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COMMISSION/COMMITTEE/INTEREST GROUP UPDATE

WOMEN'S CAUCUS: REFLECTING ON 40 YEARS OF ADVOCACY AND COLLABORATION

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As September is "Women in Medicine" month, it is important to recognize that the makeup of academic medicine has changed immensely over the past 40 years with increased proportions of women enrolling in medical school and residency and filling leadership positions.[1] It is easy to lose sight of the legacy of those trailblazers who helped reach these milestones. This column not only highlights the history and impact of the Women's Caucus on the Society of General Medicine (SGIM) and the careers of many current SGIM members but also recognizes the many "unsung sheroes" who have elevated the field to its current state.

With assistance from Erika Baker, SGIM's Director of Project Management, we "dusted off" prior internal SGIM files, which included living and historical documents and proposals. A document compiled by Rowena Dolor, MD, highlights a decade of initial milestones; it first describes the concept of the Women's Caucus in 1986 after a group of women faculty (including Drs. Sarah Williams, Debbie Swiderski, Carola Marte, Ellen Cohen, and Kathy Anastos) recognized the need for collective advocacy and collaboration towards change.[2] SGIM convened its first Women's Caucus a year later at the 10th Annual Meeting in Washington, DC. Over the course of the next 12 years, the Caucus outlined its purpose regionally and nationally, assembled geographically diverse delegates, formulated a system to work together (pre-Zoom), and collected dues to support this mission for academic GIM women physicians. The Caucus grew and created programming at the annual meetings, with varied topics that advocated for women as academic physicians and women as patients. A sampling of early SGIM programming sponsored by the Women's Caucus included the following:

- **1988:** "Women as Patients/Women as Providers" (symposium)
- **1990:** "Women Physicians: Climbing the Ladder or Breaking New Ground?" (Susan Okie, MD, Medical Reporter, *The Washington Post*)
- **1991:** "Key Elements of a Successful Change Strategy" (Discussion Moderator, Patricia Williams*)
- **1992:** "The Use and Abuse of Power" (Leah Dickstein*)
- **1993:** "The Body Politic: Women, Body Image, and Culture" (Catherine Steiner-Adair, EdD)
- **1996:** "Update on Women's Health Fellowships/Residencies" (Saralyn Mark, MD) and "Mentoring: Creating Opportunities" (Kathy Croft*)
- **1999:** "Update in Hormone Replacement Therapy" (pre-course)
- **2000:** "Issues in the Professional Advancement of Women" (Phyllis Carr, MD)

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A SEPTEMBER TO REMEMBER: CELEBRATING WOMEN IN MEDICINE

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

"A blank wall of social and professional antagonism faces the woman physician that forms a situation of singular and painful loneliness, leaving her without support, respect or professional counsel."[1]

Such were the words of Elizabeth Blackwell (1821-1910), the first woman to earn a medical degree in the United States in 1849 from Geneva Medical College, New York. The exact date of her quote is unknown, but it is easily more than 100 years old. It is encouraging to see that some progress has been made, but discouraging to see the chasm that still exists in the treatment of male and female physicians.

September is celebrated as "Women in Medicine" month by many medical professional organizations. It is a month where we recognize the contributions and successes of our female colleagues. There have been many successful trailblazing women physicians who have served as expert clinicians, educators, researchers and administrators. As noted in this issue of SGIM Forum, SGIM has been a strong advocate for female members during its history[2] and SGIM members continue to challenge the status quo regarding women's health care.[3]

As a male physician, my understanding of this critical issue is informed by my female colleagues, review of the literature, and personal observations. Current literature repeatedly demonstrates that inequities remain for equitable pay, academic promotion, and leadership positions. All SGIM members must advocate for the fair and equitable treatment of all colleagues regardless of gender, race, social background, etc. As we celebrate "Women in Medicine" month, take a moment to thank our female colleagues for their hard work and contributions to medicine.

To spotlight "Women in Medicine," see how many of the following history questions related to famous women in medicine[4, 5] you can answer—answers are posted at the end of the issue:

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BRIDGING THE PRIMARY CARE GAP: EXPOSING TRAINEES TO HIGH-PERFORMING PRACTICES TO ADDRESS THE WORKFORCE SHORTAGE

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

"The future of primary care and the pipeline of well-trained primary care clinicians hinges on the ability to adapt and innovate amidst evolving healthcare paradigms."

Early in my life, I viewed primary care through the lens of a patient or family member. Through this lens, I saw primary care for what it was and what it was not. For my grandparents, in rural segregated Georgia, primary care did not exist. This meant my grandparents died too soon from preventable conditions. For my grandmother, limited healthcare access meant she died from widely metastatic breast cancer. She had never established a meaningful primary care relationship to facilitate mammogram screenings that might have detected her cancer earlier. Screening mammography was the standard recommended care for more than a decade before her death. Similarly, I imagine that my grandfather, with his elevated body mass index and lack of primary care, likely harbored undiagnosed conditions such as hypertension, diabetes, and hyperlipidemia. Silent killers were no longer silent when he collapsed on the job and ultimately died of a myocardial infarction. I can only imagine how a primary care relationship might have changed his outcome.

As an "army brat," primary care was different for me. Born at Martin Army Hospital in Fort Benning, Georgia, and covered by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), also known as TRICARE, I had great healthcare access and met all pediatric primary care milestones. As a healthy family, our care was straightforward, including routine checkups (albeit with different military clinicians), vaccines, and dental and orthodontic care. Our experience was characterized by accessibility and reliability, a stark

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Q & A WITH SGIM'S CEO AND THE CHAIR/FOUNDER OF THE GEMS ALLIANCE

Eric B. Bass, MD, MPH; Jenny Mladenovic, MD, MBA, MACP

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In 2023, SGIM was invited to join the Gender Equity in academic Medicine and Science (GEMS) Alliance[1] to show its support for gender equity in academic medicine. Now that SGIM is a member of GEMS Alliance, I would like more members to know about its mission and work. Therefore, I asked Dr. Jenny Mladenovic to share her thoughts about the alliance that she founded.

EB: Why did you form the GEMS Alliance?

JM: In 35+ years in academic medicine, I encountered many problems that interfere with the trajectory of women's careers. Through that experience, I developed a passion for advancing opportunities for women to flourish in academic environments. I wanted to create an alliance of organizations to support gender equity in academic medicine because I believe that we are stronger together than individually. Together, we can share and innovate our lived experiences and align our efforts. The GEMS Alliance is intended to leverage the efforts and resources of organizations that are committed to advancing the careers of women in academic medicine.

EB: What are the top priorities of the GEMS Alliance?

JM: GEMS Alliance focuses on addressing four main barriers to achieving gender equity in academic medicine: 1) the pipeline; 2) gender imbalance in specialties and disciplines; 3) leadership gaps; and 4) the extra burden on women. Regarding the pipeline problem, women admitted to graduate and professional schools account for at least 50% of students, but they do not represent our diverse communities. Without a more representative student population, we will not reach equity in the future workforce. Regarding gender imbalance, women have entered some fields more or less frequently for a variety of reasons. We must find ways to achieve an equitable distribution of women in specialties if we are to reach equity for us, our patients, and our leaders. Regarding the leadership gap, women have not advanced equitably to leadership positions where the policies, resources, and culture are set and modeled. When 50% or more of assistant professors are women, we must assure they thrive in academia, reaching leadership roles to change the culture of academic medicine. Lastly, the gendered differential burden of caregiving is well documented and evident throughout women's careers. The intensive requirements of education and training compel us to consider systematic and accessible support for all women pursuing careers in academic medicine from students to residents, fellows, and faculty.

EB: How does the GEMS Alliance plan to change the culture of medicine?

JM: Culture is set by leadership. Therefore, women must achieve equity in leadership roles to achieve meaningful change in the culture that has existed for the hundreds of years that the profession has been dominated by men.

EB: What do you see as the role of male allies in the GEMS Alliance?

JM: Men are critical to achieving our goals. For generations we have depended upon their support during our journeys in medicine. Indeed, three of our six founding organizations have more men than women members. We need to work with our male colleagues to help create networks and support that have traditionally been available to men.

EB: What can the GEMS Alliance do to advance salary equity?

JM: Salary equity is one visible and easily measured indicator of the disparate treatment that women experience in our culture. The Alliance, through the strength of its members, has the ability to engage in campaigns to assure transparency and regular review, to support women in attaining leadership roles where policies and salaries are set, and to address the issues created by the imbalance of genders in certain fields, a phenomenon that results in lower salaries for women in specialties where they predominate.

EB: What can SGIM members do to support the GEMS Alliance?

JM: We greatly appreciate SGIM's commitment to being an organizational member of the GEMS Alliance. We would welcome the participation of any SGIM members who wish to participate in the initiatives of the alliance. Anyone interested should contact us at info@gemsalliance.org.

References

1. About us. *GEMS Alliance*. https://gemsalliance.org/about-us/about-gems/. Accessed August 15, 2024.

SGIM

IS IT TIME TO RE-IMAGINE "WOMEN'S HEALTH?"

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Women's Health as a medical discipline developed in the 1960s partly in response to the historical exclusion of women in medicine and research and the ensuing significant gaps in clinical knowledge. Since then, Women's Health helped to advance the care of cisgender women through research, education, and clinical practice. In recent years, however, physicians in Women's Health have adapted their expertise in trauma-informed care, sexual health, and hormone management to provide care for transgender and non-binary individuals. As its members embrace inclusivity, Women's Health is left with an unforeseen reckoning over its mission and purpose. While progress has been made, much work remains to be done: Women's Health remains underfunded, under studied, and gender disparities in clinical care remain. In this column, we examine current efforts and unintended consequences to ask the question: Is it time to re-imagine Women's Health?

Why We Still Need "Women's Health"

Keeping Women's Health in its current form acknowledges that the movement has not yet accomplished its stated mission—to mitigate disparities in clinical outcomes for cisgender women. Women and women's diseases continue to be under-represented in biomedical research and health sciences curricula, despite recognized gender-based discrimination and gaps in quality of care. The COVID-19 pandemic highlighted these disparities; for example, the practice of excluding pregnant women in vaccine trials resulted in limited data to inform decision making in this high-risk population. While landmark studies, such as the Women's Health Initiative and the Nurses' Health Study, have been instrumental in providing evidence for sex-specific care, we question whether transitioning away from the female sex-specific language of Women's Health to favor gender-neutral terminology could halt the gains made over the last 50+ years.

Women continue to receive differential clinical treatment compared to men, leading to poorer outcomes across a variety of disease states. Women's symptoms are doubted or downplayed by physicians, often viewed as "dramatic" by clinicians.[1] Women face increasing restrictions on reproductive health care, despite continued increases in maternal morbidity and mortality, particularly for Black wome.[2] As the population of women in the United States grows larger, older, and their health is more medically complex, the need for a group of physicians with expertise in the care of women is critical. The desire to remain a field with terminology that is sex-specific and feminized devotes attention to both the work that has been done and the work that is yet to be accomplished.

Why It's Time to Reimagine Women's Health

There are two reasons why it may be time to reimagine the scope and terminology of Women's Health. First, it may inadvertently lead instructors and learners to believe that these topics are only essential for certain clinicians. The development of curricular competencies for Women's Health in 1996 increased recognition that a comprehensive education in Women's Health is comprised of much more than just reproductive health.[3] Unfortunately, this conceptualization of Women's Health as a quasi-subspecialty led to fragmented educational efforts that failed to raise the minimum competency for *all* physicians. Standards for competency and expectations of learners who did not seek out Women's Health programs remained unchanged. With its current trajectory, the Women's Health movement may be creating a highly specialized workforce, but its small scale inadvertently allows the gender gap to remain in other areas of the healthcare system. To meet the needs of all patients, efforts must be expanded beyond the quasi-specialty Women's Health has become.[4]

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SGIM REGIONAL TEACHING COMPETITION: EQUALIZING THE PLAYING FIELD FOR TRAINEES AND JUNIOR FACULTY TO SHINE

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"See one, do one, teach one" is a mantra that is often echoed in medical education. Yet increasingly, we are recognizing that clinical practice alone does not prepare a person to excel as an educator. Teaching is in its own way is a sport. A clinician educator must be adept at foundational teaching skills, stay up to date on the newest moves, and need to respond to learners with nuance to remain competitive. It's a sport where passion, dedication, and mentorship equalize the playing field regardless of the size of the institution, medical specialty, or the teacher's background for success. A great clinician educator shines due to their ability to change how a learner thinks and sees the world around them.

There is an evidence base and literature that support teaching strategies and each of these take deliberate iterative practice to use effectively. Utilizing adult learning theory, the K-12 educational science and medical education literature we know best plays when it comes to teaching the next generation of physicians, including active learning strategies, case-based teaching, and interactive online technology. These strategies require preparation by the teacher and are best implemented in a safe space that promotes effective learning.

Active learning engages the learner in the process and can help the teacher identify gaps in knowledge. Strategies, such as "think-pair-share" and open-ended questions, can help to gauge where the learners are in their knowledge and where they need to progress. Additionally, engaging the learners prior to instruction allows the learner to build upon their old knowledge as they practice what they already know.[1,2,3]

Anchoring teaching in case-based examples allows the learner to see application of the knowledge to their clinical work. When in the clinical environment, utilizing the learner's patient cases can create opportunities for "just-in-time" teaching to assist them in the care of the specific patient and allow the teacher an opportunity to teach a broader clinical rule. Models, such as the one-minute preceptor and SNAPPS (Summarize, Narrow, Analyze, Probe, Plan, Select), are well studied teaching strategies for busy clinical environments.[2,4]

Clinician educators remain undervalued by the academic system despite the increased recognition of the knowledge, skills, time, dedication, and practice needed to be an effective teacher. Publications, grant acquisition, and clinical RVU dollars are often how physician success is judged. To retain the best educators, academic medicine must work to recognize their skills and promote their success. This year, the SGIM Education Committee worked in collaboration with the Board of Regional Leaders to create a new series of Bite-Size Teaching competitions at each of the regional meetings in order recognize superior junior faculty and trainees.[2]

The idea of the teaching competition originated from the 2019 Mid-Atlantic Regional Meeting at the University of Pittsburgh. The goal of these sessions is to allow students, trainees, and junior faculty within three years of graduation to show off their best teaching schemas to an audience of judges and fans. Each teaching session is allocated 5-7 minutes and can use any medium that inspires the educator. The contenders were chosen from a call for submissions sent out in each region. Applicants were asked to submit a teaching topic, their innovative teaching strategies, and to describe the impact this would have on SGIM member's learning.

There was significant enthusiasm in each of the regions ranging from 15-30 submissions, with five finalists asked to present live during the regional meetings. Judges were provided with standardized score sheets to assess the teachers on their innovation, audience engagement, and teaching strategies implemented. Some institutions had cheering squads for their trainees, while others had institutional coaches and mentors. All attendees brought a high level of energy to support these young clinician educators as they skillfully taught their hearts out. The winners were

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REFLECTIONS FROM THE SGIM EDUCATION COMMITTEE REGIONAL BITE-SIZE TEACHING AWARD WINNERS

Amy H. Farkas, MD, MS; Peggy B. Leung, MD; Yihan Yang, MD; Rani Nandiwada, MD, MS

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The love of teaching is driven by passion, joy, and a commitment to lifelong learning. This year the SGIM Education Committee was inspired to honor our trainees and junior faculty by showcasing: their skills as educators, how they inspire learners using innovative teaching strategies, how they engage learning audiences, and their development of new frameworks to enhance deeper levels of learning. The Bite-Size Teaching competition provided a forum in each region for recognizing these amazing SGIM educators.

We would like to congratulate the regional winners of the Bite-Size Teaching Competition, including:

- **Mid-Atlantic:** Dr. Jordan See, General Internal Medicine Fellow, University of Pittsburgh
- **Mountain West:** Drs. Natalie DeQulilfeldt & Yaa Asare –Resident Physicians, University of Colorado
- **Midwest:** Dr. Jennifer A. Woodard, Geriatrics Fellow, Medical College of Wisconsin
- **California/Hawaii:** Dr. Prerak Juthani, Resident Physician, Stanford Medicine
- **Northwest:** Dr. Vincent Raikhel, Clinical Instructor, University of Washington
- **New England:** Dr. Nathan Wood, General Internal Medicine Fellow, Yale University
- **Southern:** Dr. Abigail Clark, Resident Physician, Emory University School of Medicine

These individuals demonstrated their passion, creativity, and commitment to teaching. Some agreed to share insights about themselves.

Q: Tell us a little bit about your bite-size teaching presentation?

A: "I entitled my teaching session, "[What] To Eat or Not to Eat? Uncomplicating the Science of a 'Healthy' Diet." I'm passionate about the connection between diet and health, and I feel for folks who are confused about the science of nutrition."–Nathan

A: "I used a slide show to discuss the effectiveness of buprenorphine in treating opioid use disorder and introduced a basic algorithm to initiate buprenorphine in the hospital setting. I chose this topic because buprenorphine is one of the safest and most beneficial medications we have in medicine."–Abigail

A: "For the past two years I have had the opportunity to develop a rapid response curriculum for the internal medicine residents at my institution. I find this work so fascinating as rapid responses can be stressful for learners and vulnerable for patients. As part of the rapid response curriculum, I have developed several chalk talks on common rapid response categories such as altered mental status (AMS). I selected my AMS chalk talk for the teaching competition because it fit nicely within the timeframe for the competition while also presenting a useful framework for managing hospitalized patients with AMS."–Vincent

A: "I loved the Bite-Size Teaching Competition because I believe that teaching is such a big part of our training as future physicians, but we rarely get dedicated time to do it. I am so glad that the SGIM meeting had dedicated time to teaching. The topic that I picked for my teaching competition was "The Fundamentals of Right Heart Catheterizations (RHC)."–Prerak

A: My topic was "Bringing the 5M's to IM." We are not training more geriatricians, so we need to make all internists comfortable with geriatrics and give them a basic toolkit."–Jennifer

A: "I love teaching communication skills. For this presentation I focused on verbal de-escalation. I think that as physicians, every day, we have the privilege to take care of patients when they are at their lowest point and a lot of times it comes with high emotion, anger, frustration, etc. Unfortunately, we often bear the brunt of it, so verbal de-escalation is something that all of us can relate to."–Jordan

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ALIGNING BILLING WITH HEALTH EQUITY: NEW SOCIAL DETERMINANTS OF HEALTH AND COMMUNITY HEALTH INTEGRATION BILLING CODES

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In pursuit of fostering health equity and mitigating health disparities, the Centers of Medicare and Medicaid Services (CMS) has implemented several new billing codes aimed at reimbursing healthcare teams for work addressing social determinants of health (SDOH) as part of the 2024 Medicare fee schedule.[1, 2] The creation of billing codes G0136, G0019, and G0022 signifies a strategic shift towards recognizing and valuing more holistic patient care. With these codes, CMS aims to support healthcare teams in addressing SDOH, thus fostering more equitable healthcare and improved outcomes for all beneficiaries. Healthcare teams and SGIM clinicians should utilize billing of codes G0136, G0019, and G0022 to maximize coverage and payment.

Social Determinants of Health Risk Assessment Code: G0136

G0136 is a stand-alone code intended to allow healthcare teams to bill for services for assessment of SDOH (as opposed to screening). It should only be used when a healthcare provider believes the patient may have unmet SDOH needs which may impact the diagnosis or treatment of an illness, choice of treatment, or care plan. Utilization of this code has several key requirements:

- Assessment must be completed during an evaluation and management (E/M) visit (including annual wellness), on the day of hospital discharge (as long as there is outpatient follow-up), during a behavioral health office visit, or with a transitional care management service visit.
- Code can be billed by physicians, advanced practice providers, other medical professionals (including registered nurses, licensed clinical social workers, health educators, registered dietitians, or other licensed practitioners).
- Assessment should take 5-15 minutes to complete.
- SDOH conditions identified during the assessment must be documented and providers may document the conditions using ICD-10-CM SDOH-related Z codes.
- Healthcare professionals should administer a standardized, evidence-based SDOH risk assessment tool, which includes assessment of housing and food insecurity, transportation needs, and utility difficulty. This tool can be filled out by the patient 7-10 days in advance of the visit, but *the assessment by the medical professional must be done as part of the visit*.
- Practices that are Accountable Care Organizations (ACO) or enrolled in risk-based contracts should report the Z-codes on the claims form.
- Billing of code should not be performed more than once every six months.
- Code can be used for in-person or telehealth (visual or audio) visits.

Payment for G0136 is subject to cost sharing (Medicare Part B coinsurance or deductible) unless performed at an annual wellness visit. The code will have wRVU of 0.18.

Billing Examples

Acceptable: A patient is seen for uncontrolled diabetes (DM) at a follow up visit. The primary care provider is concerned about the patient's frequent difficulties adhering to their medication regimen. The clinician asks the staff to give the patient a SDOH questionnaire during triage. The patient reports difficulty paying for food and medications. The provider documents food insecurity and financial difficulties as they relate to uncontrolled DM, optimizes the medications for the patient's financial situation, and refers the patient to the clinic social worker to discuss community-based resources. The provider can bill for G0136 in this scenario.

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Unacceptable: A primary care clinic sends out a survey to all their patients regarding poverty and food accessibility. Mr. X has hypertension controlled with medication and a low salt diet. He denies any issues with paying for food, medications, or transportation. The provider cannot bill G0136 because (1) screening was performed without an assessment and (2) the patient does not have any identified SDOH needs.

Community Health Integration Codes: G0019 and G0022

G0019 and G0022 are Community Health Integration (CHI) codes that are intended to follow up on unmet SDOH needs that have been identified and documented in a prior visit that impact a healthcare provider's ability to provide quality care. Healthcare providers (i.e. the billing provider) must perform the initiating visit and must document the SDOH and what intervention(s) were implemented. G0019 and G0022 are not used during the initiating visit but can be used in subsequent visits to address the unmet SDOH. The SDOH need can be identified in an E/M visit (cannot be level 1), transitional care management (TCM) visit, or annual wellness visit.

Following the initiating visit in which the initiating/billing provider identifies the SDOH need, further services to address that need can be performed by both the billing healthcare provider and auxiliary staff (community health workers, etc.) as well as by community-based organizations that are under contract with a medical provider. When a CHI code is billed by auxiliary staff, it should be billed as incidental-to the original provider who identified the unmet SDOH.

CHI Services can include the following:

- Person-centered planning
- Health system navigation
- Facilitating access to community-based resources
- Practitioner, home, and community-based care coordination and
- Patient self-advocacy promotion.

For billing, the following key components must be heeded:

- Only one practitioner can bill for CHI per month to help avoid fragmentation. Services performed by different auxiliary staff are billed under the initiating provider.
- Prior to billing, the healthcare provider or auxiliary personnel must document patient consent due to the cost-sharing that will be incurred by the patient.
- Consent must be redone if the healthcare provider changes.
- Which SDOH are being addressed and how must be documented and may be documented as ICD-10-CM SDOH-related Z codes.
- For the first 60 minutes of care, providers should use code G0019 and for each additional 30 minutes thereafter, use code G0022.
- Code can be used for in-person or telehealth (visual or audio) visits.

CHI codes allow for billing of time spent supporting and helping patients navigate healthcare and community resources to improve their SDOH. However, these codes may require careful coordination amongst care teams.

Billing Scenarios

Acceptable: A patient with DM lost their Supplemental Nutrition Assistance Program (SNAP) benefits. The patient informs the nurse practitioner at the diabetes clinic who performs a risk assessment using a SDOH questionnaire. The provider documents the impact that food has on the patient's diabetes control and need for assistance in re-enrollment. The diabetes clinic social worker has a phone visit the next day and spends 60 minutes on the phone with the patient to assist with re-enrollment. The social worker bills code G0019.

Unacceptable: The following week, the patient follows up with their primary care physician who also charts that food insecurity is impacting the patient's diabetes. They cannot bill for CHI because it is within the same month that another provider (i.e., the nurse practitioner) billed for CHI and this provider is not providing a service to address the SDOH.

CMS recognizes that whole-person health care is most efficient when each team member operates at the top of their scope of practice, and the SDOH and CHI codes encourage this. The structure of the SDOH and CHI codes allows additional members of the healthcare team to carry out and bill for assessments. However, the limits on billing frequency and care coordination requirements when patients often see multiple providers may limit a care team's ability to fully capture care coordination and social determinants of health simultaneously.

Another limitation of these new codes is their focus on appointment-based provisions of care. Care coordination done during an in-person or virtual patient encounter is preferred. Though CMS has taken steps to recognize care coordination provided between patient visits (e.g., the new G2211 code), codes G0136, G0019, and G0022 require assessment during an initial E/M visit and subsequent billing emphasizes most services should occur during in-person or virtual encounters. Future directions should evaluate whether this is the most effective way to capture work done addressing social determinants of health and connecting patients to community resources.

While individual billing codes insufficiently address existing health inequities, they are an important step to financially capture the work that SGIM physicians and healthcare teams already do and incentivize the promotion of whole-person health. CMS and other payers should continue to work towards reimburs-

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contrast to the limited healthcare landscape my grandparents faced. Motivated by these personal experiences, I entered medicine to address inequities and provide primary care access for vulnerable populations like my grandparents.

As a physician and leader, I am even more convinced that comprehensive, accessible, and continuous patient-centered primary care is the cornerstone of an effective and efficient healthcare system. This view is reinforced by the 2021 National Academies of Sciences, Engineering and Medicine consensus report that found that "primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."[1]

Despite the well-documented benefits of primary care access in improving health outcomes, the shortage of primary care physicians is worsening. Projections from the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis project a shortage of 68,020 primary care physicians, including a shortage of 30,080 general internal medicine physicians, by 2036.[2] As academic general internists, advocating for and investing in highly functioning primary care teaching practices that train and recruit the next generation of primary care physicians is fundamental to addressing current and future healthcare challenges.

Primary Care Is Undervalued

Primary care is often not given the prominence it deserves in medical training. Trainees' perceptions of primary care are significantly influenced by its presence, or lack thereof, in their clinical education. Many training programs focus on inpatient teaching and inadequately emphasize ambulatory care. Further, trainees often spend much of their ambulatory time in specialty clinics rather than primary care settings. This limited exposure leads to diminished comfort with primary care and ultimately fewer trainees opt for primary care careers.

Moreover, the career choices of trainees are strongly influenced by their mentors and role models. Unfortunately, primary care faculty may be perceived as overworked or even "burned out" due to challenges including demands of late-night documentation, inbox management, complex intervisit care, lower compensation, and a relative lack of prestige. This negative perception can further deter trainees from pursuing careers in primary care.

The Primary Care Training Environment Is Strained and Evolving

The work of primary care is evolving rapidly with increasing work that is not patient facing. Non-patient facing tasks—such as answering electronic messages, addressing insurance and formulary constraints, and adhering to regulatory and quality documentation requirements—threaten the joy in our profession and the pipeline of learners choosing this career. Clinicians have described a mismatch between work expectations and allocated time, leading to potential tradeoffs between high quality and their personal lives—ultimately fostering guilt and dissatisfaction.[3] The shift towards value-based care and the rise of for-profit entities[4] have also transformed the primary care landscape. Combined with the pressures of busy practices and increasing physician burnout, these changes highlight the urgent need to reassess and enhance the training and support systems for primary care physicians.

In sum, the primary care shortage is exacerbated by challenges such as limited training time in high-functioning primary care clinics, insufficient support for ambulatory education, and pressures from for-profit models that may prioritize quantity over quality.

The Way Forward

To address these challenges and ensure a robust future for primary care, the Society of General Internal Medicine (SGIM) is partnering with other organizations and agencies on several policy recommendations aimed at enhancing resident training and primary care practice environments. SGIM members have long been leaders and advocates for policies that better align compensation with primary care work. We have worked with the Primary Care Collaborative (a coalition of seventy organizational members) to inform and respond to the request for information (RFI) to accompany the introduction of the Senator Sheldon Whitehouse (D-RI) and Senator Bill Cassidy, M.D. (R-LA) bipartisan *Pay PCPs Act*. This legislation is intended to better support and improve pay for high-quality primary care.[5]

In addition to legislative advocacy, SGIM continues to support the work of the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) to operationalize work from the Hess Institute. Hess Institute work groups have been addressing the primary care workforce shortage by focusing on compensation, training, and team-based care. These work groups have made recommendations related to team composition and function, leveraging technology, aligning compensation with primary care work, and improving learner experience in primary care. This year, SGIM committed to additional financial resources to support efforts to benchmark team roles and best practice across academic general internal medicine practices.

Additionally, the ACLGIM education focused work group, led by Drs. Lauren Block and Anne Cioletti, focused on increasing learner exposure to and training time in high functioning primary care clinics, most relevant to expanding the primary care pipeline. This group was charged with proposing new training recommendations that

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1. **1849:** She became the first woman to earn a U.S. medical degree. After being turned down by 10 medical schools, she was eventually accepted by and graduated from Geneva Medical College in New York. She also founded the New York Infirmary for Indigent Women and Children to serve the poor in 1857, and the Woman's Medical College of the New York Infirmary in 1867.
2. **1854:** In 1850, she entered the first class of the Female (later Woman's) Medical College of Pennsylvania, and later became a professor there. When the Philadelphia Medical Society barred female physicians from training in clinics, she recruited an all-women board to establish a hospital where women could train. In 1866, she was appointed dean of the Woman's Medical College of Pennsylvania, this becoming the first female dean of a U.S. medical school.
3. **1861:** She became the first female surgeon in the U.S. Army. Denied a commission as a medical officer because of her gender, she volunteered to work on the Civil War battlefields caring for the wounded. She was eventually appointed assistant surgeon of the 52nd Ohio Infantry. After being taken prisoner in 1864, she became the first woman to receive the Congressional Medal of Honor.
4. **1864:** She became the first Black American woman to earn a medical degree. In the post-Civil War period, she cared for freed slaves who did not have access to medical care. She was also one of the first African Americans to publish a medical book, Book of Medical Discourses.
5. **1889:** When she was young, she saw a Native- American woman die because a white doctor refused to care for her. Years later, she became the first Native-American woman in the United States to earn a medical degree graduating from the Woman's Medical College of Pennsylvania at the top of her class in 1889. In 1913, she achieved a lifelong dream by opening a hospital in the remote reservation town of Waterhill, Nebraska.
6. **1953:** She devised the first tool to scientifically assess a neonate's health risks and need for potentially life-saving observation. The 10-point score is still considered the gold standard for determining the health of a newborn. She was also the first woman to head an academic department and hold a full professorship at Columbia University College of Physicians and Surgeons.
7. **1969:** She published *On Death and Dying*, a pivotal book that revolutionized the treatment and understanding of dying patients. This Swiss-American psychiatrist was an advocate for better treatment of the mentally ill and the terminally ill, and is known for defining the five stages of grief. Her work was a catalyst for modern hospice care, living wills and the death with dignity movement.
8. **1983:** She became the first female president and sixth overall president of the "Society for Research and Education in Primary Care Internal Medicine" (SREPCIM) which later became the Society of General Internal Medicine (SGIM) in 1988.
9. **1990:** She became the first woman and the first Hispanic to serve as U.S. Surgeon General. Novello's career spanned academia, private practice and the U.S. Public Health Service, where she became a leader in AIDS research.
10. **1993:** She became the first African- American Surgeon General of the United States and the second woman to hold that position. She did not see a doctor until she was 16 years old. With funding from the GI Bill, she graduated in 1960 as the only woman in her class. She was forced to resign in 1994 after coming under fire for several controversial statements on such topics as sex education, masturbation, and the distribution of condoms in public schools.

Perhaps this will prepare you for #SGIM25 trivia night!

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BEST PRACTICES *(continued from page 9)*

ing providers and health systems that address the broader social and community level factors that impact patient health. This reimbursement should focus on rewarding team-based provisions of care and whole person health.

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MEDICAL EDUCATION *(continued from page 6)*

offered mentorship from the SGIM Education Committee and the opportunity to showcase their teaching sessions virtually to SGIM members.

Events like the SGIM Bite-Size Teaching competition provide SGIM members an opportunity to obtain recognition of excellence as a clinical teacher. This year, we hope that our SGIM members will encourage trainees and junior faculty to submit a proposal for this new annual regional event. The SGIM Education Committee hopes these competitions will provide a space for mentorship and push SGIM members to innovate while showing how much they value teaching as a part of their careers.

Click on the hyperlink and watch the Bite-Size Teaching competition![5]

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FROM THE REGIONS *(continued from page 7)*

Q: How did you showcase who you are as an educator and your goals of teaching through the teaching strategy you used in the competition?

A: "One of my favorite learning activities to do with learners is called a "think-pair-share." Learners get a chance to think by themselves, chat one-on-one with a neighbor, and then share what they discussed with the larger group. This allows both introverts and extroverts to engage with the learning in a way that feels comfortable to them, and it's much more interactive than a lecture."–Nathan

A: "I really love chalk talks because they allow me to modulate the interactivity of the session based on the learner's questions and thoughts. As confusing as rapid responses can be, developing clear frameworks for learners can allow them to organize their decision making."–Vincent

A: "I opened the presentation with the story of a patient I saw as a resident. It helped being able to relate the skills back to a real-life example. I also employed the use of a metaphor, in this case a bridge and crossing a bridge together with the patient and then with that metaphor, using it as a mnemonic."–Jordan

A: "I always love case base presentations and focusing on a patient that ideally the whole team is familiar with. But in this case, I

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A second argument for reimagining the field recognizes that the boundaries of Women's Health have become less clear in the wake of increasing conversations around gender identity and expression. Traditionally, Women's Health providers have specialized knowledge and comfort with gender specific and trauma-informed care. Given this expertise, Women's Health clinics have organically become a place for patients to seek gender-affirming care. However, while Women's Health providers have expanded their scope, the language and clinical spaces utilized to represent their services has not evolved. Continuing to use language that ignores the breadth of work in these clinics may directly harm gender-diverse patients. Additionally, failing to evolve labels may perpetuate disparities in research, education, and access to care.

What Now?

Part of the challenge of re-envisioning Women's Health arises from medicine's historical over-reliance on strict binaries (e.g., healthy v. diseased, gay v. straight, male v. female). These binaries do not reflect the true nature of sex and gender and fall short when a more nuanced examination is needed. In the case of Women's Health, the question arises: is a field with such a reliance on binaries still the best way to meet the patient's needs? Consideration must be given to the power of words—and the current approach may need some course correction to reduce siloing and to ensure that the spirit of inclusivity in the current care is reflected in how Women's Health presents itself to the world.

What is the right way forward? The terminology *sex and gender-based medicine* has been proposed for some current Women's Health spaces and training programs. The discipline of "Sex- and Gender-Based Medicine" (SGBM) gained traction in the early 2000s.[5] The pioneers of SGBM, like the pioneers of the Women's Health movement, fought for standardization of sex-based funding, research, and education. Folding Women's Health into "Sex- and Gender-Based Medicine" addresses the issue of narrowing Women's Health training and educational efforts to those with interest. However, while eliminating "women" from the lexicon is more inclusive, this terminology risks inadvertently re-centering cisgender male health.

One thing seems clear: it is impossible to address this complex landscape with a simple label change. To accommodate a diverse patient population and the needs of all learners, Women's Health must become more inclusive in its teaching, cultural competency, and narrative. Using gender-neutral language—such as spouse/partner, they/them, or chest/pelvis—in clinical encounters and teaching normalizes a gender-inclusivity mindset. Asking *everyone* about gender identity and chosen pronouns, and teaching trainees to do the same, invites a culture of acceptance of gender-diverse patients. All learners should be able to perform a competent, trauma-informed history and physical for all patients regardless of their gender identity.

There will be times and places where Women's Health is still the most appropriate moniker, but the title Women's Health must be up for discussion if it is no longer serving the community it is intended to represent. Engaging stakeholders, including patients, is the best path forward to re-brand, enhance, or develop clinical, educational, and research spaces. In addition, we need to demand prioritization and dedication to gender inclusion from policy makers, test writers, and national programming. These are areas in which SGIM members can actively engage in this dialogue, advocacy, research, and education. Some SGIM members are already engaged in this work. For example, the Sex and Gender Women's Health Education Interest Group recently updated its name from the Women's Health Education Interest Group. However, this work cannot just be limited to specific interest groups. Instead, SGIM as an organization should consider intentional approaches to minimize the siloing of expertise. Sex- and gender-specific knowledge should be valued in every space where cisgender women and gender minorities receive care. The Women's Health movement requires an acknowledgment of the inclusivity already pursued now, and continued efforts to diffuse expertise across all clinicians and spaces so it may become unnecessary tomorrow.

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Early Caucus-sponsored topics from the 1990s are still relevant today to SGIM members, demonstrating the need for continued structural improvements.

The Caucus provided intentional resources for networking and support. A place where women in SGIM gathered for camaraderie, education and career development. In subsequent years, an assortment of interest groups relevant to SGIM's female members blossomed, including the Women's Health Medical Education, Obstetric Medicine, Intimate Partner Violence, and Gay & Lesbian Interest Groups. From 2005-07, Drs. E. Bimla Schwarz, Michael Carson, and Pam Charney worked with these interest groups to draft a precursor to the recently published "core competencies in women's health."[3] These SGIM members experienced considerable challenges when seeking the support and endorsement of SGIM leadership in specific areas, so they partnered with Drs. Karen Freund, Missy McNeil, and Ellen Yee to focus on processes, programming, and a united ask. Their goal was to ensure that issues of importance to SGIM's women members could be effectively communicated to SGIM Council.

In May 2007, SGIM Council approved the formation of the Women's Health Task Force (WHTF) marking a pivotal transformation. The task force's goal was to facilitate dialogue through monthly conference calls between these interest groups and the Women's Caucus, to advance research, education, clinical practice, and health policy relevant to women's health.

Initially, the WHTF promoted faculty development and educational opportunities in women's health for SGIM members funded in part by an unrestricted grant. Collaborating with the Annual Meeting program committee, the WHTF celebrated the work and expertise of women professors through sponsored keynote lectures, poster tours, and the Distinguished Professor in Women's Health award. In 2007, Dr. Deborah Grady was the first recipient of this award which continues to recognize accomplished women leaders annually.

In 2011, SGIM President-elect Dr. Harry Selker recognized the importance of developing a structured mentorship program to enhance women's career development. Under the leadership of Dr. Amy Gottlieb, the Women's Career Advising Program (CAP) launched in 2012. CAP aimed to reinvigorate efforts towards the career advancement of women, aligning with the original interests of the Women's Caucus. CAP has since supported nearly 500 participants with an emphasis on sponsorship.

Over the subsequent years, the WHTF transitioned to the Women and Medicine Task Force (WAMTF) to reflect its broader mission beyond women's health. In 2018, SGIM Council decided the WAMTF should become the Women and Medicine Commission (WAMC). Now with ongoing organizational resources and direct communication to SGIM Council, WAMC encompasses multiple interest groups with dedicated leaders and members focused on diverse gender equity topics. The Women's Caucus, now a subcommittee of the WAMC, focuses on its original efforts (mentorship, networking, and advancement of women) but adapts to meet the dynamic needs of women in SGIM.

This formal and intentional recognition and support of women members by SGIM has been invaluable in spurring innovative work and cross-institutional collaboration within the Women's Caucus and beyond. Members still recognize common historical obstacles at academic institutions across the country. In recent meetings, members note a lack of women leaders at the Division, Department, and Dean levels. They express concerns regarding part-time employment as a barrier to career advancement and leadership opportunities. Most recently, Caucus attendees expressed limited awareness of or comfort in negotiations—specifically focused on retention packages. Some found the entire concept new, allowing gender inequities to persist.[4] Much like in prior decades, scholarly collaborations are developing from these discussions so that shared experiences can be disseminated for shared solutions.

To address these current concerns, Caucus leaders, with the support of WAMC, aim to build stronger ties at regional SGIM meetings by creating local Caucuses as first-line contacts for members. With a clearer understanding of regional issues and the convenience of geographic proximity when networking, members can leverage the regional Caucuses to advocate for needed change with a ground-up approach.

As the Caucus liaisons between WAMC, SGIM Council, and the SGIM regions, the Caucus plans to partner with other groups under the WAMC umbrella, including the Parenting Interest Group and the Scholarship Group. These groups share the vision of advancing the careers of women by helping navigate parenthood and non-traditional work schedules and creating pathways to publication respectively. Caucus leaders are also working on outward partnerships by strengthening ties with Association of Chiefs and Leaders in General Internal Medicine (ACLGIM), negotiating initial ACLGIM memberships for LEAD mentors and CAP sponsors for Caucus members.

The Caucus was created thanks to the collaborative efforts of many women. A number of these early members became full professors with leadership roles and scholarly success in academic medicine, and today these women still support and champion SGIM. In this current iteration of the Women's Caucus, its leaders aim for continued advancement of women through promotion and into leadership, to coordinate collaboration through scholarship, and to foster a community through networking. Over the next 40 years, future generations of SGIM members

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will celebrate improved parity in leadership and true professional equity as the Women's Caucus's efforts lead to further change!

The authors express specific appreciation to Erika Baker and Dr. E. Bimla Schwarz for their help with this column. We included the names of women of whom we had clear documentation of their impact; we know more faculty had a hand in this work despite not being named, and for that we are grateful.

(*It is unclear what professional degree these presenters had as it was not in the associated documentation.)

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prioritize high-functioning primary care experiences and continuity for internal medicine residents. Their preliminary recommendations consider the timing and amount of clinical time in primary care practices, trainee panel size, and curricular content to support trainee population management and intervisit care. The work group also considered the faculty, staff, and time needed to enable efficient practice management and ensure consistent and high-quality ambulatory trainee supervision.

Next Steps

It is important to acknowledge that recommendations to expand and improve primary care training are not new and not final. While similar recommendations for change were previously proposed to the Association of Professors in Medicine (APM) without success, this should not deter SGIM members from revisiting the issue now, especially considering the evolution in primary care and the urgent primary care physician shortage. These proposed recommendations are a crucial and necessary first step as we begin to engage stakeholders across SGIM, ACLGIM, American College of Physicians (ACP), Alliance for Academic Internal Medicine (AAIM), the Accreditation Council for Graduate Medical Education (ACGME), and other groups to advocate for policy implementation. When discussing these draft recommendations with colleagues at AAIM, we will need to consider the perspectives of program directors and department leaders from both community settings and major academic medical centers.

Not only the future of primary care but also the pipeline of well-trained primary care clinicians hinge on the ability to adapt and innovate amidst evolving healthcare paradigms. By prioritizing comprehensive training, supportive team-based practice environments, and policies that align payment with work, SGIM can ensure that future generations of primary care physicians are equipped to deliver high-value care and improve health outcomes for all.

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had to create a case and used an AI generator to create a picture of the patient and bring her to the forefront of the teaching."–Jennifer

A: "I first started with objectives of my presentation and what the audience can expect to get out of my talk. From there, I went through a standardized approach to RHCs called "WCP" (Is the patient Wet?; Does the patient have decreasing Cardiac output?; and Does the patient have elevated Pulmonary artery pressures?") approach. Then I demonstrated how this approach can be applied in real examples."–Prerak

Q: What was the impact of the competition on your identity as an educator?

A: "Every time I lead a learning session and pose questions to the audience, as in this session, I get new responses from the learners. Many of their responses tend to fall into buckets and patterns that are predictable, certainly, but there are always new ones. This helps me to continue to see myself not only as a teacher, but also as a lifelong learner."–Nathan

A: "It really gave me confidence. It gives validation to my work that I have been engaged in for so long. I really have an aspiration to be an expert at teaching physician communication skills and this opportunity was one step forward."–Jordan

A: "I was lucky to be invited to participate in the competition because it gave me dedicated time to create a presentation and schema for approaching tough topics in medicine. Doing more exercises like this, can help me as an educator develop more schemas for common medical problems."–Prerak

A: "This was a real honor to have my teaching recognized through this competition. I really appreciate this opportunity and it solidified the idea that intentional practice and iterative revision of teaching sessions has positive outcomes for my teaching."–Vincent

A: "The competition inspired and encouraged me to continue learning how to teach effectively. I am excited to take the feedback I received at the competition and apply it to future teaching points."–Abigail

Q: What advice would you give future competitors about preparation and delivery?

A: "I would encourage future competitors to find ways to get their learners talking to each other. Even the best-delivered lecture won't be able to compete with sessions that incorporate cooperative learning strategies. Best of luck."–Nathan

A: "I think the best step to take in preparing for a competition such as this is to seek high quality feedback from mentors."–Abigail

A: "Start with a topic that resonates with you, then define a specific learning objective. Be deliberate about how you'd like to support audience engagement and interaction."–Vincent

A: "You should be passionate about your topic, that just makes it so much easier." –Jordan

A: "It is important to have a test group. I also recommending being realistic about how much time you have and its okay to take a narrower topic because 10 minutes is not long at all."–Jennifer

A: "It's important to work backwards and see what you want the audience to take away from your presentation and then see how you can ensure that this happens."–Prerak

The SGIM Education Committee thanks these winners for sharing their teaching talents in the first set of regional SGIM Bite-Size Teaching Competitions. By sharing their teaching expertise, they can hopefully inspire others to participate in this year's competitions. We encourage all SGIM members to highlight their work and the importance of clinical educators at all our institutions.

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FROM THE EDITOR *(continued from page 11)*

Answers

1. Elizabeth Blackwell, MD
2. Ann Preston, MD
3. Mary Edwards Walker, MD
4. Rebecca Lee Crumpler, MD
5. Susan LaFlesche Picotte, MD
6. Virginia Apgar, MD
7. Elisabeth Kübler-Ross, MD
8. Suzanne Fletcher, MD
9. Antonia Novello, MD
10. Joycelyn Elders, MD

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