CIR VITALS

Winter 2013

Residents & Finance

INSIDE THIS ISSUE

PRESIDENT'S REPORT | JOHN INGLE, MD

See You Later, not Goodbye

This will be my last *Vitals* column as the national president of the Committee of Interns and Residents. The next edition of *CIR Vitals* will be addressed by the new president, soon to be elected. I will complete my term in May 2013. It has been an honor to serve CIR members, my hospital, my colleagues, their families, and our patients during the last seven years with CIR. I can only hope that the changes I have helped to bring about at the University of New Mexico will continue to positively affect the lives of doctors and patients.

I humbly thank all the resident leaders at **UNM** whom I learned from and worked closely with.

Make sure to address your basic needs of sleep, nutrition, exercise and harmonious relationships so that you can be your best to everyone around you.

The leadership, team building and negotiation skills that I have learned with CIR are invaluable to my future success as a physician champion for change. I am prepared to lead the way as many CIR alumni do. Below you will find some hard lessons I learned – things that I think residents and fellows need to do more often, so that we can make our hospitals and clinics a better place for patients and for learning.

1. Give constructive, real-time feedback. Don't save your compliments and constructive criticisms for evaluations every six months. Let those who you work with understand what they are doing well and what they could do better. Face-to-face communication

in the appropriate setting goes a long way to building great relationships and improving the way work gets done. Choose your criticisms carefully: for every critique you should provide three compliments.

2. If you see something, say something. There are a lot of skeletons that lurk behind the scenes when it comes to medical mistakes, work-hour violations, medical ethics and academic competition. Patient safety and professional integrity is something we all should hang our white coats on. It is not always comfortable to speak up, but it is the only way that change occurs.

3. Take the extra time to connect with your patients and their families on an emotional level so that they know that you really care about their health.

4. Be part of a team. We work with a lot of professionals in all areas of the healthcare system. They have all spent a long time learning and working toward their respective areas of expertise. Spend time to learn from health professionals around you. They will make you a better doctor.

5. Give respect, get respect. Everybody in our field works hard. Hard work breeds fatigue. Fatigue breeds attitude. Attitude breaches respect. Make sure to address your basic needs of sleep, nutrition, harmonious relationships, and exercise so that you can be your best to everyone around you.

6. Make every second count. I found that with staff support, timely information and the collective strength of thousands of other physicians, CIR allowed me to strategically use my time to maximize my impact.

CIR VITALS
Committee of Interns and Residents/SEIUHealthcare

Committee of Interns and Residents of SEIUHealthcare

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Cover Art: Data taken from a 2012 nationwide survey of CIR members conducted by Lake Research Partners.

Metro NY Labor Communications Council

CIR Members Lobby Congress Around Fiscal Cliff Deal

"It's so sad to see people die because they don't receive the quality care they need. They have no money to buy medication and no money to go to the doctor. It's absurd." –Dr. Ricardo Correa

On Nov. 28, members of CIR and 33 unions across 24 states gathered in Washington, DC to rally for "Jobs not Cuts" and ask Congress to reach an alternative deficit reduction deal in order to save vital social programs.

The fiscal cliff referred to more than $500 billion in tax increases and across-the-board spending cuts that were scheduled to take effect after Jan. 1 unless the president and Congress reached a deal during the lame duck session.

A deal was finally reached on Jan. 1, but it was only a temporary fix, and social service spending cuts are still on the chopping block for 2013.

"When you're a medical resident you see so many things that happen to patients because they don't have money," said Dr. Ricardo Correa, an internal medicine resident at Jackson Memorial in Miami and CIR Regional Vice President. He and colleagues at the capitol emphasized the need for Congress to invest in jobs that will lead to more access to health care. Equally concerning to Dr. Correa were the many cuts on the table that could potentially impact social programs such as education, social security, federal food aid programs and public housing—issues that have a direct impact on the health of communities.

The union members participated in a one-day training before the lobby day to fully understand the many ways these potential cuts could affect their communities.

"As residents, we don't always think about how these politics affect other professions like bus drivers and teachers, or people with disabilities," said Dr. Correa. "Not just my patients at Jackson will be affected, but others as well."

During medical school, Dr. Correa recognized that a physician's leadership should include patient advocacy. "Even thinking about these cuts just to save money is something I cannot understand. They don't consider cutting war spending, but instead consider cutting vital programs like education and health care. Health care is a right that every human has."

Jackson Memorial Hospital Negotiates

Over 700 residents at Jackson Memorial in Miami signed a petition telling their administration to "Do No Harm" to residents and patients during contract negotiations in response to the hospital's first contract proposal which would strip away many of their benefits. Pictured above: The JMH bargaining committee.

NYC Residents Tackle Health Disparities

In early October, CIR members and physician allies came together to discuss minority health and healthcare inequality in New York City as well as the struggles underrepresented minorities face in the medical profession.

As one of the most diverse cities in the world, New York faces unique challenges in treating all of its communities. CIR members face these challenges daily. In 2007, Black non-Hispanics had the highest rates of diabetes hospitalization and mortality, as well as the highest adult prevalence of diabetes and obesity. Hispanic/Latino residents reported the highest percentages of fair or poor health and poor mental health compared to other racial/ethnic groups. Asian non-Hispanics experienced a percentage of premature death (before age 75 years) at a rate 44 percent higher than among White non-Hispanics. *[New York State Minority Health Surveillance Report, 2007, New York State Department of Health.]*

With a panel of distinguished speakers including SEIU Healthcare's physician chair, Dr. L Toni Lewis, CIR members asked the hard questions about the social inequities that plague the healthcare system and what their role is in addressing these inequalities. Attendees identified disparities as a key issue to prioritize at the local and national levels and plan to host more events in 2013.

RESIDENTS & FINANCE

MEDICAL EDUCATION DEBT IS THE LARGEST FINANCIAL CONCERN OF MANY RESIDENTS. ACCORDING TO A SURVEY CONDUCTED BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES,THE DEBT MEDIAN FOR THE CLASS OF 2012 WAS $170,000, AND 17 PERCENT OF RECENT GRADUATES ARE IN DEBT FOR $250,000 OR MORE.

DID YOU KNOW?

- All student debt has increased by over 500 percent since 1999. [Federal Reserve Bank of NY, 2012]
- Student debt passed the $1 trillion mark in 2012. [Consumer Financial Protection Bureau]
- The delinquency rates for student loans is higher than the delinquency rate for mortgages, auto loans, and credit cards. [Federal Reserve Bank of NY, 2012]
- 86 percent of medical students graduate with debt. Average debt burden = $162,000. [AAMC 2011]
- 91 percent of osteopathic students graduate with debt. Average debt burden = $205,674. [AACOM 2011]
- Only 36 percent of law students and 15 percent of MBA, PhD, MPH, DDS, etc. graduate with debt.
- More than 60 percent of medical students come from families with income in the top quintile—and this has been true for the last two decades. The bottom three quintiles of family income together account for about 20 percent of medical students. [AAMC 2004]

In a 2012 survey of interns at seven CIR hospitals:

- Approximately 53 percent had more than $100,000 in educational debt.
- Approximately 30 percent had more than $200,000 in educational debt.
- Of those with greater than $100,000 of educational debt, 87 percent are concerned about this problem and 56 percent are "very" or "extremely" concerned.

GL ADVISOR

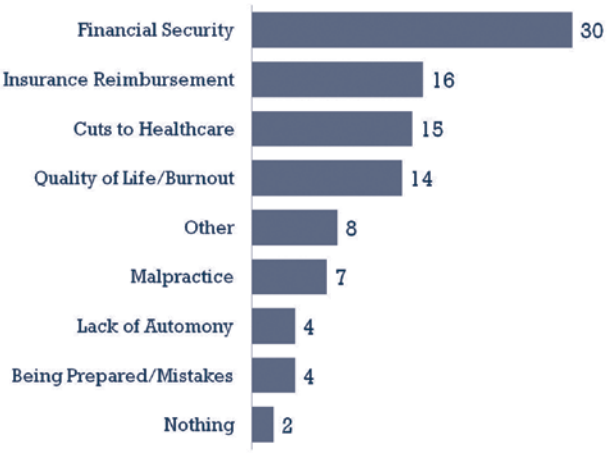
A NEW CIR BENEFIT TO HELP YOU MANAGE YOUR FINANCES

In November, CIR launched a new benefit just for members to help you manage medical school debt. GL Advisor is a full-service financial advisory firm that specializes in assisting recent medical graduates with managing their student debt. GL Advisor serves as a much needed advocate to help clients lower the cost of debt, obtain payment relief as needed, and save them time so they can focus on their career. Some of the services include:

- **A Personalized Financial Plan**
- **An Assigned Financial Advisor**
- **Tax Preparation Services**
- **Professional Investment Advice**
- **Additional Financial Services like rent vs. buy analysis and mortgage support**
- **And all these services are available to your spouse or domestic partner at no additional charge.**

You could save $60-$125 on the annual service. Visit the CIR website to learn more and claim or your discount. www.cirseiu.org/GLAdvisor

In a 2012 survey of 354 CIR members, three in 10 residents said their top concern is financial, including loan repayment.



Word from the Wards

Residents discuss their financial worries

Charmi Shah, PGY 1 Family Medicine VCME, Modesto, CA:

"One of my greatest concerns is obtaining financial security without compromising my career and life goals."

Phillip Murray, PGY 3 Psychiatry Cambridge Hospital:

"Residents are expected to work hard and not seem concerned with finances with the assumption that when you graduate you'll be financially stable. As a result, there is no effort to educate residents about even basic financial concepts—the only place I've gotten that kind of information is CIR."

Kurtis Kaminishi, PGY 3 Psychiatry, LAC+USC:

"It's really hard to balance loans—we have a lot of debt. The constraints with time and money are really different for residents; when it comes to buying a home, mortgages, paying into equity early is important. As residents we're taking a different course and that's a concession we make."

Post-Residency Contracts 101

At a recent post residency life workshop in New York, guest speaker Robert Stulberg, Esq said, "Through your residency you have had excellent employment protections. The reason you've had those protections is that you are represented by CIR, which has negotiated a collective agreement for you. When you step out of your residency, all that will end.

"Although your bargaining strength may not be equal to the bargaining strength of your potential employer, don't forget that you also come to the bargaining table with strengths. Some of these strengths include medical knowledge and training, your expertise in a field of research that can be used to attract government or corporate grants, and your ability to serve in high-need communities and build long-lasting relationships with patients."

Are you negotiating your first contract after residency? Mr. Stulberg offers the tips below.

CONTRACT ESSENTIALS:

A contract is a bilateral agreement that contains a legally enforceable promise that is supported by consideration—the legal term that refers to any bargain—for advantage or disadvantage given by one party to the other. A valid employment contract for physicians should answer the following:

- Who are the parties to the contract?
- What are the duties of the employee/what position is he or she going to occupy?
- What compensation will be provided to the employee? That includes wages, salary and benefits.
- What is the duration of the contract and under what circumstances can it be terminated?

OTHER PROVISIONS:

Physician employment contracts are likely to contain other provisions, such as non-compete agreements or restrictive covenants, malpractice insurance, and termination clauses.

Whether or not you will be able to negotiate changes to these provisions, you should at least be sure you understand what they mean so you can make an informed decision as to whether to accept the terms of the contract offer.

TIPS:

- Speak to other physicians about the hospital or medical institution you are considering.
- Find out what you can about the financial stability of the employer.
- The potential employer is going to be represented throughout this process by an attorney; therefore, it would be to your benefit to consult with an attorney before engaging in negotiations and/or signing a contract.

Public Service Loan Repayment

The **National Health Services Corps**, a federal program, provides scholarships for medical school as well as repayment programs for graduates. Those who wish to apply may do so from any state and must agree to work in an NHSC approved medically underserved location for at least two years. Corps members can receive up to $60,000 in loan repayment for two years, and may apply for additional service to continue their debt reduction.

In addition to the NHSC, many states have similar loan repayment programs. Physicians of any specialty with a connection to New York State – those who graduated from a New York State high school, college, or medical school or have done their residency at a New York hospital – are eligible to apply for **Doctors Across New York**, which will provide up to $150,000 over a five year commitment to work in an underserved area of New York. New Mexico residents may apply for the **Health Professional Loan Repayment Program** in order to earn up to $35,000 per year towards loan repayment for two years of service in a medical shortage area of New Mexico.

Other states have similar programs for qualifying physicians – find out about other opportunities at **www.cirseiu.org/loanrepayment.**

UNM Alum Balances Life and Debt in the Alaskan Wilderness

Dr. Kristen Widmer, a family physician and University of New Mexico alumna, recently began working with a non-profit tribal health consortium of 18 Native communities in Southeast Alaska. Through this work she has qualified for a loan repayment program offered by the state of Alaska for physicians working with underserved communities. Dr. Widmer's story outlines how public service loan repayment programs can be a win-win for patients and providers.

Tell me about the work you are doing with the Southeast Alaska Regional Health Consortium [SEARHC].
I provide primary care at the main hospital for the region. Our facilities in Sitka on Baranof Island are the healthcare hub for 18 rural villages. Our patient population is Alaskan Native—Haida and Tlingit mostly. I work in the main Indian Health Service facility most of the time doing primary care clinic, urgent care, emergency room, inpatient medicine, and obstetrics. Each one of the family physicians has a village that they travel to. Every six to eight weeks I go to Huna, a beautiful seaside community of about 800 people that lies across the bay from Glacier Bay National Park.

What is a village visit like?
Usually they are about one week long. Some people go by bush plane, float plane, or ferry, leaving on Sunday and coming back on Friday. There are no roads connecting the towns and villages of Southeast Alaska, so I either get to Huna directly by bush plane, which is about a 30-minute ride, or by ferry from Juneau which takes about three hours. Both methods provide great views of the seas and mountains, especially on clear days. There is only one restaurant and very limited produce at the one grocery store, so I bring a cooler full of food to the nice lodge where I stay. In many of the villages, physician assistants, nurse practitioners, and community health aides manage patient care when the doctor isn't there; I mainly see the more complex patients as well as OB patients.

Tell me about the loan repayment program you were able to apply for with this position:
I'm getting loan repayment through a program called SHARP (Supporting Health Care Access through Loan Repayment), a new state program specifically for primary care doctors. The application process was pretty straightforward. I had to fill out a short form and send some paperwork to each of my loan companies to validate that the loans were taken out for educational purposes. Recipients are prioritized based on the needs of the patient population. I have been accepted and will receive $35,000 per year tax-free on top of my salary. I should have my loans paid off in three years!


Dr. Kristin Widmer

What has been most surprising about your work?
I thought the biggest challenge would be doing inpatient work and juggling the management of OB patients while doing primary care clinic—but actually it has been seeing patients in Huna. I have been surprised by the complexity of cases there—rheumatological conditions, cancer, transplant patients—things I haven't managed before.

What made you want to work in rural Alaska?
Prior to doing my residency, I worked up in Nome, AK doing community health aide training. I really loved living there and being a part of a small community in a far corner of Alaska. The intensity of the weather and geography inspires art and music and brings people together in beautiful and unusual ways. I loved having access to unlimited back country that is by far some of the most spectacular in the world. By the time I finished my training, I was longing to come back. Sitka provides not only beautiful scenery, but also great hiking, fishing, sea kayaking, and backcountry skiing. I've just bought a sailboat and am learning how to sail as well.

What have you learned so far in this work?
I've learned that no matter what, I have to do some basic things—eat, sleep, exercise, and play outside. Otherwise I'm no good. I've also learned I need to take time and build relationships with my patients, which can be just as therapeutic as medical intervention.

What words of advice would you give a physician considering the kind of work you're doing now?
I'd encourage people interested in broad-based, rural work to take an away month in residency to try it out. The Indian Health Service is a great place to start. Just like finding a residency, it's about finding a place where your quality of life is going to be good.

Learn more about the SHARP loan repayment program: **bit.ly/sharploanrepay**

SPECIAL REPORT

Hurricane Sandy

RWJ: Hope in the Midst of the Storm

DR. CHRIS MENDOZA, EMERGENCY MEDICINE, PGY 2
Robert Wood Johnson University Hospital (UMDNJ)

People who go into emergency medicine—doctors, nurses, techs—most of us go into it with the ability to thrive in chaotic, hectic situations. After Sandy, the day-to-day moaning and groaning about the job disappeared and everyone put on their working hats because we knew we were going to be there for several days in a row.

When it comes to disasters, emergency personnel are essential. More than anything, our preparation included clarifying our schedules. Everyone needed to know where they were going to be and where their colleagues would be.

The hospital administrators were amazing—they opened up the atrium, a space about half the size of a football field, to patients, their families and staff, and provided cots and a warm place for people to sleep. It was overcrowded, but most people were just happy to be somewhere that had heat. I'm always impressed by the job that a lot of the people I work with do, especially under these kinds of circumstances.

Clinic closings added to the patient load, but there was also a large population of people, mainly elderly, who needed electricity to administer their medications, or to use machines at night that help them breathe. I had a couple of patients who were displaced from Atlantic City and they were bused to shelters in New Brunswick.

One patient stands out in my mind. He was maybe 60, HIV positive and an ex-IV drug user who now works in a deli. He came in because he was short of breath. It turned out that he had pneumonia, which is concerning for someone like him. When we met, he was a super nice, sweet man. All he wanted was a hot meal because he hadn't had one in three days. I told one of the nurses in emergency and she volunteered to help. Shortly afterward, the nurse told me that the same patient was about to walk out against medical advice. When I went back to see him he said, "I can't eat his crap, there's not even any meat," it was a drastic change from the man that

Dr. Chris Mendoza

I had met just 30 minutes before. When I asked him what happened, he broke down and started crying hysterically. He had no idea about the state of his home and the shelter was closing that day.

"Everything I own is in two little bags," he said. "I need all my medications. I need everything. If they close the shelter I'm going to lose it all. And how am I going to get back to Atlantic City if they bus everyone back and I'm in the hospital?"

He was in a very tough place, but through several phone calls back and forth to the shelter, in the midst of a very busy emergency room, the nurse and I were able to find a Red Cross volunteer willing to pick up his belongings and bring them to the hospital. Everyone came together for this guy. I know it sounds strange, but as an emergency room doctor you don't usually get to help patients in that way.

The experience was stressful, but it brought staff members together because we're a team—we're a good team. Everyone understood the situation we were all in and everyone at the hospital was pretty wonderful under the circumstances. It was sweet. It's one of those things that gives you hope.

CIR Members Confront Superstorm Sandy, a Disaster of Historic Proportions

On October 28, 2012 Superstorm Sandy hit the New York/New Jersey region, causing devastation and disruptions to millions along its path. Residents at CIR hospitals were on the frontlines of patient care and many lost access to their places of residence or were displaced entirely by the closing down of their hospitals. Though the storm represented a profound test of our safety net, CIR residents and fellows—working with nurses, attending physicians and all the other members of the healthcare team—rose to the occasion, providing compassionate care under punishing and complex conditions. The following articles represent just a few of the stories of CIR members illustrating their challenges, triumphs and reflections in the aftermath of the storm.

A Night to Remember, Hurricane Sandy and the Trauma that Unfolded

DR. DABANJAN BANDYOPADHYAY, GENERAL SURGERY, PGY 5
St. John's Episcopal Hospital, Far Rockaway, Queens

The day of the hurricane proved to be much tougher than I originally anticipated. I expected a storm outside and calm inside, but when it rains it pours. There was no transportation and roads were closed down. Even the ambulances weren't operating the day of the storm. Some of the homes near the hospital had flooded and many of their cars were completely totaled. I hadn't fully grasped the enormity of this hurricane and its effects on the Rockaways and how our proximity to the water would affect so much.

After a hectic day of bedside procedures, inpatient needs, and a bustling emergency department, a young patient was dropped off at the hospital the night the storm hit. He had sustained a gunshot wound to the abdomen. His vitals were stable at the time, but he was in and out of consciousness. He was 16 years old. When he arrived, the main power to the hospital had gone out, and we were dependent on emergency generators. As the frantic scene unfolded before my eyes, I tried calling the attending surgeon, but the phone lines were down.

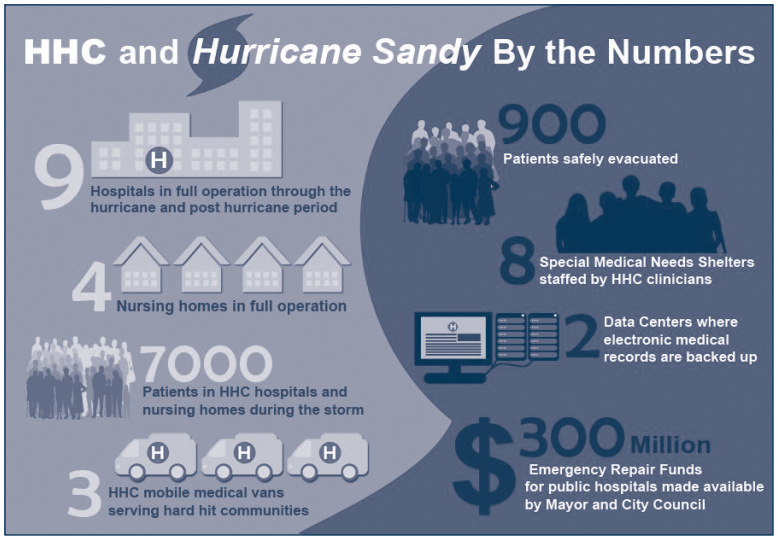
My team and I called down the list of attendings, including general surgeons, vascular surgeons and urologists—all to no avail. I realized that precious time was passing, so I made a decision and spoke to the Chief Medical Officer. I decided the safest place for the patient would be in the operating room in case any life-saving action was necessary, and for the eventual exploration of the abdomen that was looming. The CMO agreed.

We were finally successful in contacting both the on-call attending surgeon and the chief of surgery, but the phones cut out during our conversations and they were again unreachable.

The OB/GYN attending came to the OR to help in the exploration of the patient. He lay on the table, intubated. I stood above him, scalpel in hand as the Chairman of Surgery made it to the OR, rushing from his house after the dropped call.

Reviewing the X-ray films taken in the emergency room, we realized how lucky our patient was. The bullet missed his spinal column, aorta, spleen and other vital organs by the narrowest of margins. Not only did he get shot in the hurricane, he came to a hospital running on backup power, with overworked employees, and attendings willing to risk their lives in order to save his. While the odds were against him, we were able to repair the damage to his bowels. The next morning, he woke up and thanked all of us for the decisive actions we took on that harrowing night of the storm.

This article is taken from an interview and first person account written by Dr. Dabanjan Bandyopadhyay.



SPECIAL REPORT
Hurricane Sandy

Inside the Bellevue Evacuation – One Resident's Story

DR. MARC MANSEAU
PSYCHIATRY, PGY 4
Bellevue Hospital Center, New York

As the storm raged outside, I sat in my relatively unscathed apartment and neighborhood in Brooklyn watching and reading in horror as one catastrophe after another fell upon the medical center where I had spent the past three-plus years working and learning.

First, NYU-Tisch Hospital was evacuated emergently as the storm surge flooded the basement and the backup generators failed. Then, before NYU's email system went dark, I learned that the research animal facilities were compromised. I pictured years of hard work and numerous experiments on the verge of breakthrough going down the drain. Next, I learned that Bellevue was running on backup generators and was initiating a partial evacuation.

Bellevue is the heart and soul of the NYU psychiatry residency program. A public hospital with over 300 psychiatric beds and one of the busiest psychiatric emergency rooms, it provides care for some of the sickest, most disadvantaged people in the city, country and world. Many of us choose the program largely because of Bellevue, and through our training, grow to love it and the service it provides in a deep and complex way.

So when I received an email from one of our chief residents on Tuesday morning asking for residents to come in and help out, I barely left time to brush my teeth. The scene that I encountered when I arrived was surreal. The hallways were dark and eerily quiet. The National Guard was everywhere, and the smell of the generator diesel hung pungently in the air. It was one of those moments when life imitates fiction, and it felt like I was living out some sort of post-apocalyptic television plot.

It quickly became clear that the main task was to let the administrators and physician leadership figure out what needed to get done, while trying to keep the hospital functioning at a safe level and get as many patients out as possible. For the heroic staff present during the hurricane, this meant creating a human chain from the ground to the thirteenth floor to pass fuel up to the generators before the National Guard arrived to take over the task.

As Tuesday turned into Wednesday (many of us lost track), psychiatric administrators and staff worked furiously to get patients discharged or transferred. It seemed like I saw Bellevue's director of psychiatry every time I turned around, her demeanor somehow as sweet and openly caring as ever. I worry that the pregnant director of consultation liaison psychiatry did not leave or even rest for days as she helped coordinate the safe transfer of hundreds of patients who could not be safely discharged to other local hospitals.

After the official evacuation order was announced that Wednesday afternoon, the pace of the work picked up. We had to get everyone transferred by Thursday at noon. The National Guard showed up to mass-evacuate a unit just as we were signing the very last piece of paperwork.

This experience left me with many lessons. I have come to respect my supervisors and colleagues more than I could ever imagine. I have also been reminded of the vital importance and value of rigorous, intensive clinical training – training that prepares you for anything in clinical work and, to a certain extent, in life.

Finally, I can't help but strike a bit of a political note. This disaster and response reminded me that how we choose to value each other and work together as a society matters in a profound way. Bellevue is a public hospital, funded with taxpayer money, with a mission to take care of all comers, regardless of class, insurance, race, gender, sexual orientation, or immigration status. If Bellevue didn't exist, far fewer patients in New York City (particular psychiatric patients) would have access to the skills, dedication, and passion of so many talented healthcare workers.

And Bellevue would not have been able to safely evacuate all of its patients over a series of a few days without the coordinated effort of the local, state, and federal governments, including the National Guard. In the national discussion about the size and role of government, I hope that we can be rational and intelligent about what government actually does and what the human costs of drastic cuts would be, especially as our country confronts multiple colossal problems including the increasing effects of climate change.

Highland's History of Patient Advocacy

This year marks Highland Hospital/Alameda County Medical Center's 14th anniversary in CIR, but ACMC housestaff have been organizing and taking collective action since long before they voted to join CIR.

Residents at ACMC have been at the forefront of patient care and organization efforts for decades, advocating for the inclusion of resident voices in healthcare policy decisions.

In 1991, as the effects of massive budget cuts and layoffs in California were becoming painfully clear to physicians throughout the state, the housestaff at Highland Hospital educated the public on the consequences of inadequate public health care and lobbied elected officials to stem the tide of hospital layoffs and community clinic closures.

One especially dramatic and evocative action was the staging of a Die-In outside the hospital. Dozens of residents marched outside and then "died," laying out on the ground with tombstones noting the causes of death related to inadequate hospital care.

"DEAD because of $6 million budget cuts," read one tombstone. "DEAD because my emergency lab result took hours," said another. Following the protest, a county poll showed that 83 percent of voters would support raising taxes to help fund public health services.

Prior to joining CIR, ACMC residents had an independent housestaff union, the Highland Association of Interns and Residents (HAIR).

Residents employed the same tactic one year prior, in the midst of a five-month contract dispute with Alameda County. More than 35 residents marched to the Alameda County Offices and staged their Die-In in order to call attention to their concerns about the quality of care at the hospital and the need for residents to have a voice. Their actions helped settle the dispute, and their new contract was drawn up to include negotiating rights around curriculum, numbers of housestaff and improved working conditions with wage increases, call limitations, an affirmative action fund, and other gains.

New Highland Contract Prioritizes Patients and Residents

ACMC residents settled contract negotiations in October 2012, resulting in gains for all PGY levels and investments and patient care and safety..

The Patient Care Fund was increased to $70,000, a $10,000 increase from the previous contract. An additional $10,000 was set aside to fund QI projects in the hospital.

CIR members also recognized the importance of cultural competence in medicine and negotiated for a $15,000 diversity fund to recruit and retain applicants who are more representative of the patient population in Alameda County, which is primarily Latino and African American— a continued effort since the affirmative action fund negotiated in 1990.

"I was impressed by the congeniality and sense of common purpose found in re-negotiating the resident physician contracts with Alameda County Medical Center," said Dr. Dominick Maggio, a PGY 2 in emergency medicine. "This helped prove to me that the entire organization is dedicated to the same value of serving the underserved."

Chiefs at the hospital also benefited from this round of negotiations. While a salary differential was expected for all chiefs, not everyone had received payment. The new contract addressed this with a one-time payment for all chiefs. Equally important was a 12 percent cap on any healthcare premiums that might increase—becoming a direct cost to residents. Residents also received extra funds for attending medical conferences.

Through this latest round of negotiations, housestaff continue the legacy of patient advocacy and strengthening physician community at Highland.

The Alameda County Medical Center Bargaining Committee.

Maimonides Residents Gain Notice for Medication Reconciliation

In the first year of a new quality improvement project, residents at Maimonides Medical Center in Brooklyn, NY have significantly improved medication reconciliation, showing improvement of up to 44 percent in some departments. The results of the resident-driven quality improvement project will be published this spring in the *American Journal of Medical Quality*.

The medication reconciliation project was the first QI initiative undertaken after CIR and Maimonides negotiated a collective bargaining agreement in November 2010 that established a QI incentive program for housestaff.

"As residents we felt it was very important we tie in the benefits we were getting in our contract with the care we were providing to our patients; we wanted to connect those two in some way," said Dr. Michael Kantrowitz, Chief Resident in Internal Medicine, in a presentation at the Partnership for Quality Care (PQC) conference in Washington, DC this past fall.

"We decided there were three core elements," Dr. Kantrowitz explained. "It had to be patient focused. We didn't want this to be something that happened on paper, we wanted to see results in our patients' care. We really wanted a process that we could own and improve. And finally, we really wanted to be able to measure it."

Both residents and administrators saw an opportunity with the rollout of a new Electronic Medical Record system, which gave them a window to examine how medications are managed during transitions of care. When they reviewed the data, they saw problems with dosage changes not being communicated.

"A patient would be on one dose of a medication in the hospital and be discharged on a different dose without any clear reasoning as to why," Dr. Kantrowitz said.

"So we saw these problems, and it scared us as residents and scared the hospital administration and that made medication reconciliation even more important to us."

Residents from all departments worked with the organizational performance staff and Maimonides Vice Chair of Medicine Dr. David Cohen to develop and refine a chart auditing process. The EMR, handwritten progress notes, and the list of medications patients were given on their way home were compared to assess the safety of the discharge process.

"Since residents do the bulk of that work, it was really important that we have the input into redesigning the process," Dr. Kantrowitz said. "We needed to ensure that it was conducive to our current work flows, including our rounding process and our overall discharge process, so that was really the context of when medication reconciliation was done.

After a year of work that included intensive peer education and faculty support, Orthopedic Surgery, Psychiatry, and Internal Medicine showed increases in quality of 21 to 44 percent. Other departments continued to analyze their results and strive for improvement. Residents who met their target received bonuses according to the CIR contract. But Dr. Kantrowitz said improving patient care and resident ownership over the project ultimately drove its success.

"We didn't have the higher ups in the hospital telling us what to do, we told them what we needed to fix and how we were going to fix it, and they gave us the institutional support to do it."

To see a video of Dr. Kantrowitz's presentation on the Maimonides Medication Reconciliation project, visit **www.cirseiu.org/medrec.**

QUALITATIVE IMPROVEMENT				
	BASELINE Resident Chart Review May 2011	Target	Resident Chart Review May 2012	% Improvement
Medicine	57%	77%	89%	32%
Ortho	39%	59%	71%	32%
Psych	39%	59%	83%	44%

Share Your QI Project

CIR will be launching a new website devoted to quality and patient safety. You'll be able to share your QI work and get useful feedback from peers and experts, check out resident-run projects, pick up essential QI and patient safety tools, and find out what's going on in patient safety and quality at your hospital. ***To submit a quick abstract of your ongoing or completed project, please email vfernandez@cirseiu.org for the project template.***

Telluride Roundtable Produces Resident Patient Safety Projects

Dr. Nate Margolis, a PGY 4 resident in Radiology at Bellevue Hospital Center, has maintained an interest in patient safety throughout his residency, but last year's Telluride Conference helped to reinvigorate his passion. "I decided to go into medicine because I wanted to help people, and I felt that medicine was a rewarding field in terms of being able to promote health to the community at large," said Dr. Margolis.

The Telluride Patient Safety Conference, held in Telluride, Colo., was founded eight years ago by Drs. David Mayer and Tim McDonald of the University of Illinois Medical Center. Last year's conference provided an opportunity for residents to discuss strategies for improving patient safety. CIR and partnering hospitals sponsored nine residents—all committed to implementing patient safety projects in their own hospitals.

Dr. Margolis shared his experience of how the conference inspired him to create the *badge buddy,* a tool for residents to facilitate adverse event reporting.

At Telluride, residents had the opportunity to build relationships across hospitals and specialty, sharing experiences and challenges. One common theme was the difficulty in reporting errors and near misses. The process of reporting medical errors varies widely across institutions, and many residents are unaware of how to report them, Dr. Margolis said.

Dr. Nate Margolis, far right, with fellow CIR Telluride scholars.

"One thing that struck me was Tim McDonald's advice, 'On the first day of residency you should learn where your locker is, where your beeper is and where to report patient safety errors.' It was something I had never thought of before, and I don't think residents normally do. That was the genesis of the badge buddy idea," said Dr. Margolis.

After Telluride, Dr. Margolis connected with administrators and residents who were forming the NYU Medical Center Patient Safety Council. Error reporting was an important issue for both administration and residents. It was there that Dr. Margolis presented the badge buddy idea—a badge that would instruct residents on how to make an adverse event report. The council lauded the idea as a low-cost, high-yield way to begin addressing the issue.

Bellevue residents rotate between NYU Medical Center, Bellevue and Manhattan VA Hospital. Since each institution's procedure around error reporting differs, the council's solution was to include basic information on how to report errors for all three hospitals.

"We targeted housestaff for this initiative because housestaff don't usually report medical errors. Nurses report about 90 percent of the errors reported at NYU. Nurses and other practitioners do a great job of reporting, but physicians, especially residents, are not," said Dr. Margolis.

Equally important was educating residents on the process and highlighting the ways in which the administration could support them in their efforts. The team created a PowerPoint presentation that was disseminated to program directors, who then shared the presentation with their teams.

The *Badge Buddy*, a tool to facilitate adverse event reporting among residents.

While the culture of medicine is to defer to the person with most seniority or power, residents and other healthcare providers recognized that it is everyone's job to ensure the safety of patients. Participants at Telluride stressed the importance of shifting the culture of medicine to improve the quality of care patients receive and the way doctors practice. "We're trying to make medicine more egalitarian. Any person who's related to patient care should report anything they see as unsafe—the resident, nurse, respiratory therapist or nurse's aide. They should all have the power to make an adverse error report," said Dr. Margolis.

Other projects undertaken by Telluride participants include improving the quality of resident progress notes and development of care plans, and implementing a system for identifying medication ordering errors.

For information about applying for this year's conference, visit **www.cirseiu.org/telluride.**

Institute of Medicine Hears Testimonies about the Physician Workforce

The Institute of Medicine (IOM) has convened a committee to study the governance and financing of Graduate Medical Education (GME). The committee, co-chaired by Donald Berwick, M.D., and Gail Wilensky, Ph.D., is tasked with developing recommendations for policies to improve GME for the 21st century. The IOM GME committee was asked to review, among other topics: the numbers of residents, GME slots, and balance of primary care providers, specialists, and subspecialists; training sites; and financing options, among other concerns. At its public meeting on Dec. 20, the panel heard testimonies from residents and fellows, including CIR President John Ingle. Here are excerpts from three of the presenters:

John Ingle, MD, CIR National President

Fellow, Laryngology, University of Pittsburgh Medical Center

"An analysis CIR conducted in September 2011 suggests that safety-net hospitals are a critical pipeline for bringing primary care physicians into medically underserved communities. In the study, we analyzed whether New York safety-net hospitals, specifically those in Brooklyn, disproportionately trained more primary care physicians who continue to practice in a New York Health Professional Shortage Area (HPSA) than physicians trained in non-safety-net hospitals.

The results of our study suggest that safety-net hospitals train a larger proportion of primary care physicians who practice in federally designated shortage areas in New York than non-safety net teaching institutions. Specifically, 44 percent of primary care physicians in New York State shortage areas received at least part of their training at a safety-net hospital. However, these hospitals received only 28 percent of the CMS-funded residency slots in New York State. Our results are consistent with a study in Southern California, which found that primary care physicians who train in a HPSA are more likely to choose to practice in a HPSA.

If we are serious about increasing the number of primary care physicians, alleviating healthcare disparities and ensuring the highest level of training for residents, shuttering safety-net institutions will undermine these goals."

Tiffany Groover, MD, MPH

PGY3, Internal Medicine Boston Medical Center

"How else do you increase the numbers of those interested in careers in primary care, prior to residency training? Some effective options need to be put in place, because as the expense of medical school increases, not only will this decrease the numbers of medical trainees, but it will most assuredly decrease the number of underrepresented minority trainees.

I remain committed to service as a primary care physician as I prepare to serve as a National Health Service Corps scholar. I have always had a great interest in primary care and have been afforded opportunities to commit myself to the field without the heavy financial burden.

Throughout my medical school training and most notably in residency, many of my colleagues made it clear that primary care would not be an option and specializing was the only viable decision. One of the most prominent reasons was the need to repay the staggering educational loans acquired during medical school.

Of the residents in the Boston Medical Center primary care program, 100 percent commit themselves to a career in primary care after the completion of residency. This outcome is a testament not only to structure and the commitment of the program to train great primary care physicians; but also to the potential benefits we could see by improving the financial commitment to this program and others like it."

Heidi Schumacher, MD

PGY 3, Pediatrician, Children's National Medical Center, Washington D.C.

"My colleagues and I make up some of the 30 percent of pediatricians and 50 percent of pediatric subspecialists trained at freestanding children's hospitals. Thousands of rotating residents, especially in the surgical field, receive their only pediatric training in such facilities. I feel strongly that freestanding children's hospitals provide the best training for future leaders in the field. However, we are subjected to an arduous and unpredictable funding structure. The annual appropriations process through which the children's hospital GME (CHGME) funding is approved each year actively discourages innovation or expansion in children's hospital training programs.

My hospital has been unable to expand as we had hoped in order to meet projected workforce needs because, although each resident trains for three years, congressional funding is only approved for one. I hope that CHGME funding and structure remains an important issue of discussion as we plan for workforce development goals relating to the health and medical care for America's children."

How Is Your State Preparing for the *Affordable Care Act*?

Healthcare reform has been slowly implemented since 2010, and many states are in varying degrees of preparation for the dramatic expansion of coverage set to begin in January 2014. In order to comply with the Affordable Care Act (also known as "Obamacare'), governors and state legislatures have had to thoughtfully make decisions on issues concerning insurance regulations, Medicaid, the healthcare workforce, Health IT and other factors that will extend coverage to an estimated 32 million currently uninsured citizens.

The ACA requires each state to decide on the following:

Does the state create its own health insurance exchange? This is the centerpiece for expanding coverage to individuals and families who do not receive benefits on the job, as well as for small businesses who currently receive expensive insurance rates on their own. These online marketplaces will offer easily-understood plans with a consistent minimum standard of benefits. Exchanges must be open for enrollment on Oct. 1, 2013, selling qualified insurance plans that will begin Jan. 1, 2014. Once open, members of Congress and their staffs will be required by law to purchase their own insurance on the exchange. Although the federal government has provided full funding for states to set up exchanges, dealing with the governance, logistics, and infrastructure is a large endeavor, and only 17 states have committed to operating their own.

Will the state expand Medicaid? Although many states cover most persons who are under the poverty level ($22,050 for a family of four) in their Medicaid programs, other states exclude childless adults and parents entirely, or only allow them to participate with incomes far below the poverty line. The ACA intended to expand Medicaid coverage to everyone in the country at 133-138 percent of the poverty level or below. The federal government would initially pay for 100 percent of the budget for those newly eligible, ultimately tapering that off to 90 percent—a bargain compared to the percentage that states normally pay for Medicaid beneficiaries. However, the Supreme Court decision that upheld the ACA declared that states had the ability to reject the expansion, and some states are considering doing so.

Want to know how your state stacks up and what more work needs to be done by your statewide elected officials? Check out the chart below:

State	Will the state operate a Health Insurance Exchange?	Federal grants received to set up exchange	Will the state expand Medicaid?	How many more people would have health insurance? How much would that increase the state's Medicaid budget? (Urban Institute Analysis, HIPSM 2012)
California	Yes. Under both Governors Schwarzenegger and Brown, California has been a national leader in setting up its exchange, which will be called Covered California. HHS gave conditional approval on Jan. 3, 2013.	California has received Planning and Establishment Grants under the ACA totaling $237 million to date.	Yes. California has also submitted a waiver to HHS to allow Medi-Cal to be expanded by some counties prior to 2014.	1.86 million people would be insured for a 3.8% increase in the state's Medicaid budget.
Florida	No. Governor Scott announced that Florida will make no effort to set up a health insurance exchange. The national health insurance exchange, run by HHS, will be open for Floridians to enroll in plans beginning October 2013.	Florida received a Planning Grant under the ACA totaling $1 million, but returned the money in 2011.	Florida remains undecided. Although initially Governor Scott indicated the state would not comply with the ACA under any circumstances, he has softened his rhetoric since the election.	1.276 million people would be insured for a 7.9% increase in the state's Medicaid budget.
Massachusetts	Yes. The Massachusetts Connector is already the model for a health insurance exchange, and the state has passed regulations to make it fully compliant with the ACA. HHS gave conditional approval on Dec. 7, 2012.	Massachusetts has received Planning and Establishment Grants under the ACA totaling $90.3 million to date.	Yes. Governor Patrick has announced that Massachusetts will expand Medicaid under the ACA.	16,000 people would be insured for a net decrease in the state's Medicaid budget.
New Jersey	No. Although a health insurance exchange bill twice passed the legislature, Governor Christie vetoed it each time. He has indicated that the state will partner with the federal government to run an exchange and is currently negotiating with HHS to split the responsibilities.	New Jersey has received Planning and Establishment Grants under the ACA totaling $8.7 million to date before it halted development.	New Jersey partially expanded Medicaid in April 2011 to cover 70,000 additional childless adults. However, Governor Christie has been noncommittal on a full expansion in 2014.	291,000 people would be insured for a 4% increase in the state's Medicaid budget.
New Mexico	Yes. Although Governor Martinez vetoed legislation to establish an exchange, she did submit an application to have the exchange operate as part of the existing New Mexico Health Insurance Alliance. (The legality of this move is currently a source of controversy). HHS gave conditional approval on Jan. 3, 2013.	New Mexico has received Planning and Establishment Grants under the ACA totaling $36 million to date.	Yes. Governor Martinez announced on Jan. 9 that New Mexico will expand Medicaid under the ACA.	208,000 people would be insured for a 3.8% increase in the state's Medicaid budget.
New York	Yes. Governor Cuomo established the health insurance exchange to be run by the Department of Health by executive order in April 2012. HHS gave conditional approval on Dec.14, 2012.	New York has received Early Innovator and Establishment Grants under the ACA totaling $182.6 million to date.	It is widely presumed that New York will expand Medicaid under the ACA.	320,000 people would be insured for a net decrease in the state's Medicaid budget.

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- Check out our new resources center! Visit us for information on job openings, career development, research funding, conferences and more: **www.cirseiu.org/resources**

Next Issue of CIR Vitals: Women in Medicine

- As women surpass the 50% mark in medical school enrollment and make headway in traditionally male specialties, how do they experience residency? And what can they expect in the healthcare marketplace?
- Do you have a story to share about the unique contributions and challenges of women in medicine? Contact us at vitals@cirseiu.org.

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