal Medicine and Geriatrics, Northwestern University Feinberg School of Medicine. Dr. Bryk (brykja@upmc.edu) is an assistant professor of medicine and medical director of the University of Pittsburgh Medical Center Health Plan Enhanced Care Program in the Division of General Internal Medicine at the University of Pittsburgh Medical Center.

(In this article, the authors present a case followed by a discussion of strategies to address this patient's needs. Though similar in style to a clinical case conference, our discussion centers on the psychosocial, rather than medical, aspects of care that profoundly impact our patients' lives.)

Case Presentation

Next in clinic, you have a 53-year-old man with non-obstructive CAD, hyperlipidemia, and gout. Upon chart review, you notice he has been in the emergency department 16 times in 12 months for various pain concerns. He has had 3 different primary care providers over the past 2 years; you find that his last PCP discharged him for "behavior concerns." He saw a psychiatrist once in the past year who diagnosed him with severe generalized anxiety disorder and possible obsessive-compulsive disorder. He has a low IQ of 79.

You enter the room with trepidation and find a pleasant, anxious man. He feels "rather well" today and just wants to establish care, so you proceed to better understand why he has such a troubling history. He lives with his brother, whom he describes as "mean." He was

very close to his father who, unfortunately, passed away 3 years ago and his life has "been bad" since this time. He completed high school and some technical school. Although he is currently unemployed and relies upon SSI benefits, he has had jobs in the past and enjoyed them. You discuss his frequent ED visits and he expresses a desire to change and reduce them. You mutually agree to a goal for him to apply for a job by your next visit in 2 weeks and for him to call you instead of going to the ED. You leave the visit feeling surprised at your success.

After a promising first visit, problems arise. He calls the clinic up to 30 times per day. Your nurse and social worker note that he often hangs up mid conversation or acts in a bizarre fashion on the phone, including mimicking staff or staying silent for long periods of time. He

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FROM THE EDITOR

TOO SMART FOR YOUR OWN GOOD

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

"When did you get so clever?"

"When I realized I wasn't as clever as I thought."

—John Connolly, *The Infernals*

I recently spoke to a potential recruit for a faculty position in one of our academic practices. Although predominantly a clinical position, there was also the opportunity to precept residents and teach medical students. This particular applicant was one year out of residency and unsuccessfully tried to land a fellowship in one of the more competitive procedure oriented specialties. The failure to secure a spot forced him to contemplate what he most enjoyed in medicine. The applicant described that one of the most rewarding parts of his training was developing relationships with patients and their families and impacting their lives. He articulated that desire without hesitation and so clearly that I asked why he had considered subspecializing in the first place? The answer really didn't surprise me.

He described the typical experience of most residents in the United States. The pressure and expectations of fellowship training, as a logical and certain next step that follows internal medicine training, start early. In medical school, students pick electives in areas that they may be interested in practicing 4-5 years in the future. When visiting programs, as part of the residency interview process, they are bombarded with data about how many and which subspecialty fellowships the program's recent housestaff matched into. No residency director ever boasts about how many of their residents chose generalists careers. What information applicants receive regarding graduating residents who chose primary care or hospitalist medicine as a career choice is usually not explicitly stated and merely assumed to be everyone else who didn't get a fellowship.

Then, there is the argument that if you are a high-performing resident with great board scores who is asked to serve as chief resident, you should pursue one of the more competitive fellowships. A resident with that pedigree deserves to pursue cardiology or GI, not general medicine. When I was chief, I was told by one of the GI attending that I "was too smart to do primary care." Back then, I was not as quick with a comeback as now. Actually, I'm not that good now, but what I would say to "not being smart enough" is that I worry that I am not smart enough to be a generalist. If only I could focus on one or a small set of organs and master the associated diagnostic and therapeutic procedure needed. To be sure, my colleagues in GI, cardiology, and endocrine are

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MEDICARE: PART “S”?

Karen DeSalvo, MD, President, SGIM

Maybe the medical system, including Medicare, should not be the primary source of funding for addressing the SDOH. Perhaps we should not use Medicare dollars to pay for bike lanes or develop “Medicare: Part S.” Rather, the nation should invest in public health, social care, and other key sectors that impact health more than the healthcare sector.



I was recently searching the SGIM Forum site to find one of my President’s columns from this year and one that I had penned in 2005 popped up. Rereading them after all this time brought back a swirl of memories. I wrote it in the intense weeks just after Hurricane Katrina made landfall. We were scrambling to rebuild our city and healthcare system after it had been knocked to its knees.

Early on, I wanted to bring opportunity from tragedy, not rebuild the same system that led to generations of poor health and inequity. Rather, I hoped we would build a person-centered system that could meet the physical, emotional, and social needs that I knew were driving inequities and suffering. Some of the work was grass roots and institutional, including standing up our academic infrastructure and building prototypes of community health sites that could show what addressing whole health in teams would look like.

Our plans were grander than building prototypes. We also were focused on driving systemic policy that would

move the frontline care sites from prototypes and projects to sustained, vibrant care options. As we laid out our vision and action plan, we knew that we would need to make a big shift in how money was allocated. Given the heavy reliance on federal funds to support the healthcare infrastructure, HHS was a key actor in long term financing of our new vision. Amongst our many asks, one was support for non-medical social drivers and built environment upgrades to make a more walkable community. They said they “pay for beds, not bike lanes.” In essence, they were clear that there wasn’t a “Medicare: Part S”—S for social determinants of health (SDOH).

How times have changed! Fifteen years later, HHS is now actively putting forward models in SDOH. Amongst the many things that have come full circle is that the architect of the CMMI Accountable Health Communities, SGIM member Alex Billieux, is now assistant secretary for health in Louisiana and instrumental in translating that SDOH model to Medicaid policy.¹

Starting with innovation from State Medicaid programs, the nationwide trend is finding ways for

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Editor In Chief

Joseph Conigliaro, MD, MPH, FACP
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 Elisa Sottile, MD
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BEDSIDE ROUNDING: ROLLING WITH RESISTANCE

Mel L. Anderson, MD; Sarita S. Warriar, MD; Attila S. Nemeth, MD; Jeremy P. Smith, MD

Dr. Anderson (Milver.Anderson@va.gov) is associate professor of medicine, Division of Hospital Medicine, University of Colorado Department of Medicine and Hospital Medicine Section, Minneapolis VA Healthcare System. Dr. Warriar (Sarita_Warriar@brown.edu) is assistant professor of medicine and medical science, assistant dean of medical education, Department of Medicine, Division of General Internal Medicine, The Warren Alpert Medical School of Brown University. Dr. Nemeth (Attila.Nemeth@va.gov) is associate professor of medicine, Department of Medicine, Division of General Internal Medicine, Case Western Reserve School of Medicine, and Acute Medicine Section, Medicine Service, the Louis Stokes VA Medical Center. Dr. Smith (jpsmith@medicine.wisc.edu) is associate professor of medicine, Department of Medicine, Division of General Internal Medicine, University of Wisconsin.

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Introduction

Assessing physician competence has changed markedly in recent years as accreditation bodies and training programs have adopted competency-based education and training (CBET), focusing on educational outcomes rather than processes.¹ Systematic direct observation of trainees' clinical skills is now required by the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education as part of the Next Accreditation System. Direct observation of trainees is a cornerstone of CBET and a prerequisite for learner assessment. Certain core competencies, such as Interpersonal and Communication Skills and Patient Care, cannot be adequately assessed without direct observation. Nevertheless, studies indicate that little time is spent conducting direct observation during an average medical workday, faculty report rarely using direct observation as an assessment tool, and a substantial percentage of residents and students state that they have *never* been directly observed doing certain important clinical tasks.²

Bedside rounding (as opposed to “table rounds”) represents an under-utilized strategy to increase direct observation and assessment of trainees' clinical skills. Recently, there has been a rekindling of interest in bedside rounding and in developing techniques to do so effectively. The authors address 5 commonly cited concerns with the aim of advancing the conversation about how to effectively implement and sustain bedside rounding.

“It Takes Too Much Time.”

Studies of perceived barriers to bedside rounding frequently report that it takes too much time. However, most show the duration of inpatient medicine rounds is independent of rounding location.³ A recent trial of structured inpatient attending rounds found that trainees felt bedside rounds took longer despite measured time being

no different,⁴ a finding seen in previous studies as well. We hypothesize that trainees and attendings rounding at the bedside may *perceive* time differently compared to in the conference room, leading to a mismatch between actual elapsed time and the experience. There are several possible explanations. First, team members may sense a loss of control when a patient interrupts a presentation, even for a few seconds. Second, physicians at the bedside can't as readily turn away from the conversation to return a page, answer a phone call, or divert their attention to a computer—activities that may require leaving the patient room. Third, trainees may feel unengaged and impatient when seeing patients cared for by other team members. We suggest the following strategies:

1. Explicitly acknowledge the importance of time perception and management and commit to mitigating strategies like those listed below.
2. Leverage the Electronic Medical Record (EMR) to enable brief and targeted bedside presentations, focusing on the HPI, exam findings, synthesis, and plans. Overnight admission presentations are ripe for redesign. Reconsider presentation content and organization based on goals: repeating information already known to team members is inefficient and can suggest time is not highly valued.
3. Deliberately involve all team members as best as possible, creating a paradigm of shared learning and problem solving. Active engagement creates educational opportunities for a return on the listening investment.

“My Residents Don't Want to Go to the Bedside.”

The literature around resident and student preferences for bedside rounding is mixed. Residents may view bedside rounds as beneficial for patients but less educational for themselves.⁴ In addition to concerns about efficiency, they

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may feel underprepared to present at the bedside, uncertain of what the expectations are, what language to use, what the repercussions might be of coming to an errant conclusion, and even where to position themselves at the bedside. Residents may worry about how they are perceived, especially by their patients. We suggest the following strategies:

1. Communicate a clear set of goals, objectives, and expectations with your trainees to orient them to the bedside rounding process. Include your thoughts on language and on ‘blocking,’ namely, how the team should assemble at the bedside to best achieve its goals. Talk about approaching mistakes in a way that supports resident autonomy.
2. Prepare teaching points prior to rounds, especially if doing so extemporaneously does not yet come naturally.
3. Be explicit about the care you model: say out loud how you approach a problem, what you find on physical examination, and how you reason through that patient’s care. Trainees place high educational value on such contributions.

“Isn’t This More Stressful for Patients?”

While the literature is heterogeneous regarding patient-centered outcomes, multiple studies show high patient satisfaction with bedside rounds, including patients viewing the team as more respectful and compassionate, and reporting that their concerns elicit more attention from the medical team.⁵ Preparation of the patient and preparation of the medical team are important to successful bedside rounds. We suggest the following strategies:

1. Introduce team members and roles, the purpose of rounds, and request permission from the patient to discuss their care at the bedside.

2. When summarizing for the patient, key elements of patient-centered communication should be reinforced—understandable language, pausing to check for understanding, and non-verbal cues.

“Orders and Discharges Will Be Delayed.”

Delayed order entry can impact hospital length of stay, lead to medical errors, and even impact outcomes. Furthermore, resident fatigue and interruption of order entry contribute to order-entry errors in the EMR and result in patient safety issues. Therefore, real-time order entry is important. We suggest the following strategies:

1. Bring handheld tablets and computers on wheels during rounds to allow for real-time order entry.
2. Specify roles during rounds. For example, when Resident A is presenting a patient at the bedside, Resident B will take notes of outstanding tasks for that patient’s care and, if time allows, place those orders in the EMR.
3. Allow for periodic, brief (<5 minutes) scheduled breaks during rounds to call consults or enter orders, while the attending provides focused teaching to medical students.
4. After each patient or at the end of morning rounds, briefly review the specific plans for each patient, offering to help with order entry or phone calls.

“OK, I See Your Points. But I’m Just Not Osler...”

This is a true barrier for many junior and senior faculty members. We suggest the following strategies:

1. Use a structured approach to bedside rounds. Consider MiPLAN or other frameworks. Most of these approaches consist of several common components:
 - a. Faculty preparation: Review patient information and data prior to rounds—this allows

for identification of key teaching points beforehand and focuses the bedside presentation on patient engagement, teaching, and directly observing learners’ communication and clinical reasoning skills.

- b. Team preparation: Elicit and address concerns from team members and establish mutual expectations regarding presentations and rounds. Set time targets based on clinical workflow (e.g., 5-minute presentations with an additional 10 minutes for discussion with patient and teaching) and specify roles for team members prior to entering the room (e.g., presenter, order entry, summary for the patient).
 - c. Prepare and invite the patient and other healthcare professionals to participate; make focused/prepared teaching points and actively engage learners; respond to patient emotions in the moment; confirm patient understanding of plan; elicit questions from patient, family, other team members.
 - d. Debrief: elicit and provide feedback and follow up patient or learner questions.
2. Start small and grow deliberately, perhaps with established patients who are familiar with the team members and plans for their care or with new patients.
 3. Approach bedside rounding with a mindset of deliberate practice. With even a few repetitions, elements like streamlining presentations, providing diplomatic adjustments to plans of care, and navigating challenging situations will become more natural. Faculty who teach bedside skills to students strongly endorse that their own skills improve in doing so. Patients, learners, and faculty all have opportunities to benefit from bedside rounds.

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MULTIPLE TRAUMAS

Angela Suen, MD

Dr. Suen (suena@upmc.edu) is a graduating PGY-3 in the UPMC Internal Medicine Global Health and Underserved Populations Track.

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“**T**ry to avoid sticking yourself with the needle—she’s a prostitute,” a resident said to me as he handed me the needle and driver. The patient laid before me was a young black woman in her early twenties stabbed over 20 times in the face, neck, chest, arms, and legs. “Jane Doe” read her chart and she was writhing in pain. While she was given light doses of lorazepam and lidocaine, she still cried out with every saline wash, every stitch we placed. She begged for more pain medication. At one point, she refused further wound closure until her pain needs were addressed.

As her wounds were dressed in succession, Jane was subjected to a series of handovers. Details of her medical care were interlaced with commentary, “I have to warn you, this one’s difficult.” “I would have finished sooner if she hadn’t complained so much.” Inside her room, half-hearted coaxes of “a little stinging here” and “just a little more” offered her no respite. She asked us over and over again, “Why are you doing this to me? You keep telling me that you’re treating the pain but you’re still hurting me!”

I asked a resident why she was not considered for the operating room. “She’s already been through enough,” the resident shrugged, and continued to adjust the light for the next row of sutures. Despite his causal assuredness, what he meant remained unclear to me. If I were the patient, I would have gladly gone to the operating room for anesthesia. She had indicated her desire to go. Why wasn’t this option offered to her?

Implicit bias describes the attitudes or stereotypes that affect our decisions and actions in an unconscious way. No physician enters the medical profession with the intent of providing biased care; yet, studies show we are all complicit in its practice. It may start with a simple subconscious assumption about a patient’s background or education, and snowballs quickly into miscommunication, suspicion, distrust, and ultimately, mishandling of patient care.¹ I worry that Jane Doe’s case is such an example. What may have been speculation about her background—a sex worker, maybe active drug use, likely of poor education—turned into beliefs about her ability to communicate her pain, her unspoken, assumed desire for opioids.

The role of implicit bias in treating pain is well documented. Scores of studies have shown that Caucasians presenting with bone fractures are more likely to receive

pain medications than African Americans or Latinos, even when controlled for pain severity and insurance coverage. A study by Hoffman published in 2016 involving medical students and residents in Virginia found a strong correlation between the number of false racial beliefs and the likelihood of undertreating pain for black patients when compared to white patients.²

The roots can be traced back to our history of racial bias in medicine. Racial biology, a pseudoscientific belief that African Americans are biologically different, declined in popularity after World War II. But these beliefs still exist in some form today. Many subjects in Hoffman’s 2016 study falsely believed that blacks have less sensitive nerve endings than whites; Dr. Samuel Cartwright made similar claims in 1851. More than a third of subjects in the same study asserted that black skin was thicker than that of whites, while a physician published this statement over a hundred years ago.³

I met Jane Doe as a medical student. While I was introduced to the concept of implicit bias in medical school, I failed to identify it during the encounter. I thought about her for months afterward because the whole situation seemed so wrong. Brought to the emergency department before I arrived, she was still getting stitched up by the end of my twelve-hour shift. She continued to beg for pain medication, water, ice chips, and food through the night. After the trauma of the attack, she was subjected to the trauma of our care. But what could have I said to change her course of care, especially from my position in training? I was not prepared with the language to discuss the potential role of implicit bias with the resident.

I am now a resident. I regularly see cases where implicit bias may have played a role in a patient’s care. Yet, I still hesitate to discuss it openly. I worry that my questions would be interpreted as an insinuation that someone may be racist, rather than as an opportunity for an open conversation. Unlike cognitive biases, we have yet to develop a language and framework for approaching implicit bias. We could improve patient care if we systematically challenged our implicit biases in the same way we do with cognitive bias.

Methods to address implicit bias in clinical practice are lacking. Scientists have found that trainings around self-realization, such as the implicit association test (IAT) can help providers explore subconscious biases.

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While medicine has started to adopt practices in identifying implicit bias, there are few opportunities to continue the discussion in residency and beyond.⁴ There is little to no guidance offered around how to address these biases in real time.

Implicit bias continues to be a heated topic of national conversation. Physicians, nurses, residents, and trainees must have these conversations as well. We must not fall behind the natural speed of progress.

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MEDICAL EDUCATION: PART I

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Discussion

Bedside rounds provide an opportunity for direct observation of trainees, can be done effectively and efficiently through selection of a method and deliberate practice, and are generally preferred by patients, but can still be met with resistance by trainees. The evidence shows that faculty and residents can adapt and benefit over time, but conversations about real and perceived barriers are needed, especially around the experience of time.

Awaken and develop your inner Osler by joining the authors at SGIM

2020 in Birmingham, Alabama, for a TEACH workshop covering these and other strategies for effective bedside rounding!

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FROM THE EDITOR

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indeed smart. *We all are.* To prematurely close the thinking of a student or trainee that a generalist career is somehow the lesser road traveled at such an early stage in their career is irresponsible and a disservice to our learners. I make this point to highlight the importance of the work we do as academic generalists and why SGIM is so important.

SGIM members continue to expose our trainees to a broad set of generalist careers, including ambulatory and hospital medicine and geriatrics. SGIM members also occupy the myriad careers that generalists can evolve into, including

research, education, and leadership roles. With the annual meeting coming up in May, consider sponsoring a student or trainee to attend. There is no better way to catch the passion of general internal medicine than an SGIM National Meeting.

In addition to the meeting, the SGIM *Forum* represents an excellent opportunity to showcase what a career in academic general medicine looks like and what we care about. This month's *Forum* is a good reflection of the many topics and areas of interest to generalists and what is likely to be presented at the meeting. Dr. DeSalvo continues to address

the issue of social determinates of health, the annual meeting's theme, in her President's column on how we can pay to address them. Dr. Allyn and colleagues report on an interdisciplinary collaborative approach to improve the care of patients with chest tubes. Dr. Anderson, et al, provide a conversation calling us to rekindle the age-old practice of bedside rounding. Rounding out the issue are two wonderfully written Breadth and Perspective pieces and a Morning Report.

Share this and other issues with your residents and medical students—they may thank you someday.

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CHEST TUBE MANAGEMENT IN HOSPITALIZED PATIENTS: AN INTERDISCIPLINARY COLLABORATIVE APPROACH

Rebecca Allyn, MD; Jeff Zoucha, MD; Marshall Miller, MD; Gerard Salame, MD;
Martina King, MD; Brendan Notestein, NP; Janice Van Bockern, PA; Maria G. Frank, MD

Dr. Allyn (Rebecca.Alyn@dhha.org); Dr. Zoucha (jeff.zoucha@dhha.org); Dr. Miller (marshall.miller@dhha.org); Dr. Salame (Gerard.salame@dhha.org); Dr. King (martina.king@dhha.org); Mr. Notestein (Brendan.notestein@dhha.org); Ms. Van Bockern (Janice.vanbockern@dhha.org); Dr. Frank (Maria.Frank@dhha.org)—Denver Health Hospital Authority.

Approximately one million adults are hospitalized each year for pneumonia in the United States—50,000 die from its complications.¹ Para-pneumonic effusions (PPE) can occur in up to 40% of patients with bacterial pneumonia.¹ Large uncomplicated effusions can effectively be drained by therapeutic thoracentesis; however, complicated PPE and empyemas require tube thoracostomy (TT).

Multiple studies²⁻⁵ have shown that the intrapleural administration tPA and DNase in patients with pleural infection increases chest tube output while decreasing surgical referrals and hospital length of stay. The treatment protocol consists of twice daily intrapleural administrations for three days. At our institution, 714 adult patients were hospitalized for pneumonia in 2017 with 20 (2.8%) requiring TT. At our organization, Pulmonary, Interventional Radiology (IR) and General Surgery (GS) have the ability to place chest tubes with the informal agreement that all aspects of its management are to be implemented by the service performing the procedure, including tPA and DNase administration. This arrangement was poorly enforced during evening hours leading to confusion and conflict for providers and nurses, delay in doses and unintended complications related to the lack of expertise of covering providers.

Given the twice daily administration of tPA and DNase coupled with the lack of 24-hour in-hospital coverage by two of the three services (Pulmonary and IR), Hospital Medicine (HM) was often asked to perform the administration of intrapleural fibrinolysis (IPF). Many HM providers felt they lacked the training to safely perform IPF.

Intervention and Findings

In order to standardize chest tube management, HM proposed to assume responsibility of all chest tubes placed for pleural infection. The key stakeholders in Pulmonary,

IR, and GS supported the transition. Review of hospital policies and procedures revealed neither a protocol nor electronic medical record (EMR) order set to standardize the process of IPF administration.

The initial step involved a joint meeting with our Tier-1 stakeholders: leadership of HM, Pulmonary, GS and IR with the goal of highlighting the importance of standardizing chest tube management in regard to its effect on patient care as well as interprofessional relations; and to assess interest and motivation in formalizing the transition of chest tube management to HM.

Out of the three services that regularly place chest tubes, only GS provides around-the-clock coverage with in-house providers. Because chest tube management contributes to the education of surgical residents, it was felt that chest tubes placed by GS should continue to be managed by surgical residents, leaving HM to only assume management of chest tubes placed by Pulmonary and IR. A HM Work Group (HMWG) composed of Physicians and Advanced Care Providers then formed and conducted a gap analysis by performing literature review and determining our current vs. ideal state. Tier-2 stakeholders were also identified and consisted of leadership from Pharmacy, Nursing, Central Supply, and IT.

The HMWG was tasked with developing a stepwise approach leading to formation of a policy and standardized protocol for the administration of tPA and DNase. The steps included: 1) creating a gap analysis with identification of actionable findings; 2) developing evidence-based guidelines for IPF; 3) creating required training for staff; 4) working with pharmacy and IT to generate an EMR order set for TT and IPF; 5) collaborating with IT to create a standard EMR note for documentation; 6) analyzing and proposing quantitative and qualitative measures of success; 7) obtaining approval by institution's policy and Executive Committee of Patient

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Safety and Quality (ECPSQ); and 8) facilitating a hospital-wide implementation of the process.

Between March and May 2018, the workgroup met on a weekly basis and addressed the following concerns and inefficiencies (see table) related to lack of chest tube management standardization:

1. *Hospitalist-Consultant communication conflict:* Given the previous understanding that the service that placed the chest tube was in charge of its management, conflict arose with twice daily IPF as there is not 24-hour in-hospital coverage by the Pulmonary and IR services. By formally transitioning responsibility to HM, calls to consultants decreased significantly leading to perceived improved collegiality.
2. *Lack of a standardized process for chest tube management:* We found a significant variability

in style of chest tube placed and recommendations on technique for administering medications between the services placing chest tubes. Based on literature review, we developed a protocol agreed upon by all services standardizing medication administration, thus decreasing variability and increasing patient safety.

3. *Lack of an order set and readily availability of IPF drugs:* Previously, tPA and DNase for intrapleural use were not on the pharmacy formulary and therefore an order could not be placed in the EMR, requiring providers to call pharmacy and place a “verbal order” for the medicine to be dispensed. The HMWG facilitated the addition of tPA and DNase for intrapleural use to the pharmacy formulary and to our point-of care medication dispensing system on the inpatient units. This action streamlined our process and reduced calls.

An order set was also created in our EMR, which is time efficient as well as standardized for patient safety.

4. *Unreliable documentation and billing:* A “dot phrase” (macro) to standardize IPF administration documentation in our EMR was developed and distributed among hospitalist providers. This dot phrase included time-based codes to facilitate billing for the procedure and clarified the time and result of the procedure.
5. *Hospitalists’ inconsistent training and confidence with IPF and TT management:* To reduce stress and conflicts with consultants, hospitalists would frequently agree to administer IPF after receiving verbal instructions from the sub-specialty provider. Many HM providers felt that their training was inadequate to safely administer

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Actionable Items by Tube Thoracostomy with Intra-Pleural Fibrinolytic Management Protocol

Actionable Item	Finding Pre-protocol	Post-protocol
Number of phone calls involving Hospitalist (MD/APP) per dose	1. RN to HM to request/remind IPF dose 2. HM to consultant to request/remind IPF dose 3. HM to pharmacy for IPF verbal order 4. RN to HM to notify dose readiness 5. HM to RN for “unclamp tube” verbal order	1. RN to MD to notify IPF dose readiness
Number of phone calls by Nurse per dose	1. RN to HM to request/remind IPF dose 2. RN to HM to notify dose readiness 3. HM to RN for “unclamp tube” verbal order	1. RN to MD to notify IPF dose readiness
Standardized management of TT	Variable	Standardized
Ease to order IPF	Multiple verbal orders	Order set in EMR
TT management documentation and billing	Variable Concern for lack of billing capture	Standardized Good billing capture
Number of estimated missed doses/year	30% of evening doses \$18,000/year (average)	None expected
Estimated medical errors	Variable	None expected
Perceived hospitalist (MD/APP) self-confidence in IPF administration	Variable	Good
Accessibility to training material	No standardized training. Wide-ranging between literature review and over-the-phone instructions from consulting MD	Accessible 27/4 in EMR dashboard

TT: Tube Thoracostomy, IPF: Intra-Pleural Fibrinolytic; HM: Hospitalist; MD: Medical Doctor; APP: Advanced Practice Provider; RN: Registered Nurse; EMR: Electronic Medical Record

CLINICAL REASONING FOR A WORSENING RASH: WHEN YOU'RE LEFT WITH THE DIAGNOSIS OF EXCLUSION

Jessica J. Dreicer, MD (Presenter); Jesse Keller, MD, and Stephanie Halvorson, MD, FACP (Discussants)

Dr. Dreicer (jd3nd@virginia.edu) is a hospitalist and co-director of the Internal Medicine Residency Patient Safety and Quality Improvement Track at the University of Virginia Health. Dr. Keller (kellerje@ohsu.edu) is a dermatologist at Oregon Health & Science University (OHSU). Dr. Halvorson (halvorss@ohsu.edu) is division chief for hospital medicine and medical director for clinical integration at OHSU.

A 74-year-old man with a history of myelodysplastic syndrome was transferred from an outside hospital with subacute, progressive cutaneous and oral lesions and fever which had worsened despite broad spectrum antibiotics. A few weeks prior to admission he was started on 60 mg of prednisone for a new diagnosis of temporal arteritis. The dose of prednisone had been decreased to 30 mg on admission. The patient reported a recent history of inadvertently injuring his left fourth finger, a tender, “marble-like” mass in his left axilla, and erythema and swelling of his left eyelid.

The differential diagnosis includes three main categories: infectious diseases, rheumatologic disorders, and paraneoplastic conditions. A typical bacterial infection seems less likely given the patient’s worsening on broad spectrum antibiotics. Atypical infections such as Nocardia, mycobacteria, or fungal infections should be considered. The patient was recently diagnosed with a rheumatologic disease, temporal arteritis, though this does not explain the lesions on his skin or mucosa. Other considerations include neutrophilic dermatoses, inflammatory disorders that can present with fever and rash. Given patient’s age and history of myelodysplastic syndrome, one should consider paraneoplastic syndromes and age-appropriate cancer screening.

The patient’s exam revealed left conjunctival irritation and a left upper palpebral conjunctival erosion, multiple 2-6 cm eschars with heaped up brightly erythematous to slightly violaceous borders on the left upper chest, left axilla, and right neck. Additionally, he had an exophytic, hyperplastic, erythematous plaque on the upper frontal gingiva, and a necrotic appearing finger. Dermatology was consulted and performed a punch biopsy of the left upper chest that revealed a diffuse dermal neutrophilic infiltrate with ulceration and necrosis. Blood and tissue cultures were negative, as was a broad-spectrum polymerase chain reaction for common types of bacteria, making infection unlikely. An evaluation for occult malignancy, including a computed tomography scan of the chest, abdomen, pelvis, and positron emission tomography scan, were unremarkable. The patient’s skin and oral lesions continued to worsen.

In conjunction with dermatology, it was determined that the most fitting diagnosis was “pyodermatitis/pyostomatitis vegetans” (PD/PSV) a type of neutrophilic dermatosis that involves skin and mucosa. Typical first-line treatment is steroids so the patient’s prednisone dose was restarted at 1mg/kg/day (a dose of 70 mg daily) and he quickly began to improve. His oral lesions sloughed off and his skin lesions began to recover.

Neutrophilic dermatoses are a large, uncommon heterogeneous group of auto-inflammatory skin disorders that occur in patients with underlying hematologic malignancies, inflammatory bowel disease, and rheumatologic conditions. The most familiar examples are Sweet syndrome and pyoderma gangrenosum. Other conditions do exist on the spectrum and share features of both disorders.

Neutrophilic dermatoses had been considered early in the patient’s course. PD-PSV would be the best fit but was thought less likely given the rarity in patients without inflammatory bowel disease. This diagnosis was later reconsidered after work-up for other conditions returned negative. Ultimately, PD-PSV was determined to be the best fit given the distribution of skin and mucosal involvement, lack of more viable alternative diagnosis, and swift response to high-dose steroids. Additionally, the history of pathergy following injury of the patient’s finger fits with a diagnosis of neutrophilic dermatosis.^{1,2}

The name of the disorder is descriptive: pyo comes from the Greek word for pus, the breakdown product of neutrophilic inflammation, dermatitis means inflammation of the skin, stomatitis means inflammation of the mucosa, and vegetans describes the “heaped up” morphology of the lesions. PD-PSV is a rare subtype seen almost exclusively in patients with underlying inflammatory bowel disease. It is the only type of neutrophilic dermatosis known to consistently affect the mucosa (both oral and genital).³ Eyelid involvement has been documented previously, most notably in a report by Leibovitch et al which describes a case of bilateral eyelid margin ulceration and pustules unresponsive to broad-spectrum antibiotics.⁴

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The patient subsequently underwent an outpatient colonoscopy and had three colonic biopsies which were negative for colitis. At a follow-up visit three months after discharge the patient was noted to have complete resolution of his skin and mucosal lesions. A gradual steroid taper was initiated without recurrence at two years of follow up.

First-line treatment for PD-PSV consists of treating the underlying condition. When not feasible, high-dose prednisone, 0.5mg/kg to 1.0mg/kg/day, is warranted in the absence of contraindications. Steroid-sparing agents include dapsone and colchicine, which both have anti-neutrophilic properties.⁵

The patient's lack of improvement on the initial dose of 60 mg of prednisone and rapid improvement on 70 mg is interesting and indicates that sufficient immunosuppression had not been reached with 60 mg.

The initial temporal artery biopsy slides from the outside hospital were reviewed by members of our ocular pathology department and the diagnosis of temporal arteritis was not substantiated.

The inflammation seen on the temporal artery biopsy was likely neutrophilic inflammation from PD/PSV.

It is unclear whether the patient's history of MDS was contributory in this case, but we suspect that it may have been given the strong association between leukemia and other marrow abnormalities with Sweet syndrome. There is a single case report of pyoderma vegetans in a patient with MDS of type Refractory Anemia with Excess Blasts.⁶

Summary Points:

- Neutrophilic dermatoses are an unusual group of disorders which should be considered in patients with neutrophilic inflammation underlying rash in the absence of infection.
- Pathergy is a unique sign that is suggestive of neutrophilic dermatoses.
- History of neoplastic conditions particularly lymphoma and leukemia as well as inflammatory bowel disease should be identified as particular risk factors for neutrophilic dermatoses.

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IPF and perform subsequent TT care, causing stress and anxiety. We developed a training module which had both an in-person training session, providing time to practice different tube manipulation and a picture-based protocol that was added to our online dashboard for easy, real time access.

6. *Safety concerns related to lack of training:* There was at least one patient safety event reported in the first quarter of 2018. The patient suffered no injury; however this was as an error related to insufficient nurse

communication. Safety concerns were addressed by developing the training as well as the order set, which includes more detailed nursing instructions.

7. *Financial waste:* The IPF protocol for PPE includes intra-pleural dosing every 12 hours for 3 days. We estimated that due to confusion on who was expected to administer dose, time inefficiency, and lack of training, at least 30% of nocturnal doses were not administered after being mixed in the last year. Our pharmacy's cost per dose of 5 mg DNase and 10 mg tPA in 30

ml is approximately \$1,000. Our Institution's calculated yearly cost (6 doses x 20 patients) is \$120,000. The missed 30% nocturnal doses would result in approximately \$18,000 annual waste. No doses are expected to be missed after launching the protocol.

8. *Time inefficiencies:* It was also assessed that before protocol, HM providers would spend between 30-60 minutes to accomplish IPF. The process consisted of the following: contacting consulting service to

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BEING THERE

Amy D. Lu, MD

Dr. Lu (Amy.Lu@ucsf.edu) is a VA Quality Scholar at the San Francisco VA Medical Center and clinical instructor at the University of California, San Francisco.

(Patient names and specific identifiers were changed or concealed to protect patient privacy. The views and opinions expressed in this article are those of the author and do not reflect the official position of the Department of Veterans Affairs or any agency of the U.S. government. Acknowledgements: Dr. Gaetan Sgro for his encouragement and thoughtful edits on this piece.)

The screen flickered and the clinic room came into view. The nurse adjusted the camera and the image of a thin older gentleman appeared on my computer screen. He was neatly dressed in a worn plaid button-up, seated on the exam table, looking around the room searching for cues for how to act.

I glanced at my own reflection to check my framing on-screen before focusing my gaze into the camera. I had just started my new role as a telemedicine urgent care physician within the VA. This was my first day on the job and the second patient I had ever seen over videoconference. One of the first lessons I learned while shadowing a seasoned telemedicine clinician was the importance of looking directly into the camera lens when speaking to a patient. It mimics the natural eye contact made during in-person interactions that communicates attentiveness and compassion.

Earlier that morning, the charge nurse at this rural Northern California clinic had messaged me about an 81-year-old veteran who had called the clinic about a possible new diagnosis of cancer. His primary care physician had no openings but the patient had seemed so distressed over the phone that she thought scheduling him into telemedicine urgent care clinic was the next best option.

As I reviewed his chart, my heart sank. He had recently undergone a colonoscopy that unearthed a malicious-appearing polyp quickly transforming into a cancerous mass. The rest of his chart was sparse with details about his life or circumstances. Several notes mentioned his long-standing battle with PTSD and mistrust of the medical establishment. Others alluded to his social isolation and lack of family support.

I had been well-trained and well-practiced during residency to have difficult conversations. Gather friends and family that the patient would want near. Find a quiet space. Be gentle but direct. Allow for silence. Sit with the patient. But nothing in my previous experience prepared me for engaging in such a conversation over video. Would it be awkward? Would I be able to gain his trust? How was I supposed to be there without actually being there? I braced myself for the worst.

“Hi Mr. S, I’m Dr. Lu,” I began, “Have you ever seen a doctor over video like this before?”

“No—” he replied, his gaze tentatively landing on the screen in front of him. “This is all new to me.”

“Well, it’s good to meet you and I’m glad you came in today,” I reassured him (though it felt like I was just reassuring myself). I gave a rehearsed spiel about the purpose of our video visit, explaining that this was the quickest way for him to speak with a doctor, and promising that I would do my best to address his concerns the same way that I would if I were seeing him in person. I asked for his verbal consent to proceed and he responded with the slightest nod.

I took a deep breath and continued to look straight into the camera lens. “Tell me what’s been on your mind since the procedure.”

“Well,” he paused, “...they found something in my colon...and they want me to get surgery. Then I would have to get chemo treatments and I would have a bag that I would have to empty. I just don’t know if I want to go through with all that.”

“Tell me more,” I said.

He had seen his primary care physician a few months earlier feeling a bit more tired than usual. It had been their last meeting before his doctor of 40 years formally retired. He was surprised to learn that he had lost about 10 pounds over the course of a few weeks, but he reassured his doctor that it was probably due to the extra work he had been putting into his garden. But his doctor was worried enough to order some blood work which revealed a low red blood cell count. The next thing he knew, he was being wheeled out of the endoscopy suite at the local hospital and the gastroenterologist was yammering away about scheduling him with a surgeon to cut out his colon as soon as possible. He was told with the right combination of therapies, this growth can be treated, even cured. In his post-anesthesia haze, he signed papers and agreed to half a dozen follow-up appointments with various specialists.

But in the last few days, all he could think about was the road ahead. The surgery didn’t scare him, the life after it, did. He thought about how exhausted chemo treatments could make him, what adjustments he would have

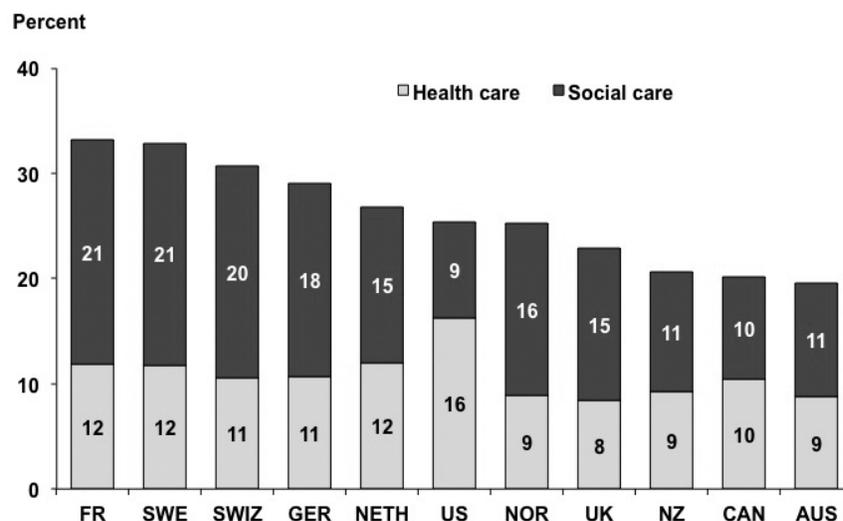
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Medicare and Medicaid to be flexible enough to support, and sometimes encourage, the healthcare system to identify and address SDOH in the patient population. For the Medicare Advantage programs, this includes allowing supplemental benefits to be used to support social care services. So, our dreams from 2005 are coming to fruition.²

This narrative of increased SDOH activity is playing out across the country. Innovative models of care, education, and health system community partnerships aimed at addressing the social determinants of health are providing valuable insights into what works and what doesn't. The recent National Academy of Medicine Report—"Integrating Social Care in to the Delivery of Medicine"—provides many examples and a framework for action. For members who will be at the May 2020 Annual Meeting in Birmingham, they will have a chance to hear from authors of this report in a special symposium and in the Saturday Plenary.

This work by the healthcare system amounts to finding pathways to leverage the medical systems financial and other resources to assist patients with addressing SDOH. But the reality is that the challenges faced by our patients are bigger than what the health system can do alone. It is even "bigger" than major national health systems, like Kaiser, and health plans, like United. Although they are doing good with downstream actions for individual patients through referrals to a food bank, rideshare support, and air-conditioning units, the social care, public health, and other systems to which these health care organizations are referring their patients are under-resourced and becoming ever more strained by new referrals and expectations. Further, these new care models aren't often informed by the decades of deep experience and knowledge that the social care providers could bring to bear.

Exhibit 8. Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Funding partnerships and actions between and by the medical and social care systems is increasingly an important topic. Paying for addressing SDOH from healthcare dollars has the downside of missing the opportunity to address social drivers upstream before they impact health. It also runs the risk of medicalizing social needs and linking key things like housing to enrollment in an insurance plan or linkage to a specific healthcare provider.

In the past year, there has been an exciting sea change in the policy environment. Luminary health economists from across the political spectrum are calling for an approach to financing SDOH. Rather than relying upon transfers from the health care payment sources, they are looking to identify alternatives.

The options essentially include: 1) creating a modified version of social impact bonds that allow the private sector to recoup their investments down the road; 2) pooling public dollars from various health and social care programs; and 3) making investments upstream to more appropriately resource the social care system to better balance the funding along the lines of our peer

nations (see figure). I am delighted to see that these brilliant minds are beginning to build a roadmap for funding SDOH that doesn't require us to depend upon the health care system or on the creation of Medicare: Part S.

One approach is described by Len Nichols and Lauren Taylor as a way to create a private sector solution for a failure of the public sector. They have outlined an innovative model driven by the private sector allowing for even the most pragmatic to see the self-interest in funding social services. This model would involve pooling private sector dollars with long-term sharing of gains from the rewards of better community health and lower social services expenditures.³ Dr. Nichols is working with communities across the country to roll out demonstrations of this approach.

Another great economist who is traditionally considered conservative is Stuart Butler. In January, he published a brief and really interesting paper in *JAMA* that called out the need for public sector funding of services and systems that address SDOH. Butler writes the following:

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“But examples from the federal, state, and local levels show what can be done and often is being done to braid or blend financial resources to achieve cross-sector goals. If we make greater use of such tools to make it easier to combine funds in this manner, we will help to realize the full potential of this broader approach to achieving good health.”⁴

Allowing communities to pool funding from disparate sources helps spread, scale, and sustain successful multi-sectoral approaches to address SDOH at the community level. Unfortunately, the lack of clarity on how communities can pool disparate sources of funds can be a barrier to community-level interventions to address SDOH. Agencies in the federal government should use existing authorities to help communities build

and leverage pooled funding approaches and test these approaches.

In truth, that HHS official was perhaps right in what she said to me that day in Baton Rouge after Hurricane Katrina. Maybe the medical system, including Medicare, should not be the primary source of funding for addressing the SDOH. Perhaps we should not use Medicare dollars to pay for bike lanes or develop “Medicare: Part S.” Rather, the nation should invest in public health, social care, and other key sectors that impact health more than the healthcare sector. In this way, we are more likely to have a partnership models where the strengths of all the sectors can come together to develop a seamless experience in an appropriately resourced *system* that really is capable of addressing the physical, emotional, and social needs of our patients and communities.

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request help, discussing patient with pharmacy and placing a verbal order, waiting for medications to be mixed and brought to the bedside, quickly reviewing “how-to-administer IPF”, administering it, clamping the TT and returning in 30-60 minutes to unclamp. This led to inefficient use of physician time, with an estimated waste of 30-60 physician-hours/year. These inefficiencies were addressed by the protocol.

Next Steps and Operational Implications

Through this multidisciplinary, collaborative, consensus-building process, we were able to develop successful and lasting partnerships; improve efficiency and decrease waste; enhance patient quality of care and safety; standardize documentation leading to better billing capture; develop and implement the 24/7 access to educational materials;

and enrich communication and collegiality amongst services. The protocol was approved by the ECPSQ and instituted as a hospital policy at our organization and is currently under implementation phase.

Hospitalists provide 24/7 patient care, and they are uniquely positioned and trained to collaborate and partner with many diverse departments to foster safe and efficient care for our patients. This project highlights the importance of communication and collaboration as the keystone for operational success.

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misses multiple visits and will often schedule, cancel, and re-request to schedule the same visit. His behaviors appear focused on getting attention. When he comes in, he has not made any progress toward completing the goals. After 4 months, you note he has had 33 ED visits. You and your staff are stressed and on edge. There have been requests to discharge him from the clinic, but you feel that isn't right.

Case Discussion

Although this patient's specific issues are unique, it is likely that many inter-nists have worked with patients with some similar behavior patterns. These behaviors present challenges to a traditional healthcare system in terms of resource utilization, staff time and energy, and disruption to the care of other patients. In this discussion, the following seven clinicians who specialize in coordinating care for complex patients offer their perspectives:

1. Dr. Hilgeman and Angela Becker, APSW: What approaches might you employ to help address this patient's behavior?

One tool that is often under-employed in primary care is a Memorandum of Understanding (MOU). This document can help care teams and patients develop a mutual understanding on how to best interact with the clinic. Overall, this document should be written in positive terms, incorporate the patient's input, reflect his/her background, and focus on the desired behaviors.

There are 4 key elements that should be included in this document: 1) rationale for the document; 2) key parties included in the MOU; 3) expectations of both the patient as well as the clinic or provider; and 4) consequences for not following the agreed-upon expectations (if appropriate) and specific time frame.

It is important that this document is shared with all care providers involved with the patient so it is consistently enforced. For a patient

like ours, when limits are set in one department but not another, the behaviors can often escalate.

2. Dr. Henschen: How would you address these behaviors when he shows up in the Emergency Department?

Establishing consistent boundaries, both over time and across settings, may address his behaviors and preserve staff wellness. Our team of physicians and social workers creates stand-alone behavioral plans that delineate these boundaries to clinicians. We partnered with our IT department to create notifications alerting us when our patients are in the ED, alerting ED staff toward the behavior plan, and recommending they contact us directly during business hours. We also can be a sounding board, so their frustrations can be directed toward us rather than toward the patient. In that way, our team aims to be a source of support to the staff of our hospital system.

Even if your system does not have the capability to implement automated alerts, proactively reaching out to ED teams with recommendations a few times will help establish a pattern. Your recommendations may become 'chart lore' and can be carried forward without the need to reach out indefinitely. Although every patient presents unique challenges, promoting consistency, clear boundaries, and open communication between the clinic and the ED are important first steps.

3. Drs. Bryk and Leon-Jhong: How might clinicians uncover the underlying causes of challenging patient behavior?

Seeking further understanding behind a "challenging" patient's behaviors is important not only to provide effective care, but also to avoid physician burn-out. Patients who are recognized as acting outside of social norms, either overly aggressive or overly submissive, should be screened for trauma.¹ Patients who have

experienced trauma are more likely to have physical and mental health conditions and more likely to overutilize health care. We generally ask, "Is there anything I need to know to help me take better care of you?"

Once a clinician is aware of past trauma, it can inform the way that they care for the patient. In this case, we may find that the death of the patient's father left him abandoned, seeking out attention in any form. Our goal in this case would be to establish the clinic and doctor-patient relationship as a stable, safe, supportive force, but establish clear expectations and boundaries.² For example, we may arrange for the doctor to call the patient at a certain time each week or that we will return calls within 24 hours. This can help the patient to not feel abandoned as they work to build positive coping skills.

4. Dr. Tang and Nicole Gier: How would you maintain personal wellness while caring for a patient like this?

Before entering a conversation or visit with a patient who triggers distress, consider taking a "mindful moment." This moment could involve taking a deep breath and allowing whatever thoughts and feelings that show up to be present without judgement. Acknowledge that this is a difficult situation and validate to yourself that your emotional response is normal and human. Consider asking yourself: "What do I need to do or hear right now?" An encouraging word or a gesture such as holding your own hand can be a kind response to pain.

Your values can also be a guide in tough moments. Consider writing down and carrying with you a written reminder of why you engage in this challenging work. One of the authors carries in her wallet a note that reads, "while this moment may be difficult to bear, I am here to be of service and be helpful where I can."

Finally, consider engaging your

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colleagues, nurses, social workers, trainees, and other team members in processing and validating the experience of caring for patients whose behaviors impact us. Sharing the experience of our own distress can make us feel less alone and remind us of how much we have in common with one another.

Conclusions

Although there isn't a single solution that can meet the needs of every patient with challenging behaviors, a set of common strategies may provide a way forward. Memorandums of understanding can help to set

expectations and promote positive behaviors. Clear communication strategies with acute care providers can make life easier for everyone. Determining whether underlying trauma plays a role can help the patient as well as the care team. Lastly, maintaining wellness by acknowledging that you are entering a difficult situation, tapping into your values, and engaging support from colleagues can give you the strength to persist and thrive in this work. Using these approaches to address patients with complex needs may improve care while supporting the clinicians in their vital work.

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PERSPECTIVE: PART II (continued from page 12)

to make for the ostomy, and the time he would be spending at the hospital instead of the woods. He couldn't help but wonder if the extra time promised by the treatments would bring him more loss than gain.

As we talked, everything else seemed to fall away—the clinic, the screens, the awkwardness. I was right there with him in that quiet room—sitting, being silent, listening to his story.

He had served in the Army during Vietnam. He was lucky to have gotten out alive and was awarded the Purple Heart for doing what he thought was just a part of his job. He went on to travel the world, marry his childhood sweetheart, and raise a family together. When she suddenly passed away from a stroke a decade ago, he moved into a modest cabin surrounded by redwoods, where he found solace from his

PTSD in nature. Now he spent most of his days working in the garden. He'd even grown enough squash to sell at the farmer's market this year. Each day was a blessing.

"Doc, I'm 81 years old and I've had a good life," he concluded, "I know I don't have too much time left and I don't have any regrets. I just want to be able to live like this however much longer I am able. Is that ok?" He looked straight into the camera as he uttered those last three words, his eyes pleading for my permission.

The worries and preconceived notions I once held, vanished. I understood what he needed from me as a doctor. I understood that we had both come to the right place despite the 400 miles that separated us.

We discussed his goals and made some plans. He was going to exchange the appointments with the

surgeon for time with a palliative care physician. He resolved to reach out to his estranged family. As our conversation wound down, I assured him that I was only a phone call away should he want to talk again.

"This was really something," he remarked. "I didn't know what to think when I came in today or how this was going to work. But I'm glad I'm here. Thank you for everything, doc."

Much has been written about the disruption of the doctor-patient relationship by the encroachment of technology. Nobody goes into medicine to stare at a computer screen. But what if, instead of a barrier, that screen becomes a window. You inch closer, and on the other side, the rich expanse of a human life draws you in until the frame melts away.

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