AUGUST 2026 V49, NO. 8

SGIM FORUM

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ANNUAL MEETING UPDATE

SOCIETY OF GENERAL INTERNAL MEDICINE ANNOUNCES AWARD AND GRANT RECIPIENTS FROM THE 2026 ANNUAL MEETING

Francine Jetton, MA, CAE, Senior Director of Communications & Publications, SGIM

The Society of General Internal Medicine presented numerous awards and grants at its Annual Scientific Meeting, held May 6-9, 2026, at the Gaylord Hotel and Convention Center, Oxon Hill, MD. SGIM is proud and pleased to announce the recipients by category.

Recognition Awards

The Robert J. Glaser Award—Presented to *Allan S. Detsky, MD, PhD (Mount Sinai Hospital-Toronto)* for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Herbert W. Nickens Minority Health and Representation in Medicine Award—Presented to *Monica Peek, MD, MPH (University of Chicago Medical Center)* for a demonstrated commitment to cultural diversity in medicine.

Elnora M. Rhodes SGIM Service Award is presented to *Carolyn Clancy, MD (Washington DC Veterans Affairs Medical Center)*. This award is given to members of the Society who have demonstrated extraordinary service to SGIM and its missions.

ACLGIM Chiefs Recognition Award—Presented to *Mitchell D. Feldman, MD, MPhil (University of California, San Francisco School of Medicine)*. This award is given annually to the general internal medicine Division Chief who best represents excellence in division leadership.

The ACLGIM UNLTD (Unified Leadership Training in Diversity) Award—Recognizing that academic leaders are expected to navigate complex structures and systems; the Unified Leadership Training for Diversity (UNLTD) Program aims to equip current and aspiring academic leaders with the essential skills to thrive and drive diversity in academic organizations. The 2026 recipient is *Michael Charles, MD (University of Illinois at Chicago Medical Center)*.

The ACLGIM Leadership Award—Given to a member of the ACLGIM who is within the first 10 years of faculty

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appointment. It recognizes skills in leadership in any number of areas of academic medicine, including clinical, educational, research or administrative efforts. The 2026 recipient of this award is *Thomas R. Radomski, MD, MS (University of Pittsburgh School of Medicine).*

The Quality and Practice Innovation Award—Recognizes a general internist and their organization that has successfully developed and implemented innovative role model systems of practice improvement in ambulatory and/or inpatient clinical practice. The 2026 award was presented to *Primary Care Behavioral Health Integration Program PC-5HIP at the University of Chicago (Neda Laiteerapong, MD, MS).*

The Excellence in Medical Ethics Award—Recognizes the original scholarship that SGIM members have done to advance medical ethics. The 2026 award was presented to *Matthew DeCamp, MD, PhD (University of Colorado School of Medicine).*

The John Goodson Leadership in Health Policy Scholarship awards funding for one incoming Leadership in Health Policy (LEAHP) scholar who is working in the field of clinical practice/payment reform. The 2026 recipient is *Melissa Chiang, MD, MBA (University of California, San Francisco School of Medicine).*

Research Awards

John M. Eisenberg National Award for Career Achievement in Research—Presented to *Rachel M. Werner, MD, PhD (University of Pennsylvania School of Medicine)* in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator of the Year—Presented to *Elizabeth Tung, MD (University of Chicago Division of the Biological Sciences, The Pritzker School of Medicine)* for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research Mentorship Award—Presented to *Anne N. Thorndike, MD, MPH (Massachusetts General Hospital, Harvard Medical School)* in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper of the Year—Presented to *Eric T. Roberts, PhD (University of Pennsylvania School of Medicine)* for his 2025 publication "Loss of Subsidized Drug Coverage and Mortality among Medicare Beneficiaries." This award is offered to help members gain recognition for their papers that have significantly contributed to generalist research.

Founders' Grant—Awarded to *Joseph Nwadiuko, MD, PhD (University of Pennsylvania School of Medicine).* The SGIM Founders Award provides up to $10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a "jump start" to establish a strong research funding base.

Lawrence S. Linn Needs-Based Travel Grant—The Lawrence S. Linn Needs-Based Travel Grant supports trainees, residents, and students presenting work in HIV, AIDS, PrEP, transgender health, and sexual and gender minority health at the SGIM26 Annual Meeting. Recipients are selected through a review process and receive $800 to help offset travel costs, advancing SGIM's commitment to supporting emerging scholars and impactful research. The 2026 recipients of this grant are as follows:

- *Anne Peacock, MD, MSW (Emory Healthcare)*
- *Allison Knoedler, MD (Indiana University School of Medicine)*
- *Fidel Vazquez, MD (Tulane University School of Medicine)*
- *Shreya Shaw (Ohio State University Medical College)*
- *Andrew Travis (University of Chicago, Biological Sciences Division, the Pritzker School of Medicine)*
- *Shana Zucker, MD, MPH, MS (University of Pittsburgh School of Medicine).*

Mary O'Flaherty Horn Scholarship—Awarded to *Juan Lessing, MD (University of Colorado School of Medicine).* This two-year career development grant is awarded to a junior clinician-educator to promote their academic career while maintaining a healthy balance between personal and professional responsibilities by providing the scholar with a flexible schedule and protected time to engage in meaningful career development and scholarly activities. This grant funds the scholar $30,000 yearly for two years in addition to their institution matching $30,000 yearly for two years.

Clinician-Educator Awards

Achievement in Education and Innovation Award—This award recognizes gifted teachers who have demonstrated a track record of employing innovative teaching methods, developing outstanding courses and curricula, or novel educational programs shared at a national level. The 2026 recipient is *Kimberly D. Manning, MD, MACP, FAAP (Emory University School of Medicine).*

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Mid-Career Education Mentorship Award—Recognizes outstanding mid-career clinician educators actively engaged in education research and mentoring junior clinician educators. Presented to *Craig Noronha, MD, FACP (Boston University School of Medicine)*.

Frederick L. Brancati Mentorship & Leadership Award—Presented to *Leah Marcotte, MD, MS (University of Washington School of Medicine)*. The Brancati Award honors an individual at the junior faculty level who inspires and mentors trainees to pursue general internal medicine and lead the transformation of health care through innovations in research, education, and practice.

Scholarship in Medical Education Award—Presented to *Sarah Merriam, MD, MS (University of Pittsburgh School of Medicine)* for individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

Presentation Awards

Mack Lipkin, Sr., Associate Member Awards—Presented to the scientific presentations considered most outstanding by students, residents, and fellows during the 2026 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2026 are as follows:

- *Amanda McArthur, PhD (Johns Hopkins Medicine)* "Conversations about Diabetes Self-Management in Primary Care Encounters: When Do Patients Disclose Medication Nonadherence?"
- *Maisie Orsillo, DO (Yale School of Medicine)* "We Are the Doctors for You—Improving Internal Medicine Resident Education to Better Serve Adults Living with Disabilities: A Randomized Controlled Trial."
- *Isabel Ostrer, MD (University of California, San Francisco School of Medicine)* "How Many Hours Do We Work Anyway: Quantifying Work Efforts Among Primary Care Providers Nationwide."

Milton W. Hamolsky Junior Faculty Awards—Presented to the scientific presentations considered most outstanding by junior faculty during the 2026 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2026 are as follows:

- *Anand Habib, MD, MPhil, MHS (University of California, San Francisco School of Medicine)* "Healthcare-Systemwide Causes and Severity of Moral Distress among a National Sample of Practicing Physicians: A Cross-Sectional Survey."
- *Adam Markovitz, MD, PhD (University of Michigan Medical School)* "REACH for the Best, Leave the Rest: Selection and Coding in Medicare's Newest ACO Model."

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.

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- *Sumit Agarwal, MD, MPH, PhD (University of Michigan Medical School)* "Cash Transfers and Birth Outcomes: A Population-Based Quasi-Experimental Study of the Rx Kids Unconditional Care Prescription during Pregnancy and Infancy."

SGIM Clinical Vignette Oral Presentation Award—Recognizes the best presented clinical cases by a medical student, internal medicine residents, or GIM fellows (not faculty) at the SGIM National Meeting. This year's recipients are *Clare Nimura, BA (The Warren Alpert Medical School of Brown University)* "Not All Hallucinations Are Psychosis" and *Andrew-Huy Dang, MD (University of California, San Diego)* "When the Headache Is More Than a Migraine: An Uncommon Cause of Temporal Pain."

David E. Rogers Junior Faculty Award—awarded to junior faculty for workshops judged to be the most outstanding among those presented at the 2026 annual meeting. The Zlinkoff Fund for Medical Education endows these awards. The 2026 recipients of the award are as follows:

- *Matthew N. Metzinger, MD, MS (University of Pittsburgh School of Medicine)* for the workshop titled "Mindful Self-Compassion: A Proven Way to Accept Yourself, Build Inner Strength, and Thrive with Career Transitions."
- *Miriam Robin, MD (SUNY Downstate Health Sciences University)* for the workshop titled "Tiny Stories, Big Impact: Exploring Narrative Medicine in Just 100 Words."
- *Amteshwar Singh, MD, FACP (Johns Hopkins University School of Medicine)* for the workshop titled "Measuring What Matters: Designing Valid and Reliable Surveys in Health Professions Education."

Innovations in Medical Education Oral Abstract Award—Lauren Phinney (University of California, San Francisco/San Francisco Health Network) for the abstract titled "Leveling Up for Boards: Theory-Informed Gamification of Team-Based Residence Exam Preparation."

Distinguished Professor of Women's Health Best Oral Abstract Award—Karly A. Murphy, MD, MHS (University of California, San Francisco School of Medicine) for the abstract titled "Women with Serious Mental Illness Are Falling through the Cracks in Breast Cancer Screening: A Gap Analysis across an Urban Health System."

Distinguished Professor of Women's Health Best Poster Award—Nicole Luche, MD (University of Pittsburgh Medical Center) for the poster titled "Changes in Teratogen Prescribing Patterns in States with Variable Abortion Policies Following the Dobbs v. Jackson Supreme Court Decision."

Distinguished Professor of Geriatrics Best Oral Abstract Award—Kathryn A. Martinez, MPH, PhD (Cleveland Clinic) for the abstract titled "Primary Care Physician Perspectives on Estimating Patient Life Expectancy to Guide Colorectal Cancer Screening decisions for Older Adults."

Distinguished Professor of Geriatrics Best Poster Award—Audrey D. Zhang, MD (Beth Israel Deaconess Medical Center) for the poster titled "Telemedicine and Health Care Contact Days Among Older Adults Under Changing Reimbursement Policies."

Distinguished Professor of Health Equity Best Oral Abstract Award—Alana Biggers, MD, MPH (University of Illinois College of Medicine) for the abstract titled "My ESSENCE: A Pilot Study of a Mindfulness-Based Digital Health Intervention to Improve Sleep and Cardiovascular Risk in Black Adults with Type 2 Diabetes."

Distinguished Professor of Health Equity Best Poster Award—Aakrsh Misra (University of California, Los Angeles David Geffen School of Medicine) for the poster titled "Trends in Cardiometabolic Risk Factor Burden and Treatment by Race and Ethnicity among Adults with Atrial Fibrillation."

Distinguished Professor of Hospital Medicine Best Oral Abstract Award—Teryl K. Nuckols, MD, MS (Cedars-Sinai Medical Center) for the abstract titled "The Cost-Effectiveness of the START Hospital Addiction Consultation Service for Opioid Use Disorder Treatment."

Distinguished Professor of Hospital Medicine Best Poster Award—Blair Golden, MD (University of Wisconsin School of Medicine and Public Health) for the poster titled "Association Between Cognitive Impairment and Clinician Prescribing at Hospital Discharge: A Nested Cohort Study."

SGIM

FORUM PHILOSOPHY: WHERE EVERY VOICE MATTERS

Megan McNamara, MD, MS; Alia Chisty, MD, MS
Co-Editors-in-Chief, SGIM Forum

Letter from the Co-Editors-in-Chief:

Since 2021, we have been working together as part of the leadership team for the Career Advising Program (CAP). This relationship then led to our leadership roles in the Women in Medicine Commission (WAMC). Both groups promote the advancement of women, either through sponsorship of early career women physicians or through efforts that promote women's health, sex and gender-based education and healthcare delivery, and the professional development of women physicians. Since January 2025, much of the professional work we have passionately undertaken has come under scrutiny as directed by the national government. Suddenly, our lived experience as women physicians felt threatened, devalued, and discredited. This cannot encapsulate the challenges that our colleagues with intersecting identities or identities less commonly represented in medicine might experience. Or it might not capture the challenges that you, the reader, might have experienced!

We acknowledge that the last 18 months have been difficult for both physicians and patients. We have been navigating these turbulent times by surrounding ourselves with people who share our values. SGIM has been our safe haven, providing us with fellowship and shared purpose. As new SGIM Forum Co-Editors-in-Chief, we want to give back to the SGIM community by creating a space for communication, discourse, and expression of disparate viewpoints. Please write, share, pontificate, and influence. As the famous poet Rumi once said, *"Raise your words, not your voice. It is rain that grows flowers, not thunder."* Let's raise our words together. Only then can we continue nurturing our patients, our learners, our colleagues, our society, and each other. Only then can we continue to advocate for a just health system that brings optimal health for all people.

Thank you for being our safe haven and our community.

—Meg and Alia

THIS IS MY HAPPY PLACE

Mark D. Schwartz, MD
President, SGIM

"We gather because community turns concern into determination and relationships into action."

In my President's Column before the Annual Meeting, I asked a simple question: *Why do we gather?* I suggested that we do not come together simply because it is tradition or because professional societies need annual meetings. We gather because our work requires community.

A few weeks later, when I arrived in Washington, DC, for SGIM 2026, I found myself thinking about that question again.

The night before the meeting began, I met with Rita Lee, SGIM's next President-Elect, in the hotel lobby. We were getting to know one another and beginning the process of leadership transition, much as Carlos Estrada had done for me a year earlier. One of the first things Rita said was, *"This is my happy place."*

The comment stopped me for a moment because it felt both deeply personal and immediately familiar. Over the years, I have heard members describe SGIM as their professional home, their extended family, their community, or simply *"my people."* But Rita's phrase captured something slightly different. It was not about obligation or professional advancement. It was about *joy*.

In a year when many of us worry about the future of academic medicine, research funding, primary care, and the health of our patients and communities, it is remarkable to me that a national professional meeting could still evoke that response. What is it about SGIM that makes people feel that way? As the meeting unfolded, I began to find answers.

Before arriving in Washington, DC, I had challenged myself, and perhaps some of you, to talk with strangers. As an introvert, this does not come naturally to me. Like many people, I am drawn toward familiar faces and comfortable conversations. Still, I tried. And as President-Elect, I experienced something new and slightly disorienting: strangers came to talk to me. Some simply smiled or nodded as we hurried between sessions while others stopped to introduce themselves, say *"best of luck,"* ask thoughtful questions, share concerns or ideas, or simply say, *"hello."* These brief encounters became one of the unexpected gifts of the meeting.

One morning, I was standing with Martha Gerrity, a longtime friend and former SGIM President. We were chatting over coffee between sessions. Like many members, both of us had affixed ribbons beneath our name badges—among them, a green ribbon indicating that we were SGIM donors. A young woman approached and introduced herself. She had noticed our donor ribbons and wanted to thank us. She said, *"I was able to attend my first SGIM meeting a few years ago thanks to a scholarship funded by donations and I have been coming ever since. I am very grateful."* In that brief conversation, I was reminded that the future of SGIM has a face, a voice, and a name badge. SGIM's future is sitting in today's workshops, presenting posters, and finding its footing just as many of us once did.

I attended various interest group meetings, even those at 7:00 AM, to meet members working on topics outside my usual circles. I listened to many discussions, including topics on climate and health, education, and advocacy. SGIM's breadth of interests and members' energy were striking. Some have become year-round communities that produce scholarship, develop leaders, mentor trainees, and sustain collaborations. The discussions reminded me that SGIM is a collection of individual members with hopes, concerns, passions, and aspirations for our profession. The future of SGIM will be shaped by these conversations, not just serious dialogues in boardrooms.

Of course, annual meetings are not only about relationships. They are also about work. Some of my most important conversations occurred in meetings that most attendees never saw. Because the meeting was held in Washington, DC, SGIM leaders met with representatives from the VA, AHRQ, PCORI, and other federal agencies. Together with SGIM CEO Eric Bass, outgoing President

PRESIDENT'S COLUMN *(continued from page 6)*

Carlos Estrada, and incoming ACLGIM President Jane Liebschutz, I had the opportunity to listen, learn, and strengthen relationships that will matter greatly in the years ahead.

These conversations revealed how national policy changes impact our colleagues, institutions, and communities. They reinforced my appreciation for SGIM's emphasis on relationships. Professional societies matter because trust, built over years, is invaluable when challenges arise. A strength of SGIM is the ability to pick up the phone, ask a question, seek advice, or collaborate on a shared goal.

In nearly every conversation, whether with federal leaders, committee chairs, trainees, or longtime members, I heard the same concerns. *"I am worried about my research funding." "What are we doing to rescue primary care?" "Will my trainees find a place for themselves in academic general internal medicine?"* Yet alongside those worries, I heard something else: determination. And that, I think, is where the deeper response to Rita's observation begins. We come together to renew our shared purpose, strengthen our collective resolve, and return home ready for the work ahead.

The challenges facing academic medicine are real. Research funding is shrinking. Primary care remains undervalued. The pipeline into general internal medicine is fragile. Patients face growing barriers to care. We didn't solve these problems in Washington. What changed was my confidence that we have the people, relationships, creativity, grit, and collective capacity to meet them together. That may be SGIM's greatest strength.

At several points during the meeting, I found myself reflecting on Carlos Estrada's leadership over the past year. Carlos's Presidential Address was inspiring and generous. He celebrated colleagues, acknowledged mentors, highlighted the accomplishments of members, and reminded us that despite the real challenges facing academic medicine, remarkable work continues across SGIM every day.

At one point, music by Mercedes Sosa filled the room. Carlos moved to the rhythm, smiling, waving his hands, and inviting all of us to share in the moment. He did not need to say that joy belongs in our work. He showed us. At a moment when many of us are anxious about the future, Carlos reminded us that joy is not a distraction from the work—it is part of how we sustain it.

The phrase *happy place* can sound almost frivolous in a time like ours. But this is not what Rita meant, and it is not what I experienced. Happiness is the presence of purpose, connection, and hope. It is the feeling that the work before us matters and that we are surrounded by people willing to do it together. That spirit carried through the meeting.

We thanked staff and member volunteers. We taught and learned together. We celebrated with the award recipients. For example, we honored Carolyn Clancy as she concluded her extraordinary leadership career at the VA and received SGIM's Elnora Rhodes Service Award. SGIM has developed the important habit of not simply celebrating accomplishments—we celebrate people.

By the time the meeting ended, I felt as I often do after SGIM meetings. Exhilarated and exhausted. Ready to go home. Filled with more ideas than I have time to pursue. Carrying new questions, new relationships, and new possibilities. And thinking once again about Rita's words. *"This is my happy place."*

The conversations that began in Washington are far from over. Over the coming year, and especially as we gather in Seattle, Washington, in May 2027 to celebrate SGIM's 50th anniversary ("SGIM@50 Honoring Our Legacy, Shaping the Future of GIM"), I hope we continue imagining the future of general internal medicine with the same optimism, generosity, and determination that filled this year's meeting.

Back in May, I asked why we gather. After spending a few days with all of you in Washington, DC, I think I have a better answer. Yes, we gather because not only do people need a place where they belong but also, they need joy and inspiration to sustain our difficult work. We gather because community turns concern into determination and relationships into action. We gather because the work requires community. For many of us, that community is SGIM.

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SGIM 2026 ANNUAL MEETING PHOTOS

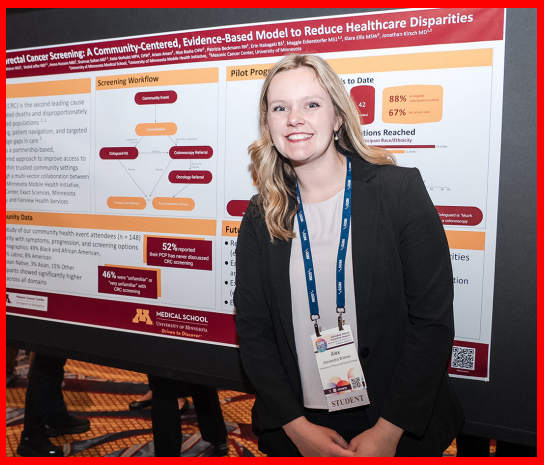


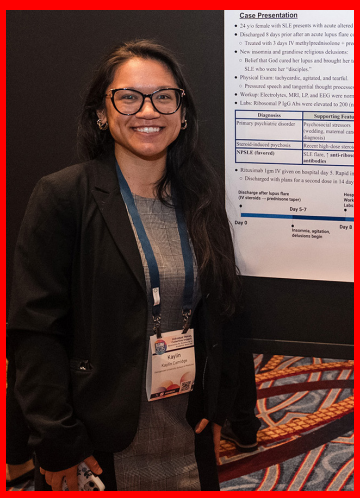






SGIM 2026 ANNUAL MEETING PHOTOS *(continued from page 8)*





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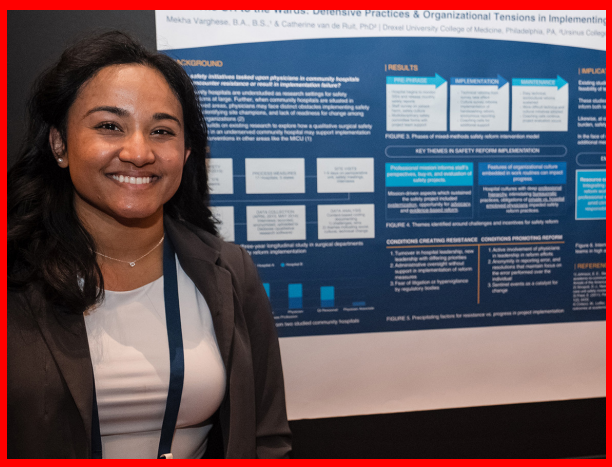
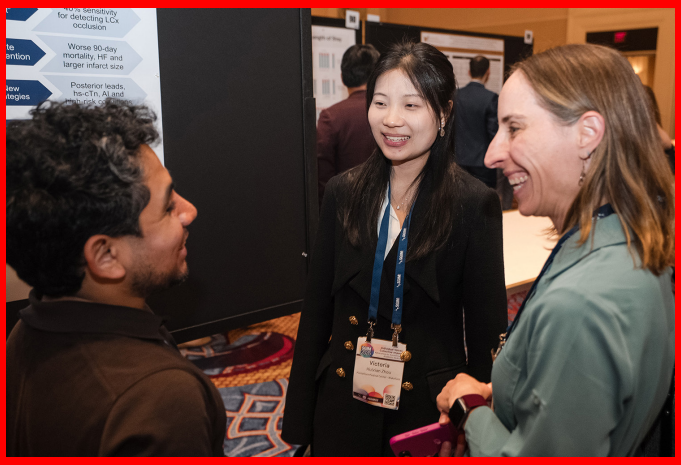
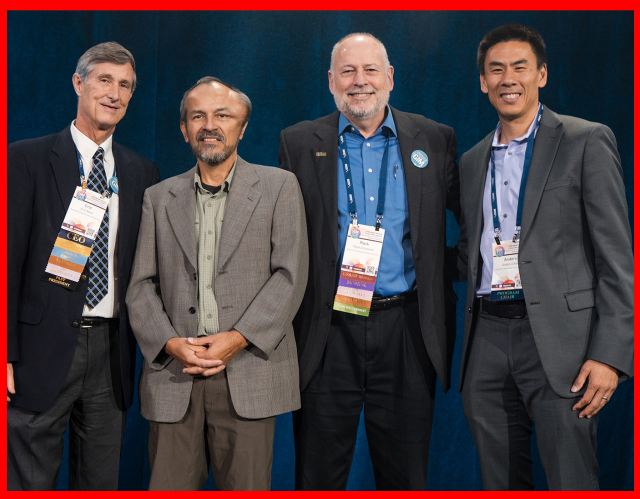




SGIM 2026 ANNUAL MEETING PHOTOS *(continued from page 10)*

SGIM 2026 ANNUAL MEETING PHOTOS *(continued from page 11)*

SGIM 2026 ANNUAL MEETING PHOTOS *(continued from page 12)*



Q & A WITH SGIM'S CEO AND PRESIDENT ON COUNCIL'S PRIORITIZATION OF HOW TO MAXIMIZE VALUE TO MEMBERS

Eric B. Bass, MD, MPH; Mark D. Schwartz, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Schwartz (Mark.Schwartz@nyulangone.org) is the President of SGIM.

SGIM's Council held its annual strategic planning retreat on June 10-12, 2026. The agenda was packed because we had many decisions to make about how to address major challenges and opportunities without exceeding the limits of our organizational capacity. SGIM is thriving in many ways, but it is operating in a moment of extraordinary change. Academic generalists face workforce shortages, financial pressures, threats to research and education funding, rapid advances in artificial intelligence, and growing demands for advocacy and leadership. At the same time, SGIM members continue to generate new ideas and opportunities for the Society. The challenge before Council was to determine which work would bring the greatest value to members while remaining realistic about organizational capacity.

In a previous SGIM Forum column, I shared my reflections on the unique value of SGIM.[1] Now I'd like to share how our President succeeded in leading the Council through a series of decisions that called for explicit prioritization of how to maximize value to our members.

EB: Why did you decide to open the Council's strategic planning retreat with a discussion on "bringing organizational value"?
MS: As you know, we spent a lot of time preparing for this Council retreat because the society is facing many major threats to our mission while continuing to run many programs and initiatives that were launched years ago. SGIM has demonstrated that it is a resilient organization, defined as having the "capacity to maintain continuity and effectiveness through disruption and uncertainty."[2] However, to meet the challenges and opportunities we are now facing, SGIM must become a more agile organization, defined as having the "capacity to adapt its direction and actions in response to changing conditions."[2] In my opinion, the best way to increase agility without losing resilience is to ensure that any changes in direction are grounded in a commitment to prioritizing what is most valuable to our members.

EB: How did you engage Council members in determining their views about the value of SGIM to members?
MS: I asked Council to reflect on four questions:

- Why should people belong to SGIM in 2030?
- What is the unique value of SGIM to members?
- What problems do members want SGIM to solve?
- What makes SGIM indispensable to members?

In the ensuing discussion that was captured on a flip chart, Council members identified numerous ways in which SGIM brings value to members. Then I asked each Council member to allocate five sticky dots to the values they considered to be most important. It surprised me how quickly Council members converged around a common set of themes. The highest-ranked values reflected something deeper about why people belong to SGIM as illustrated below:

- *SGIM is an academic home*. The message is that SGIM is where people who identify as generalists find their professional home.
- *SGIM is a leadership and career accelerator*. The core message is that SGIM helps people advance.
- *SGIM is a values-based community*. The inspirational message is that SGIM stands for something.
- *SGIM is a supportive professional ecosystem*. The basic message is that members help each other succeed.

When I fed Council's input into ChatGPT, I received the following powerful statement of SGIM's unique value to members—SGIM helps academic generalists find a professional home, grow as leaders and scholars, connect their work to their values, and become part of a community larger than themselves.

EB: How did Council's prioritization of values influence decisions that were made?
MS: Throughout the retreat, we wrestled with difficult decisions about how to make best use of our organiza-

FROM THE SOCIETY *(continued from page 14)*

tional capacity. We had to remind ourselves to consider the desired outcomes of each potential activity and how those outcomes related to the values of highest priority to members. I believe that the emphasis on value to members helped us make room for important new commitments while also sharpening the focus or wrapping up previously existing initiatives.

The values exercise became a touchstone throughout the retreat. When discussing new initiatives, Council considered whether they would strengthen SGIM's role as an academic home, create opportunities for leadership and career growth, reinforce our values, or deepen the connections among members. Those questions helped guide decisions to launch a new task force on the future of academic primary care internal medicine, strengthen support for academic hospitalists, and be more disciplined about initiatives that might stretch organizational capacity without clearly advancing member value.

EB: What do you hope members take away from this discussion?

MS: I hope members know that Council is thinking carefully about the future of SGIM. We are committed to innovation and growth, but we also recognize that every new initiative requires time, staff support, volunteer effort, and financial resources. The values exercise reminded us that our most important responsibility is not simply to do more. It is to focus our energy on the things that matter most to members and that make SGIM indispensable as an academic home and professional community.

References

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2. ASAE Research Foundation. 7 Measures of Success Series. *ASAE*. https://foundation.asaecenter.org/research/7-measures-of-sucess/. Accessed July 15, 2026.

SGIM

MEDICAL EDUCATION: ARTICLE I

REFLECTIONS FROM THE 2026 SGIM EDUCATION COMMITTEE AWARD RECIPIENTS

Athina Vassilakis, MD, MPH; Ann E. Perrin, MD, MPH; Mark Troyer, MD, MPH; Christine Bryson, DO, MPH; Amy H. Farkas, MD

Dr. Vassilakis (av2060@columbia.edu) is Associate Professor of Medicine at Columbia University Vagelos College of Physicians and Surgeons. Dr. Perrin (perrinae@upmc.edu) is Clinical Associate Professor of Medicine at the University of Pittsburgh School of Medicine. Dr. Troyer (mark.troyer@osumc.edu) is Associate Professor of Medicine at Ohio State University Wexner Medical Center. Dr. Bryson (christine.bryson@baystatehealth.org) is Associate Professor of Medicine at University of Massachusetts Chan Medical School. Dr. Farkas (ahfarkas@mcw.edu) is Associate Professor of Medicine at the Medical College of Wisconsin and Milwaukee VA Medical Center.

The SGIM Education Committee is pleased to highlight our 2026 award winners. We asked them to reflect on their careers and share their advice with the next generation of clinician educators.

Mid-Career Education Mentorship Award: Dr. Craig Noronha

1. Was there a specific experience that put you on your career path?

As a young faculty member, I did not know what medical education was. I applied unsuccessfully for one of the clerkship positions—twice. Then an associate program director asked if I would take over the peri-operative clinic and medicine consult service. Even though I was not excited about this opportunity I said yes. This role made me realize there are other ways to be involved in medical education beyond the traditional roles like program director, clerkship director, and more. I made connections and learned the breadth of the education space.

Not getting a position was some humble pie; but, with time, I learned that many factors go into these decisions. Even if you are the perfect candidate, there might be other reasons why they don't choose you.

MEDICAL EDUCATION: ARTICLE I *(continued from page 15)*

2. What advice would you give to junior faculty interested in pursuing a similar career?

First: Be open. Being open to new opportunities and being involved in education for different levels of learners expands your possibilities.

Second: Think clearly about your role. There is a lot of citizenship and service in medical education. But opportunities that excite you, even if they are unpaid, can be meaningful. You would be amazed how much you can share your talents, skills, and knowledge with those around you; these experiences may lead to future opportunities.

Third: Talk to people. Every person has a different path and a different approach. You must figure out what works for you, what your values are, how much you want to do, and what you are interested in to chart your own journey.

3. How have your formative mentorship experiences impacted the way you now serve as a mentor?

I have had mentors who have been out for themselves. I appreciate that now, because I know from experience the type of mentor I *don't* want to be. I want to be a mentor who succeeds when my mentee succeeds.

I also realize that my most impactful mentors were the ones who were sponsoring me. I've taken that to heart. People need to be recognized and sponsored for opportunities. I try to make that a focus of my mentorship.

Connection matters, too. When my mentors could not mentor me, they would connect me with someone who could. Recognizing your limits as a mentor and connecting a mentee with the right person is invaluable.

Finally, life mentorship is critical. My colleague had kids before me, and she has helped me understand what is important to me in life. In many ways, her mentorship has been the most valuable to me.

Scholarship in Medical Education Award: Dr. Sarah Merriam

1. What continues to inspire you to pursue medical education scholarship?

I became interested in educational scholarship while aiming to support learners. As I developed my identity as a clinician educator—tackling challenges, trying something new—those things made me feel so intellectually alive! From there, the idea of helping trainees develop into excellent physicians nurtured that spark.

While encountering new challenges, I was able to create a community of inspiring educators who served as amazing role models. That sense of community keeps me engaged, questioning and seeking. By encountering the same gaps as others, we can work as partners to ask the questions that matter. It gives the work meaning and keeps it from feeling cold, dry, or boring.

2. How do you protect and balance your schedule to make time for scholarly work?

It is hard, and we must acknowledge the very real competing demands that make it difficult to publish and disseminate work. For early educators: know it gets easier with practice. Writing, designing methods, everything, takes longer initially.

People thriving in this space have found mentors and communities that value their work. Find your tribe. An effective team makes the work feel more feasible, and the external accountability factor is huge—plus cross-institution work amplifies impact. When it's just me, I'm more likely to procrastinate, and enjoy it less.

My calendar is also critical to my success. I block time to attend to the "non-urgent, important" quadrant of the Eisenhower Matrix and schedule time to devote to each commitment I make. When I have these pockets of time, I turn off my e-mail and in-basket, and I do it.

3. How would you advise junior faculty interested in pursuing a similar career?

Start with a genuine problem you're observing—not a publication goal, but a problem to solve. The questions you ask and the work you do along the way often become educational scholarship. Another great starting point is collaborating first: learn the landscape before you launch into your own work.

And make your work count multiple times. A curriculum, a workshop, a perspective piece in a local paper—it's all scholarship. Presenting a workshop at SGIM can lead to an invitation to present at an institution's grand rounds. Add a pre/post assessment, and you can disseminate it more easily. The content can be either a how-to or clinical guide. The logistics aspects can become an implementation perspective. With a bit of advanced planning, you can make it count two, three, four times in different iterations. That's the key to academic promotion.

Achievement in Medical Education and Innovation: Dr. Kimberly D. Manning

1. How did you decide to become a clinician educator?

When I was in training, I thought teaching was having a repository of knowledge to pull from on demand. Most people who were considered to be successful teachers looked nothing like me. But whenever I saw a medical student reading, I said, "*What are you doing? Come with me.*" I felt there was always something interesting happening in the hospital—no matter what service they were on or if they were on my team. I didn't think that was teaching. My senior year of residency, when medical students nominated me for induction into Alpha Omega Alpha (AOA), one of them said, 'I do not know what you plan to do in your future, but whatever it is, it will be a shame if it did not involve medical students and learners.'

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That was the first time I thought about being an educator.

2. How do you think an exceptional clinician is defined today?

I was inspired by how Toni Morrison described herself—not as an author, but as a consumer. That idea shaped me as a teacher. I try to be the attending I would want to have. I give the lectures that I have not heard yet, write things that I have not read.

Exceptional clinicians show up, are people-centered, and think it's a real privilege to care for patients alongside learners. With this approach, the "concrete" parts that help you get promoted come naturally. You will be intellectually curious, want to write up something, and submit a workshop to SGIM. You want to present something interesting and different because there's something in it for you as the learner, as a consumer.

3. Which innovation that you developed in your career are you especially proud of?

I'm most proud of Bite-sized teaching. On a busy ward rotation in 2015, I frequently missed parts of our 45-minute resident conferences due to clinical work. The long lecture format was not working. As I was paged out of conference, again, inspired by Marshawn Lynch—known for Beast Mode—I thought "bite size teaching Beast Mode." Four mini lectures instead of one big lecture.

I worked with PGY3s to develop this concept of eight-minute lectures with five microfacts and a delivery that makes it stick. We decided presenters will be coached not only on content but also on intonation, slides, and content density. It is unique because it's brief, focused, *and* coached. That year, we won Conference of the Year from our residency program. Eventually, it elevated all teaching at Emory because learners developed high expectations. Then other institutions adopted it. It was really a proud moment to finally publish and be one of the top 10 medical education papers!

We again congratulate our winners of the 2026 Education Committee awards. Please think of the wonderful clinician educators at *your* institution and nominate them for 2027! SGIM

HEALTH POLICY CORNER: ARTICLE I

WISeR ACT: INTRODUCING PRIOR AUTHORIZATION IN MEDICARE

Christine Bryson, DO, MPH; Jonathan Zaid, MD; Radhika Prabhakar, MD; Tracey L. Henry, MD, MPH, MS

Dr. Bryson (christine.bryson@baystatehealth.org) is an Associate Professor of Medicine in the Department of Medicine at UMass-Chan Baystate. Dr. Zaid (jonathan.zaid@jefferson.edu) is an Assistant Professor of Medicine in the Department of Medicine at Sidney Kimmel Medical College at Thomas Jefferson University, Dr Prabhakar (radhika.prabhakar@nghs.com) is an Assistant Professor of Medicine in the Department of Medicine at Northeast Georgia Health System. Dr. Henry (tlhenry@emory.edu) is an adjunct professor of medicine in the department of medicine at Emory University School of Medicine.

Introduction

Prior Authorization (PA) has been a part of the U.S. healthcare system for more than 50 years, evolving over time to control increasing healthcare costs. Providers and patients alike are aware of the time-intensive nature of PA, but insurers depend upon it as a part of their utilization management. Recently, the Centers for Medicare & Medicaid Service (CMS) created the Wasteful and Inappropriate Service Reduction (WISeR) Model. This program, designed to introduce prior authorization into traditional Medicare (TM) in six pilot states for a six-year trial period, was developed to reduce waste in the healthcare system by lowering costs and easing the administrative burdens of PA. According to the WISeR materials, states' Medicare's fee-for-service payment structure incentivizes medically unnecessary treatments and tests. The program aims to apply commercial payer processes that are faster, easier, and more accurate to the existing Medicare coverage policy.[1] This article reviews the WISeR model and examines its early implications for Medicare beneficiaries and clinicians, highlighting areas where additional evaluation, stakeholder engagement, and possible refinement may be warranted.

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WISeR CMMI Model: What Is It?

WISeR was rolled out in January of 2026 in six states (New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington). For each state, CMS contracted with a private health technology company to administer the PA using AI. Companies responsible for reviews were required to employ clinicians with expertise to conduct medical reviews to validate determinations. WISeR has a limited focus on services that have been historically identified to have an increased risk of waste, fraud, and abuse: skin substitutes, electrical nerve stimulator implants, and knee arthroscopy. Inpatient-only services and any services that would "pose a risk to patients if delayed" are excluded.

Reception to the WISeR Proposal

While there is broad consensus that rising health care costs are a significant issue, healthcare provider groups and legislators have raised concerns about this new model. WISeR was released under the Center for Medicare and Medicaid Innovation (CMMI) (which is a Center in CMS that tests new payment and service delivery models) and classified as "voluntary." However, the WISeR model stipulates that if PA for the specific services outlined is not obtained, providers will face pre-payment medical reviews, effectively making the PA mandatory.

Since CMMI classified the model as voluntary, input from stakeholders via the traditional notice and comment rulemaking process was not required (as it is for the CMMI models classified as mandatory). Introducing PA to traditional Medicare without soliciting input from physicians and patients raises the possibility that unforeseen consequences may develop, such as increased administrative burdens, delays, or denials of treatment.[2] There is speculation that the introduction of PA into Medicare Advantage has resulted in inappropriate denials of medically necessary care.[3,4] It is unclear if the WISeR model will have adequate safeguards to guide PA medical decision-making and ensure that coverage decisions are consistent with the standard of care and Medicare criteria. The introduction of AI into Medicare also raises conflicts of interest for the companies contracted to manage the services,[3] as they will receive financial benefits from the savings associated with denied services. Finally, AI in health care has been shown to have clinical, ethical, and financial biases, raising the possibility that AI denials will increase health disparities.[3,4,5]

Why Should We Care?

There is no denying that fraud, waste, and abuse are present in Medicare spending, and that the costs of Medicare climb annually. It is imperative to find solutions to these issues. However, implementation of the WISeR model occurred, bypassing the usual norms and processes for engaging stakeholders.

The WISeR model may normalize PA in traditional Medicare and set a precedent for outsourcing PA via AI vendors with misaligned incentives. As internal medicine physicians, SGIM members are on the front lines of caring for these patients and will be directly affected by these changes.

Conclusion

The rollout of the WISeR model by CMS to curb spending has prompted discussion among clinicians, legislators, and healthcare organizations. Members from these stakeholder groups are concerned about the lack of public input prior to implementation, the incentives for technology firms to deny care, and the possibility that the model will worsen an already overburdened denial/appeal process for PA.

As frontline clinicians we are aware of the current burdens and frustrations associated with PAs. Through continued assessment and engagement from stakeholders, potential refinement to the model may be introduced to protect patients, avoid overburdening the health care system, and prevent bias. Advocacy by patient and physician organizations is essential for ensuring that the WISeR model is implemented in a manner that optimizes patient care and minimizes the administrative that can lead to more frustrations and inefficiencies. As CMS continues to test and refine payment and delivery models, providing opportunities for stakeholder feedback will be important to inform future policy development and implementation.

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SGIM

THE SECOND ANNUAL SGIM BITE-SIZE TEACHING SYMPOSIUM: CELEBRATING THE ART AND SCIENCE OF MEDICAL EDUCATION

Raman Singhal, MD; Yihan Yang, MD, MHS-MedEd; Athina Vassilakis, MD, MPH; Mim Ari, MD

Dr. Singhal (rsinghal2@northwell.edu) is an Assistant Professor of Medicine at the Zucker School of Medicine at Hofstra/Northwell. Dr. Yang (yihan.yang@wsu.edu) is an Associate Professor of Medical Education and Clinical Sciences at the Washington State University Elson S. Floyd College of Medicine. Dr. Vassilakis (av2060@columbia.edu) is an Associate Professor of Medicine at the Columbia University Vagelos College of Physicians and Surgeons. Dr. Ari (mim.ari@uchicagomedicine.org) is an Associate Professor of Medicine at the University of Chicago Pritzker School of Medicine.

Introduction

"As clinician educators, how do we deliver teaching so that learners actually learn?" This question was posed to a full auditorium of SGIM Annual Meeting attendees during the 2026 Rising Stars in Med Ed: Bite-Size Teaching (BST) Special Symposium.

Bite-size teaching is an effective and engaging teaching technique to foster immediate recall.[1] Since 2023, each SGIM region has hosted a BST competition to highlight the important role that excellent teaching plays in medical education.[2] This year's SGIM BST Special Symposium at the Annual Meeting brought the regional winners to one stage. Through five-minute presentations, each regional winner taught important clinical concepts in their own unique way and demonstrated multiple strategies that educators can use to promote understanding and retention among their learners. In this article, we summarize these teaching strategies and highlight our six regional winners (see figure 1).

LEARN Framework

The LEARN framework, created by members of SGIM's Education Committee, is an advance organizer and visual aid shared with the symposium audience that describes five types of teaching strategies:

1. Learner engagement strategies capture and maintain learners' attention with the subject matter.
2. Elaboration strategies clarify abstract ideas and relate new material to learner's prior experiences.
3. Application strategies allow learners to actively use new knowledge to solidify concepts.
4. Roadmap strategies help learners organize new knowledge for easier access and retrieval.
5. Need/motivation strategies refer to ways that educators appeal to learners' motivation to learn.

These educational approaches promote understanding, aid retention, and are based in adult theory.[3]

Names	Institution (SGIM Region)	Role	Topic
Amy Courtney, DO Yusuf Ebrahim, MD	Maine Medical Center (New England)	Chief Residents	Beeps & Buttons: Demystifying Diabetes Technology for the Internist
Anna Coronata, MD	University of Pittsburgh (Mid-Atlantic)	Academic Clinician-Educator Scholars Fellow	Circle of Control: Managing Moral Distress in Medicine
Jordan Hildebrand, MD	Emory University (Southern)	PGY4 Internal Medicine/Psychiatry Resident	The Internist's Guide to Suicidality in the Medically Hospitalized Patient
Jacob Scott	Rush Medical College (Midwest)	Medical Student	Check the Neck: A Systems Approach to Laryngectomy Patients
Nicole Boyd, MD	University of Washington (Northwest)	PGY3 Internal Medicine Resident	Facilitating Successful Inpatient Discharge
Niel Patel, MD	University of California San Diego (Southwest)	PGY3 Internal Medicine Resident	Bridging the Night and Day: Presenting Overnight Admissions on Morning Rounds

Figure 1

 (continued from page 19)

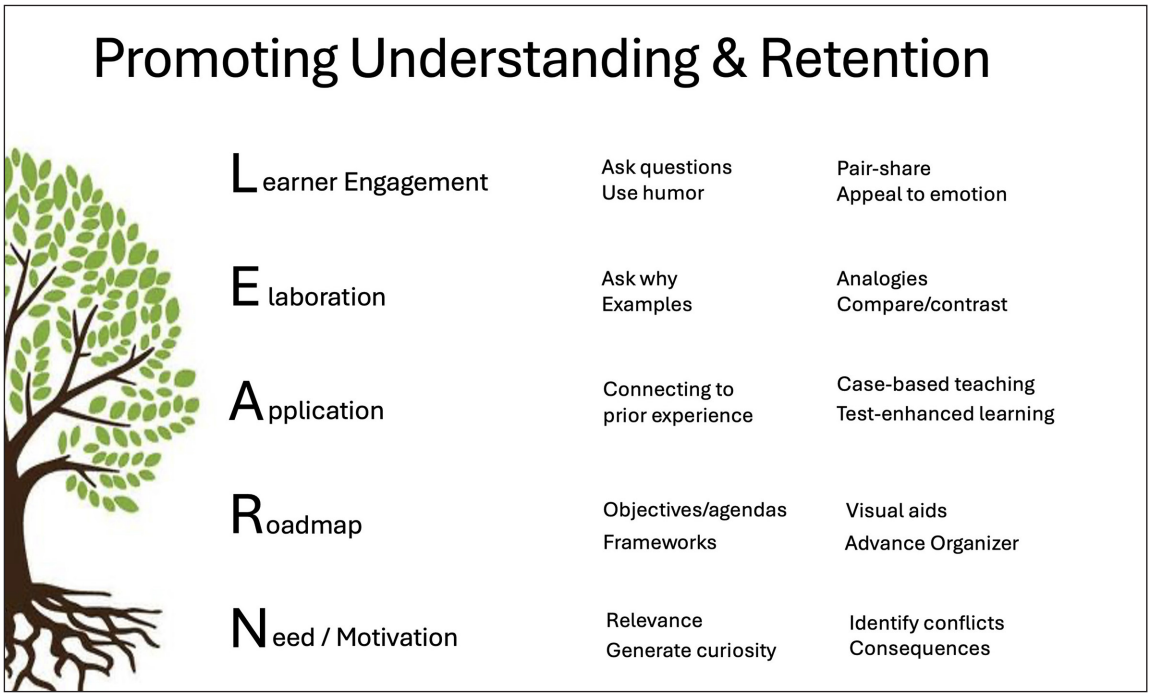

Figure 2

Each letter of the LEARN framework is juxtaposed against a visual analogy of a tree (see figure 2). Learner motivation is needed for new knowledge and skills to take root. Roadmap strategies build strong trunks and branches that support and organize new knowledge. Application, elaboration, and learner engagement contribute to the richness of the leaves, which represents new knowledge and skills.

Regional Winners

Drs. Amy Courtney and Yusuf Ebrahim taught us about using Continuous Glucose Monitors to partner effectively with patients with diabetes. Dr. Ebrahim noted that a goal of bite-size teaching is *"to make the learning both deep and memorable, making it interactive, giving you a chance to immediately apply it,"* identifying three core aspects of the LEARN framework: need/motivation, engagement, and elaboration. And the team of chief residents did just that. Their content and delivery sustained audience attention with well-placed humor in the form of memes and a physician's concerns about their Yelp reviews. Dr. Courtney asks herself, *"what are the things that can get in someone's way of using what you just taught them?"* She directed her teaching specifically to increasing comfort with using a patient's phone app in real-time, what data to look at, and what extra data is discovered by simply turning the phone to landscape orientation.

Dr. Anna Coronata introduced a model for faculty to help manage moral distress and support their learners: 1) naming concerns; 2) containing them into a "circle of concern"; and 3) refocusing on the small area of influence each person can have at any moment, the so-called *circle of control*. She used a gradual level of audience engagement to facilitate participation and connection (think to yourself, share with a partner, share a feeling in the large group) and centered the motivational aspect of her talk around personal experiences of moral distress (need), the quest for wellbeing, and the need to support learners (data-supported). The model was highlighted by clear visuals and repetition of the 3-step approach (roadmap). The vaccination refusal example (elaboration) provided a moving, motivating, and memorable practical approach to addressing moral distress.

Dr. Jordan Hildenbrand shared an approach to assessing risk of suicidality through a 4-step triage map: 1) identify the type of statement; 2) consider the context; 3) match

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the response to the level of risk; and 4) reassess. In stratifying risk—death contemplation, the desire to die, and the desire and intent to kill oneself—she highlights that the second category is the most ambiguous and requires additional questions for thorough assessment by the primary team. Through hand raising, she quickly demonstrated the ubiquity of the problem being addressed, highlighted the relevance of the talk (need), and engaged the audience. The slide visuals clearly delineated the process and organized information in a stepwise fashion, providing an easy roadmap to follow, while the practice examples provided an opportunity for the audience to apply the information in real time and make the information stick.

Jacob Scott, medical student, deftly brought our attention to a topic outside a generalist's usual scope: laryngectomies. Jacob decided to apply for the competition after seeing a patient with a tracheostomy in clinic, paired with knowing a friend whose mother had a tracheostomy. Once he had explained to the audience why this topic matters to us (need), he was able to efficiently use multiple engaging methods (roadmap, elaboration) including a framework for evaluating a patient with a laryngectomy entitled STAMP, visual aids of multiple types to help us understand the interior anatomy and external appearance of patients with laryngectomies, and cases and quizzes to ensure learning retention. *"We all have some piece of knowledge that we've worked to attain through our experiences. Instead of gatekeeping that knowledge, we should try to share it openly."*

Dr. Nicole Boyd notes that she has *"naturally gravitated toward practical skill learning for inpatient medicine and communication"* as evidenced through her presentation on facilitating successful inpatient discharges which blended these areas. Working with a clear framework, FOMITES, Dr. Boyd walked us through the key steps for a well-orchestrated discharge, breaking down a complex process into smaller steps and recognizing the various subtasks and roles we all play. Underscoring all the pieces is communication: a *"focus on how we're talking to patients, how we're talking to our colleagues, and how that shapes the care that we're providing,"* says Dr. Boyd. Reflecting on her journey thus far as an educator, Dr. Boyd has *"become increasingly aware of the shifting landscape in my role"* and *"how that changes my space in the room and how I'm able to communicate with learners."*

In his presentation related to transitions of care, Dr. Niel Patel focused on the handoff from a night admitting team to the day team. By first appealing to the plight of many a day team, he created immediate relevance to his audience (need)—how do we take best care of admissions from overnight that we don't know very well, while also managing a team of patients? Dr. Patel then provided us with a simple framework (roadmap) to think about this transition—the 3Rs, namely reconstruction, reassessment, and refocusing—to help mitigate bias. By applying this framework to a case, he demonstrated to the audience that it is easy to use and intuitive from a clinical reasoning perspective.

Conclusion

The SGIM Bite-Size Teaching Symposium continues to be an important arena to spotlight and encourage early-career educators. Dr. Courtney stated, *"When you think about early career teaching, it's an opportunity to shape the way people choose to challenge themselves across their careers, the niches they choose to form for themselves, and the ways that they choose to practice medicine."* Each of the regional winners displayed this passion for their work and inherently used multiple techniques highlighted in the LEARN framework. These methods are evidence based and are shown to improve retention and application of medical knowledge. Moreover, it is the individual expression of these techniques which makes the act of teaching invigorating for educators and keeps learning exciting for our learners.

Keep an eye out for the regional BST competitions in 2026-27 coming to a location near you! We look forward to highlighting more excellent teaching at next year's annual symposium.

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SGIM

WHEN OUTCOMES REPLACE ACTIVITIES: ACCESS, TEMPO, AND THE END OF THE 30-DAY MINDSET

Ebrahim Barkoudah, MD, MPH, MBA

Dr. Barkoudah (ebrahim.barkoudah@utsouthwestern.edu) is the Chief of the Division of Hospital Medicine and Associate Professor of Internal Medicine at UT Southwestern Medical Center in Dallas, TX, and serves as Associate Editor at SGIM Forum. The views expressed are the author's own and do not represent the position of UT Southwestern Medical Center.

In this article, I examine how Centers for Medicare & Medicaid Services (CMS)'s ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model and the Food and Drug Administration (FDA)'s Technology-Enabled Meaningful Patient Outcomes (TEMPO) pilot move chronic disease accountability beyond the 30-day readmission framework, what these initiatives mean to general internists, and where SGIM members are positioned to engage with a payment model built around twelve-month outcome attainment rather than discharge-window proxies.

In my prior institute, Dr. R called me, her voice carrying the kind of resignation hospitalists develop after a fifth admission of a familiar patient. *"He's back,"* she said. *"Third time in seven weeks. We did the discharge call. We did the meds rec. He's still on furosemide alone."*

"No ARNI? No SGLT2?" I asked.

"None of it. Six months out from his last hospitalization."

We both knew what the chart would show at discharge. Education sheets. Scheduled follow-up. A transitions-of-care note. Every box checked. The readmission would count against us anyway. That phone call captured what every general internist already knows but rarely says out loud: our quality system measures the wrong thing. Two new federal initiatives are about to measure something different.

When the 30-Day Clock Stopped Working

The Hospital Readmissions Reduction Program (HRRP) encouraged American doctors to manage a clock rather than a disease. For more than a decade now, our quality infrastructure has revolved around the 30-day window that closes before guideline-directed medical therapy in heart failure can even be reasonably titrated. Wadhera and colleagues, writing in *JAMA* in 2018, showed that HRRP was associated with an *increase* in post-discharge mortality for patients hospitalized with heart failure and pneumonia.[1] The readmission declines we celebrated came with consequences: observation stays climbed, ED triage shifted toward watch-and-don't-admit, and resources flowed to transitions-of-care workflows that documented coordination without changing disease trajectories.

What HRRP rewarded was the appearance of improvement. The disease itself remained largely untreated. CHAMP-HF found that only about 1% of eligible patients with heart failure and reduced ejection fraction were on target doses of all three guideline-directed therapy classes available at the time.[2] We built an enormous quality apparatus around a 30-day proxy while the actual disease-management chasm sat untouched for years at a stretch.

What ACCESS Asks that HRRP Never Did

CMS's Advancing Chronic Care with Effective, Scalable Solutions Model (ACCESS) will be implemented in 2026 as a 10-year, voluntary Medicare Part B initiative.[3] Participating organizations receive recurring Outcome-Aligned Payments for managing a patient's qualifying condition across a 12-month care period. The pay is conditional. If fewer than half of an organization's patients meet attainment targets for measures such as blood pressure or A1C control, the payment is adjusted downward. CMS pays half up front and reconciles the rest after the care period closes. A 90% substitute-spend floor adds a second guardrail. If too many beneficiaries receive substitute services elsewhere for the same condition, payments fall, capped at a 25% reduction.

The ACCESS program focuses on chronic conditions that every general internist sees daily, such as hypertension, dyslipidemia, prediabetes, Chronic Kidney Disease, Atherosclerotic Cardiovascular Disease, chronic pain, depression, and anxiety. and central obesity. Beneficiaries may enroll directly with an ACCESS-participating organization or be referred to by a clinician. After a minimum 90-day alignment period, they may disenroll or switch to another ACCESS organization within the same clinical track, with a new care period beginning after the switch.

Paired with ACCESS is the FDA's TEMPO pilot, announced in the *Federal Register* in December 2025.[4]

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TEMPO permits selected manufacturers to deploy digital health devices, including AI-enabled ones, under enforcement discretion in support of ACCESS care. CMS pays when outcomes are met. FDA permits the technology to be used while real-world evidence is collected. It is the first time these two agencies have explicitly coordinated payment and regulatory pathways for chronic disease technology.

Where General Internists Fit

Here is where I want to be honest with our membership.

The general internist's bread and butter has never been 12-month outcome accountability for a single chronic condition. We carry panels. We see the patient quarterly. We bill for visits, not for hemoglobin A1c control. HRRP reshaped inpatient medicine but barely touched ambulatory chronic care except through downstream pressure. ACCESS reaches into ambulatory chronic care directly and pays for sustained control, the long, slow work we have always claimed to do best but have never actually been paid to do.

Some SGIM members will benefit from this naturally. Examples include academic general internal medicine practices with embedded population health teams and primary care groups that have invested in continuous remote monitoring and integrated systems with chronic disease coaching infrastructure. Others will not. Many hospitalist groups will not participate at all unless they are embedded in systems that build the ambulatory side around them. That is not a critique. That is the shape of the model.

Dr. K, a primary care colleague from another hospital, put the design question plainly. *"We've been doing twelve-month chronic disease management for 30 years,"* she said. *"We just haven't been paid for the outcome part. If ACCESS works, primary care finally has a way to be reimbursed for the part of the work that actually matters."*

ACCESS leaves open whether participating organizations will extend primary care or operate partly alongside it. CMS allows referrals from primary care clinicians, but beneficiaries may also enroll directly with ACCESS organizations.

The Skeptic's Case

Payment economics depends on reimbursement amounts that CMS has not fully released. Beneficiary churn at 90-day switching intervals could fragment care. TEMPO's reliance on enforcement discretion sits uneasily with anyone who has watched a poorly validated digital intervention fail at scale. Center for Medicare and Medicaid Innovation (CMMI)'s track record with prior Innovation Center models has been mixed, and whether ACCESS escapes the fate of earlier models depends on payment calibration CMS has not yet finalized, and on participant performance, which the agency cannot yet predict.

But that's not really the point. The point is that CMS is finally asking the right question.

Choosing How We Answer

For more than a decade, our quality infrastructure asked a narrow question: did this patient bounce back within 30 days? ACCESS asks a different one: did this patient get better and stay better over a year? That is the question we should have been asking all along. It is also the question we have never been paid to answer.

When I called Dr. R back a week later to tell her about ACCESS, she was quiet for a moment. *"That's the patient I've been losing for six years,"* she said. *"Not the readmission. The control. If somebody finally pays for the control, the patient gets better."*

Within the SGIM community, we have both the expertise and the responsibility to engage with this transition deliberately. Many of us have spent careers managing the chronic conditions ACCESS measures. We know the science. We know the patients. The question is whether we engage with the model through our practices, research, teaching, and advocacy, or let others answer it for us. The future of chronic disease accountability is being built right now. We can help build it.

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