

## IMPROVING CARE: PART I

# FOOD AS MEDICINE: PROMOTING NUTRITION IN PRIMARY CARE

Bethany Agusala, MD

*Dr. Agusala (bethany.agusala@bagusalamd) is an assistant professor of internal medicine at University of Texas Southwestern and a certified Lifestyle Medicine physician.*

### Introduction

Chronic disease management is the foundation of general internal medicine. In my ninth year as an academic primary care physician treating a variety of chronic diseases, I am increasingly drawn to their underlying root cause. Diet is the primary risk factor for death from chronic diseases, such as cardiovascular disease, cancer, and diabetes.<sup>1</sup> This becomes evident in speaking with patients—many have harried lives, are too busy to cook, and consequently eat highly processed, convenient foods on the go.

Many studies have shown that lifestyle change interventions yield tangible health benefits: two examples are the Diabetes Prevention Program (DPP) study and the Portfolio Diet study. The DPP study compared the effect of lifestyle changes to metformin and placebo in halting the progression from prediabetes to diabetes. Participants who underwent lifestyle changes facilitated by coaching sessions and nutrition classes, exercised 150 minutes weekly and achieved 7% weight loss, ultimately resulting in nearly twice the reduction in risk when compared to metformin (58% v. 31%).<sup>2</sup> In the Portfolio Diet study, a dietary pattern emphasizing viscous fiber (from oats, barley, psyllium), soy, nuts, and plant sterols showed a similar reduction in LDL as lovastatin 20mg.<sup>3</sup>

Given that diet is the most important risk factor for death from chronic diseases in the United States and the evidence that changing diet reduces risk of disease and promotes better chronic disease management, this should be the cornerstone of medical practice. However, for various reasons, it is not. Busy general internists in primary

care cite two main barriers—a lack of knowledge and lack of time. This article will provide actionable information and skills to address nutrition counseling in a busy primary care visit.

### Lack of Knowledge

In his excellent 2016 review, Dr. Dariush Mozaffarian gives an overview of the current evidence base for nutrition recommendations. General internists should recommend that patients consume more of the foods that have been shown to be beneficial: fruits, vegetables, legumes (beans, chickpeas, lentils), whole grains (oatmeal, corn, brown rice, and others), nuts, seeds, unsaturated oils (olive, avocado, canola), fish, and fermented dairy. Patients should be advised to eat less red meat (beef, lamb, pork), processed meats (bacon, sausage, deli meats), and foods high in refined carbohydrates, sugar, and salt. Specific hazards from these foods include an increased risk of diabetes and colon cancer with red meat. Processed meats have been classified as carcinogens by the World Health Organization. Other foods, including unprocessed poultry, eggs, and dairy products like milk and cheese, should be consumed in moderation.<sup>4</sup> To summarize, patients should focus on a primarily whole food, plant-based diet—consuming 90% plant foods near their natural state.

Patients come to the office with ideas from social media about what constitutes good nutrition. There are fad diets that focus mainly on what someone should exclude from their diet. This leads to fractious “diet wars”

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## FROM THE EDITOR

# THE CONVERSATIONAL VOICE OF SGIM

Michael Landry, MD, MSc, FACP,  
Editor in Chief *SGIM Forum*

Three years. Thirty-six *Forum* issues. In my application for the *SGIM Forum* Editor in Chief, one of my central themes was my memory of what the *Forum* meant to me as an SGIM junior faculty member. I captured that essence when I wrote in my application: “My overall vision for the Forum would be a publication ‘from SGIM, for SGIM.’ The *Forum* is the conversational voice of SGIM. SGIM is a diverse organization that is heterogeneous in many aspects of memberships. We are a group of internists that works in diverse settings and promotes excellence in research, education, advocacy, administration, and clinical expertise, among other varied interests. We have national thought leaders, cutting-edge researchers, policymakers, master educators, and risk takers. Highlighting the expertise of these individuals and their contributions in ways that are thought provoking and pull the reader in to want more is the primary driver that I would plan to implement with my team.”

We will have a lot of conversations over this time as I serve as your *SGIM Forum* Editor in Chief. In any longer-term interaction, it is always proper to start with introductions. I was born and raised in New Orleans, Louisiana, and I am married and raising two sons. I attended Tulane University followed by Tulane School of Medicine. My residency in Internal Medicine and Pediatrics was followed by employment at Tulane School of Medicine and the Department of Veteran Affairs in New Orleans. Hurricane Katrina impacted my life, as it did so many others in New Orleans, but professionally, it also created many opportunities for change. I moved to full-time status at the new Southeast Louisiana Veterans Healthcare System (SLVHCS) and became Chief of Medicine in 2013 where I had the pleasure of designing and activating the new, billion-dollar, state-of-the-art Veterans Hospital. I am one of those people who can honestly say I love my job.

But enough about me, let's hear from you. “The great charm of conversation consists less in the display of one's own wit and intelligence than in the power to draw forth the resources of others.”<sup>1</sup> The *Forum* editorial team wants to hear about your perspectives, experiences, advocacy, innovations, and knowledge. We anticipate submissions as diverse as our SGIM members.

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# DETERMINING SGIM PRIORITIES FOR 2023-24

Martha S. Gerrity, MD, MPH, PhD, FACP, President, SGIM

*"(SGIM Council) had a challenging job to do—setting priorities for the upcoming year. After all, we are generalists with careers that span many areas of medicine, and we have even more interests that energize us."*



The SGIM Council held our 2023-24 strategic planning retreat in June at the SGIM office in Alexandria, Virginia—the first time we've met in our office since 2019, prior to the COVID-19 pandemic. It was good to be together in person in our own space and to see many of the SGIM staff. We had a challenging job to do—setting priorities for the upcoming year. After all, we are generalists with careers that span many areas of medicine, and we have even more interests that energize us.

The purpose of my column is to make the Council's decision-making process transparent, so members don't wonder why we are doing or not doing something. As general internists, we care about a lot of different issues, and they affect our care of patients and populations. If only we had more time and resources, we would do it all! Since this isn't the case, the job of the Council was to make sometimes difficult decisions about what to move forward and what to pause.

The ideas and activities that we pursue as a Society come from members through our committees and commissions to the Council for final approval. The SGIM Organization and Leadership diagram depicts the inter-relationships between the SGIM Council, our various leadership groups, and our members.<sup>1</sup> I encourage you to engage in our interest groups and committees since *you* determine what is important for SGIM. If multiple committees and commissions identify an issue, it usually ends up on the Council's agenda to discuss. Recent notable examples include our work on DEI and our climate impact.

As in past years, SGIM's committees and commissions submitted plans for their top three priorities for the coming year, as well as listing their ongoing activities. They were asked to comment on whether or not their plans addressed our commitment to change to Diversity, Equity, and Inclusion (DEI) and if they used our new learning management system, GIMLearn.<sup>2</sup> Council reviewed plans submitted by four core mission committees (Education, Research, Clinical Practice, and Health

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## SGIM Forum

### Editor In Chief

Michael Landry, MD, MSc, FACP  
SGIMForumEditor@gmail.com

### Managing Editor

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Tiffany I. Leung, MD, MPH, FACP, FAMIA  
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khawaja@bcm.edu  
Eric Kutscher, MD  
eric.kutscher@nyulangone.org  
Megan McNamara, MD, MS  
Megan.Mcnamara@va.gov  
Jennifer L. Michener, MD  
jennifer.michener@cuanschutz.edu  
Somnath Mookherjee, MD  
smookh@u.washington.edu  
Susana Morales, MD  
srm2001@med.cornell.edu

Malia Omale, MPH  
omalemalia@gmail.com  
Amirala Pasha, DO, JD, FACP  
pasha.amirala@mayo.edu  
Helen Pope, MD  
hpope1@tulane.edu  
Shobha L. Rao, MD  
shobha\_rao@rush.edu  
Jorge A. Rodriguez, MD  
jarodriguez1@partners.org  
Gaetan Sgro, MD  
gaetan.sgro@va.gov  
Taylor Wise, SGIM Social Media and  
Communications Specialist  
wiset@sgim.org

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# Q & A WITH SGIM'S CEO AND ACLGIM'S LEADERS ABOUT THE CRISIS IN RECRUITMENT AND RETENTION OF ACADEMIC GENERAL INTERNISTS

Eric B. Bass, MD, MPH; Mark Earnest, MD, PhD; Mohan Nadkarni, MD, MPH

*Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Earnest (MARK.EARNEST@CUANSCHUTZ.EDU) is the Past President of the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM). Dr. Nadkarni (MMN9Y@uvahealth.org) is the President of ACLGIM.*

## **EB: What was the purpose of the Hess Institute conference at the SGIM Annual Meeting in May?**

**M**E: In recent years, ACLGIM members have been grappling with the decreasing numbers of people pursuing careers in academic general internal medicine (GIM). The problem now represents a serious crisis. After seeing vigorous discussion of the problem on ACLGIM's portal in GIM Connect over the past year, the leaders of ACLGIM decided to devote the 2023 Hess Institute at the SGIM Annual Meeting in Denver to a day-long discussion of how to develop solutions that ACLGIM can champion to address the crisis.

## **EB: How did ACLGIM frame the discussion at the conference?**

**ME:** To prepare for the conference, ACLGIM hired a consulting group, The Civic Canopy, to conduct a survey of SGIM members about their views of the problem. Based on responses from 247 members representing a spectrum of professional status, clinical settings, and demographics, the survey indicated that GIM is rewarding, gratifying, and stimulating while also being challenging, stressful, and overwhelming. The conference organizers used the survey results to map barriers to different levels of system change within the medical education system and the overall healthcare system, taking into consideration the conditions for change related to policies, practices, resource flows, relationships, power dynamics, and mental models. After presenting the survey results, the organizers asked the 100 attendees to break into small groups of two, then five, and then 10 to discuss how each barrier was related to the conditions for change. The groups of 10 then selected two top ideas they felt were most pressing to address. The resulting list of possible solutions fell into eight conceptual categories, including:

1. Rebalance academic primary care compensation to align with work;
2. Share the "Proud to be GIM" message;
3. Enhance the focus on team-based care delivery;

4. Increase learner exposure to primary care through time and mentoring;
5. Increase ambulatory training time;
6. Enhance the focus on the business case for primary care;
7. Demonstrate the value of primary care clinicians to institutional leaders;
8. Expand and advocate for fluid roles between in-patient and outpatient to move to a more effective team-based model.

## **EB: What did the group ultimately select as the solutions that ACLGIM should focus on?**

**MN:** Using an electronic polling system, the conference participants selected three topics for identifying solutions about which they felt most passionate:

1. Enhancing focus on team-based care delivery;
2. Rebalancing primary care compensation to align with work;
3. Increasing learner experience in primary care and increasing training time.

The group then brainstormed about what could be done right away that would not add too much to their commitments. The resulting ideas had six main themes:

1. Organize and advocate;
2. Share our story;
3. Adjust the workflow;
4. Focus on training opportunities;
5. Collect data;
6. Take other actions.

## **EB: How can SGIM members help to address the issues identified by the conference participants as top priority?**

**MN:** ACLGIM leaders plan to form three work groups to develop and deploy specific tactics for addressing the

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# THE STRUCTURED ADVOCACY PITCH

Amirala S. Pasha, DO, JD; Rebecca Yao, MD, MPH; Mark F. Liebow, MD, MPH

*Dr. Pasha (pasha.amirala@mayo.edu) is an assistant professor of medicine at the Mayo Clinic College of Medicine and Science in Rochester, MN. Dr. Yao (yao.rebecca@mayo.edu) is a resident physician in Internal Medicine at the Mayo Clinic College of Medicine and Science in Rochester, MN. Dr. Liebow (mliebow@mayo.edu) is an associate professor of medicine emeritus at the Mayo Clinic College of Medicine and Science in Rochester, MN.*

Clinicians play a critical role in healthcare policy discussions, as their voices hold significant power and provide unique perspectives based on their intimate knowledge of both the needs of the patient and the healthcare system. The absence of their input in the law and policy-making process can lead to inadvertent and unfavorable consequences, exacerbating healthcare disparities and inequities. This is particularly problematic in a healthcare system where health outcomes are more heavily influenced by broader social determinants of health, impacted largely by political decisions.<sup>1</sup>

However, advocacy often intimidates clinicians due to a perceived lack of training or expertise. The clinical work of many healthcare professionals is not often viewed as advocacy, leading to apprehension and discomfort with advocacy-related activities.<sup>2</sup> Yet, clinicians serve as advocates in nearly every patient encounter, providing patient-centered care that often requires advocating for their patients' needs and preferences, ensuring they receive appropriate treatment, and championing their rights and dignity. Thus, advocacy and patient care are not mutually exclusive and indeed are intricately intertwined.

In addition to patient-level advocacy occurring within the context of clinical care, other levels of advocacy include systems-level advocacy taking place within groups, organizations, or institutions to improve practice and patient safety, and governmental-level advocacy to influence broader state and federal policies.<sup>3</sup>

Systems and governmental-level advocacy usually occur in formal settings with various decisionmakers (or their aides), including executives, regulators, legislators, and other policymakers. These encounters are generally discrete and brief, so advocates must communicate

concisely yet effectively to be successful. These advocacy opportunities can be compared to patient presentations on rounds. Just as we do not expect junior learners to present a complex patient effectively without a pre-established structure for the presentation, expecting a junior advocate to deliver a concise yet compelling message without a framework is also unreasonable. Therefore, we need to adopt a structured framework, such as the classical approach to a patient presentation, for early advocates so they can be more comfortable and effective in their advocacy efforts.

We propose a structured template for developing an "advocacy pitch." For ease of learning, the proposed template follows the SOAP note format commonly used in clinical documentation and presentations. Although this is mainly aimed at governmental-level advocacy (e.g., legislative advocacy), this structure is applicable to any kind of advocacy. This template will allow even novice advocates to ensure that their message is communicated effectively and will help demystify advocacy. A successful advocacy pitch should be persuasive and address the what, the why, the who, the strengths of the advocate's argument, and the weaknesses of the opposing side's counterarguments.

Before beginning the pitch, it is crucial to know your audience, find common ground, and establish a connection. This is no different than adapting a clinical presentation based on the circumstances!

Advocacy is a skill, and practice is essential to enhance any skill. This template will help to develop an effective message, and in conjunction with practice and revision, help foster the growth of a successful advocate.

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## FROM THE SOCIETY (continued from page 4)

recommendations that emerged from the conference. We anticipate that the work groups will invite SGIM members to participate, most likely through collaboration with mem-

bers of SGIM's Clinical Practice Committee, Education Committee, Health Policy Committee, Research Committee, and Program Directors Interest Group. ACLGIM is commit-

ted to devoting substantial energy to further work on addressing the crisis in recruiting and retaining academic general internists.

SGIM



# THE BLUE STICKY NOTE: A NOVEL EMR TOOL TO FACILITATE YEAR-END RESIDENT HANDOFFS IN THE AMBULATORY SETTING

Alfred Rabinovich, MD, MS; Jessica Valente, MD, MPH; Donna Williams, MD; Nancy Denizard-Thompson, MD

*Dr. Rabinovich (agrabinov@gmail.com) is a chief resident in the department of medicine at Wake Forest School of Medicine.*

*Dr. Valente (jvalente@wakehealth.edu) is an assistant professor in the department of medicine at Wake Forest School of Medicine and associate program director of the internal medicine residency program. Dr. Williams (dowillia@wakehealth.edu) is an associate professor in the department of medicine at Wake Forest School of Medicine and program director of the internal medicine residency program. Dr. Denizard-Thompson (ndenizar@wakehealth.edu) is an associate professor in the department of medicine at Wake Forest School of Medicine and vice chair of faculty development.*

**I**ncreasing emphasis has been placed in recent years on the importance of high-quality resident handoffs in the inpatient setting, particularly in the form of I-PASS.<sup>1</sup> However, there has been much less focus on resident handoffs in the outpatient setting, particularly as it relates to year-end handoffs between graduating residents and the residents who will assume care of these patients in their respective patient panel. Previous studies have demonstrated that the implementation of a standardized handoff process in the ambulatory setting during this critical period of year-end transition improves resident confidence and satisfaction and can improve patient outcomes.<sup>2,3</sup>

Prior to our intervention, the year-end ambulatory handoff system at our institution consisted of asking graduating residents to identify patients in their panel whom the resident believed to be “high-risk” and write a short handoff for each of them. These patients were considered the most complex in the panel, and thus were preferentially transitioned to a rising PGY-2 resident who would ideally receive this handoff. PGY-3 residents had previously not been provided guidance on which patients to identify as high-risk or specific instructions on how to conduct the handoff process.

A needs assessment was conducted in the form of a survey sent to all PGY-2 and PGY-3 residents (n=62) prior to the implementation of a new standardized handoff process with a response rate of 45%. This survey found that only 41% (11/27) of residents reported receiving any form of handoff when they were inheriting their new patient panel. Additionally, 67% (18/27) of residents reported feeling worried about missing something on a patient they had newly inherited.

## Implementation of a New Handoff System

We sought to develop an enhanced, standardized approach to year-end resident handoffs in the ambulatory

setting that could be viewed by any provider seeing the patient in clinic. To do so, we implemented use of the Specialty Comments Sticky Note feature in our Electronic Medical Record (EMR), Epic (Epic Systems Corporation).<sup>4</sup> The Specialty Comments Sticky Note (i.e., “blue sticky note”) is a feature in Epic that allows a provider to write notes in a patient’s chart that is specific to the user’s specialty and can only be seen by other users across the login department specialty. Notes in this field are *not* part of the permanent medical record. Utilizing this easily visible feature for resident handoffs allows residents to access handoff information more readily and prevent key tasks from getting lost in the oftentimes expansive electronic medical record.

We began our intervention by leading a workshop on our enhanced and standardized handoff process for the PGY-3 residents as part of our standard noon conference educational series. We introduced the blue sticky note feature and provided residents with a specific framework by which patients should be identified as high risk. Recommended categories that classified patients as high risk included significant medical complexity, complex social history (housing insecurity, substance use), frequent acute care utilizer, or complex medical workup ongoing. We also provided residents with a template handoff that could be copy-and-pasted into the sticky note and then modified for each individual patient.

## Evaluation of Resident Satisfaction and Clinical Outcomes

A post-intervention analysis after the handoff workshop in August 2022 showed that 79% (22/28) of graduating residents utilized the blue sticky note for their year-end resident handoffs. A follow-up survey was sent to all PGY-2 and PGY-3 residents in October of 2022 regarding their experiences with the blue sticky note

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## REFLECTIONS FROM 2023 SGIM EDUCATION AWARD RECIPIENTS

Meghan Kiefer, MD, MPH; Raman Singhal, MD; Shana Zucker, MD, MPH, MS; Amy Farkas, MD, MS

*Dr. Kiefer (meghanm@uw.edu; Twitter @meghanmkiefer) is an associate professor at University of Washington School of Medicine. Dr. Singhal (raman.singhal@mountsinai.org) is an assistant professor at Mount Sinai Beth Israel. Dr. Zucker (shana.zucker@jhsmiami.org; Twitter @ShanaInMedicine) is a resident at the University of Miami/Jackson Memorial Hospital. Dr. Farkas (ahfarkas@mcw.edu; Twitter @dramyfarkas) is an assistant professor at the Medical College of Wisconsin and Milwaukee VA Medical Center.*

**T**he Awards Subcommittee of the Education Committee is pleased to highlight SGIM's 2023 Education Award Winners! Here we share Q&A exploring their passion, lessons learned, and success.

### Career Achievement Award for Medical Education: Sue Hingle, MD

#### What inspired you to pursue a career in medical education?

Residency is when I really saw how fun it was to help turn the lightbulbs on in people, and to work with them on critical thinking. I was all set to do a Robert Wood Johnson Clinical Scholars program at the University of Chicago, but when I was chief resident, I got totally burned out. I ran 180 degrees in the opposite direction: I passed up that fellowship and went into private practice. About a month in, I realized the mistake I had made, and I decided to pursue academic medicine. When I first started, I was an associate program director and that was what I thought I would do—resident education. A couple years later, they needed someone to lead the preclinical doctoring curriculum and my department chair asked if I would do it. I started in this position and very quickly found out I love working with students! One of my mentors at the time was the Internal Medicine clerkship director, and she asked me to be the inaugural associate clerkship director, so that I could decide if that was what I really wanted to do. She then stepped away and I became the clerkship director. I did that for 10–15 years, and then one of my mentees, a phenomenal educator, had her opportunity to shine. At that point, I started to dig into faculty development, which is how I ended up in my current role in professional development across the organization, not only for our physicians but for our staff as well.

There are lots of examples of people who remain in the job too long, and the job doesn't thrive because there's no new energy and excitement. There are lots of people who go into medical education and don't get those oppor-

tunities, and then they stagnate. Lack of opportunities is a piece of burnout that a lot of people don't talk about.

#### What advice would you give to a junior clinician educator who is looking to pursue a similar career?

You need to be open to opportunities as they come your way. A lot of people tell you define your niche, but I have found the opposite to be true. In medicine we are very goal-oriented—in our reviews, we are asked “What are your three-year goals? Five-year goals?” It's good to have goals, but not have them be so specific that you close yourself off to opportunities as they arise.

I didn't think society leadership would be part of my career goals. I was busy being a doctor, educator, and mom when the opportunity to run for the governor of the American College of Physicians (ACP) Illinois chapter came up. I approached my department chair and said, “This is a great opportunity, but the timing isn't good.” He looked at me and said, “I will respect whatever you decide, but I think this will be good for you.” So I did it, and that led to huge opportunities. If I had stuck with “This is my path, this is my lane,” I would have missed out on so much because of that. There is a commercial on TV now that says, “Open your eyes—the opportunities are all around you.” And when that comes on, I think, “That's totally true! The opportunities are all around you if you take advantage of them.”

Another piece of advice from my clinical skills teacher in second year of medical school—whenever you go into a room with a patient, look at their shoes. It helps you ground yourself and be present. It's a visual way of understanding your patient as a person, letting the empathy flow. This probably applies outside of the patient room as well to our learners and to our colleagues. If you train yourself, it becomes part of what you do regularly—you put yourself in other people's shoes.

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# COMPREHENSIVE WOMEN'S HEALTH CARE: RECOGNIZING THE ROLE OF GENERAL INTERNISTS

Jennifer L. Michener, MD; David A. Hirsh, MD; Eleanor Bimla Schwarz, MD, MS; Deborah Gomez Kwolek, MD

*Dr. Michener (Jennifer.michener@cuanschutz.edu) is assistant professor of general internal medicine at the University of Colorado School of Medicine in Aurora, CO. Dr. Hirsh (david\_hirsh@hms.harvard.edu) is professor of medicine and an associate dean for undergraduate medical education at Harvard Medical School in Boston, MA. Dr. Bimla Schwarz (Eleanor.schwarz@ucsf.edu) is professor of medicine at the University of San Francisco California and chief, division of general internal medicine at San Francisco General Hospital in San Francisco, CA. Dr. Gomez Kwolek (dkwolek@mgh.harvard.edu) is assistant professor of general internal medicine at Harvard Medical School and lead, women's health sex-and gender-based medicine program at Massachusetts General Hospital in Boston, MA.*

## Introduction

Women's health training in internal medicine residency programs has evolved significantly since the 1990s.<sup>1</sup> Leading medical societies now identify competence in the provision of contraceptive care as an essential skill for all internal medicine (IM) physicians.<sup>1-2</sup> Despite this recognition, IM residencies continue to have significant gaps in teaching residents contraceptive care.<sup>3</sup> One particular deficit stands out: few IM residency programs routinely provide training in long-acting reversible contraceptive (LARC) care, which includes subdermal implants and intrauterine devices (IUDs).<sup>4</sup> Further, when IM physicians are trained, they often face challenges getting credentialed to provide LARC care.

Two recent publications highlight these gaps and their consequences and propose solutions. Both articles emphasize the critical lack of access to contraceptive care for patients who seek primary care from IM physicians. The papers stress the urgent need to address this gap in care and help patients prevent unintended pregnancies, especially given the health risks associated with pregnancy and the unacceptably high maternal morbidity and mortality rate in the United States.<sup>1</sup> This article discusses these papers and highlights their call for universal training of all IM physicians in comprehensive sex-and gender-based women's health care.

## The SGIM Sex- and Gender-Based Women's Health Core Competencies

SGIM clinician educators developed and recently published the SGIM Core Competencies in the *Journal of General Internal Medicine*.<sup>1</sup> The Competencies serve as a comprehensive set of recommendations for training IM residents in sex- and gender-based women's health.<sup>1</sup> The position paper also describes a practical approach to implementing these competencies in residency programs. The document calls for the universal training of IM resi-

dents in sex- and gender-based preventive health care, all forms of contraception, and education on abortion care and reproductive planning.<sup>1</sup> The paper includes a summary table with a broad overview of the core competencies, organized by ACGME domains. The article's appendix provides a more detailed and comprehensive explanation of each competency.

This document calls for universal education of IM physicians in comprehensive sex- and gender-based women's health care, including LARC care. Until IM physicians are competent in providing basic sex- and gender-based health care, including contraceptive counseling, this professional development will remain critical. Our faculty must be competent in providing comprehensive health care, so they can train the next generation of IM physicians to effectively care for patients.

## Credentialing Internal Medicine Physicians to Expand Long-Acting Reversible Contraceptive Access

This timely article, published in *Annals of Internal Medicine* in August 2023, highlights challenges many of our IM colleagues have faced when trying to provide LARC care at their institutions' primary care practices.<sup>5</sup> The perspective also suggests practical solutions to LARC credentialing and implementation. Regarding IM physicians' provision of LARC, the authors identify considerable and unjustifiable variation in credentialing practices, an issue that merits urgent consideration.<sup>5</sup> The paper discusses the safety of LARC procedures, especially relative to other IM core privileges, and based on this safety, argues for the universal training and credentialing of all IM physicians to provide LARC.<sup>5</sup>

The *Annals* article describes practical steps for implementing LARC training, credentialing, and care in IM departments, with detailed rationale for the recommendations and a useful table. The table highlights early

*continued on page 9*



planning considerations for IM leadership, ways to make training opportunities available to IM physicians, LARC credentialing standards, and long-term considerations for sustainability of LARC programs.<sup>5</sup>

The call for universal training and credentialing of all IM physicians in LARC care comes at a particularly critical time. In the post-Dobbs era, access to effective birth control is more important than ever. As an IM community, it is essential that we work to improve access to these forms of contraception when they are desired.

### Conclusion

IM physicians are ideally positioned to provide comprehensive sex- and gender-based primary care. As a part of IM practice, this care includes access to all forms of contraception for those who seek care from internal medicine physicians. Given the urgen-

cy of addressing our patients' needs for contraception, practical steps are needed to ensure all IM departments and residency training programs implement comprehensive sex- and gender-based health training for practicing physicians and residents.

### References

1. Henrich JB, Schwarz EB, McClintock AH, et al. Position paper: SGIM sex- and gender-based women's health core competencies. *J Gen Intern Med*. 2023 Apr 20;1-5. doi:10.1007/s11606-023-08170-y. Online ahead of print.
2. Daniel H, Erickson SM, Bornstein SS. Women's health policy in the United States: An American College of Physicians position paper. *Ann Intern Med*. 2018 Jun 19;168(12):874-875. doi:10.7326/M17-3344. Epub 2018 May 29.
3. Casas RS, Hallett LD, Rich CA, et al. Program directors' perceptions of resident education in women's health: A national survey. *J Women's Health (Larchmt)*. 2017 Feb;26(2):133-140. doi:10.1089/jwh.2016.5860. Epub 2016 Aug 9.
4. Casas RS, Prifti CA, Bachorik AE, et al. Contraceptive procedures in internal medicine clinics and resident education: A qualitative study of implementation methods, barriers, and facilitators. *J Gen Intern Med*. 2021 Nov;36(11):3346-3352. doi: 10.1007/s11606-021-06832-3. Epub 2021 May 6.
5. Michener JL, Hirsh DA, Batur P, et al. Credentialing of internal medicine physicians to provide long-acting reversible contraception. *Ann Intern Med*. E pub 2023 Aug 1. <https://doi.org/10.7326/M23-1034>. **SGIM**

## HEALTH POLICY CORNER (continued from page 5)

The final pitch will likely need to be revised multiple times from its first draft and its delivery practiced. However, our template can provide the scaffolding for developing the perfect advocacy pitch!

### References

1. Abrams EM, Louisias M, Blumenthal KG. The importance of physician advocacy. *Ann Allergy Asthma Immunol*. 2022 Dec;129(6):679-680. doi:10.1016/j.anai.2022.08.010. Epub 2022 Aug 18.
2. Horton R. The doctor's role in advocacy. *The Lancet*. 2002 Feb 9;359(9305):458. doi:10.1016/S0140-6736(02)07670-5.
3. Fried JE, Shipman SA, Sessums LL. Advocacy: Achieving physician competency. *J Gen Intern Med*. 2019 Nov;34(11):2297-2298. doi:10.1007/s11606-019-05278-y.

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### Advocacy Pitch Template

#### Subjective

Introduction (analogous to chief complaint). Introduce the subject with key information pertinent to it (e.g., bill number).

Describe who you are and why your voice as an advocate matters. Explain why the decision-maker should prioritize your perspective over others.

History of Present Issue (analogous to the history of present illness). Include context and background on the issue, as well as personal anecdotes or experiences.

#### Objective

Present relevant objective data and evidence concisely, remembering that non-clinical decision-makers often respond better to anecdotes than to data.

#### Assessment and Plan

The "assessment and plan" portion, similar to a case presentation, should start with a brief summary of the "pitch" and must clearly communicate concrete steps that the advocate wants the decision-maker to take (e.g., support or vote against a particular bill). In doing so, the advocate should keep in mind the perspective of their allies and their opponents. At times, it may even be advantageous to point out the allies and opponents in the pitch. The pitch may also need to include counterarguments while emphasizing their weaknesses. As important, is to highlight potential beneficiaries especially if those beneficiaries are a constituent of the decisionmaker.

Finally, it is crucial to try to get a commitment from the decision-maker that they will do what you want. If the solution seems adversarial or at odds with what the decision-maker might wish to do, consider reshaping the problem as one that you and the decision-maker are jointly trying to solve, shifting it into a frame of shared dilemma that you can each contribute to the solution in a mutually satisfactory way. Regardless of the outcome, always leave the meeting on good terms. Although you may disagree, don't be disagreeable.

**What is something you are proud of in your career?**

I have been able to help others feel a sense of belonging, and by doing that, to help them to learn and grow and thrive. Because of this, I have had an impact on the present and the future of medicine.

I do this by sharing of myself, showing my vulnerabilities. I show that I am human, and this allows them to be human too. I truly feel that personal wellness should be the highest priority of medicine, of education, really of just about anything, and I think you get to all of your other goals if you make that your primary goal. If we have learners who are well and healthy, they are going to be better learners, educators, and physicians. We only get there when we create environments that have that as the focus. Part of that is recognizing that we're human and sharing that.

**Mid-Career Medical Education Mentorship Award: Alia Chisty, MD**  
**What is a career accomplishment that you are most proud of?**

The first thing that came to mind was becoming a program director. I went into medicine wanting to do more healthcare advocacy and policy work. I did not consider a career in medical education until my mentors encouraged me. I had never thought about education as advocacy, but in becoming an educator I could advocate for our learners in a different way to the healthcare system, at the national level, and directly with patients. I felt lucky when I became a program director that I could stand up for residents in a way that I could not imagine.

**What advice would you give to a junior clinician educator who is looking to pursue a similar career?**

I wish I could have told the younger me to critically think about what your values are, your personal and professional interests, and the skills you can contribute. It's important that these all align with who you want to be as a

person, and that these are in line with the value systems of yourself, your team, and your institution—otherwise it is hard to work in that space. It is so important to be authentic to yourself and find your mission, and to surround yourself with people who will encourage you in that mission. A lot of us in medicine experience imposter phenomenon; you have to believe in yourself, but you also need to surround yourself with people who encourage you and see your potential even when you don't see it.

**Do you have any other wisdom to share?**

I have really spent a lot of time the last couple of years thinking about wellness means—what it means for me and what it means for all of us. How do we still love the work we do and lean into that without feeling that it's consuming everything? It is something I'm working on myself. I think wellness is making sure you find that not only does your work align with what you want to do and who you want to be, but also making sure it aligns with your other priorities. We need to make sure that we don't work at the expense of ourselves, but rather fill ourselves up and bring ourselves wholly to ourselves, our homes, and our relationships. I want to help learners reframe how work and life coexist and to find the tools they need to look deliberately at what this means for them. I encourage everyone in this career to consider how to lean into this work—which is a true honor and privilege that patients and their loved ones entrust us during the most difficult times of their lives—while finding space for rest. I worry that the more we don't lean in, the less meaning we will find.

**Scholarship in Medical Education Award Winner: Somnath Mookherjee, MD****How did your career path lead you to pursuing scholarship in medical education?**

This is a great question—but I'm not really sure what the answer is. For



Q&A with the Society of  
General Internal Medicine  
2023 Education Award  
Winners!

my whole education and professional career, I've kind of done whatever feels like the right thing to do next, and it has seemed to work out. I don't think I've ever had a five-year plan or a ten-year plan. After residency I was a hospitalist for a year, and I wanted to be an "academic hospitalist." But I didn't really know how to do a project or even how to get started doing a project. The following year I joined an Academic Hospital Medicine Fellowship—that was a really formative year. I set out planning to do work in rapid response systems and early detection of clinical deterioration but ended up focusing on physical exam education and other aspects of medical education. I think the key to finding something that was authentic, and fulfilling was having the time to explore and having many supportive mentors. You may set out thinking you are going to do one thing, but with enough freedom and support, you may find that your interests lie somewhere else. That year was important because it gave me the skills I needed to start doing projects and scholarly work.

**How do you balance your schedule so that you have time for scholarly work and clinical work?**

I don't actually have time dedicated to scholarly work—all of my non-clinical time is for educational roles. I've been fortunate in that these roles have completely synergized with my academic interests and naturally led to some scholarly work.

**What is a professional accomplishment that you are particularly proud of?**

I had an idea around 2014 to create a booklet of tips on teaching to use in our faculty development program.

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I discussed this with one of my mentors, Tom Gallagher, who encouraged me to think about how I could increase the effectiveness and impact of this project. So I tried to think a little bigger and set out to create a handbook of concise, actionable, and

easily accessible guidance on clinical teaching, I recruited Ellen Cosgrove to co-edit the book with me, and recruited dozens of expert clinical teachers to write the chapters. In 2016 we published the *Handbook of Clinical Teaching*. I think the book

has been useful to a lot of people, but for me personally, holding the published book was a moment of pride and realization that we had done something tangible to try to make the world a better place.

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## PRESIDENT'S COLUMN *(continued from page 3)*

Policy), four cross-cutting commissions (Health Equity, Women and Medicine, Academic Hospitalist, and Geriatrics), and five core operations committees (Membership, Annual Meeting Program, Finance, Philanthropy, and Ethics).

Council also needed a clear understanding of the work we are currently committed to do to better prioritize new work. We reviewed the major organizational commitments previously planned for the 2023-24 year, including the following:

- Website redesign
- New Awards Management System
- ACLGIM Hess Institute follow up (ACLGIM formed three workgroups)
- Fellows in GIM Task Force (addressing the issues identified in the Research committee report on the clinician-investigator pipeline)
- Site Selection for 2027-29 and re-evaluation of 2025 in Florida (workgroup formed)
- GIMLearn content review, development, and deployment
- Accreditation Council for Continuing Medical Education (ACCME) accreditation
- New MedEd scholarship program
- JGIM contract negotiation.

Mohan Nadkarni, president of ACLGIM, then reviewed the report from the Hess Institute conference

that addressed the crisis in recruiting and retaining academic general internists (see the CEO Q&A column in this issue). Based on the report, many SGIM committees will likely be collaborating with ACLGIM on several activities deemed top priority and impacting members in both organizations. More information will be forthcoming as ACLGIM's three workgroups move forward.

Council members used SGIM's four organizational goals<sup>3</sup> and the following guiding principles for our decision-making about each submitted plan:

- ROI for our members: how does this provide value to the SGIM membership broadly?
- Engagement: how does this bring in new or engage existing members with SGIM?
- Focus on Equity: how does this support our DEI and anti-racism agenda?
- Staff workload: what is the degree to which this changes staff utilization?

After robust discussion, Council members rated each plan as high, medium, and low priority; indicated if it would need additional staff or financial resources; identified other committees or commissions affected by the plan; and, where needed, asked for clarifying information. The Council's ratings then went to the SGIM staff for review to determine the impact on staff resources.

From this input, the Council determined which plans will move forward, need modification, or be put on hold for this year. Twenty-nine of the plans reviewed will move forward, some continuing ongoing work and others starting new work. Committee and commission leaders will receive written communication about the decisions, and Council liaisons will discuss Council's final decision and the rationale for the decision with committees and commissions at their next regularly scheduled meeting.

SGIM has an exciting year ahead filled with new resources and activities for members. Stay tuned for more information about these as the year unfolds.

### References

1. Society of General Internal Medicine. Organization and Leadership diagram. <https://www.sgim.org/File%20Library/SGIM/About%20Us/Leadership/SGIM-Organizational-Chart-3.23.23.pdf>. Accessed August 15, 2023.
2. Bass EB, Lo MC. Q & A with SGIM's CEO and the Chair of the Learning Management System (LMS) Task Force. *SGIM Forum*. 2021;44(5):4,10.
3. Society of General Internal Medicine. Vision and Values. Vision and Values | sgim.org. Published January 2022. Accessed August 15, 2023.

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between different camps, such as vegan, keto, and paleo. Many focus on macronutrients, or “macros,” like carbohydrates, fat, and protein. This terminology is unhelpful and confusing for patients and doctors alike. Carbohydrate-rich foods include fruits, vegetables, and whole grains which are clearly health-promoting. Protein sources heavily emphasize animal-based sources and neglect plant-based, like beans, which are associated with longevity and less disease. Finally, foods labeled as low fat, particularly processed foods, can have more refined grains and sugar. I recommend talking to patients about specific foods rather than using these umbrella terms.

### Lack of Time

Assessing a patient’s nutrition status and providing tailored counseling during a busy office visit can seem daunting. Utilizing a brief nutrition intervention modeled after those for substance use counseling can be helpful. This method consists of taking a dietary assessment using the 24-hour dietary recall then employing behavior change techniques, culminating in an action plan for change.

The 24-hour dietary recall is a validated tool used by registered dietitians to assess a patient’s dietary status. This tool can take up to 30 minutes to administer in the most detailed form; but, for general internists, I recommend utilizing a brief version. It is a multi-pass method consisting of five passes summarized in the table. Key points are to ask open-ended questions, such as “what was the first thing you ate after you woke up?” rather than leading questions “what did you have for breakfast?”. These allow for more flexibility for patients who have different work schedules, cultural beliefs, and backgrounds. To introduce the concept, one could say “The foods that you eat can play a big role in your health. To help me get a better understanding of your nutrition, would it be OK to discuss this?” This

**Multi-pass Twenty-four Hour Recall Steps**

Pass	Goal	Suggested Phrasing
<b>First</b>	Quick list of foods	“Walk me through what you ate yesterday from when you woke up to when you went to bed.” “What did you eat next?”
<b>Second</b>	Find forgotten foods	“Any foods you forgot?” “Between [X] and [Y], did you eat anything else?”
<b>Third</b>	Time and occasion	“When did you eat X?” “Where were you/what were you doing?” “Who did you eat with?”
<b>Fourth</b>	Description, amount, preparation, portion size	“How many eggs did you eat? How were they prepared?” “What kind of bread did you use to make the sandwich? How many slices of lunch meat? Any condiments?”
<b>Fifth</b>	Final summary	“What did you drink with your meals? Any beverages between meals or after your last meal?” “Does this represent a typical day of eating for you?”

phrasing demonstrates a core principle of motivational interviewing and behavior change techniques—respecting the person’s autonomy. One may also want to connect nutrition to a specific health concern.

As noted in the table, the fourth step can be adjusted as desired depending on time. Often a more general overview is sufficient for patients who have many areas for improvement. Those who eat healthily but struggle with weight loss, for example, may need a deeper dive.

Taking a dietary history in this way also allows for more opportunities for personalization, especially if one can gain an understanding of culturally important foods or dietary preferences to make more appropriate recommendations. Understanding how food fits into a patient’s daily routine and who obtains food and prepares meals is also critical.

After obtaining a dietary history, it is important to assess the patient’s readiness for change. Those familiar with the Transtheoretical Model of Change will recognize the stages of pre-contemplation, contemplation, preparation, action, and maintenance.<sup>5</sup> For patients ready to make a change (preparation), one can focus on setting a SMART (Specific, Measurable, Attainable, Relevant, and Time-based) goal. The difference

is highlighted here: a patient saying “I will eat more vegetables” compared to “I will eat ½ cup of steamed broccoli three days a week for the next month.” The first is non-specific while the second has all those SMART elements. This could also be thought of as a positive nutrition prescription. These may be more accessible to patients than being told to avoid or limit certain foods without offering healthier alternatives. Making recommendations to increase the healthful foods consumed will provide health benefits and over time displace the more harmful foods.

SMART goals will become action plans. Once the patient and physician agree, the action plan should be written out; I utilize the EMR visit summary. The physician should follow up with the patient on their plan at an agreed time. This could consist of sending the patient an electronic message or having a team member such as a nurse or health coach call them. Action plans should also be revisited at the beginning of the next visit.

My article lays out one approach for addressing nutrition during a busy office visit. General internists play a crucial role in focusing patients on nutrition as a driver of

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the chronic disease we see every day. Although this approach focuses on what an individual provider can do, it is essential to continue to advocate for a more health-promoting environment in our communities.

## References

1. The US burden of disease collaborators. The state of US health, 1990-2016: Burden of diseases, injuries, and risk factors among US states. *JAMA*. 2018 Apr 10;319(14):1444-1472. doi:10.1001/jama.2018.0158.
2. Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med*. 2002 Feb 7;346(6):393-403. doi:10.1056/NEJMoa012512.
3. Jenkins DJA, Kendall CWC, Marchie A, et al. Effects of a dietary portfolio of cholesterol-lowering foods vs lovastatin on serum lipids and C-reactive protein. *JAMA*. 2003 Jul 23;290(4):502-10. doi:10.1001/jama.290.4.502.
4. Mozaffarian D. Dietary and policy priorities for cardiovascular disease, diabetes, and obesity – A comprehensive review. *Circulation*. 2016 Jan 12; 133(2):187-225. doi:10.1161/circulationaha.115.018585.
5. Prochaska JO, Norcross JC. (2001). Stages of change. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 443–448. <https://doi.org/10.1037/0033-3204.38.4.443>.

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## FROM THE EDITOR (continued from page 2)

The *Forum* Editorial team would like to share the map of where we envision 2023-24 will take us. The SGIM Council and Executive Leadership requires that annual plans be submitted for Committees, Commissions, Board of Regional Leaders, JGIM, and the *Forum*. These annual plans not only help Council budget resources but also align these workgroups into a more cohesive actionable workforce that benefits the overall organization.

This year, the *Forum*'s annual plan includes the following: publication of 12 monthly issues, two or three of which are special theme issues, and the development of a quarterly Student, Resident, and Fellow (SRF) Column. We are budgeted to publish the 12 monthly *Forum* issues. The *Forum* theme issues will revolve around a specific topic or group in which all *Forum* articles focus on the chosen theme. The August edition is a special theme issue to focus on the annual meeting, the awardees, and the programming. The next theme issue, set for publication in December 2023, will focus on Geriatrics and feature scholarly contributions and subject matter expertise guided by our Geriatrics Commission. Finally, the SRF quarterly column will focus on scholarly articles *by* and *for* SRFs. The *Forum* envisions a state where SRF trainees

in Medicine will view the publication as the go-to source for timely articles, such as preparing your CV, negotiating your first job, parenting in residency, and maintaining a work-life balance. Now that we have shared the map, we hope that you will travel with us on this journey.

In the September *Forum*, communication is a focal point in the article by Dr. Rabinovich et al as they tackle the problem of end-of-training handoffs of care in trainee clinics and their novel electronic medical record intervention using sticky notes to tackle this issue. This handoff is pertinent not only in trainee clinics but also across the healthcare system. Dr. Pasha et al from the Health Policy Committee provide us with a framework to use our voices along with their structured approach to advocate for those whose voices go unheard. Dr. Michener et al summarize two recent articles that offer opportunities for Internists to have conversations regarding long-acting reversible contraceptive care with patients. The Medical Education awards subcommittee converses with the 2023 awardees regarding their passions, lessons learned, and successes. Finally, Dr. Agusala reminds us of the clinical impacts of conversations and communications around nutrition by highlighting food as medicine and the clinical im-

plications of our conversations. Her open-ended questions and suggested phrasing delineate strategies to save time for the busy clinician while creating clinical impacts in patient care.

Conversations are crucial and help to define who we are. "Conversation is a meeting of minds with different memories and habits. When minds meet, they don't just exchange facts: they transform them, reshape them, draw different implications from them, engage in new trains of thought. Conversation doesn't just reshuffle the cards: it creates new cards."<sup>2</sup>

My goal over the next three years is to have conversations that matter. SGIM members need them, and patients, trainees and colleagues will benefit from these conversations. Conversations are not unidirectional but bidirectional. This is where you have your chance to communicate with SGIM members through *Forum* submissions. Introduce yourself to others with your submissions. Take this opportunity to "create new cards."

## References


1. Bruyère J de la. *A Thousand Flashes of French Wit, Wisdom, and Wickedness*. (1886)
2. Zeldin, T. *Conversation: How Talk Can Change Our Lives*. HiddenSpring: 2000.

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feature with a response rate of 47% (33/70). Approximately 30% of residents (10/33) reported already seeing patients in clinic who had handoff information written in the blue sticky note field. All these residents reported that the handoff they received improved their ability to provide optimal clinical care for patients. Of those who had not yet seen patients with a blue sticky note handoff, 91% (20/22) reported that this type of handoff, if provided, would improve their care of complex or challenging patients. Residents were also asked what aspects of the handoff template provided to them would be most helpful when seeing complex or challenging patients. 85% of residents (28/33) felt that a “short description of any complex social issues” would be helpful, while 61% felt that “pending tests to follow up” would be helpful.

In addition to an evaluation of resident satisfaction, we also sought to evaluate the impact on clinical outcomes because of this handoff process. Pre-intervention analysis showed that at the beginning of the 2020 academic year, 137 patients were identified as high risk by 31 graduating PGY-3 resident PCPs and were transitioned to a rising PGY-2. Following complete implementation of the handoff system in 2022, 28 residents identified 167 high-risk patients for transition to a PGY-2 resident. Outcomes among these two patient populations such as number of ED visits, admissions, overdue colonoscopies, and overdue mammograms were quantified in the first four months of the academic year, both pre- and post-intervention. Notably, there was a statistically significant decrease in the number of patients with overdue mammograms in the post intervention period (62% vs 31%,  $p=.000962$ ). However, a mammography machine was installed on site at the clinic during the time between pre- and post-intervention analyses, which may bias results. The difference in ED visits, admissions, and overdue



Year-end patient handoffs in resident ambulatory clinic improve resident satisfaction and decrease use of acute care services, yet only 1 in 3 residency programs utilize them. Faculty at @WFIMRES are working to change that, one handoff at a time @arabinovichMD @IMJessValente @dwilliamsmd

colonoscopies did not achieve statistical significance.

### Lessons Learned and Future Directions

A 2014 survey of Internal Medicine Program Directors found that only 34% of respondents reported having a year-end ambulatory handoff program.<sup>5</sup> While our residency program did previously have a year-end ambulatory handoff program, a needs assessment demonstrated that a majority of residents never received handoff on new, high-risk patients. Even in instances where a handoff was completed, the resident who received the handoff may not have seen a given patient in clinic for many months. Ease of handoff access to anyone within the department is important, as analysis of patient handoffs prior to our intervention showed that only 43% of high-risk patients had a visit with their new PCP in the four months following the transition.

This highlights a significant challenge that permeates the resident clinic experience: balancing provider-patient continuity and access to care. This challenge was also unfortunately reflected in our post-intervention survey four months into the academic year, as most PGY-2 residents reported they had not yet seen a patient within their panel with a blue sticky note handoff, although most PGY-3 residents completed a handoff and patients were assigned to the PGY-2 resident at the start of the academic year. This can possibly be attributed to difficulty in promptly scheduling these high

risks patients with their new PCP. However, embedding this handoff within the EMR may bridge the gap that exists in resident clinic continuity by making the handoff visible to any resident or faculty member that may see the patient in clinic, while developing a standardized template improves clinical usefulness and resident participation.

Future directions for this project may be to re-evaluate our scheduling protocols to improve timely access to PCP visits for our high-risk patients, as well as to further evaluate and optimize how residents select high-risk patients. Additionally, we would like to see this handoff tool distributed to other clinics and residency programs, like implementation of I-PASS and other handoff tools in the inpatient setting.

### References

1. Starmer AJ, Landrigan CP, I-PASS Study Group. Changes in medical errors with a hand-off program. *N Engl J Med*. 2015 Jan 29;372(5):490-1. doi:10.1056/NEJMc1414788.
2. Young JQ, Pringle Z, Wachter RM. Improving follow-up of high-risk psychiatry patients at residency year-end transfer. *Jt Comm J Qual Patient Saf*. 2011 Jul;37(7):300-308. doi:10.1016/s1553-7250(11)37038-9.
3. Pincavage AT, Prochaska M, Dahlstrom M, et al. Patient safety outcomes after two years of an enhanced internal medicine residency clinic handoff. *Am J Med*. 2014 Jan;127(1):96-9. doi:10.1016/j.amjmed.2013.09.024. Epub 2013 Oct 8.
4. Epic Systems. About us. *Epic*. <https://www.epic.com/about>. Accessed August 15, 2023.
5. Phillips E, Harris C, Lee WW, et al. Year-end clinic handoffs: A national survey of academic internal medicine programs. *J Gen Intern Med*. 2017 Jun;32(6):667-672. doi:10.1007/s11606-017-4005-2. Epub 2017 Feb 14. **SGIM**

# DID YOU KNOW?

Michael Landry, MD, MSc, FACP; Taylor Wise, MPS; Francine Jetton, MA, CAE

*Dr. Landry (SGIMForumEditor@gmail.com) is Editor in Chief of the SGIM Forum, chief of medicine at the Southeast Louisiana Veterans Healthcare System, and an associate professor of internal medicine and pediatrics at Tulane School of Medicine. Ms. Wise (Wiset@sgim.org) is Social Media and Communications Specialist at SGIM. Ms. Jetton (Jettonf@sgim.org) is Senior Director of Communications and Publications at SGIM.*

The Society of General Internal Medicine is a member-based internal medical association of more than 3,300 of the world's leading academic general internists, dedicated to improving the access to care for all populations, eliminating health-care disparities, and enhancing medical education. But did you know that SGIM members also identify as clinicians, investigators, educators, advocates, policymakers, and administrators? And did you know that SGIM members practice across the United States as well as internationally?

SGIM's members participate in organizational activities at the national and regional levels, but did you know that SGIM members include emeritus, full, and associate members (fellows, residents, and students)? Did you know that SGIM has 10 committees, four commissions, and more than 80 interest groups? Did you know that SGIM members publish in the *SGIM Forum* and in *JGIM*? Did you know that 2,587 members attended the 2023 SGIM annual meeting in Denver, Colorado?

The SGIM Editorial team will roll out a new feature in the January 2024 *SGIM Forum* issue: "Did You Know?" is a short column that will highlight SGIM current and future activities as well as other SGIM topics from committees and commissions. "Did You Know?" will ensure that SGIM members are aware of the varied activities and offerings available to them. This new feature will also help orient new SGIM members—as well as Students, Residents and Fellows (SRFs)—to the SGIM organizational infrastructure. This also fits the core mission of our current *SGIM Forum* editorial team that the *Forum* is "from SGIM members, for SGIM members."

At the 2023 SGIM summer Council retreat, SGIM leadership and staff had the opportunity to

learn about the many activities our SGIM members are involved with through the review of the annual plans submitted to Council. Retreat attendees, some with significant SGIM involvement and experience, learned about the new goals and initiatives proposed by the commissions and committees. Many of these topics were unknown to those outside of the commission or committee proposing the new initiative. The SGIM Editorial team decided that "Did You Know?" would be an opportunity to highlight these initiatives to all SGIM members.

In January 2024, we will begin publishing these 100-150-word "Did You Know?" mini-columns. If you would like to be considered for a "Did You Know?", please submit the topic and the 100–150-word write-up to SGIMForumEditor@gmail.com. Topics and write-ups will be collected and published as word counts permit. Priority will be given for a "Did You Know?" of a time-sensitive nature.

The SGIM Editorial team anticipates that "Did You Know?" will help members learn more about SGIM as an organization and different opportunities to participate in. As Andrew Carnegie once said "The only irreplaceable capital an organization possesses is the knowledge and ability of its people. The productivity of that capital depends upon how effectively people share their competence with those who can use it."<sup>1</sup> We ask you to share your knowledge with us so we can query SGIM members: "Did You Know?"

## References

1. Carnegie, Andrew. Top 120 Andrew Carnegie Quotes (2023 update). *Quotefancy*. <https://quotefancy.com/andrew-carnegie-quotes>.

SGIM

An abstract graphic consisting of overlapping circles and squares in shades of gray and black, creating a complex geometric pattern.

**SGIM ANNUAL MEETING**  
**2024** MAY 15–18

GENERAL INTERNAL MEDICINE:  
**Strengthening  
Relationships  
and Valuing  
Our Diversity**

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