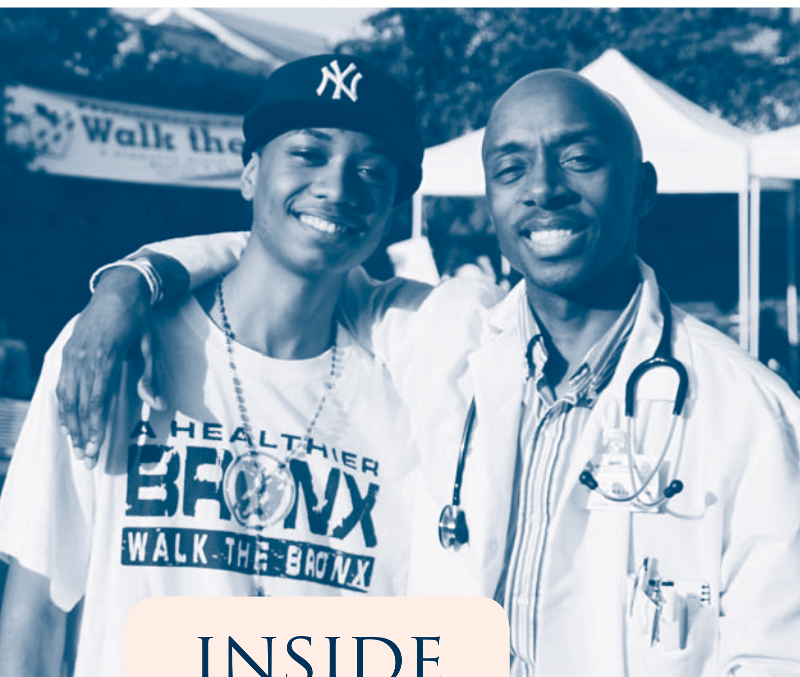
CIR VITALS

Winter 2012

Treating the Whole Community:

CIR members extend their practice beyond the hospital



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 HILLARY TOMPKINS, MD

Using Our Clinical Standing to Diagnose the Ills of our Communities

It's a familiar scene. You're in the clinic or the emergency room. You knock on the door and enter the exam room to meet a patient for the first time. Not long into the visit, you realize that whatever you can do to meet her medical needs at that moment is not going to touch the growing economic and social needs she has; needs that will likely bring them back to your clinic and emergency room again and again.

CIR means many things to many residents: negotiating salary, protecting and improving our benefits, improving everyday life in the hospital to help maximize our learning and ensuring our own personal well-being. But CIR also helps us to make sense of a dysfunctional healthcare system and empowers residents to become involved in the process of reforming our system.

What is happening right now in our hospitals, our communities and beyond to address disparities in health care is exciting. We are seeing resident physicians and community groups come together to tackle childhood asthma and obesity in places like the Bronx and New Mexico. We are seeing clergy members, activists, academic leaders and CIR members in Newark join forces to defend their public hospital against mergers or privatization that threaten vital health services to a vulnerable community. Around the country, physicians are speaking out as part of a growing public debate about inequality in this country.

This is not new to CIR. In 1970, CIR leaders in the South Bronx recognized a major disconnect between the mission of teaching hospitals and the needs of the community. They strove to empower the community around Lincoln Hospital and break down barriers to care.

Those CIR members knew then what we are finding out again today: When a doctor shows up at a community forum or event wearing a white coat, people take notice. As physicians, we must recognize that we play an important role in our communities that allows us to raise issues of inequity, both inside and outside the hospital—and when we do this, elected officials, the press and our patients listen. We can make a difference.

CIR residents often train in hospitals that serve the poorest patients, and we often see firsthand the unequal systems of health care that exist for the rich and the poor. I was fortunate to have worked at Boston Medical Center, where there is a strong tradition of providing equal care to everyone who walks through the hospital doors without regard to the ability to pay. With the economic downturn and healthcare reform in Massachusetts, this mission becomes challenging. Programs to help our populations in need, such as a food bank in the hospital, or cooking and nutrition sessions for diabetic patients are in jeopardy of being cut or no longer exist. We know the value of social programs in maintaining the health of our neediest populations. Remember, we have the ability and position in the community to lobby our local governments to make sure patients have access to parks, nutritious food and affordable preventative health care, so that our efforts to improve health are not in vain.

What are you doing to attend to the needs of your community? We want to hear about how you are taking action within your program, your hospital, or your community. Write to me at president@cirseiu.org.

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CIR on the Front Lines of Medication Safety and Quality Improvement

Photo: Erin Malone/CIR

Mary E. Burkhart, MS, RPh, FASHP; Lt. Col. Jorge D. Carillo, PharmD, MS; and Helen Haskell, founder of Mothers Against Medical Error were the featured speakers of the 2011 HHC Conference *Improving Medication Safety Through Effective Communication and Teamwork.*

Teamwork—it's the buzzword in medicine these days, but how often do teams of physicians, nurses, pharmacists, techs and hospital administrators actually discuss a common medical problem?

That was the strength of the November 30 medication safety conference that brought together more than 160 health care professionals from all 11 hospitals in the NYC Health and Hospitals Corporation (HHC) system. The conference focused on a team and systems-based approach to reducing medication errors, with emphasis on the use of opioid and effective pain management. Keynote speakers from the U.S. Army, the Ann Arbor VA Medical Center, and the founder of Mothers Against Medical Error, and a panel of HHC colleagues imparted valuable lessons; participants later broke out by hospital to identify medication safety concerns in their daily work.

"We looked at examples in which minute errors dramatically impacted patients' morbidity and mortality," said Dr. Anthony Isenalumhe, a PGY 4 in anesthesiology at Bellevue Hospital. "That was shocking. You don't think such small events make such a dramatic change.

"Most times when [providers encounter a near miss] they think of it as a personal event and they correct it on that one-on-one level, rather than thinking about it as something that should be corrected on a system-wide level," he said.

CIR has organized an annual patient safety conference with HHC since 2008. This conference was also co-sponsored by 1199 SEIU and funded by the Federal Medication and Conciliation Service and the CIR Patient Care Trust Fund.

Patient Safety Conference Spurs Lincoln to Reduce Hospital-Acquired Infections

At the 2010 CIR-HHC patient safety conference, keynote speaker Dr. Richard Shannon reminded attendees that "Hospital-acquired infections are not inevitable; they are the product of unreliable systems." Participants were challenged to create one-year plans to reduce HAIs in their own programs.

One success story can be found at HHC's Lincoln Medical and Mental Health Center. There, Dr. Abdul Mondul, Associate Medical Director and Patient Safety Officer, worked with his multidisciplinary team to reduce catheter-associated urinary tract infections (CAUTIs). CAUTI rates have fallen from 4.7 per 1,000 catheter days in 2009 to 2.9 in 2010 and 0.5 in 2011. Dr. Mondul's team even reported zero CAUTIs in the first quarter of 2011. The national range is 3.1 to 7.5 CAUTIs per 1,000 line days.

Dr. Mondul's team first standardized the policy and procedures for using Foley catheters. One significant change was to empower the nurses to remove the catheter after 48 hours if the physician had not reevaluated and renewed the order, thus ensuring that a patient's catheter was continually reassessed, that it would not remain inserted for long periods of time, and that the nurse and physician would communicate on a standardized basis.

Dr. Mondul emphasized the importance of working in teams and with complete transparency, and focusing on fixing the system rather than blaming the individual. With a working policy to reduce CAUTIs, the next challenge is to maintain a low infection rate. Dr. Mondul offered a closing piece of advice:

"The sustainability piece is important. Keep it on the radar. Make it a priority. It's hard to motivate anyone to buy into a project or initiative if you don't give the appropriate background on why we're doing it."

One-Day Conference Sponsored by CIR Policy and Education Initiative

NYC Residents Learn the Art of Patient-Centered Interviewing

Photo: Heather Appel/CIR

At *The Art of Medicine: A Physician-Patient Communication Conference* on November 19, 2011 residents learned techniques like motivational and patient-centered interviewing that are closely linked to more effective patient care and increased patient satisfaction.

The foundation of the patient-physician relationship is the ability of the physician to communicate well with his or her patient. Diagnostic and therapeutic tools such as "motivational interviewing" to change problematic health behaviors and "patient-centered interviewing" are strongly associated with adherence to treatment, lower malpractice rates and improved clinical outcomes. The tools also improve patient and physician satisfaction, yet they are not routinely included in a resident's training.

To help rectify this deficit, the CIR Policy and Education Initiative (CIR PEI) sponsored *The Art of Medicine: A Physician-Patient Communication Conference* on November 19, 2011 at the New York Academy of Medicine.

Drs. Auguste Fortin, Associate Professor of Medicine at the Yale University School of Medicine and Sheira Schlair, Internal Medicine Associate Program Director at Montefiore Medical Center in the Bronx, taught nearly 150 residents, medical students and faculty how to build efficiency and effectiveness through integrated patient- and doctor-centered interviewing. In just ten minutes, a physician can elicit the patient's entire biopsychosocial story behind the visit, arrive at the diagnosis, and impress upon patients her care and compassion.

"Allowing the patient to tell his/her symptom story is therapeutic," said Auguste Fortin, MD, MPH. "They don't necessarily want you to fix everything they tell you about, and they understand and appreciate agenda setting."

Residents who attended the workshop reported that after being trained to structure their interviews according to this technique, they experienced vastly improved efficiency and control over the interview and greatly enhanced rapport with their patients.

Other experts at the one-day conference spoke on motivational interviewing, resident wellness and overcoming culture barriers.

Speakers included Drs. Jonathan Fader, Assistant Professor of Medicine at the Albert Einstein School of Medicine; Robert Schiller, Chair of the Department of Family Medicine at Beth Israel Hospital; Ethan Fried, Internal Medicine Program Director at St. Luke's-Roosevelt Hospital Center; Andrew Yacht, Internal Medicine Program Director at Maimonides Medical Center; Farida Khan, Attending Physician at New York Methodist Hospital; and CIR resident Girish Nadkarni from St. Luke's-Roosevelt.

Thanks to a grant from the Arnold P. Gold Foundation, the conference was videotaped and the CIR Policy and Education Initiative will produce videos and accompanying educational modules available for viewing by spring. In the meantime, visit the CIR PEI website at ***www.cirpei.org***.

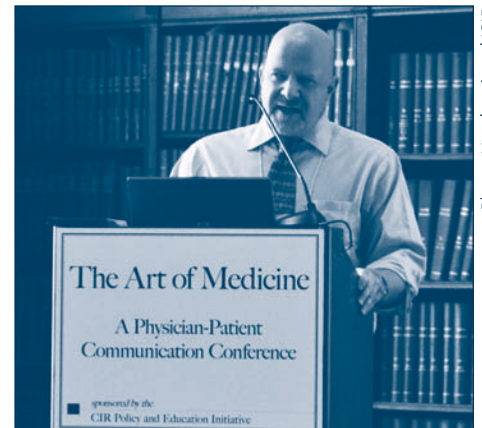


Photo: Heather Appel/CIR

Dr. Robert Schiller, Chair of Graduate Medical Education at Beth Israel Medical Center's Institute for Family Health, discusses the importance of patient-centered care at the Physician-Patient Communication Conference.

Through Negotiated Patient Care Funds, Residents Translate Needs into Action

In many CIR contracts, members have negotiated a Patient Care Fund. These funds, controlled by the housestaff, can be used toward purchases or programs that will improve the quality of patient care within the hospital. CIR Vitals *surveyed hospitals across the county to see how members are using their patient care funds.*

CALIFORNIA

Harbor-UCLA has one of the oldest and largest Patient Care Funds of all CIR contracts, with the County of Los Angeles contributing $495,000 annually. Harbor-UCLA housestaff have recently focused on medical equipment purchases. Neurosurgery residents purchased an intracranial doppler ultrasound so that they can provide a higher standard of care when performing surgeries related to the carotid artery. Internal Medicine housestaff purchased hand-held ultrasounds so that cardiology can provide bedside echocardiograms and residents can do ultrasound-guided central lines, paracentesis and thoracentesis on the floors when needed. They hope these purchases will decrease discharge wait times.

FLORIDA

At **Jackson Memorial Hospital** the housestaff have negotiated a hospital contribution of $25,000 annually to their Patient Care Fund. The Psychiatry Department recently received funding for an activity therapy improvement program. The funds will be used to purchase recreational therapy supplies such as arts and crafts, games, workbooks, music supplies, and books for psychoeducation in the mental health inpatient units.

Photo: Bill Bradley/CIR

MASSACHUSETTS

At **Boston Medical Center**, the housestaff bargained for $35,000 annually toward their fund. Residents have found innovative ways to use the fund to improve access to health care for some of their neediest patients. An Ob/Gyn resident recently requested funding for taxi vouchers to help give pregnant women with limited means transportation home. An ENT resident requested funding for prosthetic electronic speech devices to be loaned out to patients who have their voice boxes removed because of cancer. They will be able to use the loaners during their up to six-week wait for their insurance to approve a permanent device.

Cambridge Hospital residents have $45,000 at their disposal. Recently funded projects include: holiday gifts for seniors and children at the hospital; bereavement boxes to help women who have had miscarriages cope; much needed equipment for the nursery to accommodate babies born addicted to drugs; and a $5,000 grant for the Coordinated Care Fund for Victims of Political Violence.

NEW MEXICO

Though they have the newest of CIR Patient Care Funds, **University of New Mexico** housestaff have done a lot with their $80,000 fund. This year, projects included an AccuVein vein finder for the NICU, a laryngoscope for intubations in the emergency department, SonoSite probes for the MICU, and support of the Juvenile Diabetes Halloween Carnival and the Indian Health Initiative conference. Residents have also enabled the prompt discharge of patients through their Medication Discharge Voucher which provides financial assistance to patients who can not afford the medications necessary to be discharged from the hospital.

NEW YORK

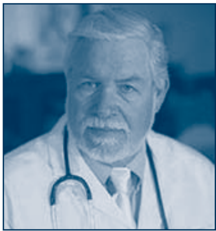
The eleven hospitals within New York City's municipal health system, **Health and Hospitals Corporation (HHC)**, share a Patient Care Trust Fund of $360,000 a year. CIR members in the HHC system have used their funds for the purchase of vital equipment as well as to support patient safety initiatives. For information on applying for PCTF grants, visit **www.cirseiu.org/pctf**.

New Mexico Housestaff Win New Meditation Room

BY DR. MIRIAM SALAS, INTERNAL MEDICINE, PGY 2, UNIVERSITY OF NEW MEXICO

The University of New Mexico's new resident meditation room is an oasis in one of the most active parts of the hospital. Though our hospital provides adequate work space, we felt our diverse spiritual needs were not being addressed. Our goal was to make a convenient space where residents could take time to address their spiritual needs without being too far from their work spaces.

The resident meditation room, converted from an old call room, was the result of productive labor-management meetings. The space sports a bench, bookcase and carpeted area as well as yoga mats and a fountain. Prayer mats and meditation benches are soon to come. Located between the call rooms and close to the wards, the meditation room is easily accessible even during work hours. With admittance restricted by badge swipe, the room affords privacy and serenity. The meditation room's immediate and constant use is a testament to its success.



Alumni Corner | Dr. Eugene Thiessen

Then and Now: Former CIR President Reflects on Physician Activism from the 1960s to Today

Dr. Eugene Thiessen has spent his career expanding the definition of physician service. After earning his MD at the University of Chicago, he trained as a surgical resident at Bellevue Medical Center in New York, served as president of CIR from 1960-1962 and continued as a welfare administrator while starting his general practice. Dr. Thiessen was an Associate Professor of Surgery at NYU for 20 years, and later practiced in emergency medicine. He also founded SHARE, the first peer support group for women with breast cancer and ovarian cancer.

CIR Vitals spoke with Dr. Thiessen about how he became a physician activist and how he sees physicians' roles today.

WHAT WERE CIR'S GOALS WHEN YOU WERE PRESIDENT?

We certainly were addressing the inequities of salaries and working conditions of interns and residents. We negotiated to get a better contract. But at the same time we were advocating for nurse services, better lab services, we went beyond. . . . We were interested in the health care of the patients in the hospital.

Ever since its founding in the late 1950s, and during my tenure as President in the early 1960s, "patient welfare" has been one of the core principles underlying the efforts and activities of CIR. For me—and I believe for CIR also—"patient welfare" encompasses more than just the quality of care given to the hospitalized patient. Among other principles, I believe it also stands for both universal access to affordable health care, and health care as a universal human right.

WHAT DO YOU THINK OF TODAY'S HEALTH CARE SYSTEM?

Health care is a right, not a privilege. It should be taken out of the hands of profit-making entities. The application of health care is as much the responsibility of physicians as the individual practice of medicine. I would like to see physicians active in the political process—not necessarily running for office but lending their professional expertise to politicians. I help my district representative in Long Island whenever I can by sending him information on health care. Physicians should be advocates not just of their own patients but of the system of health care.

WHAT DO YOU TELL A DOCTOR WHO WANTS TO GET MORE INVOLVED IN HIS COMMUNITY BUT ISN'T SURE WHERE TO START?

It's hard to imagine that anybody who seriously considers getting involved in advocating for patient care would have difficulty finding something. Open your eyes, look around where you are, listen to the news broadcasts and what's being said—pick out what interests you and you feel confident in.

About a month ago I heard on NPR that a group in California organized their practice with an emphasis on prevention. They had a clinic and they would go out to their diabetic patients to make sure they didn't have any lesions or infections on their feet—they're really making preventive medicine an essential part of the practice. They were able to cut down on expensive hospitalizations resulting from lack of care and come in under budget.

My big complaint is that politicians don't want to cut the cost of health care delivery; they want to reduce the amount that the government pays out. So the costs will stay the same if the system continues as it is now and there will be a shift on the payment from the government to the individuals. What we really need to do is figure out how to reduce the cost of health care delivery.

HOW DO YOU SEE THE OCCUPY MOVEMENT?

It is my belief that the OWS movement's most important contribution is not the development of a policy or political agenda; it is the raising of awareness and discussion about fundamental political, economic and social relationships and inequities in our society. The "movement" isn't providing answers—it's asking questions; it's asking the "whys".

After retiring from clinical medicine in 1999, Dr. Eugene Thiessen continued as a lecturer in the Department of Preventive Medicine at SUNY-Stony Brook. In 2008, Dr. Thiessen received the "Distinguished Service Award" from the University of Chicago in "recognition of honor brought to the University through teaching, research, and community service."

RECONNECT WITH CIR

We're building an alumni network of all CIR past members going back to our founding in 1957!

Connect with CIR and former colleagues by visiting **www.cirseiu.org/alumni-center.**

The Healthy Bronx Initiative: Taking the Work Beyond the Hospital

A 2011 report from the Centers for Disease Control and Prevention paints a stark picture of health disparities and income levels in the United States. People with low incomes have five to 11 times fewer healthy days per month than those with high incomes. They also have higher rates of hospitalization. According to the federal Agency for Healthcare Research and Quality, eliminating this income-related disparity would prevent about one million hospitalizations and save $6.7 billion in healthcare costs each year.

Soaring unemployment rates have only exacerbated these disparities. A 2011 report by the Commonwealth Fund found that increased unemployment levels, rising treatment costs and unaffordable insurance coverage caused four in 10 Americans to struggle to pay their medical bills last year. The Commonwealth survey also found that more than 40 percent of the respondents said that high costs had compelled them to forgo the care they needed.

These facts are all too familiar to physicians serving poor communities across the country, but none more so than the Bronx. Home to nearly 1.4 million people and ranked as the least healthy of New York's 62 counties, the Bronx is in a genuine health crisis. In February 2011, CIR members from several Bronx hospitals gathered to officially launch the Healthy Bronx Initiative to take steps to change that reality. They were frustrated with consistently seeing patients in the ER and clinics for treatable chronic conditions. They knew that factors outside the hospital were contributing to these repeat visits and they wanted to do something about it. Their goals were to educate the public on health, address structural obstacles that fuel community health problems, and to better understand the obstacles their patients face.

Residents have since been working with community organizations to address the underlying causes of two public health crises in the Bronx: obesity and pediatric asthma. The initiative has tackled these public health issues through community health programs and supporting policy and legislative solutions like the Fair Wages for New Yorkers Act. *CIR Vitals* interviewed three residents active in the campaign to learn more about the work they are doing, what motivates them and the impacts they've seen.

Health Disparities in the Bronx

CIR has nearly 2,000 members practicing in the Bronx, one of the unhealthiest regions of the country. The health disparities below illustrate why an effort like the Healthy Bronx Initiative is desperately needed in the borough.

- The Bronx is the nation's poorest urban county and has deteriorated in its health outcomes and predictors in the past year.
- The borough has the highest unemployment rate in New York State.
- Thirty-seven percent of borough residents said they lacked money to buy food at some point in the past 12 months.
- The Bronx is worst off of all New York City boroughs on almost every major barometer of health, from infant deaths to cancer to HIV/AIDS.
- The Bronx is considered the epicenter of asthma in the United States.

If you'd like to learn more about the Healthy Bronx Initiative or get involved, contact healthybronx@cirseiu.org. Read more about the initiative at www.healthybronx.org.

CIR Members share their experienc

Dr. Rick Gustave
Emergency Medicine, PGY 2

Lincoln Medical and Mental Health Center
CIR Regional Vice President

Photos: Erin Malone/CIR

"Health is not the opposite of disease," Dr. Rick Gustave said. "Physicians most definitely have a responsibility to get into the community. It's where a lot of our education should take place."

For Dr. Gustave, an emergency medicine resident at Lincoln Medical and Mental Health Center and CIR regional vice president, participating in the Healthy Bronx Initiative was a natural continuation of long-established personal and professional goals.

"The unifying theme of all doctors, our drive, is our desire to help people," he said. "[Getting into the community] is as important as pharmacology, anatomy and physiology. You're not treating the patient's cardiac system or neurologic system or gastrointestinal system. You're treating the whole patient. You need a complete picture and the only place to get that is in the community."

In his intern year, Dr. Gustave, who has the distinction of being the first Lincoln resident also born at the hospital, was encouraged to attend a community meeting that he was told would align with his interests. This community meeting was not only his introduction to CIR, it was also the kickoff meeting for the Healthy Bronx Initiative. He has since become a committed advocate.

Dr. Gustave has volunteered in wide-ranging activities, from teaching healthy eating habits

Dr. Crischelle Magaspi
Internal Medicine, PGY 2

Lincoln Hospital and Mental Health Center

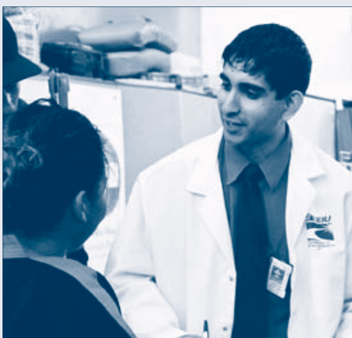
Dr. Crischelle Magaspi has done a fair amount of community work throughout her training. But her experience helping rural communities in the Philippines is a far cry from the dense urban area she now serves as a PGY 2 resident in Internal Medicine at Lincoln in the Bronx. Dr. Magaspi recounted how she's come to have a better understanding of the health needs of the community she now works with through the Healthy Bronx Initiative:

Before residency I took part in a health education program in the Philippines. We worked with an indigenous tribe that lacked access to medical care. We were primarily there to teach. For example, we taught parents when to take a child with diarrhea to a doctor to prevent dehydration. We also spoke with mayors of towns about providing ambulances for people who can't get to the hospital because there's no transportation.

In the Bronx, however, it's totally different. Here, what's frustrating is that while people have more access to care, there are environmental and lifestyle habits that compromise their health. We see that a lot in the South Bronx where I work. There are high rates of drug and alcohol abuse and a high population of asthmatics.

Dr. Deepak Das
Radiology, PGY 3

Jacobi Medical Center



Basic community health is important for everyone," said Dr. Deepak Das, a radiology resident at Jacobi Medical Center. "Community problems are reflected in health. Helping in the hospital is one side of it but preventative care and stabilizing lives outside of the hospital is equally important. That's why I do it as a physician and just generally as a person.

"I've always wanted to participate in community efforts, and with CIR and the Healthy Bronx Initiative it's very easy to get involved either politically—like through the *Living Wage*—or through events like *Walk with a Doctor*."

Dr. Das has testified twice before the New York City Council on the Fair Wages for New Yorkers Act, also known as the Living Wage Bill. "[It] is basically a campaign to afford workers a basic liveable salary to cover food, amenities, and health care." The act would require developers receiving public contracts or subsidies to pay their employees a living wage of $10 per hour with benefits or $11.50 per hour without benefits, which studies have shown is the minimum amount that a single adult would need to earn to support him or herself in the city.

eswiththeHealthyBronxInitiative

to third and fourth graders to the *Walk With a Doctor* event to fitness challenges with local elected officials.

Dr. Gustave explained that working in the community was mutually beneficial to doctor and patient. "We're all here to help each other. As I'm disseminating information, I'm also learning more and more about issues surrounding this community," he said. These opportunities also help to obviate one of Dr. Gustave's biggest complaints about his profession. "The term 'compliance' angers me. It's generally used as a physician's excuse for not exploring all the obstacles that stand in the way of his or her patients achieving their health goals.

"That concept is turned on its head when you ask patients about keeping up with regimens. I can schedule 10 or 12 clinic appointments, but working

"You need a complete picture and the only place to get that is in the community."

and putting food on the table is more important than two or three potentially unnecessary meds I'm prescribing."

In addition to CIR's roots in ensuring resident worker rights, Dr. Gustave found a group of like-minded physicians in CIR. "One of the things that I love about CIR is that it really stands out as an organization dedicated to furthering the wants and needs of residents in terms of their education and life goals. Social projects and social programs and participation—these are things that residents as a whole think are necessary," he said, likening CIR to a "super group of chief residents across the nation" who support agendas that support residency training. "It's filling a gap that residency programs and hospitals should have filled a long time ago."

As a physician, you only see one side in the hospital or clinic. I wanted to get involved in grassroots efforts because obesity is an epidemic in the community I work with. I've seen complications like diabetes, heart disease, back problems and depression. CIR is a great organization for getting a start in public health.

I participated in the Healthy Bronx *Walk with a Doctor* event; it featured a health fair and a walk-a-thon with community doctors. I had the opportunity to hand out pamphlets and talk people about their nutritional needs. In the clinic, I have a set of things to communicate but outside of the hospital you have to get people interested. In the Philippines, you'd be more authoritarian but here I've learned that you have to approach people differently. You have to know how to break the ice and establish rapport.

I also took part in the *Family Health Challenge* where we visited a community center and talked to kids 6 to 8 years old about nutrition. It was a very interactive and surprising session. The children actually knew more about nutrition than many of my patients in the hospital. One child asked, "If fast food is bad food, why is it being sold?" And that question gave me hope that things will change.

At *Walk with a Doctor,* I also met a 60-year-old woman who's very active in the community. She brought her children and grandchildren to the event and she told me that coming to community programs like this helped her change not only her own behaviors but also her family's and the way they live. That encouraged me to continue to educate. I see community work as a pay-it-forward sort of thing—you can help one person and in turn impact many others.

He has also been involved with the Bronx CAN (Changing Attitudes Now) Health Challenge. CIR residents helped monitor the weight loss and fitness

"Community problems are reflected in health."

efforts of State Senator Gustavo Rivera, who spearheaded the challenge and served as a living example of healthier lifestyle choices. "The problems that people have individually are reflected when they come to the hospital and everyone has to pay for them. It slows down ER times and affects the health of others," Dr. Das observed.

"I've been surprised at how many people come out to these events," he said. "I think people are just stunned when they see doctors out in the community. Usually they see us in the office after spending days getting their health insurance in order and then waiting weeks and weeks for an appointment. From what I've heard, they really like us being out there and appreciate being able to ask us questions in a very relaxed atmosphere."

Reflecting on the impact of the initiative, he noted, "What CIR is doing with the community is great because it's reaching out and going beyond being a regular old union. It's about being an organization that looks out for workers of all types. If you have any interest at all in working in the community, just do it because the best way to decrease your census at night is to prevent the census from ever being formed!"

To Fix Health, Help the Poor

Elizabeth W. Bradley and Lauren Taylor of the Yale Global Health Leadership Institute published a study in the journal BMJ Quality and Safety that compared 30 industrialized countries, their health outcomes, the amount of money spent on health care and where each country spent it. The following includes an excerpt and key points from the op-ed they published in the New York Times *on December 8, 2011.*

- The U.S. spends more than any other country on traditional healthcare-associated expenses, but it ranks 10th in healthcare spending if you expand the criteria to include spending on social services like rent subsidies, employment-training programs, unemployment benefits, old-age pensions, family support and other services that can extend and improve life. (29 percent of its G.D.P. in 2005, for example, as compared to 33-38 percent of the G.D.P. of the top healthcare spenders.)
- For every dollar the U.S. spends on health care, it spends 90 cents on social services. In comparison, the peer countries spend $2 on social services for every dollar spent on health care, meaning that the U.S. is spending less on health care and allocating its resources disproportionately in comparison to its peer countries that have higher health outcomes.
- Overall, the study found that countries with high healthcare spending relative to social spending had lower life expectancy and higher infant mortality than countries that favored social spending.
- The impact of sub-par social conditions on health and health costs has been well documented. For example, the Boston Health Care for the Homeless Program tracked the medical expenses of 119 chronically homeless people for several years. In one five-year period, the group accounted for 18,834 emergency room visits estimated to cost $12.7 million.

"It's time to think more broadly about where to find leverage for achieving a healthier society," wrote Bradley and Taylor. "One way would be to invest more heavily in social services…. Out of respect for individuals' rights, our current social programs are mostly opt-in, leaving holes for the undocumented, uneducated and unemployed to slip through cracks and become acutely ill. Emergency rooms, though, are not allowed to opt out of providing these people extraordinarily expensive medical treatment before discharging them back to wretched conditions and their inevitable return to the E.R.

"It is Americans' prerogative to continually vote down the encroachment of government programs on our free-market ideology, but recognizing the health effects of our disdain for comprehensive safety nets may well be the key to unraveling the 'spend more, get less' paradox. Before we spend even more money, we should consider allocating it differently."

Excerpts of this article were reprinted with permission from the New York Times.

PHYSICAL HEALTH INDICATORS, BY INCOME GROUP

Annual income

	$24K (low income)	$24K-<$90K (middle income)	$90K+ (high income)	Gap, low vs. high income (pct. pts.)
% Obese	32.0	27.9	21.7	10.3
% Diabetes	16.1	10.1	6.7	9.4
% High blood pressure	36.4	29.0	23.6	12.8
% High cholesterol	29.3	26.4	25.3	4.0
% Heart attack	7.2	3.5	2.2	4.9
% Asthma	15.9	10.5	9.2	6.7
% Cancer	7.7	6.9	6.0	1.7
% Diagnosed with depression	29.0	15.2	10.2	18.7
% Headache	18.7	10.2	7.5	11.1
% Flu	2.7	1.2	1.0	1.8
% Cold	7.0	4.7	4.3	2.7

Jan. 1-Sept. 28, 2010

This table shows 2010 data from the Gallup-Healthways Well-Being Index. To read more on these findings and other indicators of well-being visit: http://bit.ly/gallupdisparities.

We Are the 99%

Walking through the rainy streets of Washington D.C. en masse, with men, women and children from all over the US side by side chanting "We are the 99%," was truly inspirational. I had the opportunity to join the national Take Back The Capitol movement along with thousands of other people, union and non-union, from all walks of life, ethnic backgrounds and even political affiliations this past December. The main goal was to have a visible, peaceful presence in Washington D.C. to influence our lawmakers to create meaningful legislation that would create jobs, secure better health care for all and benefit the 99% of Americans and not just the richest 1%. What I witnessed was exactly that and so much more.

The People's Camp served as the main meeting place for all the people who were staying at various locations throughout Washington, D.C. Everyone had a job to do and everybody seemed more than happy to be there as a part of this movement. As an immigrant to this country, naturalized as a citizen in 2004, standing in the rain in the middle of the Washington Mall, surveying the scene of tents and people organizing in muddy shoes and makeshift raingear made of trash bags, I too was honored to be there.

We should consider it our duty to advocate for the 99%.

I was there along with a pediatric resident representing CIR and New Mexico. I cannot be sure if we were the only doctors there but everyone we met seemed thrilled to have us join the movement.

While a lot of people may feel that most doctors fall within the richest 1%, I contest that we are and should consider ourselves to be part of the 99%. Regardless of salaries, we should consider it our duty to advocate for the 99%. Particularly as emergency medicine doctors, we serve the 99%. We serve the 67-year-old female who day after day goes to work as a maid at the casino, ignoring the chest pains she feels because she cannot afford health insurance and has no primary care doctor. She just works through the pain until one day she faints at work and gets transported by ambulance to our ER Resuscitation Bay. It is a trip which may save her life; it is also a trip which will surely cost her the house and savings for which she has been working so hard. We serve her and the many people who depend on Medicaid, Medicare, those with and without insurance who deserve decent jobs, health care, and legislators who will represent them.

Drs. Linda Hodes Villamar (left) and Yadira Caraveo (right) visited the "People's Camp," participated in a healthcare speakout and joined a "We are the 99%" march during the three-day "Take Back the Capitol" event Dec. 6-8 in Washington D.C.

Admittedly, marching in the rain on the streets of Washington, D.C. is not for everybody. Fortunately, there are many ways for physicians to get involved and advocate for our patients, in and out of the hospitals and clinics. Consider writing op-ed pieces for your local paper, sending a message to your State Senators and Congress people, even simply listening to your patients and encouraging them to get involved as well.

Regardless of your political affiliation or views on the state of the economy, health care, etc., becoming informed on the latest policy developments and getting involved in actively advocating for the best interests of our patients is our duty. It is as much a part of our oath as physicians and healers as First Do No Harm.

On that gray and rainy day marching on K street, with drops dripping from my jacket and muddy water seeping through to my socks, it was clear. We are the 99%.

Dr. Linda Hodes Villamar is a PGY 2 in Emergency Medicine at the University of New Mexico.

Tackling Obesity in New Mexico through a Resident-Founded Gardening Program

"Twenty-five percent of New Mexican children are obese. They have higher rates of depression and low-self esteem and experience more instances of bullying," said **Dr. Nate Link**, a University of New Mexico Pediatrics resident and CIR delegate. "It's driven by society and it's totally preventable."

Dr. Link has taken this epidemic head-on by establishing School Gardens for Health, a food growing program based in Albuquerque schools. When it came time to choose a project for the pediatric residency program's annual Childhood Advocacy Month, a school gardening program seemed just the fit. "I worked on an organic farm for a couple summers in college. Working on a farm really demystified the food production process. There's some technical knowledge, but essentially if you put a seed in the ground and take care of it, it will grow."

With funding from a Home Depot community improvement grant, Dr. Link set up a community garden at a local Albuquerque school and was thrilled with the response. "When things started growing, the students really wanted to eat them. We had kids fighting over broccoli."

But soon he realized a limitation. "I learned a lot about working with kids and realized how overworked teachers are," said Dr. Link. With a grant from Community Access To Child Health (CATCH), the program was able to incorporate lesson plans for local teachers and build gardens at two additional schools. Doctors and other health professionals also went into the schools to present on nutrition, how the body works, and New Mexico health statistics. This year, the program will also work with local chefs to run cooking classes—ideally using produce from the school gardens.

Additionally, the program will introduce medical students to motivational interviewing, an interviewing technique first used by clinical psychologists to move patients beyond ambivalence about their

Dr. Nate Link is a PGY 2 in Pediatrics at the University of New Mexico and a CIR delegate. He founded a gardening program for school children to mitigate factors contributing to obesity in Albuquerque.

conditions and adopt healthier behaviors. First and second year medical students will have the opportunity to interview five to ten families and learn methods of community-based research. "I've learned a lot in residency about motivational interviewing, said Dr. Link. "It's difficult for families with fewer resources to make the changes needed to improve health. We need to get families involved and we need to train people on techniques like motivational interviewing to do it."

UMDNJ Resident Testifies To Protect Hospital With Special Significance

On October 13, 2011, **Dr. Fatima Wilder**, a Newark, New Jersey native and surgery intern at University Hospital, sat in a hall waiting to testify on the value of the hospital to the Newark community. The panel who heard her testimony was the UMDNJ Advisory Committee, charged by the governor to evaluate the University of Medicine and Dentistry, New Jersey and graduate medical education in the state. The committee has the power to recommend mergers and closures of residency programs and medical facilities, and UMDNJ and its affiliate, University Hospital, are feeling the pressures of a state that wants to relieve itself of the financial burden of large safety-net hospital.

Dr. Wilder knows that the hospital, with its Level 1 trauma center, is essential for the community and provides excellent training from the cases she's seen in the OR, but her connection to the institution runs much deeper. It was the hospital that saved her brother's life after a near fatal shooting incident.

"I was 17 years old and in my senior year of high school. Around 10 pm, the police came to our front door and only my mother and I were home at the time," Dr. Wilder remembered. "My oldest brother had been shot close to where we lived and he was taken to UMDNJ.…It was definitely a shock, I was in disbelief and was pretty much in a daze for the days following.

"I just remember that the attending staff definitely took the time to explain everything that was going on to my

Dr. Fatima Wilder with her brother, Shetima, who was critically injured in a shooting incident in 2000. Shetima was treated at UMDNJ hospital where Dr. Wilder now trains as a surgical intern.

ACGME Honors D.C. Children's Resident for Quality Improvement Study

In September 2011, **Dr. Daniel DeSalvo** received a surprise phone call. He was to be the sole resident to receive the 2012 ACGME David C. Leach Award for his QI project "Can a Learner-Centered Diabetes Management Curriculum Serve to Reduce Resident Errors on an Inpatient Diabetes Pathway?"

According to the ACGME, the David C. Leach award "is unique in that it acknowledges and honors residents, fellows, and resident/fellow teams and their contribution to graduate medical education."

Unbeknownst to Dr. DeSalvo, a chief resident in Pediatrics at the Children's National Medical Center in Washington, D.C., his program director, the vice chair of medication and education, and his mentor Dr. Fran Cogan had nominated him for his study, which had demonstrated a greater than 50 percent reduction in resident-related errors as a result of the educational modules he had created with Dr. Cogan.

"I didn't know what it was for," said Dr. DeSalvo. "So I was surprised, humbled, and honored to receive this outstanding award. This really is a testament to my mentors and their guidance and encouragement.

"From my time as a resident I had noticed that there were medical errors occurring with Type 1 diabetes," said Dr. DeSalvo, who has an interest in medical education and endocrinology. He worked with Dr. Cogan to develop a multifaceted educational intervention that activates learners.

His colleagues worked through the four modules: one web-based; one interactive Q&A session; one that guides residents through a diabetes pathway; and one in which residents are presented with the hospital course of a make-believe patient where several errors were embedded in the case and residents had to identify the errors and figure out how to prevent them.

Dr. DeSalvo compared the sentinel and near-sentinel related medical errors secondary to Type 1 diabetes 10 months before and after the education

Dr. Daniel DeSalvo, a Pediatric Resident at Children's National Medical Center, won the David C. Leach Award for his research on medical errors with Type 1 diabetes patients.

intervention. "It was the Mecca of education intervention," he said. "Not only did it improve knowledge, but it also translated to improved patient outcomes.

"I felt incredibly pleased at the results and I was surprised by just how significant the decrease in errors was." His colleagues were equally impressed though less surprised at their dramatic improvement. "They really felt they were empowered with this new knowledge to provide competent and complete care," Dr. DeSalvo said.

At about six months after the intervention, Dr. DeSalvo noted that there was a spike in the number of errors that were occurring, and that an education booster emphasizing proper insulin dosing and communication between team members would be beneficial. When the hospital rolls out the education intervention again next September for the new residents, the course will include this booster.

"I definitely have a passion for education, and diabetes education in particular. We'd like to roll this out to members of multidisciplinary teams, including nurses and dieticians, and also possibly standardize these modules so they can be used at children's hospitals across the country."

Dr. DeSalvo will be moving to Palo Alto in July to begin a Pediatric Endrocrinology fellowship at Stanford's Lucile Packard Children's Hospital.

family and how they took care of not only my brother, but my family as well. They tried to make sure that we had whatever services we needed, like a chaplain or nursing care. And the nurses were very involved in making sure my brother was comfortable and getting what he needed.

"The shooting [left] him paralyzed but initially we just weren't sure what his life expectancy would be because he suffered a pretty severe injury. I believe that due to the high volume and variety of patients that the hospital sees with different levels of shock and types of trauma, as well as the training being so good, the trauma team was well prepared to handle what my brother presented with."

When it came to decide on a program for residency, UMDNJ simply made the most sense to her. "It wasn't really too difficult a decision to make when deciding where to go for residency. I'm emotionally invested in the program and what they did for my family….Without UH, I don't know where so many of the patients would get their care."

And she testified to that fact in front of the UMDNJ Advisory committee. "I'm invested in the success of the hospital and in ensuring that the people of Newark get what I believe is best for them in terms of quality health care. As a first year intern, I am going to be here for the next five to seven years and want to be able to continue to serve the community that I came here to serve."

Mythbuster: Is healthcare reform going to cut physician fees by 27%?

At the end of 2011, physicians across the country were startled to read headlines that unless Congress took action, all physician fees under Medicare would be cut by over 25 percent. Some naturally concluded this was a by-product of the *Affordable Care Act* (a.k.a., "healthcare reform") that Congress passed and the president signed in 2010. Others wondered if this was at all connected to the so-called "Super Committee" this fall, consisting of House and Senate members from both parties who attempted to iron out a package of $1.2 trillion in cuts to the federal budget.

In fact, it's neither. Instead, it's the result of a badly broken formula called the Medicare Sustainable Growth Rate (SGR).

The SGR became law as part of the Balanced Budget Act of 1997. The formula attempted to restrain the growth in healthcare costs by comparing the growth in cost per beneficiary under Medicare to the growth of the economy. If the growth of Medicare costs exceeded the growth of the economy, an automatic cut to physician fees across the board would bring the two in line.

This formula made some sense in the late 1990s, when the year to year growth of healthcare costs had begun to slow at the same time as the economy was booming. But in the decade that followed, as healthcare costs skyrocketed while the economy more or less remained flat before plunging into a recession, the flaw in the methodology became clear.

During that decade, Congress passed a number of extensions to prevent the SGR cut from taking place for that year and reimbursement rates remained the same. They usually did so without bothering to balance the budget impact by cutting the funding for other programs or creating new taxes equivalent to the amount of money Medicare would save if they allowed the cuts to go through. However, since they didn't fix the underlying formula permanently, the size of the potential cut ballooned in size. By the end of 2011, it would be a 27.4 percent cut to all physician fees to satisfy the requirements of the SGR.

Many pushed Congress to permanently fix the SGR as part of the *Affordable Care Act*, but that did not make it into the final law over concerns of what it would cost. Beginning last year, Republican members of the House and Senate began insisting for the first time that any delay in implementing the SGR be fully "paid for"—that there be cuts or new revenue equivalent to the money they would save by allowing the cut to happen. This has made it much more difficult to reach an agreement to postpone the cut, and on multiple occasions has gone right up to the deadline of the previous extension without a deal in hand. At the time that we write this, Congress is again struggling with finding a package of cuts and new revenue that both sides will agree to in order to delay the SGR, as well as extend unemployment benefits and the payroll tax holiday that was instituted in 2010. In short, it's political gridlock at its finest.

Bottom line: It's neither healthcare reform, nor the budget "Super Committee" that is responsible for the ongoing threat to cut physician fees under Medicare. It's a broken funding formula from the 1990s that with luck and lobbying will once again not be enforced in 2012.

Dangers of Fatigue on Joint Commission Radar Screen

The Joint Commission issued a *Sentinel Event Alert: Healthcare worker fatigue and patient safety* on December 14, stating that: "The link between healthcare worker fatigue and adverse events is well documented, with a substantial number of studies indicating that the practice of extended work hours contributes to high levels of worker fatigue and reduced productivity." The evidence shows that fatigue increases the risk of adverse events, compromises patient safety, and increases risk to personal safety and well-being."

In the Sentinel Alert, the Joint Commission makes several recommendations to "help mitigate the risks of fatigue that result from extended work hours—and therefore, protect patients from preventable adverse outcomes."

The Alert also makes three safety culture recommendations:

- Provide opportunities for staff to express concerns about fatigue. Support staff when appropriate concerns about fatigue are raised and take action to address those concerns;
- Encourage teamwork as a strategy to support staff working extended work hours;
- Consider fatigue as a potentially contributing factor when reviewing all adverse events.

The Joint Commission accredits and certifies more than 19,000 healthcare organizations and programs in the U.S.

The Sentinel Event Alert is a newsletter that identifies specific types of sentinel events, describes common underlying causes, and recommends steps to prevent future occurrences. Past Sentinel Alert topics have included medication errors, wrong-site surgery, blood transfusion errors, fatal falls, and intimidating behavior. Download the Sentinel Alert on fatigue at **http://bit.ly/jcfatiguealert.**

Medical Students Train to be Physician Leaders

CIR's work with medical student organizations continues to expand. Here are some highlights of leadership-building activities that medical students have engaged in over the past year:

- The American Medical Student Association's (AMSA) Empowering Future Physicians' conferences featured collaborations with CIR to train medical students in grassroots organizing skills and on the importance of addressing disruptive behavior from professionals for improving patient safety.
- CIR delegate Dr. Elizabeth Homan Sandoval from Jackson Memorial Hospital led an advocacy workshop at last year's Latino Medical Student Association (LMSA) national conference. CIR has also been invited to speak on Residency Life and Advocacy at this year's SNMA national conference.
- Following an official endorsement of the Occupy Wall Street movement, AMSA organized a demonstration of health professional students and practitioners in New York City who spoke out to promote health equity. Their voices were joined by virtual supporters from around the country, successfully taking a stand with the 99%.
- Representatives from AMSA, LMSA, Student National Medical Association (SNMA), and Asian Pacific American Medical Student Association (APAMSA) attended the 2011 CIR National Convention.

Introducing www.cirseiu.org/medical-students

Medical students can find additional information, including resources, educational materials, residency advice and the popular video series "Ask a Resident" on the new med student page.

advice from residents to med students

Learning on the wards

It's important to make the most of your time in the hospital and learn the ins and outs of each department. Here are 10 ways to shine on rotations and begin shaping your career.

10. Be diligent. Be prompt or early! Don't be the first to leave, and ask how you can help. Being attentive and on time is respectful of your intern and team.

9. Less is more. Be concise. Master the skills of a 30-second, 2-minute, 15-minute, and 1-hour presentation.

8. Sit down when you can, eat when you can, and go home when you are allowed to. Remember your own basic human needs. Medical education and training is a marathon, not a sprint.

7. Keep an open mind during *every* rotation. You will learn something important in every rotation, so use this opportunity to think about your specialty selection. (Even if you think you're an internist in the making!)

6. Do your homework, but don't be afraid to ask questions. Start your readings immediately and remember that attendings are often more forgiving with medical students' "silly questions" than those of residents, so ask now!

5. If you don't know, say so. For reasons that will soon become apparent, it is better to admit what you don't know than to pretend you know everything.

4. Be a team player. Have respect for team members and take the initiative on literature searches or start a journal club if your program doesn't already have one.

3. Pick a mentor and take notes. Find a resident or an attending you admire and ask your mentor to review your patients' notes with you—you'll learn more from someone you respect.

2. Did we say work as part of a team? Nurses, techs and doctors all work together. Be humble and respectful and never bad-mouth anyone.

1. Talk to your patients! Know their cases and stories inside and out. Ask them how it feels to be a patient.

— by Dr. John Ingle, CIR Executive Vice President, Laryngology Fellow, University of Pittsburgh Medical Center

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We've launched a new section for ***Resources and Opportunities***. Here you'll find:

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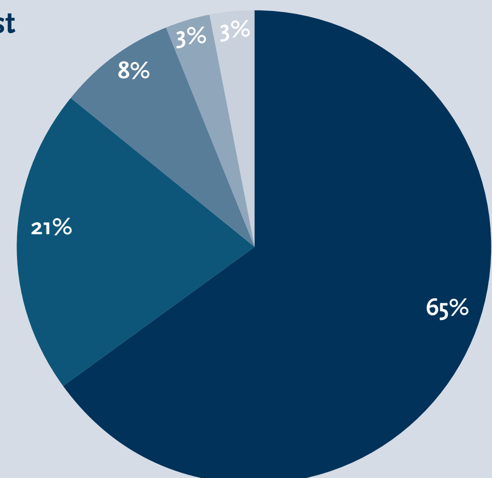
- Quality Improvement in Your Hospital
- Medical Malpractice and Alternatives to Litigation
- Work Smart: Adjusting to the New ACGME Schedule
- Healthcare Reform and What It All Means
- Educational opportunities like conferences, fellowships and awards

at cirvitals.org

Answer this issue's poll question: How can physicians make the most impact outside of the hospital to improve health disparities?

Results of last issue's poll:

What mobile app do you find the most useful in your daily work?



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