

## COMMITTEE UPDATE

## IMPROVING CLINICIAN WORK LIFE: AN SGIM JOURNEY

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The newly released National Plan for Health Workforce Well-Being<sup>1</sup> by the National Academy of Medicine (NAM) is of profound importance to our work lives as general internists and the learners, staff, colleagues, and patients with whom we work. The capacity and well-being of the U.S. health workforce have been under threat by an epidemic of burnout, and two years of the COVID-19 pandemic has exacerbated this systems issue. Now, at least 40% of nurses, 20% of physicians, and more than 25% of state and local public health department employees are considering leaving their professions. The National Plan is a stellar example of clear, actionable steps that can be taken to improve work and learning environments and clinician, trainee, staff, and patient outcomes. In this article, we identify some of the foundational work performed by SGIM members and colleagues that has contributed to the basis of this groundbreaking report.

Though not directly involved in preparation of the report, our team, in collaboration with many SGIM members and leaders in the field, has had the privilege of working in this space for more than two decades. In 1996, our work started with funding from the Robert Wood Johnson Foundation to perform a national study of physician work life and job satisfaction. The SGIM Career Satisfaction Study Group, led by Elnora Rhodes (SGIM Executive Director), Bob Konrad, Julia McMurray, Eric Williams, and the Physician Worklife Study Team supported this initial work. This was followed by years of study supported by the Agency for

Healthcare Research and Quality (AHRQ), including 1) the Minimizing Error, Maximizing Outcome Study (MEMO) linking work conditions to clinician and patient outcomes in 119 clinics under the leadership of Mark Linzer and Linda Baier Manwell, 2) the Healthy Work Place (HWP) randomized trial in 34 clinics testing interventions to reduce burnout (led by Sara Poplau), and 3) the Minimizing Stress Maximizing Success from the Electronic Health Record (EHR) project (MS Squared), led by Phil Kroth and Nancy Morioka Douglas, with a mixed methods assessment of clinician outcomes related to EHR use. Recently, members of our team have been honored to work with the Office of the Surgeon General on their “Heal Advisory” for the nation’s healthcare workers, a document with overlap and synergy with the NAM report.<sup>2</sup>

Many SGIM members were pioneers in this field and have contributed to the work that predated the NAM National Report (with apologies to any omitted in this brief summary). SGIM’s Part Time Careers and Work Life Balance Interest groups and Horn Scholarship (championed by Carole Warde, Rachel Levine, and Hilit Mechaber) were ahead of their time in recognizing the importance of work life factors. Significant accomplishments in this field were spearheaded by SGIM members including Anita Varkey’s “Separate and Unequal” paper (after an SGIM plenary presentation) on work conditions in clinics serving racially minoritized groups,<sup>3</sup> an

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## FROM THE EDITOR

# PHYSICIAN DIGITAL WELL-BEING

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

After I purchased a new smartphone during the COVID-19 pandemic a few years ago, I paid little attention to one item on the Settings menu: *Digital Well-being*. At some point, perhaps after a system update, I started getting prompts to inform me of how many more minutes (or hours) I used my smartphone compared to last week. Tapping on that reminder led me to a screen that would then tell me how many minutes I spent on various apps. Although the nudges and pointers have not necessarily changed my behaviors over the years, I started noticing how much additional time I will spend working my day job by continuing to use work-related apps on my phone. Naturally, after-hours workload for physicians is no surprise: numerous published papers on audit log or user action log data from electronic health records (EHRs) reveal what physicians have known all along. We work during business hours (and beyond to finish work), and then we often keep working after leaving the workplace. Although the American Academy of Pediatrics acknowledges that children spend an average of seven hours daily on electronic entertainment media<sup>1</sup> and recommends age-based limits on screen time, what about physicians? How much time do we spend on digital media, including required work activities *and* home life? What about physicians' digital well-being?

In routine physician work, after-hours workload (also known as *work after work*, or *pajama time*) has been closely linked with burnout.<sup>2</sup> Additionally, female physicians may spend more screen time with an EHR than male physicians.<sup>3</sup> I remember working on my university computer, apart from the clinic or hospital, just a few years ago, when a required bit of software on the workplace computer would push me with a pop-up throughout the day: a reminder to take a pause from the computer, regardless of what I might be working on at that moment, whether in an EHR or something else. As well-intended as that might have been, you can imagine what the large majority of my responses were, given research that has examined physician desensitization to repetitive clinical decision support alerts.<sup>4</sup> (Click "OK." Keep working.)

While audit log data for EHRs and additional so-called *productivity tools* on a computer may provide insight about our screen time and what we spend our time looking at during work, could it be helpful to flip

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# SGIM 2023: PROVIDING MUCH-NEEDED PLATFORMS TO DISSEMINATE SCHOLARLY ACTIVITY IN GIM

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

*"I believe that the past three years of the pandemic have provided GIM faculty and trainees across the United States far fewer opportunities to disseminate their vast array of scholarly work. As life returns to a new baseline, the availability of SGIM regional and national meetings provide a much-needed platform to present members' work and disseminate their findings."*



As we approach Spring 2023, I look forward to seeing my SGIM colleagues in person again in Colorado during #SGIM23. Although I've attended many of our national meetings since joining SGIM in 1999, I never served on an annual program committee, and, until now, I have been unaware of the extraordinary effort the SGIM staff and committee members take in assuring a successful meeting. Recognizing that the annual meeting (May 10-13) and the end of my tenure as SGIM President are only weeks away, now is the time to publicly thank our many SGIM staff—led in their program planning efforts by Corrine Melissari and Loubna Bennaoui—and the #SGIM23 Program Planning Committee Members for their work in pulling together what seems to be a terrific agenda for the annual meeting.<sup>1</sup>

The Program Committee is comprised of a multi-regional group of clinician-educators and clinician-scientists who have demonstrated their commitment to our society by volunteering many hours to craft a meeting experience that meets the needs of our SGIM membership.<sup>1</sup> Over the past nine months, I have observed the ability of our committee Chair and Co-Chair, Drs. Shelly-Ann Fluker and Milda Saunders, to create a forum where the diverse array of scholars involved in program planning can share innovative ideas, challenge assumptions, and establish new domains of conference activity with great psychological safety; ultimately creating an environment where scholars can exercise the type of design thinking to result in a better conference experience for the society's membership.

I want to highlight a few of the new opportunities that #SGIM23 attendees will experience. In addition to

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# SPECIAL THANKS TO PARTICIPANTS IN SGIM'S FORGING OUR FUTURE PROGRAM IN 2022

Eric B. Bass, MD, MPH; William M. Tierney, MD

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SGIM launched the Forging Our Future program in 2020 to instill a culture of giving among members who appreciate how much SGIM has contributed to their career success and our shared mission.<sup>1</sup> In 2022, we received a total of \$203,221 in donations, including a very generous unrestricted gift of \$100,000 from the Hess Foundation. The total included \$18,605 for the Future Leaders of GIM Fund (to cover complimentary memberships for fellows and scholarships for medical students and residents attending the SGIM Annual Meeting) and \$10,000 for expansion of the Unified Leadership Training in Diversity (UNLTD) program. Previously, the Hess Foundation agreed to allocate \$200,000 from a previous gift to support expansion of the UNLTD program.

The Philanthropy Committee led the way by achieving 100% participation of the committee in the Forging Our Future program in 2022 and reaching out to many long-standing members. SGIM's Council once again demonstrated a strong commitment to the program with 100% of Council members participating in 2022. The program succeeded in engaging 173 members in 2022. Since the inception of the Forging Our Future program in 2020, we have received 896 gifts (91 for \$1,000 or more) and raised a cumulative total of \$569,651. To date, 84% of the past presidents of SGIM or ACLGIM have contributed.

These generous contributions to Forging Our Future will allow SGIM to sustain and expand career devel-

opment programs for members while using dues and meeting fees to support the core functioning of SGIM including its many committees and interest groups as well as its strong national and regional meetings. We greatly appreciate the generous support of all members who contributed to the program as well as those who made commitments as members of the Legacy Circle for bequests and planned giving, as listed in the following table (see SGIM's web site for the full list).<sup>2</sup> While we are extremely thankful for the 173 members or 6% of our total membership who donated in 2022, we want to further strengthen SGIM's Culture of Philanthropy by setting a goal of 15% overall membership participation in 2023. By strengthening the Forging Our Future program, you are enhancing our ability to achieve the mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone!

## References

1. Bass EB. Q & A with SGIM's CEO: Launching the Forging Our Future philanthropy program. *SGIM Forum*. 2020; 43 (12): 4-5.
2. SGIM Forging Our Future. In Appreciation. <https://connect.sgim.org/forgingourfuture/thank-you>. Accessed February 15, 2023.

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SGIM workshop on 10 bold steps to reduce burnout in GIM and a follow-up project on the end of the 15–20-minute Primary Care visit by 16 ACLGIM leaders calling attention to time pressure during patient visits. Other notable SGIM-led or shared work predating the NAM report included Steve Yale's work with rural clinicians and Ellie Grossman's work with inner city clinicians in the Healthy Work Place trial, Chris

Sinsky's landmark work on time spent on indirect patient care (2 hours for every one hour in clinic),<sup>4</sup> Tait Shanafelt, Lotte Dyrbye, and Colin West's galvanizing work on burnout measures and prevalence,<sup>5</sup> and Kriti Prasad's study on correlates of stress and burnout during the Covid pandemic, demonstrating high stress among workers of color, women and non-binary workers.<sup>6</sup>

This work provided evi-

dence-based support for the foundations upon which the National Plan is based. For example, clinicians in MEMO focus groups described chaos in work conditions, which has remained an important measure of workplace challenge. The above programs and studies have shown that work overload, time pressure, and organizational culture are determinants of whether one burns out or thrives,

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**Participants in the Forging Our Future Program and Legacy Circle**

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**SGIM**

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and whether one wishes to leave or stay in their job; other partners have written on the need to protect worker mental health.<sup>7</sup> These predictor variables for burnout emanated from clinicians and learners who shared their stories with us over the years.

It is a critically important time for healthcare worker well-being, as clinician and worker distress, especially in primary care, are very high. The National Plan speaks of a need

to “optimize work conditions” to address childcare benefits, establish key performance indicators for tracking, reduce stigma from mental health matters, and value the well-being of the workforce.<sup>1</sup> We resonate with all these suggestions. Among our many partners in this work have been the Institute for Healthcare Improvement (Joy in Work international network, Jessica Perlo, lead), the American College of Physicians

(ACP wellness champion training, led by Kerri Palamara, Susan Hingle, and Daisy Smith), the American Medical Association (partnering on Coping with COVID) and Mini Z (Zero Burnout) measures with Chris Sinsky and Nancy Nankivil, and the American Board of Internal Medicine (clinician trust in organizations initiative, with thanks to Dan Wolfson and Tim Lynch).

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# MEETING THE PROMISE OF TOMORROW AT THE INTERSECTION OF HOUSING AND HEALTH

Sarah A. Stella, MD; Juan N. Lessing, MD; Milda Saunders, MD; Shelly-Ann Fluker, MD

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Access to safe, affordable housing is a critical determinant of health. Yet, millions of Americans are living in unsafe, unstable and/or unaffordable homes, or experiencing homelessness. Due to structural racism and discrimination, the housing crisis disproportionately impacts people of color, who are significantly more likely to be cost burdened, and thus to experience homelessness.<sup>1</sup>

Homelessness is associated with well-described health inequities, including a large burden of acute and chronic disease, decreased access to primary and preventative care, increased rates of acute healthcare utilization, and premature mortality.<sup>2</sup> Housing and appropriate supports, delivered via a Housing First approach, increases housing stability even among those with high medical needs and serves as a foundation for essential interventions to improve health and well-being.<sup>3</sup>

Over the past decade, the State of Colorado has become one of the least affordable states in the nation.<sup>1</sup> In metropolitan Denver alone, more than 30,000 people accessed the region's homeless services or housing supports over a one-year period between July 1, 2020, and June 30, 2021.<sup>4</sup> More than 10,000 of them were experiencing unsheltered homeless and those identifying as newly homeless rose by 99%.

In advance of the SGIM 2023 Annual Meeting: Meeting the Promise of Tomorrow in Aurora, Colorado, we have partnered with the Colorado Coalition for the Homeless—a leading provider of housing and integrated healthcare services—to identify opportunities for SGIM members to participate in advocacy at the intersection of housing and health. The Colorado Coalition for the Homeless<sup>5</sup> works collaboratively to create lasting solutions for individuals and families throughout Colorado who are experiencing or are at at-risk of homelessness. The coalition is a key partner of the National Low Income Housing Coalition's Opportunity Starts at Home

campaign, a multi-sector collaboration working across 23 states to advance federal policies that expand access to affordable housing (especially for the lowest-income renters), bridge the gap between income and housing costs, protect existing rental assistance programs, and prevent homelessness.<sup>6</sup>

SGIM members will have a variety of opportunities to learn, engage, and participate in housing-health advocacy in conjunction with the annual meeting. In advance of the meeting, SGIM will highlight relevant educational and advocacy opportunities through its online media communications. This includes our #HousingIsHealthCare social media campaign where members are invited to share their perspectives regarding whatever aspect of the housing-health connection feels most important to them as clinicians, researchers, or educators, and how they are advocating in this space within their own communities. During the annual meeting, members will be able to visit the Colorado Coalition for the Homeless education booth to learn more about their work and legislative priorities, as well as local and national advocacy opportunities with the Opportunity Starts at Home campaign.

Across all facets of patient care, we witness how lack of housing affects our patient's lives and health in innumerable ways. We understand that housing is health care. Effectively responding to this issue and shifting the paradigm will require bringing together cross-sector partners to correct longstanding racial and economic injustices and address housing as an important health-related social need. Together with our partners, general internists can be a powerful voice in advocating for policies that can help prevent and ultimately end homelessness. Join SGIM members in 'meeting the promise of tomorrow' through advocacy at the intersection of housing and health.

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# DEVELOPING A MEDICATION FOR OPIOID USE DISORDER WORKFORCE IN PRIMARY CARE TRAINING

Sarah Kurz, MD; Jane L. Abernethy, MD; Steven Tate, MD, MSc;  
Marc Shalaby, MD, FACP; Judy Chertok, MD; D. Rani Nandiwada, MD

*All authors have been members of the primary care medication for opioid use disorder (MOUD) clinics at the University of Pennsylvania. Queries may be sent to Sarah Kurz, MD (kurzs@med.umich.edu).*

## Introduction

The opioid epidemic and rising overdose rate has spurred increasingly urgent calls for expanded access to addiction medicine in office-based settings with medication for opioid use disorder (MOUD).<sup>1</sup> One of the biggest barriers to expanded MOUD care is lack of trained providers with the necessary clinical expertise.<sup>2,3</sup> Currently, within most Internal and Family Medicine residency programs, the majority of addiction medicine training is didactics, role play, and observed standardized clinical interactions.<sup>5</sup> A 2018 survey of Internal Medicine, Family Medicine, and Psychiatry program directors found that few programs taught office-based opioid treatment with buprenorphine.<sup>5</sup>

In response to the recognized need, there is interest among training programs to help build the necessary future work force to address this public health crisis.<sup>4</sup> To achieve this goal, it is critical to understand how best to structure clinical experiences to make residents comfortable treating patients with SUD. However, there is limited data on what type and amount of exposure to MOUD practice is needed to do so.

Our aim was to understand whether limited experience in a clinic caring for individuals with OUD would impact residents' attitudes toward providing care to this population and the motivation and tools to engage in MOUD care as part of their future clinical practice.

## Methods

At the University of Pennsylvania, a novel MOUD curriculum is delivered to PGY-2 and PGY-3 primary care

track Internal Medicine and Family Medicine residents. The program incorporates x-waiver training, in-person didactics, and an immersive clinical experience within a MOUD clinic embedded within the main primary care clinics in both programs. The clinics are staffed by waived attending preceptors with clinical expertise in SUD. Each clinical session has between 12-16 patients who are being seen specifically for MOUD.

To ascertain if this "dose" of training was enough to change resident perceptions, we designed a survey based on literature review and administered it before and after resident's spent time in MOUD clinic. The survey was reviewed by Medical Education and MOUD content experts and then piloted with a small group of residents for clarity prior to administration to the larger study population. Questions were designed to assess resident comfort with prescribing buprenorphine, likelihood of future prescribing, and impact on resident wellness using a 5-point Likert scale ranging from strongly disagree to strongly agree. An additional question asked respondents to rate perceived barriers to prescribing buprenorphine in their future practice both before and after participating in the clinic.

Twenty-five PGY-2 and PGY-3 primary care track Internal Medicine and Family Medicine residents were surveyed following their time in clinic between 2017 and 2019. Results from the survey were analyzed using the Wilcoxon signed-rank test to assess whether perception on a Likert scale increased (towards strongly agree) after the clinical experience. The study was reviewed by the Institutional Review Board at the University

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**"We know that a first step to expanding the provider base engaged in providing MOUD care requires a workforce that is passionate and has the necessary clinical skills. This study provides a signal that a small, immersive clinical experience with MOUD during training may be enough to start to move the needle."**

# BASIC SCIENCE FOR THE 21ST CENTURY—DATA AND POPULATION HEALTH MANAGEMENT

Riley Lipschitz, MD; Karina R. Clemmons, EdD; Zain Alfaneek, MD; Shira Yun, MD

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## Introduction

As health systems embrace value-based care, future physicians must develop a new set of skills to provide equitable, effective, and population-based medicine. Learning how to work with datasets and the “denominator” of patient populations is crucial to achieve most metrics of high value care. While medical education organizations<sup>1,2</sup> consistently emphasize the need to incorporate population health into curricula and utilize data driven approaches to population health management,<sup>3</sup> there is a gap between students conceptual understanding of population health and learners’ mastery of the practical applications of population or database management. Without an applied understanding of population-based medicine, learners can perceive these issues as peripheral to future practice and divorced from clinical and basic science learning.<sup>4,5</sup>

Data and population health management, the new “basic science for the 21<sup>st</sup> century,” should be integrated into undergraduate medical education. It is essential for physicians to develop skills in simple manipulation of large datasets to understand how to risk stratify patients, evaluate drivers of cost, and define targeted groups for interventions. From 2019 to 2022, colleagues from the University of Michigan Medical School (UMMS) and the University of Arkansas for Medical Sciences (UAMS) developed and piloted a targeted curriculum for population health and database management. This educational innovation offers a meaningful bridge from population health theory to high value, clinical practice.

## Goals and Objectives

Through a cross-institutional collaboration, we developed the Practical Population Health (PPH) Chronic Disease Dataset—a fictitious dataset of 10,000 patients with chronic illness. Coupled with a curriculum to teach

concepts in population health, this dataset was developed to facilitate medical students’ mastery of applied skills in database manipulation and population health management. The PPH curriculum guides medical students from analyzing a large dataset of patient information to identifying a specific cohort of high cost/high need patients, evaluating systemic and individual barriers to care, and identifying interventions for more equitable, high value care. Student learning outcomes were assessed using pre- and post-course surveys and qualitative course evaluations.

## Methods

The PPH curriculum and PPH Chronic Disease Dataset were piloted at two medical schools from 2019-22 to give students a framework to integrate and apply concepts of data and population health management. At the University of Michigan Medical School, the curriculum was offered to third-year post-clerkship medical students as part of a two-week course titled “Introduction to Patients and Populations.” At the University of Arkansas for Medical Sciences, the curriculum was embedded into a twelve-week longitudinal fourth-year medical student elective titled “Population Health, Health Equity and Care for High-Risk Patients.”

Students were first introduced to core concepts of population health and then provided with the PPH Chronic Disease Dataset, which included demographic data, cost of care, health system utilization, chronic disease diagnoses, and specific socioeconomic metrics. Using Excel, students learned the basic skills of creating pivot tables, sorting data with filters, and segmenting patient groups. Students risk stratified the population based on different drivers of risk, including cost, hospital utilization and number of chronic illnesses, to learn how to manipulate

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data and identify cohorts for intervention. After using the dataset to identify high-risk cohorts, students were provided with a case-based presentation of high cost/high need patients to demonstrate how the process of identifying and sub-segmenting a population could then be used to apply different evidence-based interventions.

Over three years, the curriculum was modified in an iterative fashion based on lessons learned from previous courses. The data management component ultimately incorporated the following four parts:

1. A short didactic lecture entitled “Data for Non-Data Doctors,”
2. An instructional video teaching students basic Excel skills,
3. A large group team-based learning activity to evaluate trends in the data,
4. And at UAMS a final project with student-proposed interventions to improve a gap in the population.

### Evaluation

Because the data component of our curriculum evolved over the three years, we have focused on qualitative student comments to guide our results. Student comments from both institutions on open-ended feedback questions were analyzed using a thematic analysis approach.<sup>5</sup> Themes that emerged included strong relevance of the material, new concepts not previously studied in medical school, and the value of hands-on data analysis. Representative student comments include the following:

- “This was very helpful for understanding data close to home and visualizing real health equity data.”
- “We get very little training on data interpretation/analysis during med school and learning tricks and tools on excel [sic] that we can take with us going forward will be very beneficial.”
- “This was a very useful experience in trying to utilize statistical

modeling to better understand how to use and visualize a dataset in context of patient and population.”



Newly developed Practical Population Health Chronic Disease Dataset and complementary curriculum provides medical students with a framework and data playground to apply population health management, enabling students to “see themselves” incorporating data and population health into their future careers.

### Discussion

The PPH Chronic Disease Dataset and complementary curriculum gives medical students a comprehensive framework to understand data and population health management—introducing the role of data for future physicians, teaching skills to manipulate a database, and evaluating evidence-based programs for targeted patient groups. The PPH Curriculum emphasizes real-world application of population health concepts, connecting theory with practice. Qualitative feedback emphasized that students valued learning about population health when coursework demonstrated a clear connection to clinical patient care. After working with the PPH Chronic Disease Dataset, many students felt that they could “see themselves” incorporating data and population health into their future careers. The feedback we received highlights the importance of creating real-world and applied opportunities for students to practice manipulating and utilizing population level data in medical education.

Our curriculum and the analysis have limitations, namely small student numbers, variation between institutions, and lack of rigorous quantitative evaluations due to the iterative nature of the curriculum over three years. However, there are clear opportunities to expand this cur-

ricular model. Future plans include integrating chronic disease registries from the electronic medical record for data evaluation as well as developing more simulated “playgrounds” for student learning.

Despite its limitations, the PPH Chronic Disease Dataset stands alone as a curricular innovation with great opportunities for expansion and wide-ranging application in medical education. This dataset simulates real-world population level data and can be used to teach a variety of skills to students. Beyond our PPH Curriculum, continued refinement and expansion of the dataset and a data playground could be used for a variety of applications in data analysis in medical education. We feel there is a need for further development of data resources tailored for medical student use to help teach data and population management.

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# LESSONS LEARNED FROM A VIRTUAL AND COMBINED REGIONAL SGIM MEETING: SOME RENEWED, SOME ANEW

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**O**n November 12-13, 2021, the Mountain West and the New England regions of SGIM held their second joint virtual regional conference. After the inability to meet in person due to the pandemic led to our first virtual and first combined conference in 2020,<sup>1</sup> necessity required us to return to the virtual format one year later. We opted to again join forces given the success of the previous year. With two years experience, we identified themes and lessons useful to enhance future virtual, hybrid, and combined meetings by our and other SGIM regions.

## Meeting Content

The theme of our two-day meeting was “Adapting and Advocacy: Looking Back, Moving Forward,” and content was similar to prior in-person meetings. The meeting opened with oral plenaries featuring top scientific abstracts, innovations, and clinical vignettes from each region, and member submissions were highlighted through a poster session. We featured updates in hospital medicine, primary care, and medical education, and clinicians from both regions led workshops addressing clinical care, medical education, and career development. Workshops topics included creating a primary care peer promotion program, addressing racism in medical education, training primary care providers to perform brief mental health interventions in their clinical practice, and coaching educators to build self-confidence in their learners. Experts from both regions led roundtable discussions on mentoring, diversity and inclusion

in education, advocacy, research/investigation, digital scholarship, and effective journal review. These discussions served as a venue for engagement, collaboration, and sharing of ideas across regions. Each region invited a keynote speaker to speak across the two days—Dr. Megan Gerber (Albany Medical Center) shared lessons about trauma-informed care in the COVID-19 era and Dr. Marlene Martin (University of California, San Francisco) spoke about hospitalization as an opportunity to reduce addiction inequities. Additional meeting highlights included virtual networking opportunities for each region and for trainees, region updates, and a concluding awards ceremony.

**“When virtual options for presenting are available, meeting organizers can recruit speakers from anywhere. A hybrid model allows more people to participate who, due to cost, inconvenience, limited time for travel, or other barriers, might otherwise not be able or might choose not to attend.”**

## Power in Numbers

By joining forces, our two regions attracted speakers from across the nation. The diversity of speakers brought a broad range of expertise and perspectives, expanding the content and value of our meeting. We

increased our usual number of participants. Additionally, conference attendees had a greater diversity of options to choose from in terms of workshops, roundtable discussions, and social networking opportunities. While a strictly in-person conference might not lend itself to these benefits, a hybrid conference has great potential to capitalize on the benefits of a virtual meeting.

## Lessons

When virtual options for presenting are available, meeting organizers can recruit speakers from anywhere. A

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hybrid model allows more people to participate who, due to cost, inconvenience, limited time for travel, or other barriers, might otherwise not be able or might choose not to attend.<sup>2</sup>

### Virtual Format Expanded Submissions

Both our regions received submissions (mostly for posters) from outside of our regions. We hypothesize that this occurred due to the ease of submission, the absence of travel, and because we had not outlined geographic restrictions on the submission portals. We welcomed this unanticipated event as it broadened our sense of community, and we opted to include all submissions that merited inclusion by our usual criteria.

### Lessons

Anticipate receiving submissions from outside the region and explicitly spell out any submission restrictions. If decide to accept from outside their region, consider if non-region entries are eligible for prizes.

### Benefits and Challenges of Pre-Recorded Sessions

Plenary sessions and updates were pre-recorded; workshops and roundtable discussions were live. During each pre-recorded plenary session and update, speakers were able to answer questions using a meeting platform chat function while attendees viewed the pre-recorded portion. At the recordings' conclusion, speakers gave a live, moderated Q&A videoconference session. Far more questions were answered in this format, and the chat function supported increased participation. Chat questions and comments were fascinating to read and increased the value of the talk as well as the sense of community inspired by each speaker. The chat led very naturally to live closing statements during which speakers addressed the most pressing questions and tackled deeper concepts.

Audio and video quality were for the most part excellent. However,

one session had poor audio due to a problem with the submitted file. For one session with two speakers, the pre-recorded videos were played out of order.

An additional pre-recording challenge was not everyone started playing the video at the same time; the live Q&A session therefore did not always perfectly line up for some attendees. Some sessions required back-and-forth toggling between different software platforms (in our case Swapcard and Zoom) to accommodate recordings and live video, which felt clumsy to many participants.

### Lessons

Check the quality of submitted videos ahead of time, ideally with enough time to allow for re-recording if needed. Enhanced guidelines around video submissions may be helpful. Do a trial run of each session to ensure videos are in the correct order.

Make a live announcement to all attendees to either click start to begin the recorded video on time or forego recorded video altogether. Make a live announcement when to toggle between different programs.

### Poster Sessions and Meaningful Interactions

While much of our meeting easily transitioned to a virtual format, the poster session was the most challenging to recreate. In our one-hour poster session, participants could navigate links to access individual posters. Most poster authors pre-recorded brief presentations in addition to the poster, and presenters were available for live chat during the session. Positive aspects of the virtual format included instant access to any poster, the ability to view posters from both regions, and the option to view posters ahead of or even after the conference. We found, however, that participants did not engage with the poster authors in the same way as occurs during in-person poster sessions.

### Lesson

Consider a platform that allows more direct engagement between conference attendees and poster presenters. Gamification may also be a way to increase engagement.

### Social Networking in a Virtual Format

Feedback received following our first combined virtual meeting was mostly about increasing social networking options. Virtual attendees missed having opportunities to meet and connect with others. The meeting platform did allow for participants to virtually “connect” and send messages to other attendees; however, few took advantage of this feature or participated in group community chats outside of the chat function that ran live during the conference sessions. While some sessions, such as the roundtable discussions, allowed for more socialization and networking, the informal opportunities to meet others between sessions or during poster sessions at an in-person meeting were difficult to re-create in the virtual environment. To address this, we held several virtual social hours following the plenary, including one specific for trainees. Though attendance was limited, perhaps due to the Friday evening time and attendees having other obligations at work or home, participants reported appreciating the additional networking opportunity.

### Lesson

Conference attendees desire opportunities for social networking, but recreating these in a virtual format is challenging. Holding specific sessions for social networking is one approach to providing these opportunities.

### Closing Remarks

The second joint virtual SGIM Mountain West and New England regional conference was a success. By attracting national speakers and

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# BRIDGING THE GAP: BRINGING INTEGRATIVE MEDICINE INTO MEDICAL EDUCATION

Marika Alois, MD

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Interest in Integrative Medicine and complementary and alternative modalities is growing. As general internists, we are often the first point of contact when medical questions arise. Along with the standard questions about the spot on their skin or the racing heart they notice here and there, we may be the first to field questions about dietary supplements, manual modalities, and the mind-body connection. “I read about an herb that can be helpful for depression, is it OK to take it along with my Lexapro?” “Do I need to stop taking fish oil before my wisdom teeth are pulled next week?” “Can acupuncture help with my migraines?” While these questions, in the absence of adequate training to field them, can be unnerving, it is even more disconcerting to consider that many of our patients aren’t even asking them.

Based on National Health Information Survey data, 34% of patients are using complementary and alternative medicine (CAM), and, of those patients, nearly half did not disclose their CAM use to their primary care physician.<sup>1</sup> Commonly cited reasons for this nondisclosure included failure of the PCP to ask about unconventional therapies, as well as the perception that their physician lacked the appropriate knowledge. This is not only a quality-of-care issue but also a patient safety issue. To provide our patients high quality, comprehensive primary care, we should have at least enough knowledge about the complementary modalities our patients are using to engage them in dialogue, answer basic questions, and identify safety concerns. As many educational interventions do, this starts at the medical school level.

At the University of Florida College of Medicine, we are implementing a longitudinal Integrative Medicine curriculum throughout the four years of medical student education. We are weaving this into the existing curric-

ulum in an effort to both emphasize synergy in content areas and conserve space in an otherwise full didactic program. We are utilizing a combination of Integrative Medicine corollary slides added to existing presentations, stand-alone lectures given during key content blocks, interactive workshops, team-based learning activities, patient/practitioner panels, and electives.

To study the curriculum’s effectiveness, we plan to survey outgoing fourth year medical students to assess impact on attitudes and perceived competence surrounding Integrative Medicine. Baseline data shows that students not exposed to

the curriculum had generally positive attitudes toward Integrative Medicine but low perceived competence in counseling patients about herbs and dietary supplements, manual modalities, and mind-body therapies. We expect that students who complete this curriculum will demonstrate increased perceived competence in these areas.

With an increasing demand for treatments that fall outside the realm of conventional medicine, it is important that we prepare our medical students to field questions, identify safety issues and interactions, and utilize complementary therapies in an evidence-based manner. We should strive to weave training on this into the existing curriculum in a way that emphasizes coactive content and utility at the bedside.

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“Along with the standard questions about the spot on their skin or the racing heart they notice here and there, we [as general internists] may be the first to field questions about dietary supplements, manual modalities, and the mind-body connection.”

organizing excellent plenary sessions, symposia, and workshops, our committee has created more opportunity for exposure to career coaching across the career spectrum (e.g., junior faculty, mid-career). There are also new opportunities for members to engage with senior SGIM members, including past presidents and council members, in an array of workshops and special sessions throughout the three-day conference. This year, SGIM has committed to more fully exploring the environmental impact of annual meeting, examining the impact of environmental health on the well-being of the public, and providing attendees with information to allow each to examine the way in which actions may mitigate environmental harm.

While the agenda for #SGIM23 is exciting, I am most excited to share the good news about our membership response to the Call for Abstracts. This year, we experienced the highest number of Round 2 submissions since before the COVID-19 pandemic. This year, submissions for clinical vignettes, scientific abstracts, and innovations in clinical practice and medical education were at the

highest level since 2019. In fact, this year represents the second-highest number of abstract submissions for any SGIM national meeting over the past 20 years! Clearly, deadline modifications made by the Program Committee have yielded good results, but I also believe there is a second reason for the high number submissions for #SGIM23. I believe that the past three years of the pandemic have provided GIM faculty and trainees across the United States far fewer opportunities to disseminate their vast array of scholarly work. As life returns to a new baseline, the availability of SGIM regional and national meetings provide a much-needed platform to present members' work and disseminate their findings.

I previously stated the importance of advancing the careers of SGIM members as a key value for our organization.<sup>2</sup> In my opinion, SGIM provides great value to our members through the opportunities we create to discuss their work in regional meetings throughout the fall and winter. I am glad to see that our members also view our national meetings as a forum where their

work can be discussed. Seeing the rise in interest to submit work for #SGIM23 provides hope that we will have maximum attendance at the meeting in Colorado, and I hope that attendees will further enrich the experience of our scholars by taking the time to view posters, attend vignette and abstract sessions, and discuss the implications of work with each presenter.

I look forward to seeing each of you soon!

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### FROM THE EDITOR (continued from page 2)

the perspective and instead look at physician screen time? Admittedly, I only quickly searched PubMed and Google Scholar to find some data on this, but I did not readily find what I was looking for. Perhaps physicians' screen time is under the umbrella of various surveys on physicians' personal health behaviors. One inquiring mind wants to know.

Since I discovered *Digital Well-being* on my phone, I've already taken advantage of settings that limit how much time I spend on certain apps and transition the screen to monochrome at night to remind me to stop using it before bedtime. I'll take the following measures for my own digital well-being for now:

- 1) monitor my digital device use with the help of my phone's my digital well-being tool *and* respond by reducing my usage behaviors, especially of work-related apps; and
- 2) finish writing this column and go bake that apple crumble recipe I saved last week.

What do you do to promote your own digital well-being?

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of Pennsylvania and approved as a quality improvement project. Additionally, we conducted a follow up survey in January 2022 to understand how many residents had gone on to receive their DEA with x-waiver upon graduation, how many were prescribing buprenorphine in their clinical practices, and how their experience in MOUD clinic as resident's influenced their comfort in prescribing on their own.

### Results

Twenty-five of thirty-three (75.7%) residents completed the survey. Of these 25, 76% agreed with the statement "I have more empathy for patients with addiction" (median Likert response = 4) after their clinical experience. Residents felt uncomfortable prescribing buprenorphine prior to their clinical experience. Median ratings went from 2 to 4 ( $p < 0.001$ ) for likelihood to recommend MOUD to patients and identifying candidates for therapy.

Median ratings also went from 2 to 4 ( $p < 0.001$ ) in response to the statement, "I feel empowered to care for patients with addiction disorders." Prior to the clinical experience, the top three perceived barriers to prescribing were lack of mental health resource availability, complex clinic logistics, and not enough ancillary staff support. These perceived barriers stayed consistent following the clinical experience. Prior to the clinical experience, 12 respondents answered that for them, a barrier was fear of causing patient harm from lack of expertise. After the pilot program, this decreased to four respondents. Prior to the clinical experience, nine respondents also answered that a barrier to prescribing MOUD was that patients are difficult, which decreased to one respondent following the pilot program.

For our follow up survey, 29 of 41 residents (70.7%) completed the survey. Of the respondents, 21

(72.4%) reported that they had their DEA license with X waiver, 13 (44.8%) reported prescribing buprenorphine in their clinical practice, and 28 (96.6%) somewhat agreed or strongly agreed with the statement "My experience in buprenorphine clinic in training made me comfortable prescribing on my own."



How do we provide medical trainees with the motivation and tools to engage in MOUD care as part of their future clinical practice?

### Discussion

Overall, this study demonstrates that limited exposure to treating patients with SUD increased residents self-reported comfort with prescribing buprenorphine. The response to our follow-up survey lends further strength to this signal as (44.5%) of respondents reported prescribing buprenorphine as part of their independent clinical practice and (96.6%) agreed that their experience with the MOUD curriculum during training was the reason. This study also showed that residents felt that they had made a significant impact in the care of these vulnerable patients.

Our study is limited by being at a single center with primary care Internal Medicine and Family Medicine residents who may have more baseline interest in caring for patients with SUD. It was also conducted in Philadelphia, Pennsylvania, and thus our residents have exposure to patients with SUD in the inpatient setting on a regular basis, no doubt impacting their perceptions of this patient population in various ways.

While our initial survey was designed to measure perceptions and it is not known if perceptions translate into prescribing in the future, our follow up survey indicates that many

of our graduates go on to provide MOUD care as part of their clinical practice.

### Conclusion

We know that a first step to expanding the provider base engaged in providing MOUD care requires a workforce that is passionate and has the necessary clinical skills. This study provides a signal that a small, immersive clinical experience with MOUD during training may be enough to start to move the needle.

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**COMMITTEE UPDATE** (continued from page 5)

The NAM report concludes with: “there is an ethical obligation to take action to protect those who care for all of us.” We fully agree and are grateful to our NAM partners for their inspirational work. This is the work that must be done. We in SGIM are honored to share in this work and fully endorse the timely and forward-looking NAM report.

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**FROM THE REGIONS** (continued from page 11)

submissions spanning both regions, we were able to provide a greater diversity of content and reach a larger audience, including participants who might have not otherwise been able to attend. While we continued to face challenges in optimizing meaningful interactions during poster sessions and with overall social networking opportunities, the meeting built on feedback from the prior year to provide more opportunities for member engagement, including

live chats, live Q&A sessions following pre-recorded sessions, and new social networking options. Our lessons learned can help shape future regional meeting planning, especially regarding virtual, hybrid and combined meetings.

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