

IMPROVING CARE

EMERGENCY PREPAREDNESS FOR ADULTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Christopher Hanks, MD, Hadeel Alkhairw, MD, MS-HQSM

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Adults with intellectual and developmental disabilities (ID/DD) experience healthcare disparities, including increased rates of many health conditions,¹ difficulty accessing care, and many unmet healthcare needs, even if they have access to care.² Their unique healthcare needs and challenges are often exacerbated during disasters and emergencies. The COVID-19 pandemic highlighted increased health disparities for people with ID/DD, such as reduced access to in-person care, problems obtaining prescriptions, and challenges using telehealth and personal protective equipment. Many have experienced reductions or loss of direct support professionals and support services for their residential, employment, transportation, and recreational needs. Many patients with ID/DD turn to their primary care team to assist in planning for and overcoming barriers in disasters and emergencies.

Primary care teams are challenged with a lack of resources and time and find it difficult to care for ID/DD patients who suffer from care fragmentation between care management agencies and healthcare systems. In addition, the lack of registries and population health modules that support this small, yet complex, group of patients adds a burden to the clinicians and caregivers.³

Working with a large group of self-advocates and advisory panel members from many healthcare and advocacy groups, including members of the Society of General Internal Medicine SGIM (the authors), The National Alliance to Advance Adolescent Health created a toolkit

to support primary care teams in assisting patients with ID/DD plan for disasters and emergencies.⁴ This toolkit includes two tip sheets for primary care teams and individuals with ID/DD. The sheets provide guidance on items to consider and advice on using a quality improvement process to implement the tool in medical practices. Although these sheets are designed with individuals with ID/DD in mind, a similar approach would likely benefit many other patients with complex health needs who suffer physical and mental disabilities in adulthood.

The key steps to implementing an emergency preparedness plan for ID/DD in a primary care practice are as follows:

1. *Choose a disaster emergency care plan for use in your practice.* Many templates are available with links in the primary care team tip sheet (pages 4-6 of the toolkit). You can review these and decide which ones are best for your practice.
2. *Find the population.* One approach would be to search your electronic medical record for ICD10 diagnosis codes connected to ID/DD and create a registry to track your progress.
3. *Identify your team.* We recognize that primary care is a team-based effort. Not all the work for this will be done by the physician. Identify key staff members who will assist in this quality improvement process and assign roles so that everyone can contribute

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FROM THE EDITOR

ASK CHATGPT: WHAT IS THE FUTURE OF MEDICINE?

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

In the spirit of Valentine's Day 2023, I asked ChatGPT¹ a burning question: *How does one find romance?* ChatGPT gave me a thoughtful bit of wisdom in reply after a shortlist of five suggestions on finding romance: “*Focusing on your own happiness and well-being can help attract positive experiences and relationships into your life.*” As some readers may already know, at the end of 2022, the fascinating prospects of a chatbot called ChatGPT (Generative Pre-trained Transformer) pushed boundaries in natural language processing and artificial intelligence. In this application, the technology can respond smoothly in human-comprehensible question-answer conversation. Trained by scraping the internet, both understanding and generating conversational language, ChatGPT is a large language model that seems to provide mostly coherent, even if at times superficial, responses to questions asked in human natural language. But as with any new technology, there are potential unintended consequences, despite countless opportunities.

Already, large language models show promise in comprehending and solving problems relating to answering important personalized or population-wide questions that can be only derived from analyzing large numbers of clinical notes in electronic health records.² There are even explorations into using ChatGPT technology to facilitate early Alzheimer’s disease diagnosis based on a person’s speech-to-text patterns, as one of many potential clinical applications.³ Yet, there are also major concerns around exacerbating issues around misinformation generation and perpetuation or people using generated language and passing it off as their own original work. For simple lists, I asked ChatGPT the following two questions:

What are potential applications of ChatGPT technology in medicine?

1. Clinical decision support
2. Medical education
3. Natural language processing
4. Health information for patients
5. Virtual assistants for health care providers”

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ROCKY MOUNTAIN HIGH: RECORD MEMBERSHIP, BUT NUMEROUS OPPORTUNITIES FOR GROWTH

LeRoi S. Hicks, MD, MPH, FACP, President, SGIM

"I want to bring your attention a major priority for SGIM—establishing strategies for increasing membership. Prior to the winter retreat, our staff did a remarkable job preparing Council for discussion by accumulating and presenting membership data. When compared to historical data, our total membership is at a record high. However, a deeper examination raises concerns about if we have done enough to create awareness of the benefits of membership. It is time we examine ways to strengthen our value to SGIM members and develop strategies to increase full membership."



SGIM Council members meet for a two-day retreat every winter to discuss SGIM priorities, review ongoing activities by our committees, and continue planning for the spring annual meeting. This year, our SGIM winter retreat was held at the Gaylord Rockies Resort in Aurora, CO, the venue for #SGIM23 annual meeting. It was my first time staying at the resort, and, as I envisioned more than 2,500 SGIM members and guests attending #SGIM23, I could see why the site selection committee decided on this year's vibrant location. In addition to my enthusiasm about our progress planning #SGIM23, I enjoyed the meaningful discussion with fellow Council members over SGIM priorities for the coming year. In this column, I want to bring your attention to one of the major priorities for SGIM—establishing strategies for increasing our membership.

Prior to the winter retreat, our SGIM staff did a remarkable job preparing Council for discussion by accumulating and presenting data on the current state of our membership. As of December 1, 2022, SGIM had 3,373 members. Of the total members, 2,475 (73%) are classified as full members and 799 (21%) are associate members. When compared to historical data, our total membership is at a record high. However, a deeper examination of the data raise concerns about whether we have done enough to create awareness of the benefits of membership. Total membership is at its highest level since 2012, and membership in the associate category this year rose significantly over the 644 associate members in 2021. However, unlike this growth among associate members, full membership numbers remained relatively flat since 2012. In addition, while attendance for our #SGIM22 meeting surpassed expectations, many attendees are not

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

Q & A WITH SGIM'S CEO AND PAST PRESIDENT ON A FLASHBACK TRIGGERED BY SGIM'S UPDATE OF CHOOSING WISELY RECOMMENDATIONS

Eric B. Bass, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM and served as President in 2013-14.

SGIM: What came to mind when the American Board of Internal Medicine (ABIM) Foundation recently asked SGIM to update its Choosing Wisely recommendations?

Dr. Bass: I had a flashback to the firestorm that erupted when SGIM released the first version of its Choosing Wisely recommendations in 2013 when I was SGIM's President.^{1,2} I remember a standing room only town hall at the 2014 SGIM national meeting dedicated to discussing members' concerns about the potential consequences of the recommendation initially worded as "don't perform routine general health checks for asymptomatic patients."³ At the town hall, David Himmelstein eloquently presented a critique of the studies most relevant to the topic. Subsequently, David joined Russell Phillips in publishing an article in the Annals of Internal Medicine entitled "Should we abandon routine visits? There is little evidence for or against."⁴

SGIM: What did we learn from the vociferous debate about recommending against routine general health checks for asymptomatic adults?

Dr. Bass: Ultimately, the controversy reinforced the importance of physicians having conversations with patients that place evidence in the context of a humanistic approach to the doctor-patient relationship.² We agreed that the advice should not be used to withhold coverage for visits that are needed to establish a reliable relationship with a primary care clinician. As a result of the controversy, more attention was given to the importance of having an established relationship with a primary care clinician. Although that principle was not captured by the sound bite version of the recommendation, it was entirely consistent with the purpose of the Choosing Wisely initiative—to promote conversations between patients and their clinicians around tests and procedures whose necessity should be questioned and whose potential harms and benefits clarified within the context of each patient's care plan.¹

SGIM: How have SGIM's Choosing Wisely recommendations evolved since 2013?

Dr. Bass: When SGIM agreed to participate in the Choosing Wisely campaign at the beginning of my year as President, the Society formed an ad hoc committee to develop recommendations on five high-priority topics for academic general internists across the spectrum of their clinical practice. In addition to the recommendation against routine general health checks, the committee developed recommendations against use of daily home finger glucose testing in patients with type 2 diabetes mellitus not using insulin, routine preoperative testing before low-risk surgical procedures, cancer screening in adults with life-expectancy less than 10 years, and peripherally inserted central catheters for patient or provide convenience. None of those four recommendations generated any controversy.

In 2017, SGIM updated its Choosing Wisely recommendations after a new ad hoc committee reviewed recent evidence on each topic. The recommendation that changed the most was on annual health checks. The revised version stated that "for asymptomatic adults without a chronic medical condition, mental health problem, or other health concern, don't routinely perform annual general health checks that include a comprehensive physical examination and lab testing. Adults should talk with a trusted doctor about how often they should be seen to maintain an effective doctor-patient relationship, attend to preventive care, and facilitate timely recognition of new problems."⁵ This wording is notable for the emphasis on talking with a trusted doctor.

In 2021, the ABIM Foundation asked SGIM to update the recommendations again. SGIM formed another ad hoc group to review recent evidence and determine whether any of the recommendations should be revised or retired. Fortunately, SGIM members had contributed to a recent systematic review on general health checks in adult primary care.⁶ Although new evidence was found on all of the topics, none of the recommendations required major

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GENERALIST INTERNISTS MEETING THE PROMISE OF TOMORROW AT THE #SGIM23 ANNUAL MEETING

Shelly-Ann Fluker, MD; Milda Saunders, MD, MPH

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In just over three months, we will be gathering at the Gaylord Rockies Resort in Aurora, Colorado, for our 2023 Annual Meeting #SGIM23. We are excited to share some new initiatives that will complement the traditional meeting components that bring us back every year. To keep with the meeting theme of meeting the promise of tomorrow, we will focus on sustainability and have embedded a local advocacy initiative into the meeting. Not only did we add a new mid-career mentoring panel to the popular career mentoring panel series but also we will host our first ever SGIM-wide community conversation.

Sustainability has been a focus area for both the SGIM council and the program committee this year. We are thrilled that Dr. Howard Frumkin, Senior Vice President for the Trust for Public Land, will return to his SGIM home to give the opening plenary titled, “General Internal Medicine: Meeting the Climate of Tomorrow.” His presentation will review the health impacts of climate change and address the difficulty of responding to the climate crisis in our personal and professional capacities. This hope-filled presentation will set the tone for our meeting overall as we grapple with environmental challenges within medicine and the world. Under the leadership of Beth Gillespie, our inaugural Sustainability Program Committee chair, we have worked to reduce our footprint for the meeting as SGIM makes sustainability plans. Please see our meeting website about how we are tackling sustainability at our 2023 Annual Meeting.¹

Building on a strong tradition of local advocacy at our annual meetings, this year we have proactively chosen an advocacy focus based on local needs and member expertise with the support of our Health Policy Committee. Through our advocacy focus “Housing is Healthcare,” led by our local hosts, Sarah Stella and Juan Lessing, we will learn about the local and national housing crisis and its impact on our patients and how we may support on-going efforts. This issue will be publicized through a social media campaign and supported by

clinical, research, and education meeting presentations. Our local community partner, Colorado Coalition for the Homeless, will host a booth at our meeting to educate members about the issue and their work. This approach will model how SGIM can incorporate advocacy as an intentional part of the annual meeting in the future.

We also want to ensure that our meeting continues to support the needs of SGIM members across their career lifespan. As in past meetings, we will have content focused on students, residents, and fellows as well as junior and senior faculty. In addition, we will have a brand-new Mid-Career Mentoring Panel to focus on the unique challenges faced by mid-career faculty as they transition to senior leadership. We want to thank our Mentoring co-chairs, Vidya Gopinath and Delany Goulet, for creating this panel that will feature leaders in SGIM and their local institutions: Carla Spagnoletti, Daniella Zipkin, Vineet Chopra, and Carlos Estrada.

Finally, a highlight of our meeting will be our first ever SGIM Community Huddle that will bring together our entire organization to strategize about how SGIM may support members who live and work in states with policies that conflict with SGIM’s mission. Our SGIM president, LeRoi Hicks, will host a panel discussion moderated by SGIM CEO, Eric Bass. Our panelists Marshall Chin, Giselle Corbie-Smith, Elizabeth Jacobs, and Matthew Wynia represent a diversity of our SGIM regions, viewpoints, and areas of expertise. We will engage in an interactive discussion about the tools we can use as individuals and as an organization to protect our patients and support our personal and professional values.

Thank you to all who submitted your work for consideration or served as a peer reviewer. Our scientific abstracts, clinical vignettes, and innovations in medical education and healthcare delivery have been selected and acceptances will go out on February 8, 2023. The number and quality of submissions this year made our reviewers’ job both difficult and rewarding. We anticipate that the work presented at the meeting will exceed

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INTERPROFESSIONAL TEAMS: THE NEW WAY TO PROVIDE HEALTH CARE

Elaine Cruz, DO

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In the past, primary care physicians independently cared for patients and attended to all their healthcare needs. However, the increase in complexity of patients and the healthcare system now requires an interdisciplinary approach to improve patient outcomes. Accordingly, teamwork has become increasingly important to providing safe and effective care to patients. For these reasons, several international health organizations promoted interprofessional education (IPE) to redesign health professions education (HPE) to promote interprofessional teamwork with the goal of improving the quality of patient care and health outcomes.¹ To date, however, IPE has mainly focused on preparing trainees with the individual competencies to work in an interprofessional healthcare environment.² While working on individual competencies is clearly necessary, this is not sufficient. In my view, current IPE suffers from a lack of a universal framework to teach patient-centered collaborative practice to trainees. My aim is to propose a framework to help clinician educators teach interprofessional collaboration.

Let's Start with the Basics

I believe effective communication skills should be the foundation of the framework. A qualitative study by Sutter et al found that health professionals believe that effective communication is important in collaborative practice.² Trainees must learn the basics of communicating well to help members of the team not only understand their roles but also recognize the value of other professionals in patient care. As clinician educators, we must help the trainees to practice the components of effective communication skills, which include but are not limited to listening, clarifying, assessing non-verbal cues, and judicious use of silence. Once trainees have mastered effective communication skills, they can build upon this foundation.

Building On the Foundation

In addition to mastering fundamental communication skills, health professional trainees must learn several other teamwork specific skills to be an effective member of an

interdisciplinary team. Dow et al proposed that health professional trainees must acquire a fundamental understanding of team process, leadership, and collaboration in health care.³ For a team to perform successfully, each member must understand what is required of the team and the desired goal of providing safe and good care to patients. With team process, “team members as a group should engage in reflection and feedback activities that review past team performance, assess progress toward overall goals, develop interval goals and create an implementation plan”³ to reach the team’s goals. Constant reassessment of the team’s performance helps the members to keep improving and moving seamlessly towards achieving their goals.

Good leadership skills are also crucial to the success of an interprofessional team. A good leader will need to delegate responsibilities to other team members while encouraging each member to acknowledge and respect the expertise of all the members. At the same time, effective leadership creates familiarity and makes members feel safe to participate. Once team members understand their roles and know that their expertise is valued, collaboration can occur. This is because the team members can build trust in their peers and have confidence in their actions and intentions. When there is mutual trust, each member of the team can provide and ask for assistance without feeling guilty or being judged as underperforming as a team member.

Conclusion

A well-performing interprofessional team composed of physicians, nurses, pharmacists, social workers, medical assistants, and care managers is instrumental in navigating today's complex health care system to provide excellent patient care. The collaboration of team members of different expertise can greatly improve patient outcomes. As clinician educators, we strive to teach health professional trainees on how they can provide good quality care for patients. Having a framework to teach interprofessional collaboration is crucial for clinician educators to be successful in achieving this goal.

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USING NEAR PEER COACHING FOR RESIDENCY PREPAREDNESS

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Introduction

In recent years, medical schools and residency programs have employed coaching techniques to work with students requiring additional support and, in some cases, to support transitioning from medical school to residency, or professional development as a whole.¹⁻³ Additionally, the value of peer teaching has become recognized

as a bidirectional method of improving knowledge and learner motivation, recognizing education as a core task in healthcare, and adding graded responsibility as part of competency based medical education.^{4,5} At the University of South Florida (USF), we noted an opportunity to provide directed support to students in their final year of medical school to smooth the transition to residency while promoting near-peer education and supervision. Thus, we implemented a longitudinal Residents As Coaches (RAC) program to support final year medical students intending to apply to Internal Medicine.

Program Content

The RAC program was created with a twofold goal: 1. to assist medical students in the development of core skills that are fundamental in the field of internal medicine and 2. to provide near-peer support in transitioning to residency. The EPAs, developed collaboratively by our clerkship, acting internship, and residency program leadership, focus on six high-yield topics: applied bacteriology, initiation of urgent or emergent care, manage difficult conversations, discharge a patient, perform procedures pertinent to internal medicine, and demonstrate clinical reasoning mastery. Students in this program are paired with an internal medicine resident who serves as their coach. In this unique role, resident coaches work alongside their coachees to help them construct goals related to their clinical training and residency application process,

"How one program is using residents as coaches to help aid in the development of competent and confident future internal medicine interns."

assess progress, and aid in content mastery. The process of goal setting and performance assessment requires medical students to practice self-reflection—a key component of Problem Based Learning and Improvement. Since

the program's inception in 2020, the coaching curriculum has become more robust. The coaches receive instruction on SSEPA curricular content, understanding the differ-

ence between coaching and mentoring, sample coaching models, goal setting, tips on becoming a successful coach, promoting diversity, and addressing challenges. When we started this program, the program supported 22 medical students with four resident coaches. During the second year, 13 coaches supported 39 students. This year, the program has grown to a total of 50 students and 26 coaches.

Program Evaluation

To assess the impact of our program, we solicited quantitative and qualitative feedback from students and residents. We performed retrospective pre-post surveys regarding confidence using a Likert scale (rated 1 = not confident at all and 5 = very confident). After the first year, we received responses from 10 out of the 22 students. Students indicated that their coaches helped improve their confidence in all of the EPAs with the exception of applied bacteriology. Overall confidence in SSEPAs increased from 3.45 to 4.38. Qualitative responses revealed that students felt the program provided a safe space for learning and improving clinical skills. Additionally, students felt that coaches were an asset in the residency application process. Feedback for improvement was that students would be paired with coaches earlier in the year and the request for more frequent meetings with coaches. During the second year,

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BACK TO THE FUTURE: ALTERNATIVE MODELS OF PAYMENT AND THE FUTURE FOR GENERAL INTERNISTS

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Introduction

As the U.S. healthcare system transitions towards value-based care and payment, it is crucial that healthcare professionals, including general internists, understand alternative models of care and payment and their potential impact on the medical care of patients and on practice workflow. This article will describe the evolution of value- and population-based payments, the concept behind these alternative payment models, and how general internists can shape the payment policy that will influence the future practice of medicine.

Evolution of Value- and Population-based Payments

Historically, physicians have been reimbursed under a fee-for-service (FFS) system per encounter, in cash or kind. The evolution of population-based payments in the United States began during the Great Depression. In the 1930s, industrialist Henry Kaiser paid Dr. Sidney Garfield prospective premiums and a monthly rate per employee to provide medical care to construction workers experiencing workplace injuries at his construction sites. Around the same time, Baylor University in Texas initiated the Blue Cross program as an incentive for teachers, allowing them to enroll in a prepaid plan to cover hospitalizations. Both programs expanded their services to the public in subsequent years and continue to be a meaningful influence on health care today.

The call to hold providers accountable for patient outcomes started to echo in policy corridors a few decades ago as the United States grappled with steeply rising costs of the Medicare program, inefficiencies of its healthcare system, and calculations predicting near-future insolvency of the Medicare trust fund. The accountability efforts began with the Health Maintenance Organization (HMO) Act of 1973 that promoted prepaid group practice service plans (HMOs) and found support in the Patient Protection and Affordable Care Act (ACA) of 2010, aiming to move Medicare away from FFS payments towards value- and population-based payments. The creation of the Center

for Medicare and Medicaid Innovation under the ACA enabled the Centers for Medicare and Medicaid Services (CMS) to test innovative models of care and payment with the goal of expanding the models that demonstrate improvement in clinical outcomes and cost. While these efforts have been stalled by the COVID-19 pandemic, the transition to alternative models of payment will likely accelerate in the coming years.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the Quality Payment Program (QPP) to allow CMS to initiate alternative payments under two models—the Merit Based Incentive Payments System (MIPS) and the Advanced Alternative Payment Models (APMs). MIPS was developed for FFS practices, linking adjustments in physician payments to performance on quality metrics, and allowing practices to gradually transition to population-based payments. The Advanced APMs allow practices to be testing sites for innovative CMS models or to bear financial risk for quality of care. The theme common to both programs is tying payments to quality metrics while holding healthcare providers responsible for outcomes.

Alternative Payment Models

We describe two major categories of APMs implemented by CMS of interest to general internists and primary care disciplines as follows:

Value-Based Purchasing (VBP) Program

In this model, the quality of care in a healthcare practice is compared to national standards based on quality metrics. A part of Medicare's reimbursements to the practice are held back, to be paid later as incentive payments if the practice achieves or shows improvement in scores on quality metrics relative to benchmarks. However, if performance falls below the set benchmarks, the practice may experience financial penalties. CMS has implemented VBP programs in a few healthcare settings nationally, in-

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cluding hospitals (e.g., hospital VBP, Medicare's Hospital Readmission Reduction Program, Hospital-Acquired Condition Reduction Program), Skilled Nursing Facilities, and Home Health Care settings.

Medicare Shared Savings Program (MSSP)

MSSP is the largest APM from CMS, reaching 11 million Medicare beneficiaries, and is a permanent part of the Medicare program. This payment strategy offers Accountable Care Organization (ACO) participating providers a percentage of net savings in return for their efforts to reduce healthcare spending for their patient population. To be eligible for MSSP, an ACO must accept full responsibility for the care of at least 5,000 patients for at least 5 years. There are five tracks with variable levels of shared savings and financial risk. CMS pays ACO-participating healthcare providers using customary FFS payment systems but reconciles the ACO's spending benchmark with their actual average spending at the end of the year. If the ACO's actual average spending per patient is lower than the spending benchmark, CMS pays the ACO a percentage of the generated savings. In two-sided risk models, if an ACO's actual spending is higher than the benchmark, it pays back the CMS a percentage of the losses.

Highlights of Alternative Payments

Payer and Patient-level Outcomes
Six of the 21 models tested by CMS, including ACO and surgical bundle models, demonstrated net savings by reducing inpatient hospitalizations and utilization of post-acute care services. Four models demonstrated improvement in mortality by incorporating value-based payments for End Stage Renal Disease care and preventative services for cardiovascular disease, global payments to hospitals (in Maryland), and Home Health VBP.¹ Among private insurers, Blue Cross Blue Shield of Massachusetts

Alternative Quality Contract demonstrated net saving on claims in later years.

Concerns Related to Health Equity

Besides peer grouping, the current value-based models do not adjust payments based on social determinants of health (e.g., housing or food insecurity) or clinical risk factors (such as frailty, functional decline, etc.) of the beneficiaries. Therefore, the existent quality metrics and risk adjustment calculations penalize healthcare systems^{2, 3} which provide care to medically and socially complex patients. Analysis of CMS's bundled payment program has raised concerns about the widening of health disparities in access to joint replacement procedures among African American beneficiaries.⁴ To address these concerns, CMS plans to roll out its "ACO-REACH" model in year 2023, which aims to test innovative payment models to support delivery of care for Medicare patients in underserved communities.

How Internists Can Get a Seat at the Policy Table

Research

Internists and other primary care clinicians bring valuable insights into studying models of payments and the quality metrics that dictate medical care of their patients and grade their performance. There is need for studying the impact of the models on quality-of-life and clinically meaningful outcomes of patients with complex medical and social needs. Additionally, metrics related to the well-being of the healthcare workforce including healthcare provider burnout, administrative costs to practices, and hours spent by healthcare providers in administrative tasks, should be included in analyses of these models of payment.

Advocacy and Professional Development

To ensure that the valuable perspective of internists regarding the challenges in provision of medical care is

transmitted to health policymakers, internists should consider getting involved in health policy initiatives at regional and national levels. The following is a list of a few professional development resources for medical students, residents, and clinicians:

1. Society of General Internal Medicine's Leadership in Health Policy Program
2. Courses in health law and policy at local law schools
3. Health Policy Fellowships (e.g., Health and Aging Policy Fellows Program, Robert Wood Johnson Foundation Health Policy Fellows Program)
4. American College of Physician Health Policy Internship Program

To begin your journey in the health policy world, the following are a few options:

1. American College of Physicians' Advocates for Internal Medicine Network
2. A regional council relevant to your policy interest (e.g., State Council on Aging, State Council on Substance Abuse)
3. Academic society's health policy committee (e.g., SGIM Health Policy Committee)

Conclusion

As models of payment in the United States evolve towards value-based payments, General Internists and Primary Care clinicians should be knowledgeable about and work to influence development of these models to ensure that the outcomes prioritized are in line with what matters most to their patients.

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MEDICAID EXPANSION: A PIVOTAL STEP TO COMPREHENSIVE, UNIVERSAL HEALTH INSURANCE

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Hospitals in the United States continue to close at an alarming rate, with 183 hospitals in rural areas alone shuttered since 2005. City hospitals have also suffered, perhaps most notably with the closing of Hahnemann Hospital in Philadelphia, Pennsylvania, in 2019. This troublesome trend has worsened the already poor healthcare access for many Americans, with disproportionate effects on poor and working class communities. A primary factor leading to hospital closures is a high burden of uncompensated care. This explains why a disproportionate number of hospital closures are in states that have yet to expand Medicaid and thus have higher uninsurance rates among low-income individuals.¹ Despite many of these hospitals serving as vital public goods, health care in America shamelessly invites the prioritization of profits over patient needs, an issue exacerbated by the rising involvement of private equity throughout health care.

It is in this national context that Wellstar Atlanta Medical Center (AMC) in Georgia recently closed its doors. AMC was a 460-bed hospital, one of two remaining level one trauma centers in Atlanta, Georgia, the other being Grady Memorial Hospital, the largest safety net hospital in the state and fifth largest in the United States. There was little time to prepare for the fallout from this crisis, which has already shown signs of further limiting access to trauma, inpatient, and outpatient care for many Atlanta residents.

According to Wellstar, the closure was economically necessary, as the site lost tens of millions of dollars annually due to uncompensated care. These uninsured patients will now turn primarily to Grady, a short 1.2 mile walk away, increasing the burden on the safety net hospitals' already over-taxed workforce. Grady, a 953-bed hospital, operates at full capacity daily with emergency room wait times frequently exceeding the average wait time of other emergency departments. Grady Hospital, with roughly one in four patients uninsured, was previously itself on the verge of closure in 2007 due to financial pressures. Incredibly, despite AMC's closure, Fulton county lead-

ership, where Grady is located, continues to express concerns of Grady's short-term viability reaffirming that access to health care is far from a right in this country.

In Atlanta, Grady has seen an early jump in trauma arrivals by more than 25% while other local hospitals' emergency rooms have seen visits increase by 15-30%. In all, it is estimated more than 10,000 patients will be affected by the hospital and surrounding ambulatory centers closing. Hospital closures are particularly concerning in Georgia given the states last place rank in provision of health care across all states in 2021. Unfortunately, the shuttering of these public goods is not new in Georgia, where eight rural hospitals have closed in the last 10 years. Georgia's high rate of uninsured patients at more than 15 percent, almost twice the U.S. state average, is largely a result of Georgia's lack of Medicaid expansion under the Affordable Care Act (ACA).² Georgia remains one of only 12 states yet to do so despite additional financial incentives included in the American Rescue Plan Act of 2021, on top of federal funding for 90% of annual expansion costs at baseline. Expansion would increase coverage eligibility to those making less than 138% of the federal poverty level, \$18,754 for an individual in 2022. This would make insurance available to an estimated 450,000 Georgians, including many low-income adults who cannot afford to purchase insurance and do not currently meet Georgia's narrow Medicaid eligibility criteria.

Notably, the data demonstrate that expansion drives improved health and economic outcomes. An analysis of 404 studies looking at Medicaid expansion found overwhelming evidence that expansion improved healthcare access, financial security, health outcomes, and was a positive economic stimulus for states.³ It is estimated that more than 15,000 people, thousands in Georgia, aged 55-64, died prematurely due to lack of coverage in just a four-year period in non-expansion states. Additionally, Medicaid expansion has been shown to reduce arrests for drug, low-level, and violent crime by more than

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20% when compared to counties in non-expansion states.

The current crisis surrounding AMC is tragic yet unsurprising, and it is no mistake that those who will bear the costs of AMC's closure will be poor and working class Black patients in Atlanta—the same patients who come from neighborhoods where life expectancy is 10-15 years shorter than more affluent and whiter neighborhoods. Atlanta is the most unequal city in the most unequal country amongst so-called peer nations in the world. Neglect and divestment unfortunately are too often the norm for Black Americans, seen in the concurrent crisis of crumbling water infrastructure in Jackson, Mississippi. The closing of AMC is the latest example of structural violence manifest, or as Dr. Paul Farmer explained, "...social arrangements that put individuals and populations in harm's way ... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people." There was nothing inevitable about AMC's closing and nothing abstract about the fact that with worse health access comes worse health outcomes.

Medicaid expansion remains an immediate necessity for those most vulnerable to premature death. Expansion would benefit struggling hospitals and uninsured patients throughout Georgia and other non-expansion states. It will not, however, fix the structural issues of a healthcare system that remains the most expensive compared to peer nations, costing twice per capita the comparable country average. Despite this, the United States has the worst health outcomes across many metrics. With more than 80% of health outcomes driven by policy decisions, by choices of who, what, and where to invest in, physicians and other healthcare providers must demand better for patients.⁴

We must be unambiguous in demanding a fundamentally more just

universal and comprehensive publicly funded health insurance system. Medicaid expansion is the floor, not the ceiling. We must reject a system that leaves more than 60 million people uninsured or underinsured and dooms millions of Americans to bankruptcy while burdening millions more with pervasive medical debt.

To ask how we can possibly afford universal coverage is to ignore the more urgent and obvious question of how can we possibly continue this current path?

It is not and has never been for lack of money, as seen in the corporate bailouts from the financial crisis and COVID-19 pandemic. In fact, a streamlined public insurance system would remove much of the bureaucracy and inefficiencies that plague our multi-payer, profit-driven model and would significantly lower overhead costs. A system where a single company can squeeze an unconscionable 17 billion dollars in profit from patients during 2021 as they were trying to survive a pandemic is a system built for corporations, not patients. Given the vast dysfunction and exploitation in the American healthcare system, all should welcome the simplification and equity a single insurance program would bring with the ability to negotiate and lower drug prices, the elimination of deductibles, co-pays, and premiums, and the elimination of private insurance corporate profiteering. An estimated 60,000 deaths could have been prevented had the United States had universal coverage during the first years of the ongoing COVID-19 pandemic.⁵ If profitability continues to determine what life-affirming institutions people have access to then premature death will continue to haunt poor and working class communities, like those AMC served, and similar communities around the United States. It is well past time for patients, physicians, and other healthcare professionals to organize together in demanding health justice

now, anything less risks maintaining the unsustainable tragedy that is the status quo.

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currently members, as only 41% of our SGIM members attended the meeting. I believe it is time we examine ways to strengthen our value to SGIM members and to develop strategies to increase full membership.

While in Aurora, SGIM Council spent time exploring areas to increase membership. Our data suggest that members disproportionately live in one of seven states (New York, Pennsylvania, Ohio, Illinois, Texas, Colorado, California) leaving significant opportunities to increase membership in GIM divisions throughout the northwest, central and southeastern United States. Furthermore, when examining membership by university affiliation, we found significant gaps in membership among divisions in the Independent Academic Medical Centers, among Historically Black Colleges and Universities (HBCUs) and among medical schools with disproportionately greater numbers of URM trainees.¹ Council discussed

giving more attention to recruitment at academic institutions where we have low penetrance. Our goal should be to have every GIM chief in the United States actively engage in our society.

We also recognized the need to continue our focus on the pipeline of future GIM faculty. Although we have seen a yearly increase in associate membership, when compared to 2022, the majority of medical students, residents, and fellows have not yet renewed their membership for 2023 (94%, 87%, and 74% respectively). SGIM Council members discussed the need to further develop strategies to better leverage our regional structure to engage IM program directors and GIM fellowship directors. We believe we have an opportunity to improve understanding how SGIM may better support program directors and GIM division chiefs in their efforts and that, in doing so, we will be able to solicit their longitudinal engagement.

Despite the significant decline in membership SGIM experienced early in the COVID-19 pandemic, we see an increase back to pre-pandemic levels over the past three years. Our SGIM membership staff have done an incredible job addressing our members' needs and in driving membership during the pandemic. Further, I have faith that the team of membership support staff will continue their exceptional performance in 2023. That said, SGIM is, as always, a membership-driven society. It is the responsibility of each of us, as SGIM members, to do all we can to recruit trainees and faculty into our society and to help inform SGIM leaders as to the best ways of meeting the needs of GIM faculty.

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What are the risks?

1. Misinformation
2. Bias
3. Dependence (reliance on automated decision-making and a decrease in critical thinking and clinical judgment)
4. Privacy and security
5. Ethical considerations, such as automation in healthcare, the responsibility of healthcare professionals in using and interpreting ChatGPT-generated recommendations”

The responses are sensible starting points, but not comprehensive. I also sought to paraphrase some content for the purposes of inclusion in this column, even though I don't know as of yet the appropriate ways to quote an AI-powered chatbot. In lieu of that, readers can ask these questions of ChatGPT to retrieve the

full responses, but it is also possible that the answers might change with time.

As scientific communities expand the possibilities of artificial intelligence applications, the many accompanying ethical, legal, and social issues around even more human-like technology need to be addressed in parallel. Education and digital literacy will necessarily be among these issues to address and be close to home for us as SGIM members. What opportunities and risks do new technologies like ChatGPT present? How do we engage in shaping their ethical design and applications to our daily practices and work? On this last question, I look forward to hearing more voices and views from SGIM members on what a future technology-augmented general internal medicine practice, training, and overall mission would look like.

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21 student responses were received. In this survey, students reported that coaches helped to improve their confidence in all six EPAs. Overall confidence in SSEPAs increased from 3.62 to 4.43. Students felt that coaches helped them to identify their strengths and weaknesses and aided them in the residency application process. One student stated, "I think the emphasis on teaching and learning helped me develop my identity as an internist because an internist is a lifelong learner and teacher." Some identified opportunities for improvement included being paired with someone who shared common interests. Since the start of the program, we have also seen a large growth in the number of coaches in the program from 4 to 26 coaches. We attribute this increased interest and involvement to a growing awareness of the program and to prior coaches' positive experiences.

Discussion

The RAC program provides a supportive platform by which medical students can critically evaluate their strengths and weaknesses to develop and achieve their personal and professional goals. During the fourth year of medical school, students are often interacting with faculty and staff that evaluate their performance. These evaluations may be summative and used to determine how an applicant is portrayed to future residency programs. Thus, it can be challenging for students to vocalize that they may be struggling with an area of content. The unique relationship of near peer coaching provides a non-judgmental, non-evaluative environment by which students are encouraged to evaluate both their strengths and weaknesses to develop their skills. One student remarked, "I was able to develop a close relationship with my coach and received directed feedback on my clinical skills during my AI." In addition to goal setting and self-reflection, resident coaches engage in active teaching opportunities through

one-on-one teaching, development of problem-based videos, and content lectures. One highly regarded aspect of the RAC program is the support that coaches provide as medical students navigate through the residency application and interview process. Residents provide information from personal experience on various topics, including how to impress during the acting internship, provide tips for couples matching, excel at virtual interviews, and create rank lists. One student commented, "My coach would reach out to me periodically before, during, and after my AI, and I found that extremely helpful. She was able to answer questions regarding rotations, the match process, and EPA topics." Students also enjoyed the holistic approach of coaches who focused on wellness and life outside of medicine, "It was a nice fit for me to have a coach that was relatively laid back and we also tended to discuss things outside of medicine." From a resident perspective, the ability to coach medical students one on one allows them to educate and train students who may subsequently become the internal medicine interns on their team. In doing so, we begin to develop trust and confidence that students have mastered the foundational knowledge necessary to take on the responsibilities of an intern. Utilizing resident coaches helps to fill the knowledge gaps and support the medical school faculty in addressing students who may be struggling with content. Reducing the need for faculty, gives the university a cost-conscious approach while still supporting the objectives of the ACGME and LCME.

Conclusion

The Residents As Coaches program provides a unique opportunity for students matriculating through their final year of medical school as students receive support regarding the residency application/interview process, guidance on self-assessment and goal setting and assistance in mastering clinical skills. This

non-evaluative, non-judgmental environment allows medical students to perform honest self-evaluation of their strengths and weaknesses. In doing so, students can create specific goals and work with coaches to achieve mastery of these skills prior to the start of residency. Through this process we support students in mastering SSEPAs and aid in the transition to residency. In doing so, we help to foster the development of confident and competent internal medicine interns.

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IMPROVING CARE (continued from page 1)

- to improving patient care and support the improvement effort. Care team members, such as social workers and community health workers, may be better positioned to help patients navigate community resources and address social needs.
4. *Create or update the patients' medical summary.* A medical summary is a brief document summarizing medical history and diagnoses, medications, allergies, the patient's care team, and other essential information that would help any medical provider know a patient's health needs. This should be shared with the patient and ideally stored in the EMR portal.
 5. *During a routine visit, ask, "Do you have a disaster emergency care plan?"* If they have one, ask them to bring it so you can review it and add it to their chart. If they do not have one, offer a template and ask them to begin to fill it out so you can review it at a future appointment or with another of your medical team members. Additionally, give them the tip sheet designed for adults with ID/DD and their families (pages 7-17 of the toolkit).
 6. *Discuss legal issues, wellness, and self-care.* Legal issues may include clarifying whether they have supported decision-making, power of attorney, or guardianship document. If they do, this should be included in the emergency care plan and in the medical record. Wellness and self-care issues may include identifying programs or people

- to help address self-care needs in a disaster or emergency setting.
7. *Assess the need for communication assistance.* We recommend noting the communication assistance needs of your patients with ID/DD in your medical record. Additionally, we recommend discussing how to maintain communication between you and your patients with ID/DD in a disaster or emergency where standard options may not be available, notably if your patient can use any form of telehealth.
 8. *Start with a pilot effort, assess and refine your process, and continue using quality improvement methodology.* As with any quality improvement process, next steps will be determined by what you learn after assessing your efforts.

This toolkit provides the necessary information to guide primary care teams in improving their patients' care and preparation for emergencies or disasters. This is important for those most likely to experience adverse health and wellness effects in emergency or disaster situations, such as those with ID/DD. As we look to bridge equity gaps in care, we want to highlight the care gap for this population that historically suffered stigma and isolation. Our practices aim to be inclusive and provide equitable care, advocate for our patients and identify our barriers, and note the lack of time, funding, training in GME, and cultural sensitivity. The COVID-19 pandemic, wars, climate change, and economic struggles continue to challenge our

patients and us every day. We do not want to forget our most vulnerable; some can't even talk to express their pain and basic needs. We encourage all internists to review this article and consider how to implement it in their practice.

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FROM THE SOCIETY: PART II (continued from page 5)

your expectations. We are excited to see how many of you have already registered and want to remind those of you have not that early registration ends on March 13, 2023. We also want to encourage members to book their room at the Gaylord as soon as

possible to ensure you can stay onsite and enjoy the meeting to its fullest. We are so grateful for our program committee members, all of whom are listed on our annual meeting website, for organizing a meeting to enlighten and inspire you!

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FROM THE SOCIETY: PART I (continued from page 4)

revision, indicating that they have held up well over time. The biggest change in wording is on routine annual checkups—"Don't perform routine annual checkups unless patients are likely to benefit; the frequency of checkups should be based on individual risk factors and preferences. During checkups, don't conduct comprehensive physical exams or routine lab testing."⁷

The latest wording does not explicitly refer to the doctor-patient relationship, but it is assumed in the emphasis on considering individual risk factors and preferences. It is difficult to capture pertinent nuances in the sound bite format that the ABIM Foundation prefers for all Choosing Wisely recommendations. The summary of the full version of the recommendation emphasizes that "patients who are likely to benefit from annual checkups include those who are overdue for recommended preventive care, at high risk of undiagnosed chronic illness, rarely see their primary care physician, have low self-rated health, or have a high degree of worry. Patients from historically excluded or marginalized

groups, such as racial and ethnic minoritized groups and those with low income, are at increased risk of many health problems and are more likely to benefit from checkups."⁷ A simple sound bite will never give enough emphasis to these critically important aspects of the issue. To achieve SGIM's vision for a just system of care in which all people can achieve optimal health, we must reaffirm our commitment to building trustworthy relationships with all who need care.

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BREADTH

WHY I LOVE BEING A PCP

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PCP is the term not ranked so high
We hear a low and continuous sigh
Students and residents fear this flight
And so, choose a specialty in sight
Eighteen years ago, I took this route
Since then, there is no turn around
The journey has been very steady
The love for it is more than ever ready

Initially friends became my patients
Now, patients have become my friends
The long-term relationship is very special
The stories and anecdotes are especial
The days can sure be long and busy
The forms and tasks can make one dizzy
The art of medicine keeps the fire strong
The love for profession keeps it glowing

Some complain the system is not perfect
Some complain there is not enough respect
Some complain not enough reimbursement
Some complain not enough endorsement
The joy of swimming keeps the motion
The variety of strokes improves the vision
Paper chart to electronic is indeed a transition
Going with the flow is always the best decision

Physicals, follow ups, urgent visits make the day
Different patient characters make an interesting play
The changing concept of science creates a maze
The epic updates add a convoluted glaze
Preop, pain med or puzzling fatigue
The answer is going to your PCP league
May we accept the role with cheer
Primary care physician be in the frontier

May the love come from within
May the satisfaction grow from within
May the surplus dollars not make one blind
May the abundance be felt within the mind
May I be the change I want to see
May I be the PCP I want to have
May I change from being a consumer
May I become a contributor