



SGIM *Forum*

Society of General Internal Medicine

IN CONVERSATION

PROMOTING SCHOLARSHIP, ADVOCACY, AND CREATIVITY IN THE BALANCE OF WORK, FAMILY, AND SOCIAL RESPONSIBILITY

Rachel Levine, MD, MPH; Carole Warde, MD

Dr. Levine (rlevine@jhmi.edu) is professor in the Division of General Internal Medicine, Johns Hopkins Bayview Medical Center, Johns Hopkins School of Medicine. Dr. Warde (cmwarde@gmail.com) is a Health Sciences Clinical Professor of Medicine Emeritus, David Geffen School of Medicine at University of California, Los Angeles.

The Mary O’Flaherty Horn Scholars in General Internal Medicine Program was created in 2000 in Dr. Horn’s honor. Prior to her passing in 1998 of amyotrophic lateral sclerosis, Dr. Horn was a master clinician-educator devoted to caring for underserved populations at St. Mary Medical Center, a University of California, Los Angeles (UCLA) Affiliated Internal Medicine Residency. Dr. Horn was the first internist at UCLA to split a full-time faculty position with another like-minded physician, Dr. Carole Warde. Both were able to be devoted to their families and their careers without the constant struggle of needing to be in two places at once.

The Horn Scholars Program was endowed by Dr. Horn’s family and friends to allow other physicians to find a satisfying balance. This career development award for clinician educators supports work-life balance, which Dr. Horn exemplified, by supporting those desiring to work less than full time and providing protected scholarly time. Since 2000, there have been seven Horn Scholars.

The Horn Award is a transformative experience for recipients. We are excited to announce that *starting in 2023, a Horn Scholar will be named every year instead of every three years.* The desire to support SGIM members, especially in the wake of the COVID 19 pandemic and the coincident growth of the Horn endowment,

have led SGIM leaders to this program expansion.

We sat down with the current Horn Scholar, Dr. Tyra Fainstad, 2020-23 Mary O’Flaherty Horn Scholar, to learn about her experiences.

“The Horn Award is a transformative experience for recipients. We are excited to announce that starting in 2023, a Horn Scholar will be named every year instead of every three years. Current scholar, Tyra Fainstad, shares insights from her Horn journey.”

Please describe your life before the Horn Award and what prompted you to apply for this award.

I was working as a primary care doctor and clinical faculty at the University of Washington. Like many junior faculty, I was an “approval addict.” Medical training culture left me with the idea that “life will be better once I...”. Despite this arrival fallacy, I loved my job, especially teaching. Drawn to feedback reception, mindset theory and psychological safety, I had dreams

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FROM THE EDITOR

THE THINGS WE DO NOT SAY

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

I tried not to write another COVID-19 related column. This is hard: The Netherlands just began to re-emerge in mid-January from its strict COVID-19 regulations. *Again.* Going for another post-lockdown trim of my mane, conversational wayfinding to another topic with my usual hair stylist was impossible. This is our present, when a deceptively simple, “How are you?” evolves into more extended conversations about how the pandemic mutated routines and livelihoods. This was especially true for my hair stylist: classified as a contact profession, her business had been forced to shut down during the first lockdown in March 2020 for months, and again in this most recent lockdown. I have forgotten the many flavors of lockdowns of the past two years, but her business was always the first to be forced closed.

I noticed a certain guardedness as she spoke, snipping away at my locks. I mentioned going to a Christmas market in Germany for part of a day. Behind her mask, she commented that the Christmas period is usually very busy for the hair business. However, because the hair salon was forced to close, she had been out of work. With a pinch of positivity, she mentioned that usually she can't go to the Christmas markets in Germany because of work, but this time she did. (Although The Netherlands may have closed all non-essential businesses throughout the country, larger neighboring countries did not.) As she shared this, and then paused, it seemed like her typical energy, pleasant talkativeness, and optimism were drained. I could not see her smile as she usually does—or the smile in her eyes, over her mask in the mirror, or hear the smile in her voice as she spoke—sometimes also while gently trying to sell me hair products, talking up their benefits while fluffing my fresh coiffure with her bare hands. Maybe it was just a bad day.

Days later, I still thought about her and our chit-chat. She has kept my short crop in control for well over three years. It did seem like more than a bad day. We can talk about many things, yet when we talk, the things we do not say can be the most valuable. We need to be able to hear each other. And it's not just COVID-19 again.

SGIM

SGIM AS HEALTH ADVOCATE DURING THE PANDEMIC AND BEYOND

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

"In the 24 months since the beginning of the pandemic, SGIM has provided more than 90 advocacy statements and/or legislative endorsements. Most of those endorsements have been advocacy items related to COVID-19. As we continue to fortify ourselves against the ongoing assault of COVID-19, it is critical for us to see the impact of our small yet mighty society of ~3,000 members."



I do my best to learn from others who exist beyond my physical (personal, institutional, national, global) borders to help better understand and appreciate how others approach issues. An example is what I have learned from our Canadian neighbors (~30+ of SGIM members are from Canada) and their adoption of the CanMEDS framework that defines the various abilities of the physicians, including the identities of Scholar, Professional, Communicator, Collaborator, Leader, Health Advocate, and the integrating function of Medical Expert. This framework optimally articulates the varying roles of the physician, including that of serving as a Health Advocate. The framework states that physicians, as Health Advocates, “work with those they serve to determine and understand needs, speak on behalf of others when

required and support the mobilization of resources to effect change.¹ In many ways, the SGIM advocacy aim to envision a “just system of care” embodies the CanMEDS role of Health Advocate.

In the 24 months since the beginning of the pandemic, SGIM has provided more than 90 advocacy statements and/or legislative endorsements. Most of those endorsements have been advocacy items related to COVID-19. Our decisions to engage in other areas are guided by SGIM Council approved Health Policy Committee (HPC) Agenda and White Papers.^{2,3} It is important to highlight that advocacy issues related to the pandemic continue to be situated within the HPC Goals of “1) Fair and equitable Medicare reimbursement policies, 2) Adequate funding for health professions training and 3) Support for health services research.”⁴ During this same timeframe, our advocacy work has focused on improving the health and health care of our patients—a summary of those

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SGIM Forum

Editor In Chief

Tiffany I. Leung, MD, MPH, FACP, FAMIA
 Editor.SocietyGIMForum@gmail.com

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 frank.darmstadt@ymail.com

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 jettonf@sgim.org
Eric Kutscher, MD
 eric.kutscher@nyulangone.org
Megan McNamara, MD, MS
 Megan.Mcnamara@va.gov
Somnath Mookherjee, MD
 smookh@u.washington.edu

Susana Morales, MD
 srm2001@med.cornell.edu
Avital O'Glasser, MD, FACP, FHM
 avitaloglasser@gmail.com
Shobha L. Rao, MD
 shobha_rao@rush.edu
Jorge A. Rodriguez, MD
 jarodriguez1@partners.org
Gaetan Sgro, MD
 gaetan.sgro@va.gov
Elisa Sottile, MD, FACP
 Elisa.Sottile@jax.ufl.edu
David Walsh, MD
 dawalsh@augusta.edu

The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

IN APPRECIATION OF PARTICIPANTS IN SGIM'S "FORGING OUR FUTURE" PROGRAM

Eric B. Bass, MD, MPH; Martha Gerrity, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Gerrity (martha.gerrity@va.gov) is the Chair of SGIM's Philanthropy Committee.

In November 2020, SGIM launched the "Forging Our Future" program to instill a culture of giving among members who value what the organization has contributed to their careers and the mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.¹ By the end of 2021, we received a total of \$480,399 in donations and pledges. Of that amount, \$24,715 was designated for the Future Leaders of GIM Fund, covering complimentary memberships for fellows and scholarships for medical students and residents attending the SGIM Annual Meeting. About half of the amount given to the Future Leaders of GIM Fund was in memory of Dr. John Noble, SGIM's 12th president. Members also designated \$23,610 for expansion of the Unified Leadership Training in Diversity (UNLTD) program while the Hess Foundation generously agreed to allocate \$200,000 from a previous gift to support expansion of the UNLTD program. The Forging Our Future program also benefited from a previous gift of \$50,000 from the Sergei Zlinkoff Fund for Medical Research and Education that helped lay the groundwork for expanding our organizational capacity for growth.

SGIM's Council set a great example by achieving 100% participation in the Forging Our Future Program in 2020 and again in 2021. The Program ultimately succeeded in engaging 404 members, including more than 70% of the past presidents of SGIM or ACLGIM, more than 60% of the chairs of SGIM's committees and commissions, and 100% of the Philanthropy Committee members. We greatly appreciate the generous support of all members who contributed to the program as well as those who joined the Legacy Circle for bequests and planned giving, as listed in the following table on page 5 (see SGIM's web site for the full list).² By creating a new pillar of support, you have enhanced our ability to address the mission that is more important than ever.

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IN CONVERSATION *(continued from page 1)*

of reinventing the learning environment, but quickly learned that protected time and funding was necessary to innovate, study, and disseminate ideas. I ended up doing scholarship without protected time or funding, mostly on my own time. Simultaneously, I was given an abundance of well-intentioned offers and advice: "Please create this 2-day

workshop", "We are happy to have you to serve on this committee!", "Would you mentor a few medical students?", "Remember to attend and speak at all the big conferences", "The Sub-I curriculum could benefit from your eyes", etc.

I had two children after residency, and parenting was not what I expected. The harder I tried to "do

it right" the further away I got. As an only child with two ill parents, I found myself in the "sandwich generation" trying to keep the balls in the air, constantly prioritizing what felt most urgent. This was a losing game. I felt exhausted in a life I didn't expect or create. Don't get me wrong: I deeply appreciated

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IN CONVERSATION (continued from page 4)

and loved my position at UW. I did have a half day a week of protected time and the relationships I made in my clinic were pivotal for my development.

However, I was lost in a culture that taught me to value my worth by my external assessments. A culture that taught me that to be happy, I had to sacrifice my current self for

my future self. A culture that whispered that my physical and mental health came second.

I decided to move home to Colorado to be closer to family. I was recruited to the University of Colorado by my medical school mentor, Dr. Mark Earnest, who would be my future division head. Before I left Washington, Dr.

Earnest passed along the Horn Award call. I remember opening the e-mail on a cold Seattle afternoon thinking “is this for real?” The award felt like a beacon of light from someone who saw that I was barely keeping my head above water. Someone who knew I had been unable to even consider the big

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OBSERVATIONS AND LESSONS FROM IMPLEMENTATION OF INPATIENT INTERPROFESSIONAL COLLABORATIVE PRACTICE AT THE BEDSIDE

Temple A. Ratcliffe, MD, MS-HPed; Luci K. Leykum, MD, MBA, MSC; Jacqueline A. Pugh, MD

Dr. Ratcliffe (ratcliffe@uthscsa.edu) is an associate professor in the Department of Medicine at The Joe R. and Teresa Lozano Long School of Medicine at the University of Texas Health San Antonio and the South Texas Veterans Health Care System and a 2016 Josiah Macy Jr. Foundation Faculty Scholar. Dr. Leykum (luci.leykum@austin.utexas.edu) is a professor in the Department of Medicine at the Dell Medical School at the University of Texas at Austin and the center lead for the Elizabeth Dole Center of Excellence for Veteran and Caregiver Research in the Department for Veterans Affairs. Dr. Pugh (pugh@uthscsa.edu) is a professor in the Department of Medicine at The Joe R. and Teresa Lozano Long School of Medicine at the University of Texas Health San Antonio.

Interprofessional education (IPE) is key to developing the interprofessional teams that are considered vital to improving our healthcare system and bridging well-known quality gaps.¹ Preclinical IPE, or IPE outside of the clinical learning environment, is relatively well established and implemented with varying levels of authenticity, sophistication, and effectiveness at most health professions schools, in part driven by educational regulatory requirements. More recently, there has been an increasing recognition that IPE, in order to fully realize its benefits in practice transformation and improved patient care, needs to move beyond the classroom to the clinical learning environment.² Calls for innovation within this intersection of IPE and interprofessional collaborative practice (IPCP) speak to the national urgency in moving IPE beyond the classroom.

Implicit in the idea that IPE is necessary to transform our clinical environments is the underlying recognition that current healthcare systems are inadequate: physician-centric, silo'ed, fragmented, and insufficiently responsive to the totality of patient needs. IPCP could address these shortcomings. While there are many encouraging clinical models that encompass aspects of the World Health Organization's definition of IPCP, widespread adoption of transformational, patient-partnered IPCP, which meaningfully involves patients and families, remains elusive.

We created such an IPCP environment on our adult inpatient medicine teaching service.³ Workflows on these teams were interprofessionally integrated, requiring significant changes in daily activities for all involved professions. Rounds were collaborative and patient partnered at the bedside, and additional workflows, including dedicated time for team reflection and learning, were built into the day. While the experience was not perfect, we found that learners appreciated patients' roles on the team³ and we observed modest process improvements. Ultimately, with

the pandemic, our IPCP initiative ceased. With the recognition that creating patient-partnered IPCP environments is challenging, we reflect below on lessons learned and implications.

First, patient-partnered IPCP does not represent an incremental improvement on the status quo of inpatient adult medicine. Rather, it represents complete system redesign.

In our case, the redesign required had consequences at the system, team, and individual levels. Acknowledging this multi-level system complexity at least partially explains why implementation of transformational, patient-partnered IPCP remains a wicked problem and why typical quality improvement efforts, such as Plan-Do-Study-Act (PDSA) cycles, are ill-suited for this transformation. It also makes apparent why such tremendous energy is required from all involved in such initiatives to make and then sustain the redesign. While we are not suggesting that incremental improvements on our current healthcare delivery systems are without value, we are concerned that they may not be sufficient for the transformational change that patient-partnered IPCP requires.

To successfully accomplish the needed transformation, IPCP teams (and well-functioning teams in general) require partnership and input from all healthcare system stakeholders, leveling of hierarchy, and unwavering leadership support. This inclusive, constructivist approach is necessary, time-intensive, and, at times, exhausting. Consideration for appropriate, potentially reduced clinical workload in the context of transition to an IPCP care model is necessary. IPCP models, and subsequently teams, that emerge in conducive environments will be quite different across contexts. Even within our healthcare system, new patient-partnered IPCP teams with the same underpin-

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nings functioned differently on different inpatient units within a single hospital. Because these IPCP team differences may reflect important differences in each care setting (i.e., spatial layout, staff deployment and availability), they should be respected and not necessarily considered implementation flaws.

Second, the skill set required for successful IPCP is greater than that for which team members are currently equipped.

As the Interprofessional Educational Collaborative's (IPEC) core competencies for interprofessional practice (interprofessional practice, roles and responsibilities, interprofessional communication, and teams and teamwork—with 39 interrelated subcompetencies) make explicit, providing optimal care in IPCP settings requires additional knowledge, skills, and attitudes than that required in traditional care models.⁵ This is not an “either/or,” it is a “both/and;” health professionals practicing in these settings need to develop both profession-specific and interprofessional competency. Patients and families, as vital team members, require guidance as well.

Even with training, expectations, and iterative feedback to promote team member skills and team effectiveness, IPCP creates challenges with cognitive load for team members, and particularly learners, when engaged in true collaboration with patients and families at the bedside. Care conversations at the bedside are dynamic and rich, but also unpredictable; their complexity invariably leads to increased extraneous cognitive load (while variably affecting intrinsic cognitive load); this increased cognitive load will be more challenging for less experienced team members and learners to overcome.

Sensemaking, a social act of developing a shared mental model about what is happening and acting in a coordinated way based on that understanding, is a necessary team skill for managing the dynamic and often unpredictable nature of IPCP;

further, it offers a framework to think through best practices for IPCP creation and support. In prior work, we noted that inpatient teams with observable behaviors that promote team sensemaking (e.g., defining the task at hand, clearly articulating the intent of care plans, soliciting concerns), have improved patient outcomes.⁴ Incorporating design elements that promote effective sensemaking (e.g., time for teams to reflect and learn together) could allow IPCP teams greater capacity to engage in sophisticated sensemaking required for working within contemporary, complex healthcare systems. Building teams' sensemaking capacity, particularly across professions, takes time. This is another reason to consider clinical workload when introducing new systems of care to allow interprofessional teams time and space to develop and grow.

One challenge that quickly becomes apparent when building and growing IPCP teams is that while the interprofessional group tasked with disrupting the care environment evolves together, the interprofessional team members that form the actual teams delivering care are, in contrast, transitory, especially in teaching environments. As organizations move towards IPCP models of care, it will be essential to examine how to increase stability of teams through exploring staffing models that allow for increased continuity. Because discontinuity cannot be eliminated, however, strategies to rapidly orient and engage transient individual team members meaningfully in the constructivist team creation/maintenance process are needed. Creating a scaffolding for new team members is critical. This scaffolding can take many forms: team reflections, overlap of team members, simulation of IPCP activities, real-time coaching, and scripts and educational tools. All these approaches promote the specific behaviors that enable effective IPCP sensemaking. Our experience suggests that using multiple approaches is more likely to be successful.

Our healthcare system's status quo is not acceptable for patients, learners, or care professionals. IPCP represents an important opportunity to meaningfully engage patients, families, and a diverse group of health professionals to develop the individualized, inclusive care plans that are necessary to improve outcomes. IPCP must be recognized as a fundamental redesign of our current system that requires an expanded skill set from clinicians and learners across the health professions. Our experience speaks to the importance of (1) recognizing the magnitude of the task of implementing IPCP and adjusting team clinical workload accordingly over time; and (2) recognizing the importance of sensemaking as a critical IPCP and system transformation skill, using purposeful strategies and scaffolding to teach and promote effective sensemaking behaviors.

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A MEDICAL DIRECTOR'S QUEST TO MAXIMIZE INTERPROFESSIONAL CARE IN A RESIDENT CLINIC: LESSONS LEARNED

Jason Ehrlich, MD

Dr. Ehrlich (jehrich@northwell.edu) is associate program director of the Zucker Hofstra/Northwell Residency Program at North Shore Manhasset and Long Island Jewish Hospitals and medical director of the Medicine Specialties at Glen Oaks, the teaching clinic for Long Island Jewish Medical Center.

Scholars of the Patient Centered Medical Home (PCMH) have generated a robust literature to illustrate that the interprofessional (IP) model of primary care delivers value. When IP care and IP culture are maximized, a practice can achieve that tantalizing goal of improving patient care while simultaneously reducing provider and staff burnout.^{1,2} IP education is a crucial adjunct to this schema, as training all members of a practice in one another's capabilities maximizes true team functionality.³

The experience of our resident clinic, native to Northwell Health's Long Island Jewish (LIJ) Hospital and in recent years transitioned to a community location, illustrates some of the promise and pitfalls that one might encounter in trying to transform one's clinic into a high-functioning IP environment. I have been core faculty in our institution's grant-supported, intensively interprofessional IMPACcT clinic⁴ for six years and have, along with outstanding colleagues, had the privilege of teaching IP education principles regionally and nationally. In assuming directorship of the LIJ clinic as we prepared for our move, I was enthusiastic about relaunching the practice in highly interprofessional form. I am hopeful that the following discussion of our journey will help to offer some ideas as well as some cautions to those on a similar path.

Demonstrate Commitment to IP Leadership and Processes

Coming into my tenure as clinic director, I was fortunate to inherit a culture oriented towards positive IP interactions. Our full-time faculty featured within its ranks our clinical pharmacist, double appointed at St. John's University and Northwell, and acknowledged as a crucial part of practice leadership. Huddles had been put into place to lead off patient care sessions ever since the practice became a PCMH, and IP staff attendance was expected at each.

Make Sure Your IP Staff Feel They Are Valued Stakeholders in the Practice

Weekly Practice Improvement Team (PIT) meetings were also instituted upon PCMH certification, conducted every Monday as a working lunch. Faculty leadership,

residents, Registered Nurses, Medical Office Assistants, Care Managers, Registered Dietician, Social Workers, Medical Secretaries, and Front Desk staff regularly participated in these meetings, working together to optimize practice workflows and policies. This gave every member of the team a consistent opportunity to contribute to practice design, enhancing mutual commitment and sense of practice ownership.

Educate Administration that IP Resources Are Not an Extravagance, but Fundamental

The most clinically significant unmet need in our PCMH was ready access to Behavioral Health (BH) resources. Advocating for an embedded BH practitioner provided a lesson both in the value of direct action and in the limitation of this approach. After a lengthy series of diplomatic emails, phone contacts and intra-divisional strategizing yielded no tangible resource, I opted for a blunter approach. Righteously citing our patients' high level of need, the repetitive ED visits that could be avoided with BH access, and the inequity of resources across resident practices at our institution, I was able to secure an in-person meeting with the BH service line leadership and essentially insist upon a commitment towards an embedded practitioner.

...But Be Prepared with a Clear Plan for Resource Implementation

Direct advocacy with those best positioned to provide material help seemed to unlock some resources. We moved to the head of the line to onboard a BH practitioner via a recently launched, government-sponsored program. What I had not sufficiently accounted for was that the constrained physical space our clinic occupied at that time would soon undermine the delicate arrangements we had made. Despite faculty willingly ceding already scant room to our new BH professional, the crowded space and limited available technology gave his supervisors the likely quite accurate impression that we could not meet the program's minimal support requirements. Our long-sought BH practitioner was pulled

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from the practice and it seemed that many months of effort had gone for naught.

Maintain Resilience through Setbacks

The experience taught several lessons. I'd thought the missing link in our BH effort was a strong pitch to administration, and advocacy with the right people in power had seemed to make a difference. But without an adeptly designed infrastructure for our new BH practitioner to feel valued and productive in our practice, the IP collaboration for which I'd fervently hoped could not materialize. In the long view, however, the collapse of this shared effort did make our institution's BH leadership very aware of our practice's specific needs. When our clinic's physical circumstances changed, we were first in line for another chance to bring a therapist into our practice.

Active Listening for Opportunities Pays Dividends

We caught a break a few months later when our long-planned move to a more spacious location finally came together. We now would have the workspace we'd need to expand access for patient visits and better deploy IP staff. At this point, certain opportunities seemed to present themselves for the taking—so long as we seized upon them when we first heard any inkling of a development that might help us. Keeping an ear to the ground for institutional and local initiatives that could potentially yield clinic resources became the centerpiece of our IP team construction strategy moving forward.

Collaborate Creatively to Develop Programs with Willing IP Colleagues

When the BH service line suggested they might be able to free up a Care Manager to provide counseling a few days a week, we pounced on the opportunity. We were able to take advantage of a nascent collaboration with the psychiatry residency to

embed senior residents as consultants within our practice. We worked to develop this relationship, and it has become the linchpin in caring for our patients with severe mental illness. Collaborating with our always-innovative Psychiatry colleagues to weave together our new practitioners' services, we soon developed a truly integrative BH team.

Recognize When Promising Opportunities Fall into Your Hands

A collaboration between LIJ's in-house pharmacy and our institution's new commercial pharmacy venture created the opportunity for us to embed a pharmacy liaison in our practice, to help with securing access to medications for our patients with the least financial resources. This practitioner has expertly reduced the substantial burden that medication prior authorizations impose upon clinicians, thereby permitting us to more boldly prescribe therapies that we otherwise might have counted out as unattainable for our coverage-challenged patients. Pharmacy faculty meanwhile managed to open a channel for pharmacy residents and students to join our team huddles. Productive collaborations with substance misuse counselors, attorneys, and social workers from a medical-legal partnership with Hofstra University Law School, community health workers operating within a Medicaid-driven initiative, and a state grant-supported Cancer Screening Program have followed.

IP Education Burnishes IP Care

The more IP educational moments we create, the more integrated our IP care has become. We continue to run our PIT meetings every Monday and afford time in each huddle for IP practitioners to contribute within their areas of expertise. In our annually organized QI projects, we place IP collaboration front and center, ensuring that project design is optimized by content experts throughout and maximizing what we can achieve for our patients. At the outset of this

academic year, all staff worked together to design a case-based resident orientation session which prominently featured our diverse IP offerings, aiming to drive optimal collaboration from day one.

IP Care Is the Future for Primary Care Physicians

If we want to do well by our patients while preserving our own wellness and hold out any hope of representing primary care as an appealing career to our current residents, we must maximize the IP presence in our practices. To achieve these goals, a number of approaches can work. But if we really want to build resident clinics' IP offerings in the current business environment, one within which clinician-educators have to Robin Hood many of the resources we need, it will be crucial for our SGIM community to work together to deftly identify and nimbly deploy all the effective strategies that we possibly can.

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COLLABORATION WITH MEDICAL SOCIAL WORK IN RESIDENT PRIMARY CARE PRACTICE: A NEEDS ASSESSMENT

Rebecca Shafer, MD; Ariana Ram, BS; Lauren Block, MD, MPH; Karen Campbell, LMSW; Daniel J. Coletti, PhD

Dr. Shafer (rshafer2@northwell.edu) is fellow, Department of Medicine, Zucker School of Medicine. Ms. Ram (aram18@pride.hofstra.edu) is a medical student, Zucker School of Medicine. Dr. Block (lblock2@northwell.edu) is associate professor of medicine, Zucker School of Medicine. Ms. Campbell (kcampbell11@northwell.edu) is director, Division of General Internal Medicine, Northwell Health. Dr. Coletti (dcoletti@northwell.edu) is associate professor of psychiatry and medicine, Zucker School of Medicine.

Introduction

In recent years, evidence has suggested that an inter-professional [IP] approach to primary care improves health outcomes.¹ Medical social workers have been integrated into primary care settings to address complex medical and psychosocial needs among patients.² Social workers facilitate case management, provide counseling and psychotherapy, and help patients navigate the healthcare system to obtain needed services.² Incorporating social workers into an IP team in teaching settings can be challenging.³ A major barrier to integrating social workers into primary care is an incomplete understanding of the social worker's role among medical providers, leading to underutilization of social work expertise.⁴ The extent to which the social worker is integrated into primary care settings impacts the social worker's ability to provide quality care to patients.⁴ There is a need for clarity of the roles and capabilities of a social worker in an academic IP team.⁵

Goals and Objectives

We sought to understand views about the role of the social worker within the residency practice at the Northwell Health Division of General Internal Medicine. Personnel changes afforded us an opportunity to conduct a needs assessment with providers to re-think the role of social work as we reorganized our interprofessional team. Interviews and focus groups of medical residents and faculty members assessed (a) understanding of social workers' professional roles in the primary care setting and (b) expectations for partnership, collaboration, and assistance in addressing the social determinants of health.

Methods

This qualitative project included 30-minute focus groups with Internal Medicine Residents (PGY-1, PGY-2, and PGY-3) during their ambulatory rotations as well as individual interviews with pharmacy and physician faculty

and one resident. All participants answered the same open-ended questions using an interview guide designed to articulate the role of a social worker and barriers to integrating social workers into IP teams. Participants were recruited by convenience sampling. Focus groups were co-led by two or more members of our project team (AR, RS, DJC) and conducted virtually using a videoconferencing platform. Participants provided verbal consent to have the interviews audiotaped. Data analysis included content analysis of group/interview transcripts in an iterative process including all researchers. Two raters reviewed each interview to identify emergent themes that occurred across participants. The Northwell Health IRB reviewed this project and determined this to constitute quality improvement.

Results

A total of 11 residents took part in three focus groups—two additional faculty members and one resident were interviewed individually for a total of 14 participants. Themes of focus groups and interviews included best practices for collaborating with social workers, suggestions to optimize the activities of social workers in primary care settings, perceptions about the social worker role, barriers to collaboration, and education and training about the role of social work (see table). The social worker role was perceived by participants to be a “resource hub” and a “link to community resources.” Social workers were noted to “address needs outside the scope of [the medical] clinician's role” and serve as a patient advocate. For patients with barriers to care including insurance problems, social workers were perceived as key navigators.

Residents noted that much of their experience interacting with social workers occurred during their inpatient rotations, and they appreciated the role social workers played in facilitating safe discharge and communicat-

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Qualitative Themes and Illustrative Quotes

Theme	Quote	Participant
Best practices for with collaborating social workers	“We’ve always had really positive joint visits where...I’m helping with more of the like application aspects of it but [the social worker] is helping more on—the psychosocial aspects that are prohibiting that patient from achieving their goals.”	Pharmacist
Suggestions to optimize the activities of social workers in primary care settings	“Better integrate into interprofessional team”	Physician
Perceptions about the social worker role	“They’re like, resource waterfalls basically and they have resources for everything.”	Resident
Barriers to collaborating with social work	“The workload is so intense that often...there can’t be like a warm handoff, and then the patient kind of gets lost.”	Resident
Education and training about the role of social work	“Lack of formal training about social worker role”	Resident

ing with outside facilities including rehabilitation centers. Collaboration with social workers was also noted to be an important part of outpatient practice. One participant noted that social workers adapted “services to be culturally inclusive for patients.” Social workers facilitated transportation to appointments, arranged treatment for substance use disorders, and helped patients struggling with difficult environmental situations including domestic violence. Though one respondent shared that “we tend to get social work involved when things are going badly,” several participants noted wishing they had engaged social workers earlier.

Residents and faculty noted several barriers to working with social workers, including communication challenges. The time pressures of ambulatory care made it hard to include the social worker on an emergent basis—for example, when “people come in for one problem and then their one problem becomes 10 problems and you don’t have time for...a family meeting or a social meeting.” One participant noted appointment no-shows and late arrivals to be a barrier to involving interprofessional team members in medical visits. Pandemic-related increases in social distancing and remote work presented an additional layer of communication challenges.

Participants noted receiving some information about the role of

social workers during orientation, but as one attending mentioned, “you’re learning a lot of things [during orientation] and you don’t have a good understanding of how things work in other ways... [so] it gets lost.” Participants wanted to know more about, “the things that social work can make happen.” One participant requested a “sheet saying exactly the things that a social worker might be able to [do]...” There was a consensus however that the best training about social workers came from direct, frequent interactions, and “actually sending the patients to the social worker for a specific reason.”

Participants had several suggestions to improve collaboration with social workers in primary care. They requested enhanced integration of social workers into the interprofessional team and more consistent interactions. It was also recommended that the practice establish dedicated social work appointments “scheduled for that specific purpose” of addressing social needs. Finally, more comprehensive pre-screening of patients for social needs was recommended to identify patients who would benefit from social work involvement.

Discussion

Obtaining perceptions about the role of social workers among primary care professionals is key to identifying staff training needs about the

ways social workers support medical care and can serve as full members of the IP team. Social workers are perceived as a “resource hub,” and advocates for patient needs and experts in overcoming barriers to healthcare such as insurance, transportation, and applying for home-based services. Few participants associated the social worker role with behavioral health and counseling. We found this perspective interesting since the practice has a respected and well-utilized social worker providing psychotherapy to our patients, suggesting a training need to clarify the distinctions between medical and psychiatric social work. Many residents received training about the social worker role during orientation and requested ongoing exposure to a social worker’s responsibilities in the ambulatory setting. Time constraints serve as one of the biggest barriers to working with social workers. Limitations of this project include the small sample of stakeholders at a single training site. Team meetings, preventative pre-screenings, and “warm handoffs” between the patient, provider, and social worker are needed to ensure coordination of care, and are also challenging due to time constraints. Ensuring that residents and social workers understand each other’s roles and responsibilities can help foster collaboration to serve patients’ medical and social needs.

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MISSED OPPORTUNITIES IN ADDRESSING CARE ACROSS THE CANCER CONTINUUM IN GENERAL INTERNAL MEDICINE

Danielle Amundsen, BS; Youngjee Choi, MD; Larissa Nekhlyudov, MD, MPH

Ms. Amundsen (amundsen@jhmi.edu) is a fourth-year medical student at Johns Hopkins University School of Medicine. Dr. Choi (ychoi47@jhmi.edu) is an assistant professor in the Division of General Internal Medicine at Johns Hopkins University School of Medicine. Dr. Nekhlyudov (lnekhlyudov@partners.org) is a professor of medicine at Brigham and Women's Hospital.

As general internists, we care for patients across the spectrum of many diseases, including cancer. For cancer care, we are at the forefront of developing and promoting recommendations for prevention, risk reduction, and screening. We are often the ones to diagnose cancer and help our patients navigate the early phase of treatment. During later phases of the cancer continuum, general internists' roles include co-management with oncology colleagues, facilitating transitions from active treatment and at the end-of-life, and guiding patients through decision making and goal setting. Recognizing this unique contribution of general internists, a group of SGIM members launched the Cancer Research Interest Group in 2006. During its first 10 years, the Interest Group galvanized efforts in clinical care, research, education, and policy.¹ The group, now Cancer Care, Education, and Research, continues to be active within the Society. Since 2006, the population of cancer survivors, or individuals living with and beyond cancer, in the United States grew from approximately 10 million to 17 million.² Internists must be prepared to care for this growing population and lead innovative research and medical education efforts across the cancer continuum.

As members of SGIM, we were interested in exploring whether our organization has kept up with the population trends and led innovation across the cancer continuum. To do so, we characterized cancer-related abstracts presented at the 2015-19 annual SGIM meetings for their content across the cancer continuum (prevention, screening, diagnosis, treatment, survivorship, and palliative/end-of-life).³ Of 3,437 scientific abstracts, we found that 304 (8.8%) related to cancer. Among cancer-related abstracts, our further findings revealed a robust emphasis on cancer screening (47.7%) with moderate attention to prevention (17.1%) and treatment (18.8%) but missed opportunities for research in other phases of the cancer continuum, especially survivorship (4.0%) and end-of-life care (9.5%). These findings held true across Scientific, Innovation in Clinical Practice, and Innovation in Medical Education abstracts. This emphasis likely reflects the comfort and experience internists have with earlier

phases of the cancer continuum and our limited training and integration in survivorship and end-of-life care. It is also possible that the abstracts presented do not fully represent the breadth of research conducted by SGIM members but rather showcase those that are submitted and/or accepted for presentation. Furthermore, abstract presentation may not reflect the actual attention to these phases of care in day-to-day clinical practice.

The national calls to improve cancer survivorship care began as early as 2005 by the Institute of Medicine (now National Academy of Medicine) in *From Cancer Patient to Cancer Survivor: Lost in Transition*, a book that emphasized the need for quality care including prevention, surveillance, intervention for consequences of cancer and cancer treatment, and coordination between specialists and primary care providers.⁴ Several organizations launched initiatives to answer this call. For example, the American Cancer Society published breast, colorectal, prostate, and head and neck cancer survivorship care guidelines for primary care physicians. The American Academy of Family Physicians (AAFP) has published primary care recommendations for caring for survivors of a variety of cancers. As a collaborative effort to promote education and collaboration between primary care and oncology specialists, the AAFP, American College of Physicians, and American Society of Clinical Oncology (ASCO) hosted an annual Cancer Survivorship Symposium. ASCO also developed core competencies and a curriculum for physicians caring for cancer survivors. Despite these efforts, translating the calls for changes in practice take time and may still be trickling down, particularly when generalists are challenged by the poor communication and coordination in our health care systems and electronic health records (EHR). The urgent need for innovation in clinical care, research, and policy to advance cancer survivorship care remains.⁵

We call upon SGIM as an organization to take an active role in addressing the need for research and innovation in clinical care, education, and policy across the cancer care continuum, with specific attention to

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ideas I once had with my miniscule amount of protected full-time equivalent (FTE). I knew then that this award was a game changer.

The application for the Horn Scholars Award involves not only the applicant but also the GIM Division Chief, the Chief of Medicine and two Mentors. Can you share a bit about the experience of putting together this application?

I had a unique experience in that I was applying while planning to transition institutions. I had gone to medical school at University of Colorado and was fortunate to have continued relationships with Dr. Earnest and another mentor Dr. Karen Chacko, who introduced me to the team that now supports my career. This feeling of support from a group that didn't even know me was perhaps the first example of my external approval addiction shifting to a healthier source of internal validation. Even though they had never worked with me, they *believed that I deserved the support anyway*. In a culture that teaches us to prove ourselves first and then be gifted with resources, this was a welcome and important shift. I will be grateful to my team at Colorado forever.

Describe your life now, after receiving the Horn Award.

It is not an exaggeration to say it is night and day. The award allowed me to become certified through the Life Coach School and to build something that I am proud of and eternally excited about. It also gave me the space to breathe when I needed it most. I worked with a physician coach in 2020 and defined my purpose, values, and vision statement. I identified areas where I was holding myself to unhelpful standards that ironically got in my way. I began to think big, question norms and decide what to create from a place of abundance, rather than the scarcity (we are expected to do more with less) that is so tightly woven into academia today.

I feel centered, excited, and proud. The Horn Award gave me the protected time and, more importantly, the belief that I “deserved” the time. This was the beginning of an important mindset change for me.

Tell us about your scholarly focus and how you have used your protected scholarly time.

I teamed up with a colleague, Dr. Adrienne Mann at CU, also a certified coach and who shares my passion for physician burnout mitigation. In 2020, we created Better Together Physician Coaching: a six-month online, group life coaching program crafted specifically for issues women residents face including confidence, imposter syndrome, feedback, career decisions, and micro/macroaggressions at work.

We piloted Better Together in a randomized control trial in 2021 with 101 women-identifying residents across specialties and were thrilled to find improvements in burnout, self-compassion, and imposter phenomenon in intervention participants. We are planning to expand the program nationally in 2022. Our findings support what we already know to be true about coaching: normalizing emotions, holding a compassionate space for authenticity, and using metacognition to nonjudgmentally look at self-sabotaging patterns WORKS.

What has surprised you most about this experience?

The Horn application was the first time I had written about my successes with candor and honesty. That process eased my fears about being seen as arrogant if I had something to say. I am still surprised when someone refers to me as an expert in physician wellness and coaching, but now am quicker to reframe my self-deprecating responses into a simple “thank you.”

I am also surprised by my own productivity. A commonly held belief is that if we give ourselves

a break, we might become lazy, unproductive, or worse, forgetful, and harmful to patients. What I know from positive psychology and self-compassion literature is that the opposite is true. The most productive year of my life was the first year of my Horn Award. Taking the time to define and create my own future gave my actions laser-like focus. I have stopped saying yes to everything, and even more importantly, dropped the attached guilt.

What recommendations do you have for anyone who is interested in applying for the Horn Award?

Do it! The application process alone was so beneficial. I have a few colleagues who applied for the award and didn't get it. They ended up turning their application into a proposal that their institutions ultimately supported. I have used questions from the application with mentees. No bad can come from writing your dreams, fears, and core-whys on paper and then from sharing that with a team of mentors.

What are your plans post Horn Award?

Now that I have successfully learned to carve out healthy personal development time, I will continue this habit indefinitely. I know that the sacrifice of my personal time for work not only feels terrible, but also does not benefit my career in the long run. It's a lose-lose that I refuse to engage in again.

In terms of career—I'm going big! Dr. Mann and I are building a team of coaches and creating a model for institutional support of physician coaching. We ultimately hope to offer our coaching program to everyone that wants it at all levels of training, career stages and intersections. Stay tuned!

For questions, please contact the authors: <https://www.sгим.org/career-center/awards-and-grants/grant-awards/horn-scholarship>.

actions are discussed below.⁵ As we continue to fortify ourselves against the ongoing assault of COVID-19, it is critical for us to see the impact of our small yet mighty society of ~3,000 members.

Patient Advocates

We continue to advocate for access to care for our patients inclusive of COVID-19 testing and contact tracing. Other issues where we have contributed include Part B coverage of blood pressure cuffs as well as the loosening of federal prescription of buprenorphine regulations to treat opioid use disorder. In the mist of the pandemic, we continue to be active in the call to protect reproductive rights. We continue to demand affordable healthcare services and access for our patients during the pandemic and beyond.

Front-Line Clinicians

We joined our partners to demand strategies on issues such as public support of scientific integrity, address the scarcity of PPE, whistleblower protections, vaccine mandates for healthcare workers, leave policies enhancement, as well as temporary economic assistance to non-profits, primary care providers, and small businesses impacted by COVID-19.

Equitable and Fair Reimbursement

We continue to seek the full range of care and equitable reimbursement for remote care (telemedicine) over the course of COVID-19. Our legislative activities in the United States include work to avoid the planned Medicare Physician Fee Schedule (MPFS) payment adjustment as well as alleviate the impact of budget neutrality requirements for any adjustments to the fee schedule. We continue to support financial solutions that provide stability to safety net providers, while ongoing research and long-term policy changes are considered. This is inclusive of recommending peer grouping based on social complexity to ensure providers and

practices caring for the most socially vulnerable patients are not unfairly penalized. In addition, we sought out a more harmonized portfolio of alternative payment models that would advance health equity while reducing cost.

SGIM recommends further review of clinical quality and health equity measures that evaluate the care needed to address the SDOH for at-risk populations. The pandemic provided the opening as well for us to join with others and support the National Academy of Sciences, Engineering, and Medicine, report on “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care which calls for fundamental reforms on how primary care is funded.”⁶

Research and Healthcare Infrastructure

We support the ongoing expansion of licensure flexibilities for the duration of COVID-19. We spent many of our coalition activities focused on the support of CMS reimbursement for telehealth services inclusive of audio only options.

We support healthcare infrastructure by lobbying for increased appropriations for agencies such as HRSA, CDC, NIH, CMS, AHRQ, and VA to address cross-disciplinary research exploration, emergency supplemental funding for ongoing and innovative research, improved pandemic preparation and response, care delivery, and workforce development, especially related to diversity. Continued support for enhancements to our “public health infrastructure to pay for such essential activities as disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies” is needed.⁷

We continue to focus on funding that supports cross-disciplinary and primary care research, often exemplified by the health services and

translational research of many of our members. We use our advocacy platform to support further research on health-related societal issues, such as the implementation and outcomes of telemedicine and the social and basic science research needed to solve issues of structural racism and inequality. We also use our expertise to call attention to the need for the United States, as well as other countries, to track COVID-19 data that is stratified by race, ethnicity, and census/geographic location to fully understand the impact of the pandemic and identify solutions. In addition, we continue to advocate for research on the prevention of violence as well as the need to address research workforce diversity, equity, and inclusion.

SGIM supports the provision of additional funding to restart research projects and training programs disrupted by COVID-19.

Workforce

We continue to advocate for loan forgiveness and hazard pay to provide financial relief for COVID-19 front line workers. We also support the continued expansion of all levels of office/outpatient E/M services (CPT codes 99202-99205 and 99211-99215) provided by resident physicians using the primary care exception. We also support the ongoing reauthorization of the Community Health Center Fund (CHCF), Special Diabetes Program and Special Diabetes Program for Indians (SDP/SDPI), Teaching Health Centers Graduate Medical Education (THCGME), National Health Service Corps (NHSC), and Personal Responsibility Education Program (PREP).

SGIM continues to advocate for immigration solutions that retain the current policy of “Deferred Action for Childhood Arrivals” as well as ensure accessible visa services for international medical graduates.

The CanMEDS framework provides a comprehensive tool to review

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the various roles of physicians within society. In our work both within and outside of SGIM, we should all use our role as a Health Advocate during the ongoing pandemic and always to “lead the way to better health for everyone.”⁸

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survivorship and palliative/end-of-life care. For example, further research in survivorship, in collaboration with our oncology colleagues, could include the development and evaluation of new long-term care models for post-treatment cancer survivors, secondary cancer prevention and screening, management of mental health, and management of late and long-term treatment effects. General internists can expand upon palliative and end-of-life research in areas such as communication, advance care planning, and symptom management. Creating EHR tools to identify cancer survivors and incorporating prompts for surveillance testing, similar to those that currently exist for those patients with diabetes, can improve the quality of care. Encouraging providers to annotate the problem list with cancer history (for example, type of cancer, year of diagnosis, treatment exposures) may be a simple quality improvement project. Fostering collaborative relationships between internists, oncologists, and other specialists can offer a team-based

approach to improve clinical care and promote academic scholarship. SGIM members can develop and incorporate cancer continuum curricula into medical school, residency training and continuing medical education. Lastly, we encourage SGIM members to get involved in local and national efforts in cancer-related guideline development and dissemination.

In 2030, there will be more than 22 million individuals living with and beyond cancer—we will continue to see more of these patients in our clinical practice.² We urge SGIM and its members to lead interdisciplinary research, education, and policy changes to improve the lives of this growing patient population.

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