SGIM FORUM
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To Promote Improved Patient Care, Research, and Education in Primary Care and General Internal Medicine

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TWO ITEMS OF NOTE FROM SGIM

In this issue, we present two important initiatives for SGIM: the Patient-centered Outcomes Research Institute (PCORI) grant awarded to SGIM in 2014 and the Proud to Be GIM campaign, which was launched in September 2015. Both projects feature important innovations of value to SGIM members. First, with PCORI, data are being gathered from various assessments to identify the best strategies for "democratizing" clinical research by incorporating the values of patients and patient advocates in patient enrollment, study design, and communication and dissemination of results. The #ProudToBeGIM campaign will use social media outlets and campus-based events to highlight career opportunities in GIM with the goal of revitalizing primary care as a career path that both attracts the brightest minds and makes the world a better place. Please join me in your support of these two mission critical activities.

—Karen R. Horowitz,* Forum *Editor

FROM THE SOCIETY: PART I

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Engaging PCORI Priority Stakeholders through SGIM: An Update

Jennifer Kraschnewski, MD, MPH, and Leslie Dunn, MPA

Dr. Kraschnewski is assistant professor of medicine and public health sciences, Department of Internal Medicine, Penn State University, and Ms. Dunne is Director of Development at the Society of General Internal Medicine.

The Patient-Centered Outcomes Research Institute (PCORI)-funded project[1] "Engaging PCORI Priority Stakeholders through SGIM" is now more than six months into the implementation phase. The project goals are to educate SGIM members about PCORI research and to provide avenues for better engagement in the PCORI research process for clinicians and clinician-educators. We began with a popular series of sessions at our 2015 Toronto Annual Meeting and will continue with a general assessment to identify key attitudes and strategies to facilitate both provider and patient involvement in these research opportunities. The 2016 Annual Meeting in Hollywood, FL, next May will incorporate sessions based on the recommendations and findings of these activities.

2015 Annual Meeting Session Keynote

Joe Selby, MD, executive director of PCORI, had an enthusiastic audience at the Toronto meeting. His presentation highlighted the Institute's activities of the last four years and projections for the future. PCORI's mission is to help people make informed health care decisions and improve health care delivery and outcomes by producing and promoting high-integrity evidence-based information that comes from research guided by patients, caregivers, and the broader health care community.

PCORI focuses on delivering the means to: substantially increase the quantity, quality, and timeliness of useful and trustworthy informa-

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PCORI Sessions at the 2015 Annual Meeting in Toronto

Jennifer Kraschnewski, MD, MPH; Joan Neuner, MD, MPH; Michael Rosenblum, MD; and James Richter, MD

Dr. Kraschnewski is assistant professor of medicine and public health sciences in the Department of Internal Medicine at Penn State University, Dr. Neuner is associate professor of medicine at the Medical College of Wisconsin, Dr. Rosenblum is program director of the Internal Medicine Residency at Baystate Medical Center and assistant clinical professor at Tufts University School of Medicine, and Dr. Richter is director of gastroenterology quality management at Massachusetts General Hospital.

The Patient-Centered Outcomes Research Institute (PCORI) aims to teach clinicians and clinician-educators about the process and opportunities within their research networks and foster a climate that allows key community stakeholders greater participation at all stages of research. SGIM members represent important stakeholders in this process, so sessions were held at last year's annual meeting to address patient-centered outcomes research (PCOR) topics for clinicians, clinician-educators, and researchers.

Pragmatic and Patient Centered

In addition to focusing on trials that are patient centered, PCORI is interested in funding pragmatic trials. Although clinical trials remain the gold standard in conducting research, they only come in two flavors: explanatory and pragmatic. Most studies conducted today remain explanatory, which means they test an intervention under ideal circumstances. Pragmatic studies, on the other hand, test interventions in real-world settings. As a result, pragmatic trials have greater generalizability and are more likely to be successfully disseminated.

Our session, "Pragmatic and Patient-Centered: Clinical Trials Done Differently," featured three clinician-investigators, a patient partner, and a PCORI program officer. The purpose of the session was to discuss three different approaches, as demonstrated by the projects presented, to designing and conducting a trial that is pragmatic and patient centered. Speakers discussed successes and challenges to engaging patients and stakeholders in all aspects of research and in how to successfully develop stakeholder relationships. Time was allotted for questions and answers to discuss attendees' experiences with and questions about patient-centered research and pragmatic studies. Key insights are presented below:

- Cynthia Chuang, MD, MSc, Penn State College of Medicine, discussed the MyNewOptions Study, a PCORI-funded trial to reduce unintended pregnancies through an online reproductive life planning tool. She discussed the impact her patient partners and community advisory board had in improving her research design during the early phases of the study.
- Elizabeth Jacobs, MD, MAPP, University of Wisconsin School of Medicine and Public Health, shared her PCORI-funded study Peer-to-Peer Support to Promote

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Multi-year Career Development Programs: Increasing Value for SGIM's Membership

Marshall H. Chin, MD, MPH

For most of us, it's a lifelong quest to become a master clinician who is the complete package as a doctor and healer.

Promoting career development has always been one of the core missions of SGIM, so I'd like to discuss what's been happening in this area. Career development is one of SGIM's six strategic priorities, and we are at a pivotal stage considering how to bolster our programs.

On the first day of every inpatient medicine block I attend on, I gather the team in the conference room and draw a timeline on the white board. I mark on the timeline the third-year student, fourth-year student, intern, resident, fellow, attending physician, a 10-year gap followed by the denotation of "mature attending physician," and for some at the end of the timeline—"master clinician." I use the timeline to discuss expectations for each team member at his/her stage of training and also to allay the fears of students who may be intimidated by how advanced the residents are. Developing into an outstanding clinician is a gradual process that requires experiential learning, guidance, and feedback. Even after completing formal training, we mature over a 10-year period in our practice style, comfort, and communication with patients. For most of us, it's a lifelong quest to become a master clinician who is the complete package as a doctor and healer.

Similarly, when I meet with residents considering research careers, I draw a timeline indicating three years of residency, two to three years of research fellowship training, and then five to seven years as a mentored junior faculty member before becoming an independent investigator.

One of SGIM's best qualities is the generosity of its members. I am struck by how much of the annual meeting is teaching and career development—members trying to help other members develop their knowledge and professional skills so that they can do a better job taking care of patients, teaching students and residents, investigating cutting-edge questions, and improving our health care system.

Let's review some of SGIM's current career development offerings. For most of SGIM's history, career development opportunities were largely what members and committees submitted as workshops rather than a systematic approach to the core topics and skills necessary to succeed in diverse career pathways. For example, over the years I've attended a variety of workshops at the regional and national SGIM meetings on how to be a better teacher, covering topics such as bedside teaching, giving feedback to learners, and creating a curriculum. These workshops were very helpful but isolated—similar to how medicine grand rounds at most institutions consist of a series of stand-alone lectures.

Regarding SGIM's one-on-one mentoring programs, I was a mentee as both a fellow and junior faculty member, I co-directed the program for five years, and I have served the role of mentor in it many times. The one-on-one mentoring program is largely a cross-sectional program, helpful for giving mentees an objective fresh look at their current position and career aspirations. I directed a year-long SGIM mentoring program that was in existence for only two years. The lesson learned from that program was that a specific project is needed to cement the mentor-mentee relationship; general advice only goes so far.

A few years ago, a number of longitudinal training and mentoring programs arose in SGIM and ACLGIM (Association of Chiefs and Leaders of General Internal Medicine). SGIM's Education Committee started the TEACH program. In the TEACH program, cohorts of 20 to 25 learners develop core teaching skills as early clinician-educators through a combination of a full-day precourse and in-person workshops at the SGIM annual meeting, direct observation by a coach at the home institution, and independent online TEACH community discussion throughout the year. The TEACH program is designed to be far more comprehensive than a single workshop or workshop series at the SGIM annual meeting. Core courses include establishing an effec-

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How Does SGIM Set Educational Policy Priorities?

Robert B. Baron, MD, MS, and Mark Liebow, MD, MPH

Dr. Baron is associate dean for Graduate and Continuing Medical Education and faculty in the Division of General Internal Medicine, Department of Medicine, at the University of California, San Francisco. Dr. Liebow is associate professor of medicine and a member of the Division of General Internal Medicine, Department of Medicine, at the Mayo Clinic..

You may be asking yourself why SGIM puts more work and resources into supporting a $39 million program for primary care training (Title VII) than a $10.6 billion program for graduate medical education (GME). The simple answer is that the smaller program is more vulnerable and has fewer supporters, so it needs our help more.

No one said health policy was intuitive. Medicare has now supported graduate medical education (GME) for 50 years, but it doesn't use the money to direct training toward the workforce we need but instead pays the money to hospitals. Many residency programs don't even know how much money is paid to their own hospitals on their behalf.

People figured out within a few years after Medicare started that paying money to hospitals to support inpatient training was not a good way to encourage training in primary care specialties, especially as those specialties increasingly shifted to outpatient work. Consequently, Congress created a program to support residency training in general internal medicine, general pediatrics, and family medicine. A few years later, faculty development grants for general internists were added. The program, later known as Training in Primary Care Medicine and Dentistry (TPCMD), has been funded ever since but at levels far lower than Medicare GME spending. Typically, for every dollar spent on primary care training, $250 is spent on Medicare GME funding.

Why the imbalance? Medicare GME payments come from the Medicare Hospital Trust Fund (Part A), which is funded by the Medicare payroll tax—an extraordinarily stable source of tax revenue. Also, Medicare GME payments, like the rest of Medicare, are automatic, which means that they are made on the basis of formulas established by law. Changes literally take an act of Congress, which is never easy, particularly when almost all members of Congress have teaching hospitals in their districts or states. Those hospitals are often large employers as well as major providers of care in their communities, so their claims of major injury from proposed cuts in GME funding are taken seriously by legislators. Those claims even have some validity. Many urban academic medical centers depend on their GME payments to keep themselves from going into the red. SGIM doesn't oppose Medicare GME funding, though we have recently suggested in a position paper[1] that changing the rules for how the money is paid would better serve the country. However, our voice in favor of significant reforms faces opposition from organizations that stand to lose out if GME is better aligned to meet national workforce needs.

TPCMD, usually known as a Title VII program because it is authorized under Title VII of the Public Health Service Act, is dependent upon annual appropriations from Congress. That means that Title VII programs compete with every other federal program that doesn't receive automatic funding. This so-called discretionary funding is always limited but especially so in the current fiscal climate. In the name of deficit reduction, in 2011 Congress set even more stringent spending limits on discretionary spending—limits that stretch to 2023. Furthermore, Congress set separate limits for defense and non-defense discretionary spending so that increasing funding for a health care program, for example, means cutting a K-12 education program or money for the national parks. The fact that Title VII programs put money into fewer Congressional districts or states than GME funding does means fewer legislators hear from constituents or organizations advocating for continuing or growing the Title VII programs, making Title VII an easier target for budget cuts. SGIM's voice, offered as part of a coalition for Title VII funding as is typical in Washington, is much more influential here.

Our advocacy is not always for the program as it is. For years the Title VII program had a pronounced bias toward funding family medicine programs, which made particular sense in the 1970s when most were new and needed support to thrive. More recently the program has also strongly emphasized the training of physician assistants. At SGIM, our efforts are to ensure that funds are allocated as the law intends—to produce a workforce that is aligned with national and regional needs. We strongly believe this includes training primary care general internists—as well as family physicians and other health professionals—to care for the underserved. While Congress has the ultimate say on how much money annual appropriations programs get, it's not the only say. While the president asked for the same amount for the TPCMD program for fiscal year (FY) 2016 as Congress appropriated in FY 2015, which is a cut in real dollars because of inflation, for years different administrations wanted to eliminate the program and did not include any money for it in the president's budget proposal. While Congress need not implement what is in that proposal, what the president suggests matters. It was much harder to get funding for Title VII programs when the administration did not ask for any money for them.

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Physician Payment Reform: The Stages of Change

John Goodson, MD, and Tom Staiger, MD

Dr. Goodson is associate professor of medicine at the Harvard Medical School, Massachusetts General Hospital, in Boston, MA. Dr. Staiger is chairperson of the Health Policy Committee and medical director of the University of Washington Medical Center.

The longstanding and profound undervaluation of complex primary care is changing, and SGIM has been a key leader in this process. There is more hope now for payment reform than any time in the last 25 years.

The Tale of Our Demise

In 1991, Medicare declared that physician payment would be based on the resource-based relative value scale (RBRVS). All subsequent payment models, including commercial carriers, the Department of Defense, the VA system, and current innovative payment models, use the RBRVS paradigm in some fashion. The premise of RBRVS is that physician services can be priced relative to one another on the bases of "resources." The definition of "resources" is subject to considerable debate. Officially, the Centers for Medicare and Medicaid Services (CMS) define these as "physician time and intensity," but there is no established measure of "intensity" *per se*. In the original research that preceded RBRVS, intensity was defined in terms of "technical skill, mental/physical effort, and psychosocial stress."

Since implementation, the assignment of values for each physician service—paid in relative value units (RVUs)—has consistently favored proceduralists and interventionalists.[1,2] As a consequence, the primary care workforce has dwindled. With starting salaries that are less than half those of the elite procedure-based specialties,[3] such as interventional radiology, the numbers of graduates who choose primary care has dropped to levels that make the primary care workforce unsustainable. Non-physician providers have backfilled gaps, but when medical care becomes complicated and nuanced, there are far too few fully qualified physicians to meet the need. This substantial decline of the specialty of primary care has happened in real time. We are an endangered profession.

"Don't get mad, get organized"

There is real change coming. SGIM has been the key thought leader and broker in this process. This began in 2004 with the formation by the American College of Physicians (ACP) of the Subspecialty Advisory Group on Socioeconomic Affairs (SAGSA), a multispecialty committee. SGIM was invited to participate. SAGSA provided opportunities for physician-to-physician networking and collaboration around shared concerns. Between 2005 and 2007, SGIM participated in the most recent revisions of the work RVUs assigned to the outpatient evaluation and management (E/M) codes. The work values went from 1.1 RVUs to 1.42 and ultimately to 1.5 for a 99214 service code. Without survey participation by SGIM members, this effort led by ACP would likely have foundered.

In 2012, SGIM was invited by the American Academy of Family Physicians (AAFP) to participate in a physician payment reform task force. SGIM was a leader in mapping out payment reform options. This participation resulted in a new set of peer-to-peer relationships. With discussions around common concerns, knowledge and understanding evolved. Through shared work, credibility and trust developed.

This year SGIM began its own effort to effect real change in the Medicare payments for primary care. This began with an open phone call in early February and progressed to the formation of a coalition of 16 professional organizations ranging from family medicine to neurology and including infectious disease, gastroenterology, rheumatology, endocrinology, and many more.

This coalition submitted a letter to CMS requesting the redefinition and revaluation of the outpatient E/M codes and the creation of more appropriate documentation expectations. This was followed by direct conversations with the key leadership within CMS and the Center for Medicare and Medicaid Innovation (CMMI), House leadership and staff (both Democratic and Republican), key House and Senate committees (both Democrat and Republican), and the Medicare Payment Advisory Commission (MedPAC). Erika Miller from CRD, working on behalf of SGIM, provided the energy and continuous support for the innumerable contact points.

There were months of uncertainty. We were concerned that other specialty societies would commandeer Congressional opinion, but there was also a steadfast commitment on the part of the 16 participating organizations that deficiencies of the E/M codes must be addressed. All were convinced that real change in the Medicare payments for complex cognitive services was long overdue. All came to share a common belief in the compelling need for the E/M service codes to be reworked.

CMS Engages with Purpose

CMS responded with an alternate pathway in the calendar year (CY) 2016 Physician Fee Schedule proposed rule. This required a shift in thinking, but the coalition held. The proposed rule, released for public comment in July, commits the agency to a change in payment for E/M services across the board—a much broader and more ambitious agenda than the coalition proposed. Rather than rework the existing E/M

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If You Build It, They Will Come: A Model for Sustainable Medical Education Scholarship

Jennifer Corbelli, MD, MS; Carla Spagnoletti, MD, MS; Doris Rubio, PhD; Kevin Kraemer, MD, MS; Robert Arnold, MD; Sonya Borrero, MD, MS; Raquel Buranosky, MD, MPH; Julie Childers, MD, MS; Michael Elnicki, MD; Shanta Zimmer, MD; and Melissa McNeil, MD, MPH

The authors are affiliated with the Medical Education Research Steering Committee, which promotes successful scholarship among clinician educators at all career stages at the University of Pittsburgh.

Clinician-educators (CE) have many reasons to be motivated to engage in research, particularly in the area of medical education. Medical education scholarship affords CEs the opportunity to develop skills and gain experiences that enhance the richness of an academic career through national collaborations and presentations, publications, and mentorship. These faculty members, as expert educators, are also uniquely poised to leverage research skills for the benefit of residents and fellows interested in medical education scholarship. Finally, medical education research can assess needs and shape education innovations, and CEs have an ideal vantage point to identify needs for novel curricular programs. Yet CEs face challenges to achieving success in scholarly pursuits. While their roles as leaders in education may readily lend themselves to scholarship, the funding sources, protected time, mentorship, and other institutional support necessary for success in research endeavors are often lacking. In an effort to overcome these barriers, we developed and implemented a Medical Education Research Steering Committee in the Division of General Internal Medicine (DGIM) at the University of Pittsburgh.

The committee is comprised of 11 faculty members and includes a professor of biostatistics and senior and mid-level CEs and clinical-investigators. All committee members have extensive track records in successful research and mentorship. Faculty who serve on the committee have included in their job descriptions time for the professional development of other faculty and fellows. No additional time is provided for committee membership.

We developed a standardized application protocol consisting of an abstract and three-to-five page narrative (i.e. aims, background and significance, approach, timeline). The committee reviews project proposals from faculty and fellows in DGIM. Proposals that involve internal medicine residents as co-investigators with faculty primary investigators (PIs) are also encouraged. Faculty who submit proposals to the committee generally have limited amounts of protected time for research as part of their institutional support, the majority of which is used for medical student and/or resident education. A small percentage of this time may be devoted to scholarship.

Reviews are initially conducted by three independent committee members. The committee then meets to discuss each proposal. Projects deemed to have direct applicability to the mission of the division leadership, the potential to make a strong impact on local or national medical education, and strong potential for national dissemination and publication are prioritized. For proposals that require revisions, one of the reviewers becomes a designated mentor for that proposal. He/she then meets with the applicant to discuss the committee's recommendations. For those requiring major revisions, investigators are asked to present the revised proposal at a future committee meeting before a decision is made about support. Those requiring minor revisions are resubmitted to the designated mentor, and the decision about whether to support the revised proposal is made at the committee member's discretion. Each committee member reviews approximately two projects per six-month period, with a combined total of four to six hours of faculty time—divided by three faculty members—spent per project. Awardees typically have one year from the date of the award to complete the project. If additional time is needed, the awardee must reapply for continued support. In addition, faculty and fellows are encouraged to submit proposals for review and feedback before they apply for any external funding.

DGIM includes the Center for Research on Health Care Data, which is comprised of faculty in biostatistics and research methodology. The funding provided to awardees supports the costs for the expertise housed within the data center. The yearly budget for the division for all projects supported through the Medical Education Research Steering Committee is $50,000. This support comes from funds accrued by DGIM from a combination of indirect funding from research support and reimbursement for medical student teaching from the University of Pittsburgh School of Medicine. Faculty can receive up to $5,000 of support per project, and fellows are eligible to receive $2,500 per year during their fellowship. Fellows are required to perform much of their own data management under the guidance of a statistician.

Outcomes and Next Steps

In each of the first three years after committee formation, seven, eight,

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Standards

Dorothy Jensen Sanderson, MD, FACP

Dr. Sanderson is chief of internal medicine at the Phoenix Indian Medical Center in Phoenix, AZ.

It started as just another day in diabetes clinic. I felt the way I typically did when I saw her double digit A1C. I imagined that when I entered the room, I would describe, once again, how poor her performance as a diabetic patient really was. I would warn her, once again, of all of the tragedies that loomed due to her uncontrolled diabetes… the wounds, the amputations, the infections, the blindness, the dialysis. But maybe this time, something would change. I would get through to her, and she really would become successful in lowering her A1C.

I look back on the brand new internist I was back then, assigned to work for the Indian Health Service at a remote reservation clinic. Most of my patients struggled with uncontrolled diabetes. I would go through my checklist, trying to be a thorough and diligent provider. I would make sure that all of their labs were completed and that I had dutifully explained all of the results that needed improvement.

Many of my patients spoke no English. They lived without electricity and running water. They hitchhiked to their appointments because they either had no vehicle or no money for gas. They endured the tragedies of rural poverty and told me stories about the family members who were killed since their last appointment. After years of hearing the stories, I grew to deeply respect their strength and fortitude.

But not that day. That day, all I could see was another double digit A1C and not the person struggling to hold it all together. My tone was cold and condescending as I scolded her for her failure to manage her diabetes.

I will never forget what she said: "You always make me feel bad about myself. I don't know if I can come to see you anymore."

Her words changed my practice. They made me look inside myself and ask what I was so angry and impatient about. Did I see her failure to meet the standards for diabetic control as my failure? Was the standard more important than the patient?

I immediately apologized and asked her to give me another chance. I worked hard to be aware of my tone, to look for kinder ways to share news of poor diabetic control with her and all of my patients. I looked for gentle ways to encourage her. I praised her for small improvements and was so excited when her A1C came down to 9. But that improvement was not sustained. In fact, for most of the 11 years that I served as her primary care physician, she did not meet the standards for diabetic control.

On the surface, it might have seemed to chart reviewers that nothing was happening during her frequent visits with me and that I was a failure. I certainly felt that way at times.

One day, though, she came in looking scared. She had been experiencing chest pain and was worried she had developed heart disease. She was so overwhelmed with anxiety that she could not speak about her fears to anyone…except me.

All those years, when it seemed nothing substantial was going on during her frequent appointments, we were building a relationship she could trust. Finally, after almost driving her away, I had earned her trust. She knew I would care for her body and her spirit with compassion.

I had finally met her standard. As it turned out, that's the standard that mattered the most.

SGIM

Midwest SGIM 2015: An Innovative Success

Christopher Bruti, MD; Andrea Sikon, MD; and Michele Fang, MD

Dr. Bruti is membership chair of Midwest SGIM and assistant professor at Rush University Medical Center; Dr. Sikon is past-president of Midwest SGIM, chair of the Department of Internal Medicine & Geriatrics, and associate professor at the Cleveland Clinic; and Dr. Fang is president of Midwest SGIM and associate professor at the University of Iowa.

The Midwest is home to SGIM's largest region, spanning 13 states with more than 700 members. This year, the Midwest SGIM Annual Meeting was held at the Cleveland Convention Center in downtown Cleveland, OH, on August 27-28, 2015. Our theme was "Engaging Patients in the 21st Century: Innovations in Models of Care, Education, and Research." Tremendous work has been done in recent years to transform our models of care in general internal medicine (GIM). Technological advances and changing patient expectations have altered our relationships with the systems, teams, and patients we interact with daily. In this ever-advancing field, we are striving to meet patients where they are and when they need us in innovative ways to maximally engage them in their care. Recognizing that general internists need to find ways to use technological, educational, and clinical advances to improve patient care, we were excited to see our membership's response to our call for work highlighting the innovations of the Midwest region. Attendance approached the record set in 2014, with 289 submissions and 209 attendees at the first Midwest SGIM meeting outside of Chicago, IL.

Each plenary speaker addressed a component of our innovations theme with six main objectives: 1) share successful innovations around engaging patients through the use of technology, 2) examine ways to blend demands for increasing patient access with provider needs for self-care and resilience, 3) share demonstrations of creative community-based partnerships that heighten patient education and outreach, 4) explore ways to teach trainees how to engage patients, 5) develop techniques for engaging trainees in practice transformation, and 6) distinguish how to conduct patient-centered outcomes research and effective quality improvement studies.

Neil Mehta, MBBS, MS, FACP, associate professor of medicine, director of Education Technology, director of the Center for Online Medical Education and Training at the Cleveland Clinic, and Web editor of the *Journal of General Internal Medicine*, delivered an engaging plenary titled "Helping Students Practice What They Preach—Leveraging Technology in Education and Patient Care." He provided an enthralling talk about the challenges of medical education in the era of of big data (i.e. electronic health records (EHRs), social media, and genomics). Maximizing the use of genetic data and artificial intelligence to customize care of patients will require general internists to learn the language of technology and collaborate with data specialists including computer scientists. Dr. Mehta encouraged the audience to embrace technology to augment but not replace the human role in patient care and education.

Elizabeth Jacobs, MD, associate vice chair for Health Services Research in the Department of Medicine & Health Innovation Program at the University of Wisconsin-Madison, discussed her exciting experience in Patient-Centered Outcomes Research Institute (PCORI)-sponsored research in a talk titled "Patient-Centered Outcomes Research: the Wave of the Future." The PCORI model is an innovative research format that uses a combination of patient stakeholders, traditional research methods, and big data to provide truly patient-centered outcomes. PCORNet is a database that integrates health data for studies and catalyzes research partnerships among Clinical Data Research Networks (CDRNs), which are based in hospitals and health centers. Patient-Powered Research Networks (PPRNs) are run by groups of patients and their partners who are focused on one or more specific conditions or communities and are organized to share health information and participate in research. Dr. Jacobs described her research in comparing community-based peer-to-peer support to standard community services in the promotion of health and wellness among older adults at risk for frequent use of acute-health care services and/or nursing home placement.

The Thursday plenary session was devoted to top-ranking vignettes, innovations, and scientific research. Rushad Patell, MD, from Cleveland Clinic presented "Ockham's Razor to the Rescue!" This presentation illustrated a rare case of Frederick's ataxia presenting with abdominal pain, broad-based gait, and Romberg's sign. Andrew Schamess, MD, from The Ohio State University presented his work demonstrating how home visits to patients with multiple comorbidities can lead to reductions in readmissions. The EHR was used to help select patients and follow outcomes in these patients after two years. Wei Wei Lee, MD, described efforts at the University of Chicago to study patient perceptions on physicians' use of the EHR during office visits. Most patients in their study felt that the EHR improved coordination of patient care, especially among multiple specialties. The biggest challenge faced by physicians was to ensure that communication skills did not suffer while working with EHRs in the presence of patients.

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tion available to support health decisions; speed the implementation and use of patient-centered outcomes research (PCOR) evidence; and influence clinical and health care research funded by others to be more patient centered. PCORI strategic priorities include:

- Funding research designed to improve patient care and outcomes through patient-centered comparative clinical effectiveness research (CER);
- Building communities skilled in PCOR through the training of clinicians, researchers, caregivers, and patients/patient advocates;
- Enabling and involving the stakeholder communities to generate and prioritize research questions and to actively participate in PCOR through the creation of the Eugene Washington Engagement Awards for Knowledge Building and Dissemination; and
- Establishment of key advisory panels on topics including rare diseases and communications.

Dr. Selby also discussed PCORI's five national priorities for research: assessment of prevention, diagnosis, and treatment options; improving health care systems; communication and dissemination research; addressing disparities; and accelerating patient-centered outcomes and methodological research.

Please see our article outlining the other exciting sessions held during the meeting on page 2.

Help Us with Our Assessment

The aims of this project are to increase the opportunities for clinicians and clinician-educators to participate in PCORI research and to share the perspectives of SGIM members with PCORI to improve the research process.

This fall, we will be asking SGIM members and others to participate in an assessment to determine their perspectives and understanding of how to best engage and participate in potential research opportunities. This survey process will be directed to several key populations including clinicians and clinician-educators and patient and family participants/advocates to ask about their attitudes and needs regarding participation in PCOR and to understand the barriers and facilitators that affect their ability to participate.

[1] This project was funded through a Patient-Centered Outcomes Research Institute (PCORI) Engagement Award initiative (EA-1283-SGIM). The content does not necessarily represent the views of the Patient-Centered Outcomes Research Institute (PCORI), its Board of Governors, or Methodology Committee.

SGIM

NEW PERSPECTIVES

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codes, the agency will develop add-on codes that can be attached using a -25 modifier to the existing E/M codes. In the case of outpatient primary care, these codes could be attached to a 99214 service code and would provide added payment for both the increased intensity of medical decision making (MDM) of complicated outpatient care and the added post-visit work that extends from a complex visit. How many RVUs would be generated from these codes has not been determined, but the concept that there is a broader range of E/M work than can be captured by the existing service code definitions and a commitment to reform is the most important change in the "relative" valuation process since the inception of RBRVS. SGIM has led this coalition and without SGIM, this would not have happened.

SGIM Opens a Pathway for Future Research and Development

There is more. CMS and CMMI are coming to understand that the accurate valuation of E/M services is not only relevant to the world of fee-for-service medicine but also to all new innovative payment schemes. But more research is needed to fully understand the complete topology of E/M work for the cognitively dependent specialties. This includes the broad and complicated agenda we face in primary care and deep and complicated world of our colleagues in specialties such as infectious disease, rheumatology and endocrinology. To support this, SGIM has now moved on to lead the creation of a new more formal Alliance of Cognitive Specialty Societies that will become an enduring presence in the debate on how to ensure the appropriate definition and valuations for physician work within the RBRVS use by Medicare. This Alliance will press the need for evidence-based physician payment policies.

References

1. Goodson JD. Unintended consequences of resource-based relative value scale reimbursement. JAMA 2007; 298:2308-11.
2. Kumetz EA, Goodson JD. The undervaluation of evaluation and management professional services: the lasting impact of current procedural terminology code deficiencies on physician payment. CHEST 2013; 144:1-6.
3. Sinsky CA, Dugdale DC. Medicare payment for cognitive vs. procedural care: minding the gap. JAMA Intern Med 2013; 173(18):1733-7.

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tive learning environment, writing teaching objectives, assessing learners, and providing feedback. Electives include ambulatory teaching, small group teaching, and remediating the struggling learner.

ACLGIM's LEAD program trains early- and mid-career faculty in leadership skills. In-person training occurs twice a year in conjunction with ACLGIM and SGIM's annual meetings, supplemented by monthly independent readings, online discussions, and scheduled coaching. Some of the core topics are those presented in the *Harvard Business Review's 10 Must Reads* teaching series, and workshop topics include engaging conflict, strategic planning, and team success. Another example of a longitudinal mentoring program is the SGIM Women's Health Task Force Career Advising Program, which links female faculty early in their careers with male or female mid-senior faculty interested in advancing women in medicine for a minimum two-year commitment of at least semi-annual contact. Another model is that of SGIM's Disparities Task Force, which has held a series of webinars on grant writing and mentorship.

Intensive courses are another mechanism for career development. SGIM's Academic Hospitalists Task Force has collaborated with the Society of Hospital Medicine to present the Academic Hospitalist Academy. The Academy is typically a four-day training event that covers a broad range of topics including teaching, creating scholarly work, leadership skills, mentorship, quality improvement, patient safety, and the business of health care. For general internal medicine fellows, periodically a half-day pre- or post-course to the SGIM annual meeting provides training in core topics such as grant writing, mentorship, and applying for jobs, as well as the opportunity to network.

These current SGIM career development programs are a testament to the ingenuity and generosity of SGIM members, committees, and task forces, yet we can do more. SGIM Council chose career development and healthy growth of membership as two strategic goals of our organization. Career development is one of the pillars of our society, and successful recruitment and retention of members is dependent upon providing value. In the 2014 SGIM member survey, the top priorities of membership included career development and building leadership and administrative skills.

We are in the very early stages of planning what multi-year career development programs and opportunities might look like. Members of the Annual Program Committee recently had a conference call with representatives of several of SGIM's committees and ACLGIM to discuss the development of multi-year career development pathways. For the 2016 meeting, the Annual Program Committee is piloting a new career development skill-building workshop series called CaREER (Cultivating Care, Resilience, and Excellence in Education and Research) that will address important transitions and milestones in the career development of general internists across all stages and facets of their career. As part of this effort, the committee has created a new career development submission category for workshops.

SGIM Council will discuss multi-year career development programs in more detail during its next conference call. Several fundamental questions must be addressed. For example, what are the core career pathways needing career development programs? Does SGIM have offerings relevant for trainees, early faculty, mid-career faculty, and senior faculty? One of my former advisors, Mary Tinetti, once told me that newly promoted associate professors are some of the most neglected members of our academic community. They are perceived to have "made it" through promotion, leading us to redirect our attention to current learners and early faculty at our institutions. However, mid-career faculty face a series of key challenges such as finding the right leadership opportunity, becoming an outstanding mentor, and effectively influencing internal or external policy. I was heartened at one of the most recent SGIM meetings when I heard some of our most distinguished senior members saying they were looking forward to attending an interest group that afternoon on life after retirement. Career development at SGIM never ends!

Should we concentrate on workshop and course offerings at the annual meeting, expand webinar opportunities during the year, consider how to increase use of GIM Connect as a social media educational tool, build comprehensive longitudinal programs analogous to TEACH and LEAD, or combine any or all of the above? What are the core skills and topics that should be covered in multi-year curricula? How can we most effectively teach emotional intelligence and interpersonal skills (e.g. awareness of personality types, personal strengths and weaknesses, communication, negotiation) with our available teaching modalities? What should be the organizational structure for multi-year career development programs? How should the Annual Program Committee; SGIM's committees, task forces, and interest groups; and mentoring programs interact and collaborate on these programs? Are some core topics best taught across career pathways, or is there value in maintaining separate tracks and cohorts of learners? What programs are feasible, and which should be prioritized? These questions are important and fascinating, and we welcome your input as SGIM considers the best ways to provide additional career development opportunities for you.

My learners like it when I show them the career development timelines for the clinician and the investigator. The timelines break down the mysteries of becoming an expert into concrete guideposts that provide a career roadmap. Similarly, multi-year career development programs and pathways have the potential to enable more of SGIM's membership to reach their goals in a timely manner. Let's see what we can do together.

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Aging in Place. She described some of the challenges of conducting a patient-centered trial in multiple locations and how stakeholders played an important role in shaping her trial.

- Stephen Hwang, MD, MPH, University of Toronto, discussed the At Home/Chez Soi Study. This randomized controlled trial of scattered-site housing focused on mental health supports for individuals who were homeless and had mental illness. He brought with him Ms. Susan Gapka, a dedicated campaigner for social justice, who served as a People with Lived Experience Advisory Member to the study. Ms. Gapka described how she was able to work with investigators in ensuring the study remained patient centered throughout the trial.
- Diane Bild, MD, MPH, senior program officer in the Clinical Effectiveness Research Program at PCORI, discussed how PCORI funding differs from other funding mechanisms. She also described the different funding mechanisms within PCORI, including those focused on improving PCOR methodologies; health care systems; communication and dissemination; assessment of prevention, diagnosis, and treatment options; and addressing disparities. She also mentioned a call for large pragmatic clinical trials (i.e. funding five-year studies for up to $10 million).

Incorporating PCOR to Develop Learning Health Care Systems

PCORI was established by Congress in 2010 to close the gaps in evidence needed to improve key health outcomes, identify critical research questions, fund patient-centered comparative effectiveness research, and disseminate those results. PCORI articulated five national priorities: 1) assessment of prevention, diagnosis, and treatment options; 2) improving health care systems; 3) addressing disparities; 4) communication and dissemination research; and 5) accelerating patient-centered outcomes research. All research programs ideally adhere to best practices in the planning, design, and conduct of every research project for the findings to be reliable and worthy of adoption.

The PCORI Methodology Report provides baseline requirements and a framework for those best practices. The report includes vignettes that illustrate different ways in which good study methodology makes a difference to patients and their care. These include stories of patients' experiences navigating choices and weighing options and examples of published studies that capture the impact of good methodology.

PCORI criteria for funding includes:

- *Patient centeredness*. Is the proposed research focused on questions and outcomes of specific interest to patients, their caregivers, and clinicians?
- *Burden*. Is the condition or disease associated with a significant health burden in the US population?
- *Potential for improving health care practice*. What is the likelihood that this research will change clinical practice or clinical decision making?
- *Timeliness*. Are potential projects associated with this topic likely to be accomplishable within a three-to-five year time frame? Would new information generated by research be likely to have an impact in practice?

Systems, not just individual providers, need to listen, learn, and improve, too. PCORI is seeking applications to study the comparative effectiveness of alternate features of health care systems, innovative technologies, incentive structures, and service designs that optimize the quality, outcomes, and/or efficiency of care. Health care systems may encompass national, state, and local health environments; organization and/or practice settings; family and social supports; and the individual patient.

Most hospitals and health systems focus on patient engagement because of their mission to deliver high-value care despite potentially negative economic consequences. For many, the goal is to get meaningful reports of performance at an individual physician or patient level segmented by shift or day of week. These reports are being used by hospitals and physician groups who know that they need to meet patients' needs in order to maintain market share. Regardless of how contracts will look a few years from now, if health care providers do not have patients, they will not be successful.

A "Health Literate Care Model," which endorses health literacy as a cultural value modeled by leadership and integrated into all aspects of planning and operations, has been proposed. To succeed, organizations must build longitudinal partnerships with patients and community partners to drive ongoing management of chronic conditions and utilization of preventive care services and to improve long-term quality and cost outcomes. Encouraging patients' participation in decision making through simple interventions can potentially help patients become more engaged and informed. Clinical information systems provide real-time reminders about needed services during patient visits, help track care delivered to different populations, and assist with planning future care. Community partners encourage patients to connect with resources in their communities as well as offer insights into the social determinants of health and health literacy.[1]

PCORNet Big Data Studies

The PCORNet Big Data Studies session, led by Joan Neuner, MD, and featuring Gary Rosenthal, MD, Cynthia Chuang, MD, and patient researcher Jim Uhrig, PhD, provided an introduction to PCORNet focused on the clinician and clinician-educator wishing to get more involved in research. The

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FROM THE SOCIETY: PART II

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session began with an introduction to PCORNet, the national Patient-centered Clinical Research Network, and covered the PCORI vision to improve upon weaknesses of research that is too "slow, expensive, and unreliable," doesn't answer questions that matter most to patients, and is unattractive to clinicians and administrators. PCORNet initially funded 29 clinical data research networks and patient-powered research networks and now has representation in every US state. The session then focused on examples from PCORNet sites, with Dr. Chuang outlining how her PaTH Network has been working to engage patients in their research. Dr. Joan Neuner presented information about the Greater Plains Collaborative extending from Minnesota to Texas and led by the University of Kansas and University of Iowa. She discussed the collaborative process involved in working with 11 institutions to develop a study of breast cancer patients in the Greater Plains Collaborative. Dr. Uhrig, a patient researcher in PaTH, presented his experience with interstitial pulmonary fibrosis and his perceptions of how patients can help focus research questions. Finally, Dr. Rosenthal outlined opportunities for clinicians to become involved in research, discussing both the intellectual and practical challenges in doing so and calling for creative solutions such as relative value unit (RVU) credit from academic institutions for clinicians who enroll patients in research.

Patient Engagement

Patient participation is the cornerstone of PCOR and its focus on improving health care. It is critical that patients and other key stakeholders are integrated into the planning of studies, how the protocols are carried out, and the analysis and dissemination of study results. The PCORI engagement principles are founded in reciprocal relationships, co-learning, trust, transparency, and honesty and are the framework for patient engagement in research.

Our patient engagement workshop at the SGIM annual meeting in Toronto highlighted the benefits, challenges, and rewards of engaging patients in research. The session focused on patient participation from both the perspective of the patients/family members and from researchers to emphasize the necessity of relationship building and trust.

- Clarissa Hoover of FamilyVoices shared her experiences as a family caregiver to highlight the essential nature of fostering relationships where safety is assured and vulnerability is supported by the entire team. Empowering patients and family members to ask questions, to be respected as different but equally important, and to be involved in the decision-making process was emphasized in her discussion.
- Dawnmarie Harriot of Working for Change described the necessity of getting the right people onto the team and recognizing and addressing pitfalls and external challenges as a caucus. She underscored the benefits of working with people with lived experience as a means to both improve the research question and the potential outcomes.
- Jeffrey Whittle, MD, MPH, Medical College of Wisconsin, described his unique experiences working with Veteran's service organizations to recruit and engage patients in mental health research. Dr. Whittle emphasized the need to develop personal contacts, to learn about and accept organizational culture, and to recognize that the institutional review board and other academic "expectations" may not be widely understood or recognized by the community.
- Jennifer Thomas from the Institute for Educational Leadership described her unique experiences as both a patient and advocate working with youth on development and leadership. She noted that young people frequently need additional support, that access needs to be viewed with an open lens, that patient participation may need to include monetary support, and that the patient voice is key for engagement.
- Our session was concluded by Shivonne Laird, PhD, MPH, program officer for the Eugene Washington PCORI Engagement Awards Program. Dr. Laird described PCORI goals and process while highlighting recently funded projects. She closed the loop by discussing and reinforcing fundamental themes raised by speakers when describing their experiences and research activities.

Reference

1. Koh HK, Brach C, Harris LM, Parchman MC. A proposed 'health literate care model' would constitute a systems approach to improving patients' engagement in care. Health Affairs 2013; 32(2):357-67.

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HEALTH POLICY CORNER

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What our Health Policy Committee recommends SGIM advocate for depends not just on whether we think the program is good for Americans and for general internists but also whether the program needs annual renewal or is at risk for being changed for the worse. We also consider whether our advocacy will make a difference. Our experience with funding primary care training shows we can make a difference with carefully targeted work.

Reference

1. Jackson A, Baron RB, Jaeger J, Liebow M, Plews-Ogan M, Schwartz MD. Addressing the nation's physician workforce needs: the Society of General Internal Medicine (SGIM) recommendations on graduate medical education reform. J Gen Intern Med 2014; 29(11):1546-51.

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FROM THE REGIONS

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In response to previous Midwest member regional surveys, we focused on promoting networking and collaboration and offered group-mentoring sessions on hospital medicine, work-life balance, contract negotiation, medical education, research, and SGIM *Forum* over lunch on each day. We also continued one-on-one mentoring this year. These activities were organized by our at-large council member Kurt Pfeifer, MD, of the Medical College of Wisconsin. In addition, we had the first ever Midwest "Night on Fourth Street," where members gathered for informal appetizers and networking.

Meeting highlights included updates from national SGIM by SGIM president Marshall Chin, MD, of the University of Chicago; a health policy update presented by Health Policy Committee member and national SGIM award winner (2009) Mark Liebow, MD, of the Mayo Clinic; and a highly informative update in GIM presented by Michael Rothberg, MD, and Stacey Jolly, MD, of the Cleveland Clinic.

Our regional meeting was in itself a huge innovative success: We broke new ground with a new location, new mentorship opportunities, and new sponsors. Members from the entire region contributed by serving as committee chairs, institutional champions, reviewers, moderators, poster judges, mentors, and meeting participants. The success of the meeting is a direct result of everyone's hard work and love for GIM. We look forward to building on the success of this conference and continuing to innovate as we look toward 2016. SGIM

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and six proposals were awarded, respectively. Project titles are listed in Table 1. Three proposals were rejected due to the low-impact potential of the work. One is currently in the process of being revised, and two are currently under review. The total amount awarded since cre-

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Table 1. Projects Approved by the Medical Education Research Steering Committee

Project Title
Understanding the Role of Interns as Teachers: A Cross-sectional Survey of Behaviors, Attitudes, and Predictors of Intern Teaching
Evaluation of VA Women's Health Fellowships: A Survey of Developing Leaders in Academic Women's Health
Health Policy Curriculum for Internal Medicine Housestaff: Building a Curriculum from the Grassroots
Teaching Medical Educators to Teach Communication Skills: 10 Years of Experience
Using Facial Expressions to Improve Doctor-Patient Communication
Implementation and Evaluation of a Curriculum to Improve the Post-hospital Follow-up Visit Curriculum in the Ambulatory Setting
Primary Care Providers' Approach to Breast and Cervical Cancer Screening in Primary Care
Implementation and Evaluation of a Breast Health Curriculum for Internal Medicine Residents
Establishing Consensus with the Delphi Technique: Priorities for Pediatric Palliative Care *Fast Facts and Concepts* Content for the Education of Pediatric Interns
A Virtual Patient Experience to Develop Clinical Reasoning in Junior-level Japanese Resident Physicians
Head CT Scan Use in Frequently Admitted Medical Patients
Palliative Care Curriculum for Pediatric Residents
Developing and Implementing an Intern Teaching Curriculum
Assessment of Burnout Among Internal Medicine Housestaff
Design of a High-value Cost-conscious Care Curriculum
Redesigning an Ambulatory Curriculum for Internal Medicine Housestaff
A Brief Mindfulness-based Self-care Intervention for an Inter-professional Group of Palliative Care Providers
Collaboration Between the University of Pittsburgh Division of General Internal Medicine and the *Annals of Internal Medicine* to Create Online Virtual Patients for ABIM Maintenance of Certification
A Local and National Assessment of Resident Autonomy
Improving Residency Conferences: Enhancing Engagement by Integrating Learner Preferences and Principles of Adult Learning
Addressing Health Literacy through Clear Health Communication: A Training Program for Internal Medicine Residents

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ation of the committee is $76,500. The average amount awarded per project to date is $3,600.

Of the 21 funded projects, a total of six CE faculty members were PIs, and six were co-investigators. Among PIs, one was a professor, one was an associate professor, and four were assistant professors at the time proposals were awarded. The ranks of faculty co-investigators ranged from assistant to full professor. Eight fellows were PIs, and two fellows were co-investigators on faculty projects. Six projects included internal medicine residents as co-investigators.

Of all 21 proposals awarded financial support, nine manuscripts have either been published or accepted for publication. Six manuscripts are either currently under review or are in the process of being revised and resubmitted. Seven manuscripts are in development. Primary authors have given 18 national presentations (i.e. oral abstracts and posters) related to these funded projects. Fifteen project-related workshops were presented at national meetings.

We are planning several key next steps to further evaluate the impact of the committee. We have not been able to quantify its impact through a comparison of current CE scholarly activity to that which occurred prior to committee formation. Given that projects develop over years from inception to dissemination, we suspect that we will be able to make this comparison after another one to two years. At that point, we will compare the number of publications and national presentations among awardees to the number achieved by CEs over the same time period in the years preceding committee formation. We will also compare the number of people who successfully completed and disseminated projects, as an explicit committee goal is to afford faculty members avenues for scholarship who have not previously undertaken these pursuits. Next steps also include plans to continue to expand the number of mentored projects and to expand mentoring expertise to increase the strength and number of qualitative projects. Finally, we will compare, using the same measure, the academic productivity of fellows who graduated before and after committee formation. We hypothesize that the support from the committee increases the likelihood that fellows will be successful as they develop their careers as CEs. This may enhance their competitiveness in their search for faculty positions and help set them up for success as junior faculty. In three to five years, we will examine whether fellows who graduated after committee formation have been promoted earlier than fellows who graduated prior.

The Medical Education Research Steering Committee is an innovative model that can be applied in varying forms at many academic institutions. The fact that other institutions may not have a data center and/or the funds available to provide financial support for projects may limit generalizability. However, even if support for statistical analysis does not exist, the mentorship provided by the committee offers the expertise and structure needed to develop, complete, and disseminate medical education projects successfully. Our results demonstrate that limited amounts of faculty time and funding support, when effectively leveraged, can engender success among CE faculty and trainees as measured by publications and national presentations.

SGIM

University of Cincinnati College of Medicine General Internal Medicine Opportunities as Academic Hospitalist

The Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking Board Eligible Internists to join our faculty as academic hospitalists. Hospitalist faculty are members of the Division of General Internal Medicine, **which performs the bulk of resident and student teaching for the Department of Medicine**.

Responsibilities include:

- Providing patient care in several settings, including attending on traditional resident-led ward teams, attending on the resident-led medical consultation service, and leading a hospitalist team including an intern;
- Teaching in our Internal Medicine Residency program which has been granted status as an ACGME Educational Innovations Program; and
- Teaching medical students on clinical rotations.

Academic opportunities include:

- Direct teaching of medical students in all four years of our new clinical curriculum;
- Collaboration with researchers in our Center for Clinical Effectiveness and Center for Health Informatics; and
- Participation in Hospital quality improvement activities.

Opportunities also exist for training in Improvement Sciences and traineeships with mentored research experiences in Outcomes and Clinical Effectiveness leading to a Master's degree in Clinical and Translational Research.

Our hospitalists **are leaders in improving both patient care and clinical processes** at the University of Cincinnati Medical Center and have a **passion for teaching and improving patient care**.

Salaries are competitive, with opportunities for increases based on productivity.

If you are interested in joining the University of Cincinnati in Hospital Medicine, applicants should contact: Mark Eckman, Director, Division of General Internal Medicine via email at Mark.Eckman@uc.edu .

We are recruiting for July 2016.

The University of Cincinnati is an affirmative action/equal opportunity employer.

UNIVERSITY OF Cincinnati

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SGIM LAUNCHES #PROUDTOBEGIM CAMPAIGN

The percentage of internal medicine residency graduates entering the field of general internal medicine (GIM) fell precipitously during the 2000s. As recently as 1998, more than half of PY-3 internal medicine residents planned to enter GIM, whereas by the mid-2000s, that percentage had fallen to about 20% (source: In-Training exam Questionnaire, courtesy of American College of Physicians). This has led to a supply of internists—particularly primary care internists—that is insufficient to meet demand. Despite current initiatives aimed at redesigning the primary care workplace and compensation for primary care, an even greater need for general internists in the near future is anticipated.

SGIM Council and its Health Policy Committee have undertaken several initiatives to influence policymakers regarding the design of the primary care workplace of the future and the development of appropriate reimbursement models. These initiatives include sponsoring the National Commission on Physician Payment Reform from 2012 to 2013 and engaging regularly with Centers for Medicare and Medicaid Services and others regarding payment reform. However, given the wide range of options available to residents completing an internal medicine residency, the Society's leaders believe that it is critical to communicate to trainees the incredible opportunities available to general internists both now and in the near future.

Council chartered a working group within the Society (SGIM Communications Task Force, chaired by Ann Nattinger) to develop a communications plan to ensure that trainees (particularly medical students) have the opportunity to carefully consider a career in GIM. The resulting campaign, #ProudtobeGIM, highlights GIM as a career path that offers physicians the opportunity to impact lives and speaks to the values of a new generation of medical students eager to make a difference. The campaign features general internists leading health care into the future—at the forefront of medical education and innovation—and making an impact at an individual and societal level.

In September, SGIM formally launched the campaign via social media and other SGIM communications avenues. We have partnered with a number of organizations, including the American College of Physicians, the Association of American Medical Colleges, the American Medical Student Association, and Primary Care Progress, to bring this message to the largest audience possible and disseminate information about opportunities available through the campaign. The #ProudtobeGIM website (www.proudtobeGIM.org) contains helpful materials that can be used to discuss GIM career options with trainees, including video materials, blog comments, and a slide deck about the field of GIM and career options within the field. More than 30 institutions made inquiries about a pilot program offering modest funding for hosting GIM informational events for medical students. Although only six could be funded for the first phase of this work, several others are still holding an event without funding. From these pilot phase institutions, we plan to identify the types of messaging that speaks most effectively to trainees and refine our portfolio of tools for engaging trainees (and faculty) in developing a better understanding of the field of GIM. The initial response to the #ProudtobeGIM campaign has been overwhelmingly positive.

An issue that has historically been problematic for the field of GIM is a lack of positive regard and even disrespect from some of the other specialists in our academic centers. The #ProudToBeGIM campaign helps us to recall what we have found the most satisfying about our field. As care delivery is re-designed and payment mechanisms are revised, the resulting structures must optimally support internists and other members of our care teams in providing outstanding care for patients according to the triple aim: improving the patient experience of care, improving the health of populations, and reducing the cost of health care. A motivated and satisfied expert workforce is critical to achieving these goals. #ProudToBeGIM aims to ensure that we recruit intelligent and compassionate colleagues to work alongside us and that this workforce will be sustainable for years to come.

—Ann B. Nattinger, MD, MPH, *Medical College of Wisconsin*
Brita Roy, MD, MPH, *Yale University*
Francine Jetton, MA, *SGIM*

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