

SIGN OF THE TIMES

THE STATE OF MEDICAL CARE IN THE CARCERAL SYSTEM

Aprotim C. Bhowmik, EdM

Aprotim Bhowmik (abhowmik1@pride.hofstra.edu) is a fourth-year medical student at the Zucker School of Medicine at Hofstra/Northwell in New York City.

Upon my arrival, I felt like I was walking into a sort of playground, except the children were adults—and some could only move with the assistance of a cane. Instead of sandboxes and slides, there were pull-up machines and basketball hoops with nets made of rusted chains. Everyone wore a uniform, not unlike the scrubs I had on, except theirs was a light tan, darkened by dirt and wear-and-tear. But between me and them stood a rigid steel fence taller than four humans standing on each other's shoulders. While playing, they—not unlike children—occasionally acquired boo-boos in need of medical attention, though their insult was on the order of broken jaws and contorted limbs. They would come into the clinic, where I would sit with the rest of the team on worn-out chairs on un-mopped floors. We would dig through paper medical records as healthcare staff in the 1900s might have done, rummaging for crumpled bandages in a paltry stack of medical supplies, before starting a negotiation with prison security about how to transport them to the ER. Usually, the patients would have to wait for hours, sometimes overnight, sitting in their cell, injury unhealed and mind unwell.

Origin of the Carceral System

We often view incarceration as a necessary evil, a system that must exist to “handle” people who cannot function outside of their cells. Although there are instances of people being put in the royal jails of historic kingdoms and imprisoned by past empires, rates of incarceration have never been this high, nor has the carceral system

ever been this profitable. How did we end up in this position?

In the past, many societies (e.g., Indigenous tribes on the land currently known as the *United States*) had a different approach. Offenders were sent to an area separate from the rest of the community (without being locked into a cell) and supplied with ample resources before a timely reintegration. Other societies, such as the ancient kingdoms and empires, did have a concept of imprisonment, but this approach became more prominent in the 17th and 18th centuries, with the rise of profit-based economies (i.e., capitalism). Suddenly, incarceration could be done privately for monetary gain.

This pursuit of profit that continues into the present day, makes it unsurprising that one of the missions of prisons has been to find people to incarcerate to fill the prison. It would be easier to find people to fill the cells if generalizations could be made using race, ethnicity, socioeconomic status, etc. For example, in 19th-century United States and Britain, the poor were viewed as being predisposed to both wrongdoing and disease, and it was thought that prisons (not medical care) could control both.¹ At the same time in history, colonialism was running rampant, and many enslaved Black and Indigenous people in the United States were incarcerated for resisting slavery and colonialist expansion, respectively.

Today, according to the Prison Policy Initiative, a disproportionate number of incarcerated people are Black/Brown, low-income, unhoused, and unemployed.²

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FROM THE EDITOR

BECOMING A MAN FOR OTHERS

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

"Volunteers don't get paid, not because they're worthless, but because they're priceless."¹

It seemed that the dismissal bell rang louder that day as my classmates and I celebrated the end of another school year. As I completed my junior year at Jesuit High School in New Orleans, Louisiana, the freedom of summer lay ahead. I envisioned plans for relaxation and unwinding from a strenuous academic year. Little did I realize as these first days of my summer unfolded in 1985, I was about to embark on a special journey that would span the next 40 years.

At a Jesuit high school, one of the main teaching mottos revolves around "becoming a man for others." In her article for *America* magazine, associate editor Molly Cahill describes the evolution of this motto, "Father Pedro Arrupe was the superior general of the Society of Jesus when he gave his 1973 address that popularized the term that would eventually become Jesuit canon. Speaking to graduates of Jesuit schools in Europe, he suggested that the Society's mission in education should respond to the 'signs of the times' and seek God's justice on earth. The portrait of a Jesuit school alumnus was laid out; he should be a "man for others."² Relevant to my high school experience, this translated to a mandated 100 hours of community service prior to graduation for me to be considered a "man for others."

To complete this requirement, students could choose one of many options such as after school tutoring for at risk grammar school students, trips abroad to build infrastructure in Central America or one of a variety of summer camps for special need campers. I chose to serve as a counselor at a week-long overnight summer camp for children with muscular dystrophy. I worked with a 13-year-old camper, Damian, and we bonded over laughs and shared experiences that week. I returned to the muscular dystrophy camp for the next four summers to continue my service to Damian and these campers. What stuck out to me was his comment that this was his chance to be normal, as every camper was "like him." People did not stare at him and his wheelchair as there was an armada of wheelchairs at camp transporting campers of all ages, races, and sizes.

During that first summer, I met an experienced staff member at this muscular dystrophy camp. Tony was a co-director for another special needs camp for children

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EMBRACING UNCONTESTED ELECTIONS: AN UNEXPECTED PATHWAY TO INCREASE ENGAGEMENT AND DIVERSITY TO SUSTAIN SGIM

Jada Bussey-Jones, MD, FACP, President, SGIM

"A move to an uncontested election format may streamline the election process, reduce member loss, and facilitate our commitment to diversity and broad member engagement, ensuring a vibrant and sustainable future for SGIM."



Voluntary service and leadership within the Society of General Internal Medicine (SGIM) is our greatest strength and a critical function of our organization. Maintaining this volunteer pipeline necessitates an intentional strategy to ensure the future of the association. SGIM Council has been considering changes to the election

format as one way to ensure a sustainable future. The question is, "Why change?"

This conversation began with the participation of our SGIM executive team (President, President-Elect, CEO, COO) in the inaugural Council of Medical Specialty Societies (CMSS) Governance & Leadership Excellence Across Medicine (GLEAM) Program. This program,

designed to support the governance and leadership of medical specialty societies, brought together society leaders, and provided tools and connections to enhance organizational leadership. Sixty-two participants from 20 societies convened over a six-month period.

Surprisingly, GLEAM facilitators informed participants that the majority (> 60%) of high performing boards slate *uncontested* elections, moving away from competitive *popular* elections.¹ My initial thoughts were skeptical—imagining uncontested elections would result in less transparency, fewer choices, and increased difficulty for some members to assume leadership roles. Even worse, in the current context where concerns about democracy are routinely discussed, how would this change be perceived by our SGIM members? In this column, I

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Gaetan Sgro, MD
gaetan.sgro@va.gov
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wiset@sgim.org

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.

Q & A WITH SGIM'S CEO AND THE CHAIR OF SGIM'S HEALTH POLICY COMMITTEE ON ADVOCACY ACTIVITIES IN 2023-24

Eric B. Bass, MD, MPH; Michael A. Fischer, MD, MS

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Fischer (Michael.Fischer@bmc.org) is the Chair of SGIM's Health Policy Committee.

S GIM's Health Policy Committee (HPC) is driven by our vision for a just system of care in which all people can achieve optimal health. In pursuit of that vision, the HPC has been extremely busy in the 2023-24 academic year. As the year reaches an end, I asked Dr. Fischer to share his thoughts about the most important activities of the HPC.

EB: What were the most important priorities of the HPC in the last year?

MF: The HPC covers many topics, reflecting the active work of our three subcommittees: clinical practice, education, and research. According to the health policy agenda set at the beginning of the year, the committee identified its top priorities for "active advocacy" in which members, staff, and policy consultants from CRD Associates are heavily involved:

1. Advance anti-racist policies and use an anti-racist lens to evaluate policies within the scope of the committee;
2. Ensure that existing and new payment and delivery systems support high-quality primary care for all patients;
3. Ensure that evaluation and management services reflect the full range of care provided during primary care and cognitive office visits;
4. Support robust investment in graduate medical education (GME), including an increased number of GME slots for primary care and other specialties with shortages;
5. Reform the Medicare GME program, including establishment of a payment structure that supports primary care, is transparent, holds institutions accountable for training outcomes, and results

in a highly trained, appropriately distributed workforce;

6. Advocate for a supportive policy environment for the National Institute on Minority Health and Health Disparities (NIMHD) and more funding across the National Institutes of Health (NIH) to promote health equity and reduce disparities;
7. Support funding for the NIH and Agency for Healthcare Research and Quality (AHRQ);
8. Retain and enhance the Clinical and Translational Science Awards program; and
9. Secure funding to assess the impact of emerging value-based payment and primary care research programs and their impact on vulnerable populations.

"The HPC covers many topics reflecting the active work of our three subcommittees: clinical practice, education, and research."

In addition to the priorities for active advocacy, the HPC identified priorities for "coalition

advocacy," for which we work collaboratively with other organizations to advance SGIM's positions. Those priorities are to:

1. Ensure that all patients have access to affordable high-quality health care;
2. Support steps to address substance use disorder and addiction;
3. Allocate robust funding for Health Resources and Services Administration (HRSA) Title VII programs;
4. Support collection, analysis, and dissemination of information related to healthcare workforce supply and demand;
5. Eliminate barriers to entering and remaining in primary care;
6. Foster innovative education and training programs;
7. Improve financing of training for careers in primary care;

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UNDERUTILIZED BILLABLE COUNSELING CODES FOR MEDICARE AND MEDICARE ADVANTAGE VISITS: WHAT THE GENERAL INTERNIST NEEDS TO KNOW

Walker Pride, MD; Crista Keller, MD; Scott Joy, MD, MBA, FACP; Elizabeth Parker, CPC, CRC

Dr. Pride (walker.pride@healthonecares.com) is a third-year resident of internal medicine at Sky Ridge Medical Center in Lone Tree, Colorado. Dr. Keller (crista.keller@healthonecares.com) is an internal medicine physician at Aspen Medical Group at Rose Medical Center in Denver, Colorado, and serves as a mentor for primary care physicians. Dr. Joy (scott.joy@healthonecares.com) is an internal medicine physician at Englewood Primary Care and Chief Medical Officer for HCA/HealthONE Continental Division in Denver, Colorado, a core faculty member for the HCA/HealthONE Internal Medicine Residency Program and an adjunct associate professor of medicine at Duke University. Ms. Parker (Elizabeth.Parker2@hcahealthcare.com) is a certified professional coder for the coding operations team of HCA corporate and supports the Continental Division as a Division Coding Consultant for PSG Primary Care and Internal Medicine practices.

Missed billing opportunities for Medicare-related coordination codes in the primary care setting can lead to substantial losses in work relative value units (wRVU) and annual practice revenue for general internists.¹ This article will raise awareness of the underutilized coordination billing codes within the SGIM community and discuss the proper utilization and documentation required when billing for these services in a primary care practice.

Tobacco Cessation

Tobacco dependence is a commonly discussed topic in primary care. Care for the tobacco user generally consists of two parts: counseling on cessation of tobacco use and lung cancer screening for smokers at higher risk. Smoking cessation counseling can be added to evaluation and management (E/M) visits but cannot be billed during the annual wellness visit (AWV). Medicare allows up to eight counseling sessions per year. There are two current procedural terminology (CPT) codes available for smoking cessation, dependent on time spent counseling: 99406 (3-10 minutes) and 99407 (> 10 minutes), and the wRVU values for these codes are 0.24 and 0.50, respectively. The following is an example of proper documentation in an outpatient progress note of smoking cessation counseling:

“I spent 5 minutes during this visit counseling patient about risks of smoking. Patient Readiness to quit smoking at this time (0-10). I discussed nicotine replacement therapy and/or medications with patient to assist with quitting. Patient information on health benefits of quit-

ting smoking and 1-800-QUIT-NOW counseling phone number was provided.”

Lung Cancer Screening

Based on United States Preventive Services Task Force (USPSTF) Guidelines, lung cancer screening with low-dose computed tomography (LDCT) should be performed annually on individuals aged 50 to 80 years old who have a 20 pack-year smoking history and are currently smoking or have quit in the last 15 years.² The CPT code for lung cancer screening is G0296 and the wRVU value is 0.54. This topic is most commonly covered during the Medicare or Medicare Advantage AWV, when discussion often occurs regarding other age-appropriate cancer screening such as colon, breast, and prostate cancer. The following is an example of proper documentation in an outpatient progress note for lung cancer screening counseling:

“Patient age 50-80 years confirmed. 20+ pack year smoking history confirmed. Current smoker. No acute pulmonary symptoms. Appropriate for lung cancer screening. Shared decision making occurred. Patient information provided. Open to obtain low dose CT. Order placed.”

Depression Screening

In addition to pregnant and postpartum adults, the USPSTF additionally recommends screening for depression in adults over 65 years old.² The most utilized tool for depression screening in the primary care setting is

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THE INS AND OUTS OF G2211: A BILLING CODE TO CAPTURE THE WORK YOU ARE ALREADY DOING

Caroline E. Sloan, MD, MPH; Quratulain Syed, MD; Celeste Newby, MD, PHD

Dr. Syed (Quratulain.syed@va.gov) is a geriatrician at Joseph Maxwell Cleland VA Medical Center in Atlanta, GA. Dr. Newby (cnewby@tulane.edu) is an assistant clinical professor of medicine at Tulane University School of Medicine. Dr. Sloan (caroline.sloan@duke.edu) is an assistant professor of medicine at Duke University School of Medicine.

Introduction

Physician reimbursement has historically placed higher value on procedural services and lower value on outpatient office evaluation and management (E/M) services, such as those provided by primary care providers (PCP).¹ Relaxation of documentation requirements for E/M visits in 2021 led to increased payments for PCPs, but only a 2% decline in the reimbursement gap between PCPs and proceduralists.² With the release and implementation of the G2211 code in January 2024, the Centers for Medicare and Medicaid (CMS) provided an additional mechanism for primary care providers and other physicians to receive payment for the work they do every day.^{3,4}

G2211 is an add-on code for outpatient office E/M visits that reimburses clinicians for additional work associated with providing comprehensive, longitudinal, and continuous care to patients with complex condition(s) or a single serious condition. It accounts for aspects of care that are not captured by other billing codes, including developing effective and trusting relationships over time, acting as the “continuing focal point for all needed services,” and understanding how a patient’s medical and/or social history may affect their health today.^{3,4} CMS estimates that the G2211 code will be used frequently by non-procedural clinicians and much less by surgeons and proceduralists.^{3,4}

As this code is still in the early stages of implementation, questions about its usage are common. This article describes appropriate usage of the G2211 code and provides clinical examples that may arise in a PCP’s daily practice.

What Is the Payment for G2211 and What Insurance Covers It?

The 2024 national Medicare allowable cost for G2211 is \$16.04.⁵ Only Medicare Part B is required to cover G2211. As of March 1, 2024, Cigna, Humana, and United Healthcare Medicare Advantage plans, as well as

Humana and United Healthcare commercial plans, also cover the G2211 code.⁵ Many health systems encourage clinicians to bill this code when appropriate to support its adoption by additional payers.

When Should I Use G2211?

The G2211 code can be used by physicians and advance practice providers (e.g., nurse practitioners and physician assistants) if the following criteria are met:^{3,4}

1. The billing clinician works within a fee-for-service payment model;
2. The encounter is an outpatient office E/M visit;
3. The clinician is not performing a procedure that would entail adding on a 25-Modifier; and
4. The clinician has established or intends to establish a longitudinal relationship with the patient (“continuing focal point for all needed health care services”) and provides ongoing care of one or more complex condition(s) or a single serious condition.

CMS does not stipulate any restrictions tied to length of clinical encounters, acknowledging that while expert PCPs are able to manage multiple complex problems in a short time, the cognitive load required to do so is high.

How Should I Use G2211?

Clinicians should continue using the same Current Procedural Terminology codes for outpatient office E/M visits. They can then capture G2211 as an add-on code when appropriate. There are no additional documentation requirements beyond describing the care provided for the patient’s chronic conditions and the development or implementation of a care plan. Note that G2211 is meant to specifically reimburse clinicians for their professional work *during* the clinical encounter, rather than any care management endeavors conducted outside of the encounter, which are billed separately.

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When Should I Not Use G2211?

The code should not be used in following situations:^{3,4}

1. The clinician uses a 25-Modifier on the same day as the clinic visit; the 25-Modifier is used to bill for minor office-based procedures such as suture removals and joint injections;
2. Acute visits that do not involve management of chronic issues (e.g., specialty consultations, urgent care visits);
3. Management of conditions that have a limited course (< 3 months) if the clinician does not plan to treat the patient longitudinally;
4. The billing clinician works in a capitated payment model; and
5. Medicare Annual Wellness Visits.

CMS chose not to allow use of the G2211 code in conjunction with the 25-Modifier to ensure that the G2211 code would be used primarily by clinicians delivering longitudinal care.³ However, one might envision scenarios in which coding for both G2211 and the 25-Modifier could be appropriate. For example, a PCP might engage in a discussion about diet and lifestyle while simultaneously preparing for and conducting a knee steroid injection. Physicians should use their experiences with similar scenarios to advocate for future adjustments in implementation of the G2211 code.

Clinical Examples

A PCP sees her established patient with hypertension for a walk-in visit, for evaluation of a sore throat. The PCP recommends over-the-counter remedies, counseling to avoid medications that raise blood pressure.

Yes, use G2211 for this condition that has a limited course because the PCP considered the patient’s hypertension when providing recommendations, and hypertension is a chronic condition the PCP man-

ages. The PCP should use the sore throat and hypertension diagnosis codes for this visit.

A patient presents to their PCP for their Medicare Annual Wellness visit. The clinician and patient discuss management of the patient’s diabetes and hypertension.

No, here the Annual Wellness Visit code acts as a 25-Modifier, so the G2211 code is not allowed.

A patient presents to establish care with a new PCP. The patient has hypertension and diabetes.

Yes, the patient has chronic issues that the PCP plans to manage longitudinally.

An endocrinologist sees an established patient for uncontrolled diabetes. She adjusts the patient’s short-acting insulin dose. She then calls the patient’s caregiver to relay the plan and schedules a four-week follow-up visit.

Yes, G2211 is not designed to be specialty-specific; if the code requirements are met, clinicians of any specialty can use it.

A PCP sees an established patient with hypertension and gout who has a knee effusion. He performs an arthrocentesis, adjusts the patient’s antihypertensives, and schedules a follow-up visit.

No, a procedure was performed, and a 25-Modifier will be used; a clinician cannot code for G2211 and the 25-Modifier on the same day.

A resident sees an established patient in follow-up for their diabetes, hypertension, and congestive heart failure. The attending precepts the resident and sees the patient.

Yes, use G2211 as an attending physician precepting in resident clinic; if the attending does not see the patient, it is still ok for them to use G2211 as long as they have permission to use the primary care exception.

A nurse practitioner sees an established patient in follow-up for their diabetes, hypertension, and congestive heart failure.

Yes, nurse practitioners and phy-

sician assistants can use G2211 when seeing patients independently.

A PCP sees an established patient in a telehealth visit, during which they discuss the patient’s mental health. The physician recommends starting a new antidepressant.

Yes, use G2211 during telehealth visits when appropriate.

A PCP sees a patient with diabetes who is established with a different clinician in their practice. That clinician is out sick today. The PCP and patient discuss a new diabetic foot ulcer and agree on changes to the patient’s diabetes regimen.

Yes, if the patient has developed a longitudinal relationship with their PCP’s “care team,” then using G2211 is appropriate.

Conclusion

While billing and coding can be cumbersome, G2211 is evidence that CMS is making major efforts to address PCPs’ reimbursement concerns. G2211 is not perfect, but it is a major step towards improving reimbursement to clinicians in the non-procedural specialties that have historically been undervalued.^{1,2} In particular, this new code could help SGIM members in primary care and non-procedural specialists offset the financial impact of recent Medicare reimbursement cuts, without significantly increasing their administrative burden.

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LEARNING CORE GERIATRIC PRINCIPLES THROUGH INPATIENT GERIATRIC CONSULTS

Louisa Whitesides, MD; Tahira Lodhi, MD; Christina Prather, MD; Tania Alchalabi, MD

Dr. Whitesides (lwhitesides@mfa.gwu.edu) is an assistant professor of Geriatrics and Palliative Medicine at George Washington (GW). Dr. Lodhi (tlodhi@mfa.gwu.edu) is an assistant professor of Geriatrics and Palliative Medicine at George Washington (GW). Dr. Prather (cprather@mfa.gwu.edu) is an associate professor of Geriatrics and Palliative Medicine at George Washington (GW). Dr. Alchalabi (talchalabi@mfa.gwu.edu) is an assistant professor of Geriatrics and Palliative Medicine at George Washington (GW).

Over the past 10 years, the Age Friendly Health Systems project has transformed the care of older adults in healthcare settings across the country.¹ Leaders at participating organizations have spearheaded projects that improve the care of older adults using a new framework called the 4Ms - What Matters, Mentation, Medications, and Mobility.¹ Since the initiative's implementation, more than 3,000 health systems have joined and incorporated the 4Ms in varied ways to address their systems' needs.²

The geriatric education community also recognizes that the 4Ms concept elevates core geriatric principles, but few studies demonstrate the impact of incorporating the 4Ms into geriatric curricula. One medical school created an online elective to teach 4Ms in patient assessments, care planning, interprofessional practice, and process improvement.³ A residency program designed an interactive, longitudinal, case-based workshop focused on the 4Ms.⁴ Both initiatives improved student and resident knowledge,^{3,4} and self-efficacy⁴ in caring for older adults.

In our hospital, a team of an attending physician and at least one internal medicine resident performs inpatient geriatrics consults. The faculty adopted the 4M curriculum to teach comprehensive geriatric care as part of this rotation. The attendings standardized the approach in several ways: introducing the 4Ms during orientation; requiring learners to use preset electronic health record templates that include the 4Ms; and encouraging residents to include each of the 4Ms in their clinical presentations and patient discussions.

Outcomes and Impact

Improving Consult Etiquette and Becoming Effective Consultants

Resident learners previously reported difficulty knowing how to provide support to primary services without the attending physicians' help framing a patient's geriatric

specific concerns. By applying the 4Ms framework, learners were able to identify patients' underlying geriatric problems.

Consults for safe discharges necessitated cognitive evaluations and decision-making capacity assessments. Consults about delirium required medication reconciliations. Consults for frequent falls needed mobility assessments and goals of care consults involved conversations about what mattered to the patient, their family, or surrogate.

The Geriatric attendings found that by requiring residents to comprehensively evaluate their consult patients using the 4Ms framework, residents were better able to identify and describe the often-subtle geriatric issues related to consult questions.

Providing Comprehensive Geriatric Care

Many learners previously found performing comprehensive geriatric assessments to be an insurmountable task. They tended to focus on a specific concern and missed valuable information essential to the care of older adults. Since implementing the 4Ms, learners report they can evaluate and manage geriatric syndromes more holistically.

When assessing what matters, residents learned to identify frailty, existing supports, surrogacy, care access, social determinants of health, and advance care planning preferences. When assessing mentation, residents learned to identify issues related to dementia, delirium, depression, and sleep disorders. When assessing medications, residents learned to recognize polypharmacy, and concerns of nutrition, incontinence, or constipation. When evaluating mobility, they learned to evaluate falls, dizziness, sensory impairment, gait, risk for future falls and injury, and complications of immobility, such as generalized deconditioning, and pressure ulcers.

The Geriatric attendings recognized in using these 4Ms assessments, residents were better able see the

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patient holistically and cite complexities that could make it difficult for the patient to thrive.

Identifying and Managing Appropriate Care Transitions

One dilemma learners and hospitalists face is in identifying the best patient disposition in complicated clinical scenarios. With the initiation of the 4Ms framework, learners were able to effectively plan discharges and organize care transitions.

When evaluating what matters, learners identified patient priorities, feasibility in the discharge level of care, and, when appropriate, options for comfort focused care. When evaluating mentation, learners screened for cognitive deficits that could influence the patients' ability to care for or advocate for themselves. When reviewing medications, learners identified discrepancies in medication lists and shared changes with patients, families, and outpatient clinicians as necessary. When considering mobility, learners gathered information about current functional status and support systems including community resources.

The Geriatric attendings observed that after evaluating the 4Ms, residents recommended more comprehensive, care concordant discharge plans.

Learner Satisfaction

After implementing this educational initiative, the attendings revised the optional MedHub survey sent to residents at the completion of the rotation. From the initiation of the change, approximately 62 residents rotated on the inpatient geriatrics service from 7/2021-9/2023, and 47 evaluations were completed. Overall, residents reported satisfaction with the curricular changes. Thirty-five residents (74%) reported that using the 4Ms improved their understanding of geriatric concepts, 39 residents (83%) reported that they were confident in formulating plans of care using the 4Ms, and 33 residents (70%) reported that they would use the 4Ms in their future practice.

Conclusion

As the population ages, the Age Friendly Health Initiative will become essential to daily clinical practice. By using real time, case-based teaching on hospitalized patients, trained providers can effectively teach future SGIM clinicians about the 4Ms framework and prepare them for Age Friendly practice. With appropriate education, any SGIM provider can create patient-driven geriatric care plans and become Age Friendly clinicians.

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SGIM

discuss the evolution of my thinking and new proposed recommendations from SGIM Council regarding our elections process.

At the GLEAM conference, we were asked to consider several questions:

- What are the pros and cons of popular elections?
- What happens to those who lose a popular election?
- What is the impact on that candidate?
- If you were not familiar with any candidates, how would you know who to vote for?
- How can you ensure the board is comprised of the necessary competencies, diversity, experience, and backgrounds to advance strategy?

The ensuing discussions with other medical society leaders across the country played a crucial role in reshaping my thinking. My first-time service on the SGIM nominations committee (a required role of the president-elect) provided additional insights that further informed my current belief that we should consider a change. Here's why.

No one would lose.

Uncontested elections are recommended as a leading practice for election methodology due to the potential for unselected members to become disengaged from overall involvement with the organization.¹ I remember the first time I ran for SGIM Council. I lost... and it didn't feel great. While I never considered leaving the organization, I did think carefully about whether to try again. Being nominated to a ballot for a national organization is no small task. It follows years of volunteer commitment, dedication, and service to the organization. It could feel like a slap in the face to lose—especially if it happens more than once. SGIM staff confirmed that some members lost elections and subsequently became disengaged or even left the

organization. Of course, we want to keep our membership, but it is difficult to lose members who have been engaged enough to be considered for leadership positions. Ultimately, as we try to achieve our goal to grow and ensure organizational health, the impact of losing active members who do not win in popular elections is too great.

It would be easier to slate a ballot in the setting of fewer volunteers.

SGIM has always had an open call for nominations allowing unlimited submissions, including self-nominations. However, the number of people raising their hand to serve in leadership roles has declined. Beyond SGIM, decreasing volunteerism is a trend that has been observed nationwide,² with almost one-third of executives (32%) and more than half of board chairs (53%) reporting difficulty finding people to serve on the board.³ These trends may have been exacerbated by the pandemic, when many examined and modified their priorities, often shifting their focus towards personal wellness and self-care. For SGIM, this dearth of volunteerism is most evident at the regional level, where we have already, if unintentionally, piloted uncontested elections due to limited volunteers.

We would be better positioned to strategically establish a Council with the needed diversity, competencies, and experiences to reflect SGIM.

That access to leadership service could be *expanded* via uncontested elections initially seemed counter-intuitive. In fact, organizations that intentionally define and then recruit the desired diversity, skills, connections, and experiences that the board needs may find this easier.³ The SGIM nominations committee considers several factors during the nomination process including member's region, academic focus, diversity, and prior work within the organization among other things.

The committee also considers the current board composition to understand gaps and assure appropriate representation across our organization. However, because getting on the ballot does not guarantee election, an uncontested ballot would provide additional assurance that the SGIM Council has desired skills and representation.

Compare the scenario of a candidate from an organization or academic institution with fewer SGIM members to the candidate from an organization or academic institution with more SGIM members who might have a significant advantage in obtaining votes. This is further complicated by the fact that, on average, only about 20% of SGIM members vote in our annual elections. Even among SGIM voters it is possible that you may be unfamiliar with the people on the ballot, limiting an informed decision. An uncontested ballot could give us an opportunity to identify and grow the organization with active and engaged members from smaller institutions or even those that are newer to SGIM.

Since that initial GLEAM meeting, we have had several opportunities to engage stakeholders in this discussion across the organization—at the Council retreat, regional meetings, and commission and committee meetings. We found members have initial questions but are open to the discussion.

So, what is the plan? First, no final decision has been made. Our leadership team will continue to engage stakeholders in multiple forums—through meetings, SGIM *Forum*, and GIMConnect—before we finalize any changes. The goal is to be transparent about the factors that are driving our thoughts around this potential change. Next, at our annual retreat, we will discuss a proactive plan for engagement and action. This includes discussing strategies to increase voter outreach, engagement, and participation. Importantly, we also plan to develop

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with pulmonary disorders, Camp Pelican. He invited me to attend his pulmonary camp to work with these special campers. Camp Pelican originally was a camp for children with cystic fibrosis (CF) prior to changing infection control recommendations. Camp Pelican has since evolved to include campers with other pulmonary disorders such as moderate to severe asthma, congenital pulmonary disorders and even ventilator dependent campers.

In 1985, I was a 17-year-old counselor to three campers ranging from 14-15 years old at Camp Pelican. Two of my three assigned campers had CF as their qualifying pulmonary disorder. At camp orientation, I was shocked to learn that the life expectancy of a patient with CF was 17 years old (compared to today's life expectancy in the 50s with some patients surviving into their 80s).³ This was unsettling to think that these teenagers only a few years younger than me, would not experience a full life. It is often noted that teenagers do not recognize their own mortality, but on that day, I recognized the predicted early mortality of others. Great times were had by all, and the week was enjoyed by campers and staff. Camp was exactly what it should have been for these medically needy teenagers—it was FUN! As the week came to an end, they asked me if I was going to come back to camp next year and be their counselor again. Of course, I replied “Yes” without hesitation. Thirty-nine years later, I still find myself saying “Yes, I am coming to camp.” I often reflect on this first week with Bobby, Kevin, and Buddy and how working with them and understanding their medical and psychosocial challenges impacted my eventual career choice to become a physician.

My 40-year involvement with Camp Pelican has been life altering. During this time, I graduated from high school, undergraduate, and graduate school. During these educational years, I always found a

way to incorporate attending camp and with Tulane Medical School's blessing, I was also able to make this a rotation during my medical school and residency training. Over the years, I have had numerous life changing experiences and met amazing campers and staff. The camp slogan, “Smiles and Friends Last Forever,” is part of my life's journey and I am thankful for all the experiences from my involvement with Camp Pelican. I have even had the pleasure of sharing these experiences with two of my siblings and both of my sons who have attended camp with me.

I share this month's column with SGIM members for two reasons: first, find something meaningful to you and dedicate yourself to it, and second, be inspired as well as inspiring as you “become a man (or woman) for others.”

We live in a hectic and chaotic world that pulls us in different directions daily. We are so pressed for time focusing on the tasks we “have to do” that we forget doing the things that we “want to do.” These “want to do” things are the stabilizers that help us survive the difficult times. You may not devote 40 years to a specific activity or organization, but extended involvement in a particular endeavor allows you to evolve and become a better person. This sustained involvement also slows the chaos around you when you dedicate the time to your “want to dos.” We should make the time for our “want to dos.”

In 1973, Father Pedro Arrupe said “All of us would like to be good to others, and most of us would be relatively good in a good world. What is difficult is to be good in an evil world, where the egoism of others and the egoism built into the institutions of society attack us and threaten to annihilate us.”⁴ There are many challenges that our patients and colleagues experience. For many, they may not consider their world to be a “good world.” As physicians in today's world, SGIM members can

be “men and women for others” as we treat and address our patients' physical and mental concerns. We should strive to do good in the world of today. Noted anthropologist and humanitarian, Margaret Mead motivates us and inspires us when she says, “Never doubt that a small group of thoughtful, committed citizens can change the world: indeed, it's the only thing that ever has.”⁵ SGIM has committed members that continue to change the world around them, and it is critical that we continue to do so.

As a profession, medicine is often viewed as a calling to serve others. In reviewing my 40-year journey, my involvement in Camp Pelican and my career in medicine was a calling that helps me serve others and along the way to become a “man of others.”

Will you become a “man or woman for others”?

This month, the SGIM *Forum* lead article by fourth-year medical student Cory Bhowmik describes the current state of health care in the carceral system and how SGIM members can and should be involved in education and advocacy initiatives to improve this system. We should ensure that all patients who need health care have opportunities to receive the care they need. SGIM President Dr. Bussey-Jones updates SGIM members on the evolution of her thought process as SGIM Council considers uncontested elections as a potential future for the organization. She provides the information SGIM Executive leaders obtained and how SGIM members are being involved in these discussions. SGIM CEO Dr. Bass reflects with SGIM Health Policy Chair Dr. Fischer on the priorities and successes of the Health Policy Committee over the past year. Dr. Fischer also references the presentation of the John Goodson Leadership in Health Policy Scholarship, in recognition of Dr. Goodson's exceptional contributions to SGIM's advocacy efforts,

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Relative to the general population, incarcerated people are at least three times more likely to have moderate/severe mental illness, substance use disorder, and no health insurance.² Based on these statistics, it has been suggested by advocates in and out of health care that both medical attention and social services could (1) improve the quality of life of incarcerated people and (2) potentially decrease the need for incarceration altogether.

Quality of Life of Incarcerated People

According to the Centers for Disease Control and Prevention (CDC), the percentage of incarcerated people living with either HIV or Hepatitis B is three times higher, tuberculosis six times higher, and Hepatitis C 10 times higher than in the general population. This pattern is also present for other sexually transmitted infections, such as gonorrhea or chlamydia, and, more recently, diseases such as COVID-19.³ The increased incidence and prevalence of certain diseases *might* be considered acceptable if a proportionately higher number of resources were present for diagnosis and treatment, but the actual situation is the opposite.

In New York State, for example, more than 20% of incarcerated people have a chronic medical condition and are not provided any health care.⁴ And when services are provided, co-pays are two to five dollars. Based on the \$0.14-0.63 per hour wage for incarcerated individuals, this is equivalent to a minimum-wage worker having a co-pay of hundreds of dollars.⁴ Funding for health care in prisons is significantly lower, per person, than in non-carceral settings. Equipment is obsolete, medical records are often outdated, and wait times are even worse than in many emergency rooms around the country. A case could be made that infectious diseases could be more easily handled in carceral settings, as the environment—for better or for worse—al-

lows for effective quarantine and contact-tracing, yet many diseases (such as COVID-19) have run rampant in jails and prisons. Perhaps most damning of all is the consensus among incarcerated populations that carceral health care does not seem to care about their well-being; as a result, incarcerated patients do not trust their providers.⁴

Incarceration versus Medical Care

Not only do incarcerated people have a decreased quality of medical care but also a case could be made for many (who were uninsured, unemployed, food-insecure, or had mental/physical health issues) that medical care could have played a role in keeping them out of prison in the first place.

This is not surprising given that the number of psychiatric beds has decreased from 339 to 22 per 100,000 people in the United States from 1955 to 2000. A recent study investigated this phenomenon by matching hospital referral regions (HRRs) with nearby jails/prisons and found that decreases in psychiatric bed capacity (by about 80-90 beds) were associated with an increase of 256 inmates.⁵ Similar increases in psychiatric bed capacity were associated with a decrease of 199 inmates. And this does not even consider the effect that other forms of medical care and social services could have on decreasing the number of people who are incarcerated.

Why Is This Important for Clinicians and SGIM Members?

We, as healthcare professionals and SGIM members, should always provide and advocate for compassionate and effective patient care. We should also ensure that people in need of medical care are provided with medical care, not a profit-driven substitute like incarceration. And we should not ignore the fact that incarceration disproportionately affects people who are Black/Brown, low-income, unhoused, and unem-

ployed—disparities that significantly contribute to health outcomes.

Our current system that features (1) decreased quality of patient care for incarcerated people and (2) the incarceration of people who would be better rehabilitated with medical care indicates that significant gaps remain in the compassionate and effective treatment of this population. Education about and advocacy for proper carceral health care—in medical school, residency, fellowship, and continuing medical education—are essential for the adequate medical care of incarcerated people. It is this education and advocacy that we, as SGIM members, can and should contribute to our healthcare system daily.

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8. Streamline the visa application process for physicians;
9. Support governmental funding for health services, primary care and health disparities research; and
10. Eliminate restrictive research policies on topics like gender affirming care and prevention of gun violence.

This wide range of advocacy reflects the diversity of interests among SGIM members and those who participate in the HPC.

EB: In what areas did the HPC find the greatest opportunities to make a difference?

MF: The most impactful work happens through the efforts of the subcommittees and their members who commit the time needed to identify issues and engage with policymakers. Through the Health Policy Clinical Practice Subcommittee, led by Dr. Anders Chen, we were highly engaged in advocating for changes in physician payment and better support for primary care. We supported the proposal by CMS to implement the G2211 code in the 2024 Medicare Physician Fee Schedule.¹ This code is now available for use to increase reimbursement for patients who need continuing care for a single serious condition or a complex condition. We worked closely with the Primary Care Collaborative and the American College of Physicians to advocate for adoption of a hybrid payment model to increase support for primary care. This approach is currently being considered in the U.S. Congress. We met with leaders at CMS to encourage them to change how reimbursement rates are set for evaluation and management services. We urged them to establish a technical advisory committee that would provide advice on the valuation of physician services. This idea was discussed at a recent Congressional hearing on “How Primary Care Improves Health

Care Efficiency.”² A related sign of growing CMS support for primary care is its recently announced Accountable Care Organization (ACO) Primary Care Flex Model.³ The model will test how prospective payments and increased funding for primary care in ACOs will impact health outcomes and costs of care.



@SocietyGIM Health Policy Committee
 advocates for our vision
 for a just system of care by focusing
 on issues in #healthcare #MedEd
 and #research.

Through the Health Policy Education Subcommittee, led by Dr. Daniella Zipkin, we supported an increase in the number of GME slots allocated by the Medicare Program, including support for the Substance Use Disorder Workforce Act of 2024 that proposes 1,000 new GME positions in hospitals with accredited training programs in addiction medicine. We joined forces with other organizations in preserving funding for HRSA’s Title VII programs and fighting to protect the role of the U.S. Department of Veterans Affairs in medical education. The subcommittee also prepared a white paper calling for a unified national healthcare workforce policy.

Led by Dr. Peter Cram, the Health Policy Research Subcommittee led strong advocacy for the funding that Congress appropriates for the research supported by the U.S. Department of Health and Human Services (DHHS). Several members of the subcommittee participated in virtual meetings with Congressional staff about SGIM’s requests for such appropriations. Despite Congressional pressure to greatly reduce funding for DHHS agencies and eliminate funding for AHRQ, recently approved legislation provided \$47.081 billion for the NIH (1% less than fiscal year 2023) and only a small decrease in

funding for AHRQ. In mid-April, the subcommittee submitted a letter to CMS calling for them to change their plans to increase what they charge researchers for use of CMS claims data.

EB: What else would you like to highlight about the HPC’s activities in the last year?

MF: Thanks to the leadership of Drs. Mark Schwartz and Tracey Henry, we have continued to support the Leadership in Health Policy Program (LEAHP) which cultivates a cadre of skilled health policy advocates, leaders, and educators. Many members have benefited from the superb mentoring provided by the program. At the 2024 Annual Meeting, we will announce the inaugural recipient of the John Goodson Leadership in Health Policy Scholarship, in recognition of Dr. Goodson’s exceptional contributions to SGIM’s advocacy efforts.

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the Patient Health Questionnaire-2 (PHQ-2) with a follow-up PHQ-9 for diagnosis and monitoring of depression. Depression screening can be performed once per year during an AWW with an associated CPT code G0444. Five to 15 minutes of counseling is required for newly diagnosed depression, and the wRVU value is 0.18. The following is an example of proper documentation of depression screening in an outpatient progress note:

“PHQ9 screening performed with patient by medical assistant and myself, each question individually answered and reviewed if needed. Staff is in place allowing for accurate diagnosis, development of treatment plans/follow up care and referral management if needed. Re-evaluate at subsequent visits. Time spent on screening 10 minutes.”

Obesity

Obesity has reached epidemic proportions in the United States. As of 2018, the USPSTF currently recommends referral to intensive, multi-component behavioral interventions for all adults with body mass index (BMI) greater than 30. Primary care physicians can schedule up to 22 visits per year to discuss obesity with patients. A recommended follow-up schedule for obesity counseling is weekly visits for one month, biweekly for two to six months, and then monthly thereafter. The associated CPT code for obesity counseling is G0447 and requires > 15 minutes of counseling including discussion of behavioral health risks, behavioral change, treatment goals and methods, and referrals made and the wRVU value is 0.45. The following is an example of proper documentation in an outpatient progress note of obesity counseling:

“BMI of 38.5 kg/m², stable from last evaluation. 16 minutes spent on lifestyle modifications, to include caloric restriction

to 1,600–1,900 calories and increased physical activity. Dietary assessment and Intensive Behavioral Counseling and Behavioral Therapy: Work on a target of 10,000 steps per day, 150 minutes per week of light aerobic activity such as walking. Try to incorporate two days per week of light weight training. Adopt a Mediterranean diet when possible. Increase your amount of at-home meals versus eating out at restaurants. When eating away from home, make healthy decisions. Try to avoid foods/drinks with excess sugar such as soda, juices, bread, etc.”

Advanced Care Planning

Primary care providers play a crucial role in counseling regarding end-of-life goals and wishes for care. These discussions include completion of forms such as medical power of attorney, orders for scope of treatment, and do not resuscitate orders. The CPT code for advanced care planning is 99497, is applicable to any visit if it is clinically relevant, and the wRVU value is 1.5. The following is an example of proper documentation in an outpatient progress note of advanced care planning:

“16 minutes spent specifically for advance directive care planning. Importance of advanced care planning discussed with patient including DNR/DNI and other orders, Medical Power of Attorney discussed with patient. Informational packet given with advanced directive/MPOA instructions in patient native language.”

Longitudinal Care

Finally, a complex E/M code, G2211 went into effect January 1, 2024, that is applicable to Medicare and Medicare Advantage patients for longitudinal clinical care. Documentation is not specifically required, but it is wise to consider adding, “*established patient, longitudinal care*,” in the history of

present illness or assessment sections of the progress note of that visit. This code is used exclusively during evaluation and management (E/M) visits. It may not be applied to annual wellness visits or other preventive exams, transitional care visits, or if other services are billed during the visit using a -25 modifier (e.g. a procedure). There is no limit in the number of times this code can be used in a given calendar year, and the wRVU value is 0.33.

In summary, several screening and counseling codes exist to use for Medicare patients, but these codes are often underutilized and lead to lost revenue for both internal medicine resident training clinics and attending clinical practices. Increased utilization of these codes will benefit Medicare patients that SGIM members care for as they provide needed screening services for patients (depression, lung cancer). They initiate conversations between providers and patients to help take advantage of existing community resources and initiate Advanced Care Planning conversations that can lead to better understanding of patient’s care wishes before a medical crisis. Using these screening and counseling codes also records the work provided by SGIM members and their clinical teams to show the value provided by resident and attending physicians within academic and community health systems.

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a proactive and transparent SGIM Leadership Pathway Program to establish clear trajectories toward and support for organizational leadership.

Finally, it does not have to be all or nothing. We could start with a pilot that has a partial uncontested slate. For example, we continue with a popular election for our president while having an uncontested slate for secretary. Should we continue with popular elections in any form, we will need to intentionally consider ongoing opportunities for engagement for those members who are not selected.

Regardless, there are several things that will not change. SGIM members and potential candidates will continue to have an opportunity to be nominated. Nominated candidates will continue to present their platforms so that members can evaluate their qualifications and vision for the organization.

Reflecting on my personal thought evolution, I believe that a move to an uncontested election format may streamline the election process, reduce member loss, and facilitate our commitment to diversity and broad member engagement, ensuring a vibrant and sustainable future for SGIM. SGIM Council is committed to building on these early conversations to further strengthen the governance and leadership within SGIM, ultimately benefiting our members and advancing our mission.

We should not be afraid of change.

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We Can't Wait to See You at the Next SGIM Meeting!



Midwest Region

September 26-27, 2024
Location: TBA



Mid-Atlantic Region

October 18, 2024
New Brunswick, New Jersey



New England Region

November 2, 2024
Providence, Rhode Island

From Ideas to Action:
Catalyzing Change in Academic
General Internal Medicine

SGIM25

Save the Date:
2025 SGIM Annual Meeting
May 14-17, 2025 in Hollywood, FL

FROM THE EDITOR (continued from page 11)

to the initial recipient at the 2024 Annual Meeting. The *Forum* editors offer two articles related to coding: in the first article, Dr. Pride and colleagues describe six underutilized billable counseling codes that can be utilized during Medicare and Medicare advantage codes to maximize billing; in the second article, Dr. Sloan and colleagues provide an in-depth review of one of these codes, G2211 and highlights when and how this code can be used via illustrative examples. The *Forum* anticipates that these articles will help increase revenue and capture workload for SGIM members for work that they are already doing. Finally, Dr. Whiteside and co-authors communicate their experiences in utilizing a geriatric consult experience to assist trainees in becoming better consultants and improve their

geriatric learning experiences while providing comprehensive geriatric care.

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