

BREADTH

A VIRTUAL VILLAGE

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There are already several faces on screen when I join the Zoom call. I don't recognize most of them, but it is only my 10th day at the community health center of my Primary Care rotation. The last person to join is the medicine resident, running over from a patient visit. I hear him through my earphones and through the workroom door; we are joining this meeting from our separate desks, masks briefly lowered as we lunch.

The resident begins: "Thank you all for hopping onto this Integrative Case Conference. Today we will talk about a patient with history of schizophrenia and diabetes who is well known to both the medical and behavioral health clinics. Recently she has been struggling to control her blood sugars."

During my clinical year, I have met few patients with a disease that I had not already studied in the classroom. And yet, when I encounter the disease entities in real people, it feels as if I'm learning them for the first time. For example, I did not realize how difficult not only it can be for many people to administer insulin but also how much time primary care clinicians spend on troubleshooting medication regimens.

"She has regular visits by a home nurse, so we know she is taking her medications appropriately. So what we should do is increase her insulin dosing, but she hasn't liked that idea."

I've learned the first-line treatments, the grade A guidelines, but I haven't learned what to do when a patient is not on board with what is recommended. The relationship between the medical establishment and ev-

eryone else feels especially fraught now, almost two years into the COVID-19 pandemic.

"She doesn't have stable access to food. She receives food stamps, and sometimes goes to food pantries."

Diabetes management as taught in the classroom focused on reduction of intake and restriction of certain foods. Managing diabetes in the setting of scarcity, I am less familiar with.

"And lately she has been missing her in-person appointments with the medical clinic. But we noticed that she attends most of her telehealth appointments with behavioral health. So we'd appreciate any thoughts from all of you about how we can best help her."

The Zoom room immediately begins to respond. The clinical social worker wonders whether someone ever talked to the patient about the complications of poorly controlled diabetes. The quality improvement coordinator asks about telehealth at the resident clinic. They discuss working with the home nurse to discuss increasing the insulin dose. I'm losing track of the different titles in the room—there's a recovery coach, a dentist, a pharmacist.

For 30 minutes, all these healthcare professionals brainstorm ways to better control this patient's diabetes. But the conversation is quick to shift and morph to include other problems—ongoing smoking, psychotherapy, lack of transportation. When the exchange of ideas is at its quickest, it is easy to imagine a virtual round table around which representatives from each domain of health care have gathered, the patient's life at its center. As they

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FROM THE EDITOR

WILL YOU STRENGTHEN OUR TEAM?

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
Editor in Chief, *SGIM Forum*

As I walked home from the local farmer's market, I passed a sign on the sidewalk looking to hire staff at a cafe: "Wil jij ons team versterken?" (which translates to "Do you want to strengthen our team?") This struck me as a perfect fit for the philosophy behind this month's theme issue on "Team and Interprofessional Care."

While strengthening a team can take on a variety of meanings, it is apt in the demanding and dynamic clinical and educational settings of multidisciplinary general internal medicine healthcare professionals. Patients with complex medical conditions, polypharmacy, and multiple interrelated social determinants of health have numerous care needs that can ideally be addressed through coordinated care that pools resources and expertise to provide care at the right times, places, manners, and in accordance with patients' preferences.

From an individual's perspective, strengthening the care team might mean bringing a unique expertise to their team. Orozco, et al., explore these issues and the potential for a community health worker or patient navigator to facilitate care coordination and community engagement in individual patients' health. Myong and Newman offer a medical student perspective on the visible value of multidisciplinary team care in patients' communities. For a team looking to adapt to changing healthcare environments and optimize the applications of their team members' skills, Sakumoto, et al., offer a look into an all-virtual primary care team model. General internal medicine physicians, or generalists, can identify with a variety of roles based on their clinical setting: hospitalists in hospital settings, ambulists in ambulatory settings, and now virtualists in virtual or remote settings. For leaders and organizations looking to bring on talent from diverse professional and personal backgrounds, strategic planning and intentionality are needed to foster innovation and synergy within and between care teams across different settings. Alkhaw and Torres-Deas explore the long view of primary care physicians in interdisciplinary team leadership roles.

SGIM also has its role to play throughout each of these settings with regards to promoting interdisciplinary collaboration and team-based care.¹ Lypson, SGIM

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SGIM'S COMMITMENT TO ANTI-RACISM

Monica L. Lypton, MD, MHPE, FACP, President, SGIM

"Since December 2014, medical trainees have called on medicine to address issues that affect health, specifically to dismantle racism and take a stand against issues, such as policy brutality. To meet these calls to action, the Council has begun to outline SGIM's commitment to anti-racism. We must not only focus on diversity, equity, and inclusion within SGIM but also work to change the structure and functions of the Society."

"Everyone's a little bit
Racist, sometimes.
Doesn't mean we go around committing
Hate crimes.
Look around and
You will find,
No one's really
Color-blind.
Maybe it's a fact
We all should face.
Everyone makes
Judgments...
Based on race."

—"Everyone's a Little Bit Racist"
(*Avenue Q*; Robert Lopez/Jeff Marx)



Avenue Q, the 2004 Tony Award-winning Broadway musical, compels us to confront difficult truths in society. I wonder how well this story and, specifically, "Everyone's a Little Bit Racist" would resonate in our current fractured political climate. In recent years, health care has received challenges from both within and without to begin to address many of society's greatest problems. Since December 2014, medical trainees nationwide have called on medicine to actively address issues that affect health, specifically to dismantle racism and take a stand against issues, such as policy brutality.¹ This call was the boiling point after decades of agitation. Scholars, such as Gloria Ladson-Billings, Ibram Xolani Kendi, and Eduardo Bonilla-Silva, have also challenged us to build an equitable and just society by focusing on creating policies that dismantle systemic oppression.

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Q & A WITH SGIM'S CEO AND THE DIRECTOR OF THE NATIONAL CENTER FOR EXCELLENCE IN PRIMARY CARE RESEARCH (NCEPCR)

Eric B. Bass, MD, MPH; Patrick G. O'Malley, MD, MPH, MACP

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. O'Malley is the Director of the NCEPCR.

EB: What is the mission of the NCEPCR?

PO: The Agency for Healthcare Research and Quality (AHRQ) believes that revitalizing the nation's primary care system is foundational to achieving AHRQ's mission of improving the quality, safety, accessibility, equity, and affordability of health care. According to the Healthcare Research and Quality Act of 1999, AHRQ was expected to establish a center that "shall serve as the principal source of funding for primary care practice research in the Department of Health and Human Services."¹ AHRQ has a long history of supporting primary care research and established the NCEPCR in 2015 to expand and be AHRQ's intellectual home for this work. The NCEPCR sits in the Center for Evidence and Practice Improvement (CEPI) at AHRQ, led by Dr. Arlene Bierman. AHRQ has an extensive and expanding primary care portfolio including work in dissemination and implementation, digital health, and learning health systems; it is also developing multiple funding opportunities relevant to primary care researchers and engaging in primary care tools and data development. The NCEPCR role is to provide evidence, practical tools, and other resources for researchers, evaluators, clinicians, quality improvement experts, and healthcare decision makers to improve the quality and safety of care in the nation's primary care system.² With recruitment of a new Director of the NCEPCR, AHRQ is well positioned to expand its capacity to further advance AHRQ's primary care research mission.

EB: What are your plans for building up the NCEPCR?

PO: To increase the impact and value of the broader primary care work supported by AHRQ, the current vision for NCEPCR is to expand AHRQ's on-line resources for supporting primary care research, expand its convening center function with special emphasis on primary care related issues, create a virtual community of primary care researchers and stakeholders, and ultimately to lead AHRQ's diverse portfolio of funded research activities covering priority areas in primary care research. The funded activities will encompass research on issues related to primary care delivery, workforce, and outcomes as well as primary care's critical role in advancing health

equity. AHRQ supports dissemination and implementation of research findings as well as efforts to improve primary care research methods, including use of data, networks, and support systems. The NCEPCR aims to expand this work and capacity to better meet the needs of primary care researchers and clinicians in order to improve access, quality, and outcomes of care for people and their communities.

EB: How do you plan to strengthen the primary care research workforce?

PO: Recognizing that its mission depends on having a robust primary care research workforce, the NCEPCR is committed to building the necessary workforce by developing opportunities for training programs and career development awards in primary care research. On October 22, 2021, AHRQ released a Special Emphasis Notice announcing its interest in supporting career development awards for emerging investigators in the field of primary care research.³ Also, AHRQ's mission within the Patient Centered Outcomes Research Trust Fund includes training PCOR researchers. AHRQ is advancing this mission by training PCOR researchers embedded within health systems. The Learning Health System training program has been very successful in training scholars, and one could envision expansion of this program into primary care settings.⁴

EB: What is your vision for the future impact of NCEPCR?

PO: My goal is that the NCEPCR will further its impact by: 1) making primary care better and more valued in the healthcare system; 2) improving understanding of the role of primary care within the healthcare system; 3) showing how to leverage primary care to achieve better outcomes; 4) giving primary care clinicians a stronger evidence base and tools for being more effective in managing care for people in real world settings; 5) strengthening the role of primary care researchers in the continuum of biomedical and public health research; 6) creating a listening post for primary care researchers; and 7) establishing a diverse expanded community of primary care researchers.

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SGIM INITIATIVE TO IMPROVE ITS RESOURCES FOR INVESTIGATORS— WE WANT YOUR INPUT!

Nisa M. Maruthur, MD, MHS; Kira Ryskina, MD, MSHP; Deborah Kwolek, MD; Kari Nelson, MD, MSHS; Lauren Block, MD, MPH; Bimla Schwarz, MD, MS; Kristina Cordasco, MD, MPH, MSHS; Donna Windish, MD, MPH; Michael Paasche-Orlow, MD, MA, MPH; Mara Schonberg, MD, MPH

All authors are members of the SGIM Fellows Survey Sub-Committee, a subcommittee of the SGIM Research Committee.

Background

Research is an important component of the mission of SGIM and its members, and we are in an exciting time of opportunities for general medicine researchers. The Agency for Healthcare Research and Quality (AHRQ) has established the National Center for Excellence in Primary Care¹ as its home for primary care research, and it recently announced several research funding priorities and Special Emphasis Notices focused on primary care²; these include an interest in supporting career development awards for early investigators seeking to develop careers in primary care research. Many National Institutes of Health (NIH) funding priorities, such as developing the behavioral research workforce, reducing health disparities, disease prevention and health promotion, and dementia research, are relevant to general medicine researchers.³

There are also many opportunities for training in general medicine research: The Health Resources & Services Administration (HRSA) recently renewed its National Research Service Award (NRSA) institutional research training grant (T32) that focuses on training in primary care research—19 programs are funded across the country. Additionally, the National Clinical Scholars Program (NCSP) has evolved and is flourishing with six sites across the country,⁴ and the Department of Veterans Affairs continues to be a dedicated partner in funding generalist research through the NCSP and through its own training programs for post-doctoral trainees.

While there is increasing recognition of the importance of primary care in solving today's healthcare problems, we also recognize the challenges of pursuing a career as a clinician investigator in general internal medicine. Receipt of an R01 as Principal Investigator is often thought of as the time that “independence” as an investigator is achieved, and the age of receipt of first R01 for MDs increased from 40 to 44 years between 1995 and 2020.⁵ Many generalists do not do disease-specific research and therefore may have a more difficult time obtaining NIH funding. Frequently, we meet trainees who

are interested in generalist research, but anecdotally they often do not pursue long-term research careers. We may hypothesize that difficulty obtaining funding for research and having a career based on “soft money” in combination with other factors, such as lower salaries of academic research jobs, are among the reasons that fewer early career general internists choose to stay in research careers.

What SGIM Is Doing

To understand the challenges trainees and early investigators face in pursuing research careers, SGIM will implement two surveys to current and former fellows and program directors.

Currently, about one in five SGIM members consider themselves clinician investigators. SGIM's Research Committee includes 18 geographically diverse clinician investigators who serve for at least three years and work to foster the career development of generalist investigators. The Research Committee develops research related content for the annual and regional SGIM meetings, helps organize selection committees for SGIM's major research awards, maintains SGIM's dataset compendium, and serves as SGIM's go-to committee for issues and projects that affect generalist researchers. To ensure the Research Committee is meeting the needs of generalist researchers through its many initiatives, SGIM is taking a systematic approach to evaluating and improving or adding to these resources for researchers. In December 2020, SGIM's Research Committee appointed the SGIM Fellows Survey Sub-Committee of 10 academic general internists from across the United States (80% of whom are not members of the Research Committee) to focus on how SGIM can better serve researchers.

Over the past year, the sub-committee has designed the following two surveys:

1. *Fellows' Survey*—for persons currently in or who have completed (in the past 10 years) a general medicine research fellowship;

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PATIENT ENGAGEMENT: OUR JOURNEY BRIDGING ACROSS CULTURAL, LANGUAGE, AND SOCIOECONOMIC BARRIERS

Angela M. Orozco, MD; Jessica R. Contreras, LCSW-C; Katherine C. Shaw, MD

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Ms. Rosemary (name changed) was a young woman from El Salvador who died at 33 years of age. She had limited access to education in El Salvador and immigrated to the United States. She had two school-aged children, one of whom had special needs requiring dedicated medical and psychosocial care. She lived near two close siblings and her mother. It was after her death that our medical team learned of the immense outpouring of support from her religious community, sponsoring a funeral procession and working to return her body to El Salvador. We share our journey in partnering with her and understand the hindsight lessons of missing both patient and community engagement in her care.

Our healthcare system met her as a young 25-year-old woman with nephrotic syndrome and biopsy diagnosing IgA nephropathy. The Access Partnership (TAP), a system-wide charitable program facilitating subspecialty care for uninsurable persons, allowed her regular nephrology care, but was unable to deflect medication costs and accessibility to immunosuppressive therapies. In hopes of managing her IgA nephropathy, she was trialed on high-dose steroids among other sponsored therapies. She suffered seizures in the setting of hypertensive emergency which she attributed to the steroids and so she self-discontinued them. This is one of many circumstances with her having limited understanding to medically recommended therapy. Her IgA nephropathy persisted thereby provoking refractory hypertension, end-stage renal disease, and a need for dialysis in the last year of her life.

Her last months were spent in and out of the hospital because of her progressive illness, with several unfortunate complications. She suffered a type B aortic dissection requiring surgical aortic repair. Diagnostics in this setting

then revealed several cerebral aneurysms, for which she later underwent a planned craniotomy. Following this craniotomy, she suffered a stroke, non-convulsive status epilepticus, and septic shock with *Clostridioides difficile* colitis requiring operative intervention. At 33 years old, she suffered a cardiac arrest in the operating room and without successful resuscitation.

Approaches to Bridge across Barriers in Her Care

Ms. Rosemary's presentation held competing demands between her significant medical maladies and challenging social circumstances. Her presenting symptoms and

Community health workers (CHW) or patient navigators are inherently from and within the patient's community. They bring an unparalleled ability to meet the patient where they are physically, socially, psychologically.

vitals most often made for her medical doctors to give priority to urgent clinical matters addressing her hypertension and worsening renal disease. The time desired to utilize motivational interviewing and to engage deeper in her

concerns and priorities was overrun by clinical urgency to decide between ongoing outpatient management or need for emergent referral to the emergency department. Challenges identified to optimize clinical management included costs, language discordance, limited literacy, and concerns for depression.

Costs considered included clinic visit copays, medication, transportation, and time lost at work. Initial care was in a community clinic with a sliding scale program, where she qualified for the lowest cost per visit of \$25 plus costs of laboratories. Subspecialty visits were subsidized completely as part of TAP. Medication costs varied, depending upon the pharmacy discount programs and the ability to document income. Applications for these pharmaceutical company programs required extensive outreach on the part of our social workers and staff, alongside the patient commuting to clinic in person for

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PRIMARY CARE FROM THE PHYSICIAN TO THE TEAM— WHY IT MATTERS

Hadeel Alkhairw, MD; Lucille M. Torres-Deas, MD

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The pandemic highlighted health inequities across the board and the need for access to evidence-based primary care. Primary care delivers care to every patient population, bridging the gap in access to the underserved, vulnerable, and marginalized patient populations, and treating stigmatized health conditions. Treatment of substance abuse, mental health, end-of-life, women's health, obesity, and LGBTQ issues are only a few examples integrated into primary care. We aim to elucidate the value and importance of interprofessional care in the future of primary care, physician well-being, patient outcomes, and population health.

The Role of Primary Care

The National Academies of Sciences, Engineering, and Medicine reports that the role of primary care is to improve the population's health, reduce cost/waste, and improve the patient experience.¹ It is at the core of the primary care physician's training to provide support, access, and continuity of care. The patient describes his/her/their primary care physician, "as my doctor!" Yet despite everyone's beliefs that primary care is the solution to all the above, primary care continues to be the least appreciated, funded, supported, and the most overwhelmed. Primary care physicians suffer a high burnout rate, and this shortage is one of the highest compared to other specialties.

Are Current Solutions Enough?

Recently, President Biden's the Build Back Better plan proposed an increase in residency positions targeted at primary care, mental health, and other critical specialties. The new legislation would require 25% to be allocated to primary care. This legislation, although promising, is not sufficient to solve the primary care crisis. The new physician force will need dedicated primary

care track programs with robust training in community and population health. A great example is Montefiore's Primary Care and Social Internal Medicine, a program that has a comprehensive curriculum on caring for marginalized and underserved patients, learning about advocacy, and different avenues to improve patient, community, and population health.² Caring for a complex patient population requires years of experience and advanced training.

With more than 50% burnout rate among the current physician force,³ aging population, increased medical, mental, and social complexity of patients worsened by the pandemic, and the ongoing reluctance of trainees to pursue primary care, the crisis will worsen even with the best intentions. Initiatives like the Patient Center Medical Home did not reduce burnout, mainly because the expectation and accountability solely focused on the individual physician's performance and did not extend to the team members. Many states have authorized and expanded the independent practice of nurse practitioners and physician assistants to fill the primary care access gap, yet this also requires standardization of training and advanced skills to meet the increased complexity of patient care.⁴

The Challenges and Solutions Are Complex

It will not only require adding more residency slots and increasing funding. A culture shift must also occur in the mentality of policymakers, payers, healthcare systems, administrators, physicians, their patients, and the interprofessional team. The primary care specialty needs a transition from the individual to a team-based approach, and the physician from direct care to the leader of care. This will require a fundamental change of the current force of primary care physicians and interprofessional team members via continuous medical

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KEY CONSIDERATIONS FOR VIRTUAL TEAM-BASED PRIMARY CARE

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Team-based and collaborative care is one of the seven shared principles of primary care.¹ Shared responsibility for patient care has the opportunity to allow all team members to work at the top of their training, improving patient access, care coordination, and decreasing provider burnout. Even prior to the COVID-19 pandemic and associated rise in telehealth, many groups have explored the opportunities of a virtual-first hybrid clinic.²

The Tera Practice model adopts team-based care principles augmented by tech-enabled care and communication in a primarily virtual care environment. The Tera Practice model was established in 2018 as a virtual-first practice servicing Palo Alto, California. The "pod" team model includes a physician, nurse practitioner (NP), licensed vocational nurse, and health coach. We use a virtual-first hybrid model where 90% of interactions occur via secure messaging, telephone, or video visit, which provides accessibility benefits for the patients who can get most of their care from home or work. Our care team members work from home, and the virtual-first model frees up physical clinic space (and associated costs) and provides flexibility to accommodate the care team's personal needs (such as childcare or home-based responsibilities). This has significantly increased work satisfaction amongst team members. However, there is one dedicated in-clinic day for the team to address patients' needs that must be in person to maintain continuity and connection with our patient panel.

This team-based, patient-centered model has already shown impact for improving patient access, care quality, and cost.³ The model is replicable and scalable with three "pods" operating across Northern California. Reflecting on our experience, we opine that there are three main enablers of virtual team based primary care: 1) encourage asynchronous patient communication, 2) establish "virtual back office" communication channels, and 3) apply daily synchronous team huddles to communicate essential team care items.

Embrace the In Basket

Healthcare leaders and frontline physicians have concerns about the ever-expanding in basket increasing clinician burnout.⁴ However, asynchronous modalities, such as secure chat through the patient portal and store-and-forward images of rashes, allow for triaging, multitasking, and task distribution. The in basket is shared across the pod (physician, NP, nurse) and each team member is empowered to respond to patient concerns to their level of clinical knowledge and current workload creating a more efficient use of everyone's time. For example, in a traditional office setting, three separate patients may need a 1) work note for recent illness, 2) rash evaluation, and 3) blood pressure check and medication refill, requiring three clinic slots and an hour of everyone's time. Leveraging a distributed work model, those three patients are helped in a fraction of the time. For example, for those same three concerns, 1) the physician takes 10 minutes on a video visit to discuss with the patient about the work note, while in parallel; 2) the NP reviews the rash image and messages the patient with an over-the-counter medication recommendation; 3) the nurse reviews the blood pressure logs that the patient messaged in and pends the medication refill for the physician to sign as soon as they complete the work note visit. While the work is distributed, continuity of care is also preserved because we collaborate as a tight-knit team, and huddle daily: we divide, conquer, and, most importantly, reconvene.

Utilize Omni-channel Communication Strategies in the Virtual Back Office

In a traditional physical clinic office, simple requests like "Please schedule Ms. Jones for a follow up next week," or "How do you order a Podiatry referral?" were all conveyed verbally in the workroom. In a completely virtual office environment, virtual care team communication takes more than just e-mail. The channels of communication (especially HIPAA secure communication) are sig-

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PO: Eric, how do you think SGIM can support the NCEPCR?

EB: SGIM is highly committed to supporting the NCEPCR's mission. SGIM's Health Policy Committee will continue to advocate for strong federal support of primary care research. SGIM's leadership has offered to help facilitate participation of its members in listening sessions about plans for building up the NCEPCR. SGIM's leadership also is prepared to help engage its members in efforts to develop a comprehensive curriculum for the training of primary care researchers, taking advantage of lessons learned from SGIM's work in developing a curriculum on partnered research for the Veterans

Affairs Health Services Research and Development Service.⁵

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FROM THE SOCIETY: PART II (continued from page 5)

2. *Program Directors' Survey*—for program directors of active general medicine research fellowships.

These surveys will provide us with the necessary data on the career outcomes of current and former general medicine research fellows and will identify barriers and facilitators to developing and maintaining a research career. SGIM will use the results of these surveys to enhance and add to its existing resources for researchers.

How You Can Help

Thank you if you already completed one or both of our surveys. If you have not yet done so, please act on the following:

- *Fellows' Survey*: If you completed a general medicine research fellowship in the past 10 years, please furnish Dr. Mara Schonberg (mschonbe@bidmc.harvard.edu) with your name and e-mail address. She will provide a unique, secure survey link via REDCap. This research study has been approved by Beth Israel Deaconess Medical

Center's Committee on Clinical Investigation (IRB protocol #: 2021P000995).

- *Program Directors' Survey*: If you are the program director of a general medicine research fellowship, please furnish Dr. Michael Paasche-Orlow (michael.paasche-orlow@bmc.org) also with your name and e-mail address. He will provide a unique, secure survey link via REDCap. This research study has been approved by Boston University Medical Campus Institutional Review Board (IRB protocol #: H-42364).

Please complete both surveys if you are eligible!

Next Steps

We plan to complete data collection for these surveys in March 2022 and to share preliminary findings at the SGIM National Meeting in April 2022.

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provision of needed documentation and signatures. Transportation costs were mitigated when receiving care at the clinic site within walking distance; yet for much of her follow-up at a separate campus, transportation costs rapidly accumulated. Local private taxis were preferred by the patient due to flexibility, language access, and safety. Private taxi trip costs were between \$20-50 and depended on the time she waited to see a clinician or needed to return to work. Cost of using public transit is monetarily lower, but with unreliable inconsistent schedules and fear of safety. This patient with refractory hypertension because of her untreated IgA nephropathy was often requested to attend regular follow up appointments every 2-4 weeks in her general internal medicine clinic care, in addition to her regular nephrology follow-up recommended monthly to every three months. These frequent visits add-up in cost.

Language discordance presented regularly as this patient was solely Spanish-speaking and her highest education was completing the first grade. Limited literacy further exacerbated communication barriers even with priority given to partnering with qualified bilingual providers in both her primary care and subspecialty care. It is important to note that although the patient had access to bilingual providers, her care was within a larger health system. For example, regarding access to prescriptions medications, social work paid for them at times, but the system required the patient to pick them up from the pharmacy within the system. The pharmacy staff do not often use interpreters and would have difficulties finding the patient in their system, which resulted in the patient having to find the social worker to advocate on her behalf. This created a delay in access to medications. Frequent renewals to programs, sliding fees, and appointment management, required organizational skills that without literacy make it challenging, if not impossi-

ble, to keep up. All of this combined for her need to work to meet basic needs as challenging for patient to manage together.

Despite our team's work to provide both language and culturally concordant care with the synergistic support of our physicians, social workers, and office staff, barriers remained with this patient's limited numeracy and inconsistent ability to read prescription bottles. Approaches taken to address this barrier included using numbers on the top of the prescription cap to signify how many times a day she would take said medication. Although atypical to do, we attempted prescribing her medication in a way that every medication had the same number of pills to take at a time. For example, when she was prescribed labetalol twice a day, her losartan 100mg once a day was converted to 50mg twice a day to minimize confusion.

The efforts described above to bridge the therapeutic relationship with Ms. Rosemary continued falling short, with questions of depression. Her affect was routinely blunted, although the Patient Health Questionnaire (PHQ-9) survey identified only mild depression and patient denied having concerns with her mood or outlook. During her hospitalization for dialysis initiation, a friend remained at her bedside with frequent remorse expressed at wishing to have been engaged in her care earlier, to have supported her regular intake of her medications, with hopes of having helped prevent her fate to be dialysis dependent. During her last weeks of hospitalization with complications following her craniotomy, her mother and siblings were actively engaged in discharge planning details, and, ultimately, discussions on goals of care. Following her death, a large community surrounded the family with support.

Ideas for Improvement of Care

We need to continue to advocate for system approaches to greater accessibility and equity of care to

vulnerable communities; yet, we must remain integrated into the individual facets of relationship building and flexibility to connect with our patients and align with their identified priorities. Community support to help not only translate across language but also translate across experiences and values can be accessed within an interprofessional team approach as we worked to do. Our medical team often required giving priority to urgent clinical assessments; our support staff further provided support in the recommended follow-up plans. Addressing the medical urgencies cannot be done successfully without the wraparound support in collaboration with our social work and staff colleagues.

Despite our efforts as described above, we struggled to engage with this patient. Would this greater engagement of her community have provided a different outcome? Community health workers (CHW) or patient navigators are inherently from and within the patient's community. They bring an unparalleled ability to meet the patient where they are physically, socially, psychologically. For Ms. Rosemary, we are left wondering if a CHW would have been able to engage both the patient and her community better than our efforts. A CHW may have learned of her church community or the individual friends in her life and then invited them to join in her medical visits as additional supports. This support could have facilitated the patient's limitations in understanding her medications and difficulties with medication compliance. Even in our dedicated efforts to bridge across the many cultural, language, and socioeconomic barriers, we are reflective at our failures to effectively engage with Ms. Rosemary. It is critical to patients that we work in interprofessional settings, and these teams truly be as fully inclusive as possible; ours was without a CHW—a role meant to target patient engagement.

nificantly more complex. Our team utilizes multiple channels based on urgency of request and level of care team sharing required. For example, if a patient needs an urgent medication refill, our nurse may directly message the physician on Microsoft Teams. If a team member discovers a helpful clinical workflow, they post it to our virtual whiteboard in a shared OneNote document. We avoid e-mail because our work e-mail inboxes are already too cluttered. If a patient needs a COVID-19 test, our nurse will message our Teams group chat so the physician or the NP can sign the order (the nurse will pend it). If a patient has multiple team contacts for an ongoing issue like a new cancer diagnosis, then we will document our touchpoints on a shared “High Risk” patient list within the electronic health record (EHR). Since most messaging occurs via written communication only, it is important to remain cognizant of tone and the way messages are perceived. Setting clear expectations for response times, responsibilities, and acknowledging message receipt are essential to virtual back-office communication.


Collaborate via the Virtual Huddle

Clinic huddles have often been a method to efficiently share information, collaborate, and coordinate.⁵ The Virtual Clinic is no exception, and so we huddle daily each morn-

ing to allow all team members to sync on schedules and address any clinical care escalations. It is also the central hub of our data-driven care coordination at Tera that gives us the opportunity to review key clinical quality metrics and patient panel health indicators regularly.

Conclusion

In the virtual care environment, time makes up for touch. While the team (and often the patient) are not physically co-located, as a team we can have multiple checkpoints with the

 Learn how the Tera Practice team coordinates and collaborates to deliver high-quality, patient-centered care, 95% virtually. @MattSakumoto

patient over a longer period of time. Rather than episodic 15-minute visits monthly, our team provides proactive monitoring and early intervention for any alarm symptoms. Flexible communication modalities, a collaborative platform, and team-based care enables higher quality, timelier care and a better experience for patients and the entire care team.

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To meet these calls to action, the Council has begun to strategically outline SGIM's commitment to anti-racist principles. In order to ensure we have a shared mental model, we worked to define our terminology and agreed upon the following:

- **Diversity:** SGIM is committed to promoting diversity expressed in myriad forms. Some examples include diversity as defined by race and ethnicity, gender and gender identity, sexual orientation, socioeconomic status, language, culture, national origin, religious commitments, age, (dis)ability status, and political perspective.
- **Equity:** SGIM is committed to reviewing policies to ensure no unearned or earned disadvantage. We are committed to ensuring our leadership, award, and committee structures are accessible to all and to developing systematic approaches to prevent and respond to harassment and discrimination. Equity recognizes that each person has different circumstances and allocates the resources and opportunities needed to reach an outcome. Our member and our advocacy continue to work in health equity, focusing on our vision of "A just system of care in which all people can achieve optimal health."²
- **Inclusion:** SGIM is committed to ensuring that all members feel their differences are welcomed, that different perspectives are respectfully heard, and that every individual feels a sense of belonging and inclusion. We continue to work on promoting diversity because we know that this generates a vibrant climate of inclusiveness where everyone can participate and engage in a meaningful way. No one person can or should represent an entire community.
- **Anti-racism:** SGIM is committed to opposing acts of racism, white supremacy, and oppression in our society, in other people, and in ourselves. This includes the

ways in which we all perpetuate racism with our behaviors and/or inaction in the face of structural racism and oppression. We will collect data and follow metrics to ensure we are committed in action and policy.

To ensure alignment with our mission and vision as noted in last month's *Forum*,³ we must not only focus on diversity, equity, and inclusion within SGIM but also work to change the structure and functions of the society. Our focus is on health and health care and most specifically we must reflect on our own SGIM culture, values, and structures to be more anti-racist in structure and action.

As you know, the Council convened the SGIM Anti-Racism Workgroup to review the annual plans of the committees and commissions to ensure that anti-racism work is a part of their DEI efforts and to make recommendations regarding the charge to committees and commissions as they do their work as well as make recommendations for how the Society can adopt an anti-racism strategy.³ Workgroup members include Rita Lee (Chair), Monica Lypson (President, SGIM), Eric Bass (CEO, SGIM), Chavon Onumah (Health Equity Commission), Cornelius James (Education Committee), Carol Bates (JGIM), Himali Weerahandi (Research Committee), Elizabeth Jacobs (Health Policy Committee), Naomi Waltengus (Staff Liaison, SGIM), and Erika Baker (Project Management Director, SGIM).

The workgroup further defined *Anti-racism* for SGIM as the "intentional action focused on addressing the policies, procedures, and structures that perpetuate historical and ongoing injustices and disparities. Our diverse group of stakeholders agreed to begin this work with an anti-racism and an anti-oppression lens to address intersecting identities."⁴ The workgroup then proceeded to make a series of recom-

mendations, named *Opportunities for Action*, to Council for deliberation. These opportunities were in the areas of Annual Meeting Oral Presentations, Awards, Membership, Leadership/Council, Committees & Commissions, Career Development, and Mentoring Programs.

To illustrate one of the Opportunities for Action, the following recommendations to Council from the Anti-racism Taskforce relate to Membership to ensure:

- Intentional outreach to recruit members from historically Black colleges and universities (HBCUs). This action would focus our outreach efforts to institutions with a commitment to justice as well as those potential members who might have been marginalized by lack of outreach and inclusive practices in the past.
- Intentional outreach to recruit members from Federally Qualified Health Centers (FQHCs). With consideration of a discounted registration fee to the annual meeting to bolster conference attendance. In this case, our goal is to include general internists who serve underserved communities. The addition of these clinicians to our learning communities would demonstrate community engagement and support patients. If it is financially feasible, SGIM should consider and acknowledge the limited access to resources for staff travel in these organizations.
- Intentional collection of member demographics with inclusion of multiple dimensions of diversity and breadth of options (e.g., more categories of race and ethnicity that allows differentiation beyond Asian; sexual orientation; gender identity; ability status, etc.).

Encouraging members to update their profiles and demographics is in many ways critical to all our Diversity, Inclusion, and Anti-racism

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President, provides an update on behalf of SGIM Council and highlights from the winter leadership retreat. If you are a current or recent general internal medicine fellow, or a general internal medicine fellowship program director, please read an important call for survey responses from the SGIM Fellows Survey Sub-Committee, a subcommittee of the SGIM Research Committee, by Marathur, et al. The survey provides the Sub-Committee with information on the career outcomes of current

and former general medicine research fellows and helps to identify barriers and facilitators to developing and maintaining a GIM research career. Also, Bass, SGIM CEO, and O'Malley, Director of the National Center for Excellence in Primary Care Research (NCEPCR), provide an update on NCEPCR goals for primary care researchers and how SGIM is engaged in advancing primary care research workforce development.

Each of us has an opportunity to apply our skills and perspectives

to advance—and *strengthen*—interprofessional and team care. This theme issue only begins to offer a few glimpses of this vital primary care health service. Stay tuned for more vital viewpoints to come in the next issue!

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PRESIDENT'S COLUMN (continued from page 12)

activities. Currently, we are missing race and ethnicity data for ~12% of our members. We must know more about the identities of the members so we may better serve our membership. We also recognize we must be transparent in sharing how this information will be used. While much progress has been made to collect this information, we will continue to work with the Membership Committee to hone our membership demographics and consider this iterative work. As noted in our Membership Diversity and Inclusion Initiative we are committed to change that supports all our members.

These are just a few of the recommendations to emerge from the workgroup. As additional recom-

mendations are finalized, reviewed, and digested by Council, we will share them with all of you.

“Everyone is a little bit racist,” but we can all lean in to systematically remove structural barriers and must consider changing long-standing policies that historically oppressed minoritized members and communities. This is our work towards a “Just System of Care in which all people can achieve optimal health.” This is what makes me proud to be a member of SGIM!

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SGIM Council Retreat at the Walt Disney World Swan and Dolphin in Orlando, FL, venue for the 2022 SGIM Annual Meeting. Julie Oyler, MD

each offer their tools at hand, the plan begins to take form marshalling the resources available in the clinic network which, until this moment, have floated in siloes, invisible to each other. The virtual format suits the meeting well; each person appears on screen in a square of equal size and shape. Everyone gets to stay in their office where they can return to their separate days with a click. The logistic barriers to gathering an interdisciplinary team are much fewer now than the pandemic has normalized online meetings.

As I listen, many conversations that I've had with my classmates return to mind. At debrief sessions after rotations, we exchange stories about patients who were uninsured, poor, and isolated, and how the medical system did not do much to help them. The intense schedule of the clinical year is no doubt to blame for the new tiredness in our faces, but the hard edge in our voices as we process aloud what we are seeing—that sounds like a different kind of fatigue.

I have heard the same edge, but more pointed and worn, when working with the residents at the clinic, which is a federally qualified health center, providing care regardless of the patient's ability to pay. Some said it becomes difficult to see patients who keep coming back with worsening outcomes, often because of social factors that remain unchanged.

But the residents were not alone in their exhaustion. An interview of 50 clinicians in Denver and Houston found that providing undocumented patients with suboptimal care contributed to professional burnout and moral distress.¹ Moral distress is a concept that was first described in the field of nursing; it refers to "the psychological distress of being in a situation in which one is constrained from acting on what one knows to be right."² Having to tell patients that the one medication that may help them is out of financial reach, or being unable to get necessary labs because the bills are an unaffordable

burden—these everyday occurrences take a toll. While the gap between the standard of care and the options available for most patients is something that providers face every day, it still must gnaw away at people who entered their professions to try their best to help people.

The discussion of social determinants of health has been a fixture in my medical school curriculum and, since the pandemic, public health has been among the most interest-generating topics on campus. We are encouraged to think about how individual health is shaped by our society and challenged to imagine more boldly what the physician's role can be in advocating for their patient. While I have no doubt in the capacity of my classmates to rise to that challenge, this year we have witnessed the grueling hours that residents work and the superhuman effort it takes to do more than the bare minimum. I have wondered whether our aspirations to be doctors who care for the whole patient will survive after residency.

But at the Integrative Case Conference, I saw how tending to the whole patient—as in addressing the socioeconomic aspects of their lives shaping and shaped by their physical health—does not have to further stretch the capacity of overworked physicians. During the call, questions that would have gone weeks without answers—how to change the frequency of home nurse visits, how can we assist with food insecurity—were answered immediately. Not only that, but the meeting also identified problems that had gone unseen because of lack of time or perspective.

At the end, the quality improvement coordinator summarized the action items (e.g., contacting the home nurse agency, the community health worker reaching out to the patient about food insecurity). Just before the Zoom closed, she told the resident that he should reach out if he needed anything else. Even without this meeting, I'm sure if the resident had asked, she would have

helped care for the patient to the best of her ability. But there is a distinct power to people coming together in a room, whether physical or virtual. It's why the tradition of medical rounds continues.

All those patients my classmates and I talked about whose social barriers to care seemed insurmountable—they all would have benefited from the same kind of comprehensive attention. And if I had been able to see, or even join, the interdisciplinary team at work, I would have been less discouraged about the quality of care being provided. It remains true that there are social determinants of health that cannot be addressed with individual intervention alone. But as a medical student, at the entrance of a new profession, it is empowering to know that physicians can choose to work closely with other disciplines who have deeper expertise in the social barriers to care. I have spent most of medical school asking whether as a physician, I could possibly alter the course of health inequities in someone's life. Equally important questions for me now are how to become a better team member, how to ask always whether there is someone who can advocate for my patient better than I can in this moment, and how to build a village of caregivers.

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education requirements and restructuring of graduate interprofessional medical education. We also need to address payment structure, quality measures, and patient experience, the latter relying on physician face-to-face encounters. In the surveys and metrics, the individual primary care physician is still held accountable for the poor access to care, delay in care, and health outcomes. The increased burden of in-basket, patient portal messages, and automatic release of patient results, has added to the inundation of forms, documentation, and quality measures, all of which affects physician mental health and wellbeing. When practicing in any current form of team-based care, the primary care physician must support the team while still holding the primary responsibility for everything else and expected to go above and beyond in patient care, service, teaching, community work, and/or research. Practicing in rural areas or safety nets where hospitals are less resourced and caring for socially complex patient populations carries further challenges for the primary care physician.⁵

Telehealth promises to expand access to primary care, but are the teams prepared to support the physicians to care for patients outside the in-person office visit? Many healthcare organizations and medical societies provide training and best practices for the physicians to practice telehealth. Who is training the nurses and medical assistants to provide virtual team-based care? How are we deciding their roles and their value to the patient care in the virtual realm? Who is providing funding to ensure they are part of the virtual primary care experience?

How Do We Transition to Team-based Care?

To transition to team-based care, we need high quality primary care implementation. The primary care physicians need training, time, and

empowerment to lead the team beyond the 10% administrative time. Each team member needs to be equally accountable to patient experience and quality metrics. The team's structure and training should include culturally sensitive care and a design responsive to the patient population's needs.

Transition to team-based care requires funding, sharing best practices, and, most of all, policy support. Primary care practices need to move from the face-to-face encounter that relies on the physician to a value-based system and a population model that incorporates patient experience and quality metrics. Advocacy for funding and accountability for allocation of funding requires a different approach and perspective. It is not about funding primary care—but funding the right care. Healthcare organizations are better paid for emergency room and inpatient care than prevention and chronic disease management. There is no incentive to improve staffing.

Reflecting on the COVID-19 pandemic, we learned that defeating the pandemic required alignment between policy, science, the media, and health care. It also needs primary care to manage chronic and behavioral issues, promote preventative care, reduce vaccine hesitancy, to name a few, to end this pandemic. Healthcare organizations worked quickly to share knowledge and exchange ideas to save lives. Primary care saves lives and requires a similar framework to evolve in this unprecedented time.

Conclusion

We envision the primary care physician leading an interdisciplinary team, including pharmacists, registered nurses, medical assistants, community health workers, social workers, and care coordinators, to name a few, using models that support optimizing clinical outcomes via equitable, high-value care. The right funding structure and policy

support remain the biggest hurdle to the transformation of primary care. SGIM and others have put this at the forefront. We must take it a step further by including policies that require institutions and/or community-based practices to demonstrate their budgetary plan to sustain the change after the grant funding runs out. The policies should include appropriate funding percentage details to be allocated directly towards salaries and clinical resources. Lastly, hospitals and health systems ranking criteria need to include primary care's measures of excellence in care with an equity lens.

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