CIR VITALS

Fall 2012

Politics and Medicine:
What's at Stake for Patients and Providers?

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INSIDE THIS ISSUE

PRESIDENT'S REPORT | JOHN INGLE, MD

Doctors & Politics: Treating the Ills of Our System

I have tried to wrap my head around why being politically vocal on healthcare issues makes some physicians uncomfortable. I am always inspired by how many people show up to a code in the hospital and are willing to lend a hand because a life is in jeopardy. After all, that is what we are trained to do. We know that an organized effort must be executed in a code so the best possible outcome can be achieved. I have witnessed many brave men and women skillfully perform life saving maneuvers during emergencies. In situations of life and death, we know that our efforts are best when they are coordinated.

In a poll we conducted of the CIR membership in January of this year, members overwhelmingly listed altruism or helping others as the top reason they went into medicine. These values drive us to work hard to get patients what they need, even when their insurance or lack of insurance is a barrier to care.

As physicians, we learn to master the system, working with other healthcare professionals to break through bureaucracy and barriers to care. But when you think about it, many of the challenges we face in our jobs are actually rooted in policy on the local, state and federal levels.

Our advocacy for patients doesn't need to stop when we leave the hospital or the clinic. We ought to share our knowledge and experience with elected officials and policy makers so that meaningful changes can be made in our healthcare system.

During my residency in Otolaryngology at the University of New Mexico, we worked with politicians in Bernalillo County to encourage voters to maintain the "mill levy," a tax that provides more than $80 million for indigent patient care in our state. We had to combine efforts with candidates who supported what was best for our patients.

As the UNM CIR chapter grew, we continued to have open dialogue with elected officials about key issues facing residents – childcare for physicians with families, greening the hospital, and preventing disastrous cuts to Medicaid were some of the priority issues that couldn't be addressed without advocacy at the local and state levels.

We took it a step further and developed an endorsement process so we could hear directly from the candidates on how they would tackle these issues. When our endorsed candidates win, they understand they are accountable to us.

This fall, as the election season moves forward, let's be sure to vote, but let's also consider what we can do politically as doctors over the next four years to improve health care access, quality and affordability. I hope this issue of *CIR Vitals* will give you some ideas of how to get involved. **I am calling a code on our health care system – and I hope you will show up!**

CIR VITALS
Committee of Interns and Residents/SEIUHealthcare.

Committee of Interns and Residents of SEIUHealthcare

National Headquarters

520 Eighth Avenue, Suite 1200
New York, NY 10018

(212) 356-8100; (800) CIR-8877

info@cirseiu.org; http://www.cirseiu.org

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To submit letters or articles, email vitals@cirseiu.org

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A Long History of CIR Political Advocacy

CIR members have been enthusiastic advocates in 2012 – for healthcare reform, paid sick days for workers, and living wage laws, all policies that help patients lead healthier lives. As we head into election season, take a look back at some of the other issues that residents have been involved in throughout CIR's history.

1982 In the midst of the nuclear arms race between the United States and the Soviet Union, CIR members were on a race of their own: to stop the spread of nuclear weapons and end nuclear testing. Throughout the 1980s, CIR members passed petitions, joined letter-writing campaigns, and aligned with Physicians for Social Responsibility, a group that continues advocating for nuclear disarmament to this day. CIR members were among one million people who marched in New York City on June 12, 1982 in the largest anti-nuclear arms demonstration to date, and in 1983 CIR President Dr. Terry Fitzgerald testified before the Nuclear Regulatory Commission about the dangers to patient care following a potential nuclear disaster.

1983 CIR partnered with other labor unions in establishing the Labor Committee Against Apartheid to assist black trade unionists in South Africa to gain rights and representation and to call for an end to apartheid. The CIR House of Delegates also voted that year to suspend CIR business with any institutions with ties to the South African government, and two years later CIR joined a march of thousands protesting apartheid and demanding the release of Nelson Mandela.

Dr. Barry Kistnasamy (center) from the National Medical and Dental Association of South Africa standing with former CIR President Dr. Shelly Falik (right) and former Executive Director John Ronches.

Highland Housestaff in Oakland, CA signed a pledge of non-compliance to demonstrate their opposition to Proposition 102 in 1988.

1988 As the AIDS crisis grew throughout the 1980s, residents were in the thick of the battles over how best to care for patients. CIR members at University Hospital in Newark successfully lobbied to end the practice of "patient dumping" following sharp increases in the number of AIDS patients being transferred to the hospital from other New Jersey communities, thus putting a strain on the care that Newark doctors were able to provide. Meanwhile, across the country at Highland Hospital in Oakland, residents led a rally to help defeat Proposition 102, a ballot initiative which sought to track and record the names of patients who tested HIV positive and would allow for employers and insurance companies to fire or deny coverage to persons with AIDS. The controversial measure had gained support nearing Election Day, but as residents spoke about the dangers of such a law and vowed their noncompliance should it pass, public favor quickly swung the other way, and Proposition 102 was defeated by a wide margin.

2000 Sharps injuries and the threat of exposure to blood borne pathogens are still a serious concern for healthcare workers today. But imagine our hospital world without needleless devices! That was the case in most U.S. hospitals before passage of a federal law in 2000 that required hospitals to purchase retractable, blunt and other safe equipment where available and appropriate for the procedure to be performed. That law took years of advocacy to pass and CIR members, joining with SEIU, were at the forefront of the campaign. In the 12 years since, sharps injuries have fallen dramatically.

2008 Faced with the problem of San Francisco's only trauma center and acute-care facility being shut down unless rebuilt to meet seismic standards, residents at San Francisco General Hospital rallied to help pass Proposition A, a ballot initiative seeking to raise $887 million to save the hospital. They wrote letters, phone banked, and knocked on doors to help spread information about the initiative and why it was so important to keep SFGH's doors open – and safe – for all San Francisco residents. CIR's efforts paid off on Election Day, as Proposition A passed by a landslide.

ENT residents Drs. Betty Tsai and Matthew Russell turned out to support San Francisco General Hospital.

Events Help Build a Resident Community Beyond CIR Membership

Frequently, residents approach CIR members wondering how they can join when there is no chapter at their hospital. In the past, there were few options but this summer CIR doctors organized several events to help build a resident community that reaches beyond the borders of our membership.

GENDER AND SEXUALITY IN MEDICINE ROUNDTABLE IN NEW YORK

On July 11, residents from across New York City joined together for a discussion of challenges for both LGBT patients and providers in health care. The roundtable quickly transformed into a brain storming session with ideas ranging from a grand rounds series to an LGBT health conference as well as networking events. Attendees decided to continue the conversation through a listserv and hold future events to continue planning.

WOMEN IN MEDICINE DINNERS IN CALIFORNIA

On August 8, Los Angeles CIR members invited residents from surrounding residency programs to a dinner on the status of women in medicine. One focal point of the conversation was the treatment of women physicians by ancillary staff and the lack of respect shown to them when compared with their male colleagues. The group also discussed the challenge of family commitments and the dearth of women physicians in leadership roles. The group planned to meet again in October to continue the discussion of how CIR could play a role in improving the status of women in medicine by providing a supportive network and mentorship. This dinner followed an earlier event in San Francisco during which attendees also expressed a strong desire for mentorship.

Maimonides Residents at NYC Salsa Nite

RESIDENTS CONNECT AT SALSA AND JAZZ OUTINGS IN NEW YORK

How to provide opportunities for residents to de-stress and tackle the common feelings of isolation and burnout? CIR residents in New York have established a physician community-building committee to host social events for residents citywide. On July 29, residents burned the floor at an outdoor salsa concert, and on August 26 relaxed in Tompkins Square Park at the Charlie Parker Jazz Festival.

A Housestaff-Led QI Project in Silicon Valley

By Vicki Lung, PGY 3, Internal Medicine, Santa Clara Valley Medical Center

Imagine a hospital located in the heart of Silicon Valley, with no basic computer quality standards or regular maintenance. It's hard to believe when computers are so integral to patient care and resident efficiency, but that was the reality at Santa Clara Valley Medical Center (SCVMC) in San Jose, California, a tertiary care medical center with level one trauma, good ancillary services and several excellent residency programs.

Frustrated by the daily inconveniences of malfunctioning computers, CIR members at SCVMC succeeded in incorporating new contract language in 2011 that guaranteed quarterly Information Service (IS) walk-throughs. What exactly a "quarterly Information Service walk-through" meant was left to the residents to decide. Through open forums and questionnaires, we ascertained what residents wanted from the walk-through and what their main difficulties were with the computers.

Residents wanted basic software for posting discharge summaries or printing daily notes to minimize time wasted. We screened every computer used by residents in the hospital for every critical software and hardware function. With information in hand, we were able to inform the administrators about resident satisfaction and concerns and tell them what percentage of computers did not meet our basic requirements.

IS was able to use our spreadsheet to remotely access every computer and screen and correct software deficiencies. We educated residents on how to report problems and stressed how it was part of the maintenance process.

Before our intervention, there was strong dissatisfaction with our computers. After the changes, we found that satisfaction with computers had greatly improved. Our new contract and coordination with our CIR organizer were key to compelling administrators to assist with our cause. However, it was the drive, resourcefulness and demand for improvement from the residents that made this project possible. Despite a dauntingly large project, we hope to make meaningful and lasting change with the support of CIR.

CIR MEMBERS ENDORSE NEW YORK STATE SENATOR GUSTAVO RIVERA – AGAIN!

In 2010, when the New York CIR delegation decided to endorse Gustavo Rivera for State Senator of the Bronx's 33rd district, they made CIR history. It was the first time the region had ever endorsed a candidate. Members were impressed by his commitment to public health. Two years later, Senator Rivera is running for re-election and CIR leaders have enthusiastically decided to endorse him once again.

"Senator Rivera has shown over the past two years that he is committed to securing a healthier future for Bronxites, and he's proven himself to be a strong partner on public health issues in Albany. He's been a true champion for the Bronx, and we want to see him continue the work he has begun improving the lives of the patients we serve," said Dr. Rick Gustave, CIR New York Regional Vice President and an Emergency Medicine resident at Lincoln Hospital.

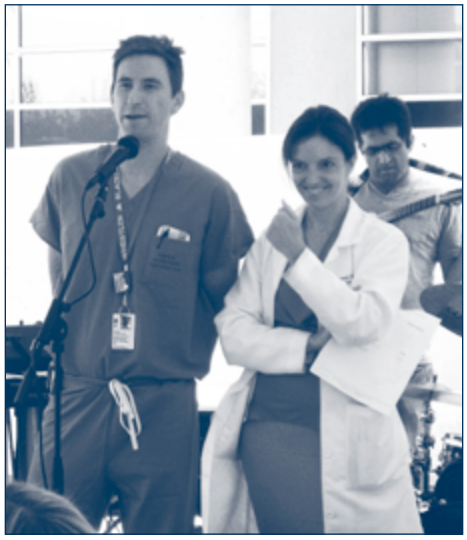
Senator Rivera worked closely with CIR members and the Healthy Bronx Initiative for his Bronx CAN (Change Atttitudes Now) Initiative. The Initiative, now in its second year, served as the Senator's platform to educate and empower Bronx residents to take control of their health. Through his monthly weigh-ins during which he was publicly weighed by CIR doctors, Senator Rivera served as a living example of healthier living. The community members joined the effort by making their own commitments to lifestyle changes and learning about the resources available in the Bronx for increased access to health care, better nutrition, and increased physical activity.

Dr. Rick Gustave, Senator Gustavo Rivera and Dr. Jacinth Ruddock at a Healthy Bronx Initiative community health fair.

NEW MEXICO CIR ENDORSES IN SENATE AND HOUSE RACES

After an extensive interview process, New Mexico CIR leaders voted in September to endorse Michelle Lujan Grisham for New Mexico's 1st Congressional District.

The leadership felt Lujan Grisham's experience directing the State Agency on Aging and as Secretary of the Department of Health had given her unique insights into the threats facing Medicare and Medicaid, programs that New Mexico patients depend on heavily. Lujan Grisham impressed the CIR delegates with the depth of her knowledge, her tenacity as a watchdog on behalf of seniors, and her advocacy on behalf of the safety net and underserved communities.



UNM residents celebrate at their annual Housestaff Appreciation Day.

"New Mexico needs a champion who will defend Medicare and Medicaid and also bring some much-needed practical insight into the real driver of healthcare costs," said Dr. Jenna Godfrey, Regional Vice President for CIR, in a statement announcing the endorsement.

The endorsement follows New Mexico CIR's earlier endorsement of Martin Heinrich, the Democratic nominee for the Senate seat being vacated by retiring Sen. Jeff Bingaman. Rep. Heinrich has represented New Mexico's First Congressional District in the House of Representatives since 2008 and has been a champion for the expansion of community health centers and programs to bring physicians to underserved areas like rural New Mexico.

NEW VCME CONTRACT MAKES STRIDES IN EDUCATION AND RESIDENT WELL-BEING

CIR residents at Valley Consortium for Medical Education in Modesto, California won a strong new contract for 2012-2015.

The contract strengthens education with new clauses like a commitment to provide UpToDate home access at no cost to residents and reimbursement for the Postgraduate Authorization Training Letter (PTAL) required for IMG residents.

In a difficult economic climate, housestaff were able to secure benefits to improve resident quality of life, a 6 percent salary increase over the life of the contract and increased funding for resident-sponsored socials for prospective residents. Housestaff will also be able to more easily support CIR advocacy work with the new payroll deduction for voluntary contributions to the CIR Political Action Committee (PAC) fund.

"What might seem like minor changes are huge for us," said Dr. Joey Chang, PGY 2, Family Medicine. "It makes the housestaff work even harder, translating into happier residents, and ultimately higher quality medical care and healthier, happier patients."

A Call for Paid Sick Days

The following was taken from comments delivered by CIR member Dr. Michelle Espinoza at a press conference in support of Paid Sick Days legislation on Sept. 19 in New York City. Dr. Espinoza is a family medicine resident at Jamaica Hospital.

As resident physicians, we have joined with a coalition of business owners, fellow union members, faith leaders and working families of every background to support New York City workers forced to choose between their jobs and their health. This work-family balance has become an urgent priority in our communities. There is never a "better time" or "better economic environment" when it's your own health, your own family, your own job. The best time to address this public health issue is NOW.

As a primary care physician, I am the first you see to help keep you healthy, help you manage your chronic medical conditions, and help prevent complications and avoid unnecessary emergency room visits or hospital admissions. But if you cannot take time off for fear of losing your job, you cannot come see me and we cannot work together to keep you healthy or prevent your medical condition from worsening, leading to even greater utilization of our healthcare system.

I'm going to tell you about a patient of mine, and how the fact that she had no ability to take paid sick days at work affected not only her, but her whole family.

Her daughter has special needs–she has cerebral palsy–and like any parent in that situation, all she wants to do is provide for her child. But giving her daughter the care she needs is expensive–she needs a home health aide, and that means she is under tremendous pressure for the finances of her household not to take any time off. She is barely able to balance work and the demands of her job and family.

She was so focused on her daughter and her family that she neglected her own health. She developed a disease called lupus and became very ill, very quickly.

The treatment for lupus involves medications to suppress her body's defenses which make her more susceptible to infections, which means she needs to be closely monitored with frequent doctors' visits.

"Let us take care of our patients—allow them the ability to see us when they get ill."

But because she could not afford to take time off, because she was so focused on putting her daughter and family first, she kept pushing – pushing through her illness and ignoring the first signs of infections. If she had come to see me, we could have made medication adjustments or started antibiotics and prevented the cascade leading to more serious infections. When she did come in, all I could do was send her to the Emergency Room. She was hospitalized, and as a physician I hoped and prayed she made it home to be with her family while she still had time.

It was for that patient that I came out to support the Paid Sick Days for All New Yorkers Act. It was important for me to stand up, for my patients, and for my fellow resident physicians with a simple plea: let us take care of our patients, allow them the ability to see us when they get ill. Make it just a little easier for those struggling with the choice of getting the care they need and putting food on the table. That can't happen unless the New York City Council brings the Paid Sick Days bill up for a vote.

Dr. Michelle Espinoza speaks out a press conference in support of paid sick days legislation in New York City.

UMDNJ Residents Secure Commitments from the State on the Future of Medical Education

University Hosital Resident Dr. Leroy Cordero speaks out at at a rally at New Hope Baptist Church in Newark, NJ on the need to protect patient care for the city's most vulnerable patients.

On Wednesday, August 22, Governor Christie of New Jersey signed into law the restructuring of the state's hospital system and the merger of Rutgers University and UMDNJ hospitals. The final bill reflected the concerns of vocal community members as well as CIR physicians.

In the time leading up to the merger, CIR members and others fought to ensure that the priorities of patients and the community, as well as protections for the workers of UMDNJ, were addressed in the restructuring.

One such effort occurred on June 13 at New Hope Baptist Church in Newark, where CIR leaders, community members, clergy and local representatives rallied to address the many concerns the proposed restructuring raised for hospital staff and the community alike.

The history of Newark's University Hospital is one born from the Newark Rebellion of 1967, the first of several riots that took place in black communities all across the country including Chicago and Detroit – responses to intense police abuse, unmet community needs and political corruption. Out of the rebellion would eventually come the Newark Agreements. Forged by community leaders and elected officials, the agreement laid the foundation for the creation of the New Jersey College of Medicine and Dentistry, with guarantees that the institution would serve the community that surrounded it – services that the mostly black, working-class community didn't have at the time.

Under the new legislation, the New Jersey Medical and Health Sciences Education Restructuring Act, Rutgers will acquire UMDNJ; however, University Hospital will not become a part of the new Rutgers. Instead, it will receive aid directly from the state.

"The end result of the state's restructuring plan should ensure that the medical school and University Hospital continue to provide care at the current level or better, be economically secure and continue their mission of training the healthcare workers of the future," said Dr. Leroy Codero Floyd, CIR member at University Hospital.

Because of the organizing efforts of invested community members, including CIR doctors, the campaign to ensure the viability of University Hospital and UMDNJ proved successful. By holding policy makers accountable, CIR residents and other stakeholders of UMDNJ gained the following victories in this new legislation:

1. Funding from the state to University Hospital is guaranteed to maintain at least the current level of service.
2. All contracts and bargaining units will remain as is, until successor agreements are negotiated.
3. University Hospital employees will stay public.
4. UMDNJ Newark and RWJ/SOPH, Cancer Center, UBHC, and all clinics will stay open and become part of Rutgers University.
5. The Newark agreements are quoted, and the legislation states that their spirit/intent will be honored.
6. The School of Oseopathic Medicine will remain semi-autonomous from Rowan. Their education/training is protected. Rowan must do whatever is necessary to maintain accreditation.

As the plan to partially merge Rowan and SOM move forward, CIR will continue monitoring the situation to ensure residents have a voice in the process of reorganization. CIR is also in the beginning stages of contract negotiations at UMDNJ. As residents continue to build ties with the local community, having a strong, unified voice is one of the ways to enhance the learning experience of physicians and the quality of care for patients.

View video of University Hospital Residents speaking out at a June 13th rally at New Hope Baptist Church in Newark, NJ: bit.ly/umdnjrally

UMDNJ Facts

Hospital: University of Medicince and Dentistry of New Jersey

Number of Housestaff: 1,291

Specialties: Over 45 residency and fellowship programs

Campuses: Newark, New Brunswick, Camden

Historical Fact: The creation of UMDNJ began as a result of the Newark Rebellion.

A Conversation with Dr. Vivek Murthy

'Doctors For America' Educates and Empowers Physicians on the Affordable Care Act

CIR leaders have teamed up with Doctors for America (DFA) to hold teach-ins on the Affordable Care Act in New York, New Jersey, and California. Doctors for America is a grassroots organization of 15,000 physicians in all 50 states that brings doctors together to influence health policy at the state and federal level. CIR spoke with Dr. Vivek Murthy, an internal medicine physician at Brigham and Women's Hospital in Boston, Massachusetts, and president and co-founder of Doctors for America, about why 2012 is a critical time for physicians to get active.

WHY IS 2012 SUCH A PIVOTAL YEAR?

This is a critical year because the fate of health reform will be impacted by the outcome of the elections. Right now we have a situation where there are many politicians who are trying to tear down parts of the Affordable Care Act, but there also are other politicians who don't want to talk about healthcare. Our goal is to get them to talk about health care, to stand behind implementation of the Affordable Care Act [and] to work on further measures that we're going to need to make sure that we get to that ultimate goal—a system where everyone has access to quality and affordable care.

WHAT ARE THE GOALS OF THE ONE MILLION CAMPAIGN?

The One Million Campaign is our campaign to bring information about the Affordable Care Act to over one million people during 2012. We're doing this because there's a lot of confusion about health reform, what it is and what it isn't, and physicians have a particular asset when it comes to their ability to communicate to the public. They have credibility, [and] they're trusted by the public on issues related to health care. It's our opportunity to get out there, to help people understand what we need to be fighting for. And it's also our opportunity to find each other, to build a community of physician advocates who can make a real impact on the political process as well as on shaping policy.

DO YOU HAVE ANY ADVICE FOR PHYSICIANS WHO ARE NOT INVOLVED IN POLITICS OR ADVOCACY ON WHERE THEY CAN BEGIN?

There are challenges to physicians getting involved in advocacy. Physicians are busy. They're not just taking care of patients 9 to 5; they're often working well beyond those hours. Getting involved can start with something as simple as educating yourself about health reform law. Another easy way to get involved is to look for activities in your home organization – whether that's a subspecialty society or an advocacy organization like Doctors for America or the Committee of Interns and Residents.

Whether it's something as small as signing a petition or something as large as organizing physicians in your community, every bit of advocacy from physicians helps. We're going to need the collective power of thousands of physician voices if we're going to see health reform through, and especially for the next stages of reform that go beyond the ACA.

Word from the Wards

What's your top concern heading into November's election?

Dr. Samrina Kahlon, Emergency Medicine, Metropolitan Hospital
…how the Affordable Care Act might change how different specialties practice.

Dr. David Eshak, Internal Medicine, Jacobi Hospital
…re-electing Barack Obama. This is our best way to get our economy back on track and to finally conclude our wars abroad.

Dr. Dennis Hsieh, Emergency Medicine, Alameda County Medical Center
Providing quality care for my patients if Romney is elected. I think he will repeal the ACA and gut the safety net to provide tax breaks for the wealthiest Americans and Wall Street.

CIR Members on the Issues

In March 2012, 470 CIR members were randomly polled on a variety of topics to help shape CIR's political advocacy efforts. See where residents line up on key issues this election season.

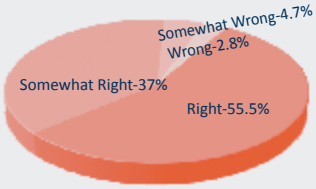
What will be *most important* to you at the polls this presidential election?

- Access to Healthcare — 20.3%
- Budget/ National Debt — 16.1%
- Medicare/ Medicaid Funding — 14.1%
- Jobs — 13.8%
- Foreign Policy — 5.9%
- Taxes — 5.1%
- Immigration — 4.8%
- Financial Industry Reforms — 4.8%
- Other — 9.6%

CIR's political mission is:

- advocating for our patients.
- fighting for healthcare funding
- pushing for a thoughtful implementation of healthcare reform

Do you feel that CIR is on the **right or wrong track** with this mission?



How do you identify politically?

- Moderate-45.8%
- Liberal-42.4%
- Conservative-11

Dr. Jose Sosa, Internal Medicine, Harlem Hospital

...heath care. If the Democrats lose the election, there might not be an Affordable Care Act. We've seen a huge improvement in the economy lately. That's why I'll be at the polls in November.

Dr. Melody Ko, Internal Medicine, Lincoln Hospital

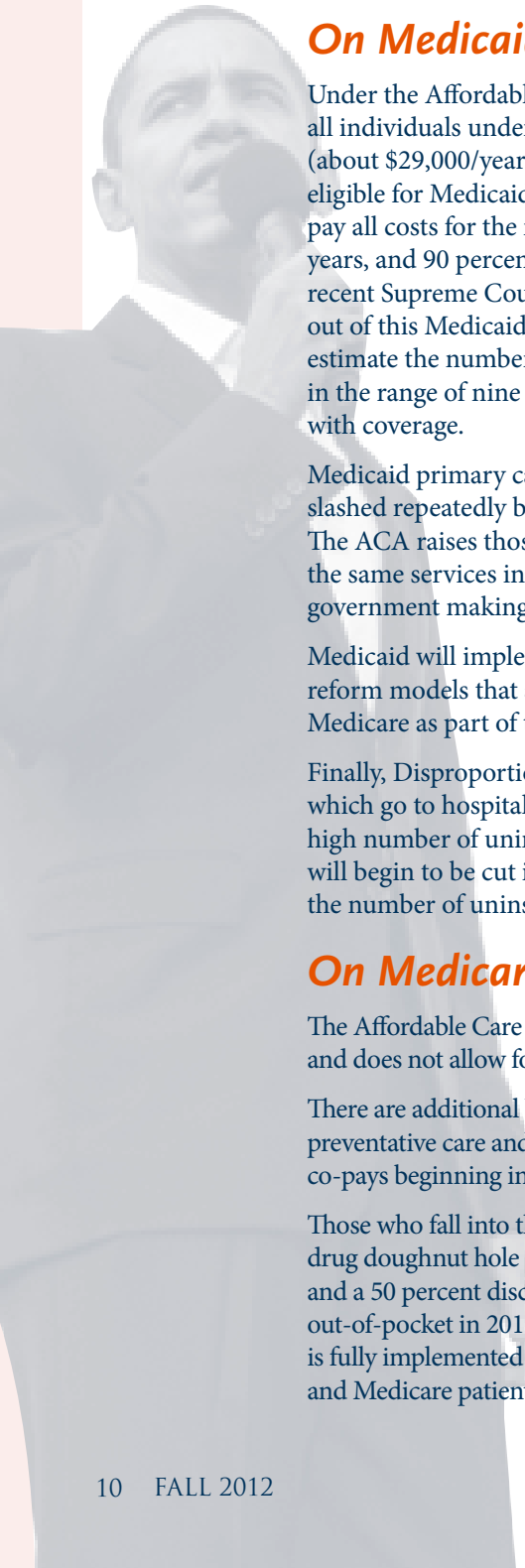
It depends on who wins the election. It's going to have a huge impact on what kind of people are going to get what kind of care. Are they going to get the insurance they need and the care they require?

Dr. Jennyffer Peralta, Psychiatry, Metropolitan Hospital

…healthcare funding. There is help for the poor, and the wealthy can pay. The middle class needs more support, particularly for mental health care.

The 2012 Election and the Future of Medicare and Medicaid

Obama-Biden



On Medicaid

Under the Affordable Care Act, on January 1, 2014, all individuals under 133 percent of the poverty line (about $29,000/year for a family of four) would be eligible for Medicaid. The federal government would pay all costs for the newly eligible for the first few years, and 90 percent of the costs thereafter. The recent Supreme Court ruling allowing states to opt out of this Medicaid expansion makes it hard to estimate the number of patients affected, but it will be in the range of nine to 15 million additional people with coverage.

Medicaid primary care reimbursements have been slashed repeatedly by states to balance their budgets. The ACA raises those payments to Medicare rates for the same services in 2013 and 2014, with the federal government making up the difference.

Medicaid will implement some of the payment reform models that are being implemented in Medicare as part of the ACA.

Finally, Disproportionate Share Hospital payments which go to hospitals that see a disproportionately high number of uninsured and charity care patients will begin to be cut in 2015, pegged to a decrease in the number of uninsured in that state.

On Medicare

The Affordable Care Act keeps the eligibility age at 65 and does not allow for any cuts to benefits for patients.

There are additional benefits for seniors, including free preventative care and an annual wellness visit with no co-pays beginning in 2012.

Those who fall into the Medicare Part D prescription drug doughnut hole received rebate checks in 2010 and a 50 percent discount on all drugs they purchased out-of-pocket in 2011 and beyond. When the law is fully implemented in 2019, the hole will be closed and Medicare patients will have continuous coverage.

Additionally, primary care providers began to receive 10 percent payment bonuses for their Medicare codes over the past year.

On Controlling Costs

The ACA tackles healthcare costs in two ways. First, it targets costs that are not directly connected to keeping patients healthier. These include requiring rebates from pharmaceuticals for bulk purchases made through Medicare (instead of paying list price); cutting the large subsidies paid to insurers in the Medicare Advantage program; dramatically escalating the tools for fighting waste, fraud, and abuse in the program; and including penalties on hospitals with a high rate of preventable hospital readmissions and hospital acquired infections.

The second method is by changing the way care is reimbursed to emphasize coordination and quality of care instead of quantity of care. This includes value-based purchasing – factoring in quality metrics and patient satisfaction scores when calculating reimbursement, and a wide range of pilot projects through the new CMS Innovation Center to experiment with new models like accountable care organizations and patient-centered medical homes.

Finally, a board of experts called the Independent Payment Advisory Board (IPAB) will begin to meet in 2015 if the projected growth in Medicare exceeds a targeted rate. The IPAB is prohibited from rationing care, changing eligibility, or increasing premiums and co-pays, nor can it change hospital reimbursement rates until after 2019. However, it can fast-track other changes to the program to meet the target growth rate.

In addition to the Affordable Care Act, President Obama has recommended lowering the targeted growth rate that activates the IPAB recommendations even further, to the growth of the Gross Domestic Product plus 0.5%—the same target figure as in Rep. Ryan's original proposal.

The Affordable Care Act is the signature domestic achievement of President Obama and something that the Romney-Ryan plan would repeal entirely. Governor Mitt Romney chose for his running mate Rep. Paul Ryan (R-WI), the author of the House of Representatives Budget which proposes major structural changes to Medicare and Medicaid. In their contrasting visions for healthcare, the two presidential campaigns present two dramatically different visions for healthcare in the United States.

This article summarizes the basics of these different visions. The descriptions of the law below are very general and do not include programs that do not directly relate to Medicare and Medicaid. CIR has already provided extensive information on The Affordable Care Act in the past through events and on our website.

You can find more specific information on our page on the Affordable Care Act at http://cir.seiu.org/healthreform.

Romney-Ryan

On Medicaid

The Romney-Ryan plan proposes to change the nature of federal funds from a matching program to a "block grant" program. Instead of matching what the state spends on Medicaid patients for that year, the federal government would provide a fixed amount that would not change, regardless of an increased number of patients or increased costs of treating those patients triggered by an economic downturn.

Additionally, this fixed amount would only increase by the cost of inflation each year – far less than the two to three times the rate of inflation that medical costs have grown over the past few decades. In exchange, each state would have additional flexibility to cut benefits or patient eligibility to make up the loss of funds.

These steps would cut what the federal government spends on Medicaid by an estimated $1.74 trillion over 10 years.

Finally, the Medicaid expansion to cover all individuals up to 133 percent of the poverty line in 2014 and to increase primary care physician fees in 2013 added as part of the Affordable Care Act would be repealed.

On Medicare

The easiest way to describe the plan is that it would move Medicare from a defined benefit model to a defined contribution model. A defined benefit is like a pension – care for Medicare patients are guaranteed and the federal government pays the full cost (minus some premiums and co-pays) for whatever the patient uses. A defined contribution is like a 401(k) – the federal government agrees to pay a set amount per patient every year and only that amount, regardless of the financial needs of the patient.

Beginning in 2023, those who become eligible for Medicare would receive a set amount of money—"premium support" or a voucher—which they can either use for traditional Medicare or for purchasing standardized private insurance plans.

Insurance plans would receive different payments based on the health of the patient and to remove the incentive to cherrypick. According to the non-partsian Congressional Budget Office, the voucher would cover approximately 89 percent of the costs for enrolling that patient in Medicare, with the rest to be made up by the patient through co-pays, deductibles, co-insurance, etc.

On Controlling Costs

The plan presumes that private insurance will achieve greater cost savings than traditional Medicare. As a result, the value of the voucher will only increase at the rate of inflation plus 1 percent each year – again, far less than the two to three times the rate of inflation that healthcare costs have increased for the past few decades. If that trend continues, the CBO estimates, the voucher will only cover 77 percent of estimated costs in 2030 and 66 percent in 2040, with the patient obligated to pay for the rest or go without.

Practically, that means the plan would re-establish the Medicare Part D "doughnut hole" coverage gap for prescription drugs, reinstituting cost-sharing by the patients for preventative care services, and allowing for co-pays for annual wellness visits. Additionally, the Romney-Ryan plan would gradually raise the Medicare eligibility age from 65 to 67 by the year 2034.

Some questions remain. First, the original plan as developed by Rep. Ryan would have kept most of the cuts and savings – approximately $700 billion – from the Affordable Care Act and used them to extend the solvency of the Medicare Trust Fund into the next decade. However, Governor Romney has said that he will repeal the ACA in its entirety, keeping none of the savings. If that is true, the Medicare Trust Fund becomes insolvent in 2016.

Finally, Medicare funds a number of programs that are not direct patient care, including Graduate Medical Education. There have been no details on whether these programs will continue at their current level or whether the entirety of the Medicare budget would instead be converted to vouchers under this plan...

From Emergency Medicine Doc to Congressional Candidate

When Dr. Raul Ruiz was 17 years old, he walked from business to business in southern California's Coachella Valley asking for business owners to contribute to his college education. In exchange for their donations, he signed a contract with community members promising to come back and work as a doctor in his hometown.

Dr. Ruiz made good on his promise. He graduated from UCLA and then became the first Latino to hold three degrees from Harvard: an MD, an MPH and a Masters in Public Policy from Harvard's Kennedy School of Government. He completed his residency in Emergency Medicine at the University of Pittsburgh before returning to his hometown in 2007.

He now works as an emergency medicine physician at Eisenhower Medical Center in Rancho Mirage, CA and is running for Congress against Rep. Mary Bono Mack, the Republican incumbent who took over the office after her husband, Sonny Bono, died in a skiing accident in 1998.

Born in Mexico and raised in Coachella, CA, where his parents worked as farmworkers, Dr. Ruiz saw the gaping needs in the community from a very young age. "We lived in a trailer for the first few years of my life, and that was considered a luxury – there were a lot of farmworkers who lived out of cardboard boxes to protect them from the heat," he said.

Today, in the emergency department, he sees the fallout of the country's economic crisis, in patients who have lost their jobs, insurance, and even their homes.

"A lot of students have come up to me in tears because they've had to defer their education to work and pay for their college education and help their family, and a lot of the seniors are really concerned about losing their quality of life and their health care," Dr. Ruiz said. "And my father told me never to complain unless I'm going to be part of the solution, and I'm running for Congress to stand up for the people of this district, to make sure that they are taken care of.

"We have one of the worst crises in the state of California – not only in the inability of the residents to afford health care, but also in the lack of infrastructure and physicians to take care of them. We have one doctor per 9,000 residents in our underserved areas, and the medically-appropriate ratio according to HHS is one to 2,000 residents," he said. He founded the Coachella Valley Health Initiative to address the problem, as well as a pre-med mentorship program for students from underserved communities who want to become doctors.

Dr. Raul Ruiz, an emergency medicine doctor, is running for congress in Coachella, CA.

Dr. Ruiz is using his campaign as an opportunity to highlight the importance of Medicare and Medi-Cal (California's Medicaid system) in his community.

"One of the starkest issues in this election is the 'Ryan plan' and the fact that Bono Mack has voted twice to turn Medicare into a coupon-like voucher system which would eliminate the guarantees of Medicare and essentially put the burden of healthcare costs on the shoulders of our seniors.

"The way we're going to save Medicare is by prioritizing our seniors, not health insurance companies, and by decreasing overall healthcare costs," Dr. Ruiz said.

He also stressed that caring for patients means addressing the factors that are preventing them from being healthy, from jobs to housing to education.

"First and foremost, we want to take care of our patients, but in order to take care of patients, we need to also address the social context in which they live . . . . That is why we need to get out of our comfort zone and go beyond the exam room and into the community and start addressing those other social determinants of health by being community advocates and taking on leadership positions in the community," he stressed.

The 113th Congress Could See Increase of Physicians in Office

With health care representing more than 15% of the U.S. gross domestic product and healthcare reform taking center stage in politics, it's not surprising that more physicians are stepping up to run for elected office. This election season:

- 28 doctors are running in legislative races—17 incumbents and 11 hopefuls.
- Among those already holding office, 18 of 20 are Republican. Seven of this year's challengers are running on Democratic tickets.
- Physicians in the 112th Congress largely represent districts in the south and west of the U.S.
- As medical practitioners, they tend to hail from Ob-Gyn and other surgical specialties; there are also three family physicians, one anesthesiologist, one psychiatrist, and one emergency doctor.

NYC Medication Safety Grand Rounds Reach Hundreds

Close to 200 front line providers in the NYC Health and Hospitals system attended a conference on medication safety and pain management held at Jacobi Medical Center in the Bronx in November 2011. But by November 2012, more than 1,000 will have attended a series of grand rounds at eight HHC hospitals – all thanks to a unique labor-management partnership.

The year-long collaboration between CIR, our sister union 1199 SEIU (which represents HHC pharmacists and LPNs), and hospital patient safety leaders, has also produced a pain management pocket guide and more than 3,000 flash drives loaded with medication safety resources for providers.

The project was funded by grants from the Department of Labor (through the Federal Mediation and Conciliation Service) and the CIR Patient Care Trust Fund.

"Our partnership and work with CIR on medication safety has been invaluable and an important step towards advancing our shared goal of achieving a culture of safety," said Mei Kong, RN, Assistant Vice President, Office of Patient Safety and Employee Safety, NYCHHC.

The grand rounds PowerPoint presentation highlights an original video depicting the tragic consequences of preventable medication errors on patients. It also provides important information on how to achieve effective pain management and use opioids appropriately, as well as emphasizing the key to reducing medication errors – improving teamwork and communication. Each grand rounds also included specific information about that particular hospital's safety record with regard to medication errors.

The presenting grand rounds team included Drs. Marian Irizzary and Thakur Hameer, CIR resident leaders at Lincoln Medical and Mental Health Center; Nelly Pakh, a Lincoln pharmacist and 1199 SEIU delegate; Mei Kong, RN and Abdul Mondul, MD, patient safety leaders at HHC.

Members of Medication Safety Grand Rounds presentation team: Abdul Mondul, MD, Mei Kong, RN, Marian Irizzary, MD, Nelly Pakh, Pharm.D.

Visit the CIR Policy and Education Initiative website–www.cirpei.org–to see the Medication Safety video featuring nationally known patient safety advocate Helen Haskell, as well as ten video clips of medication safety expert Mary Burkhardt, outlining important tips for prescribing and dispensing frequently used opioids such as morphine and fentanyl.

HHC Facts

NYC Health and Hospitals Corporation is the largest public hospital system in the U.S., with 11 acute care teaching hospitals, four long term care facilities, 80 clinics and six diagnostic and treatment centers. It employs 38,000 people. In 2008, HHC providers wrote 7.7 million medication orders. In 2010:

- More than 225,000 patients were discharged from HHC hospitals
- More than one million patients collectively accounted for five million outpatient visits and more than one million ED visits.
- More than 450,000 uninsured patients were treated

Bronx-Lebanon Internal Medicine Designs Signout App

Internal medicine residents at Bronx-Lebanon Hospital Center are armed with a new tool this year – an electronic signout app developed for the iPad and custom-designed for use at Bronx-Lebanon.

"Residents sign out in a certain way. They use paper mostly, and they write notes, scribble cards, and they're pretty good at it," said Dr. Sridhar Chilimuri, the Internal Medicine Program Director and father of the Med-eSign iPad app. "What we were trying to do is something similar, and make it electronic."

Dr. Chilimuri had previously explored signout features that are built into the hospital's electronic medical records system, but he found that they were not designed with residents' workflow in mind.

Inspiration struck when he attended the 2011 Medicine 2.0 Conference at Stanford University in California. "This is a meeting of IT geeks, venture capitalists, academia, and social media," Dr. Chilimuri explained.

There he saw a demonstration of an application designed for the anesthesia department at Stanford that monitors patients as they come into the operating room and blocks access to the LCD monitor until all the safety steps are complete. "Then they immediately pop open and all the data is there to see. All the important information is on one large LCD screen, and it'll say this is the surgeon's responsibility, the anesthesiologist's, nurse's, etc."

The Bronx-Lebanon physician was so impressed, he asked the Stanford presenters where he could buy it, but they weren't selling it – it was only for use at Stanford.

CIR member, Dr. Manoj Bhandari with Dr. Sridhar Chilimuri who developed an app to make the signout process more efficient at Bronx-Lebanon Hospital.

"I said, this is amazing, and I decided, why don't I do it? So I came home and I said, I'm going to design my own app. Why should I have to wait for all these IT companies?"

He found an Apple-certified developer who already had a relationship with Bronx-Lebanon and proceeded to sketch out the requirements for the app.

"I first met with the chief resident and said 'I want the app to look exactly the way [signouts are done] on paper.' On paper, residents usually sign out about 20 different things. But all the apps I saw will do about 2,000 things. The resident is generally signing out three things and never more than 20."

The next step was to make it dynamic. "Paper is static, so if you sign out something at 6 pm and leave, whatever the info is at 6 pm is all that's going to be there. But we said, we want it to be live, so at 8 pm somebody can update it, and it will be available for everyone."

Three months later, the product was ready to be rolled out. The app maps patients on each floor and color codes them, so they can be easily identified by the physician receiving the signout. "It's mostly designed by residents, I just had a general idea of how it should look," Dr. Chilimuri said.

Many residents didn't have iPads, but a donation from a former resident allowed for the purchase of 20 iPads. "Eventually they'll buy their own, that's what the goal is, but we wanted to get it up and running because after you start, you find some things not working exactly as people might want," Dr. Chilimuri said.

"Residents told us what they like and don't like, and there were many things I hadn't thought of, like a voice memo feature. We can't always describe everything on paper, so they can click and record a 30-second message about the patient–some crucial things that you can't really write up."

Residents were encouraged to use the $325 book/education allowance in their CIR contract to purchase iPads if they don't already have them, and the internal medicine department is kicking in $100 to make up the difference for residents who choose to do so.

Early adopters of the new technology were enthusiastic. Dr. Manoj Bhandari, Chief Resident in Internal Medicine said that the voice memo feature was popular with residents and that the app has reduced the amount of paper notes overall.

"The signout is something we all need to improve, and this is a way forward," Dr. Bhandari said.

Medicine in the Military: Life as a soldier and physician serving in Iraq

Benjamin Wind had just submitted his medical school applications when the World Trade Center was struck on September 11th. A volunteer EMT, he raced downtown to help with patient evacuation and disaster management. The experience changed him. The Navy was offering a scholarship that would pay for his medical education; in return, Dr. Wind would owe the Navy one year of service for each year of school they provided. He commissioned.

"The last time you volunteer [for the armed forces] is when you sign up. After that you're voluntold," said Dr. Wind, now a PGY 3 in Internal Medicine at St. Luke's Roosevelt Hospital in New York. And that was how Dr. Wind, a Navy reservist, found himself in Iraq in 2008 as the battalion surgeon for the 3rd Battalion, 4th Marines, 7th Regiment, rebuilding medical clinics and treating local children's congenital heart problems.

"One of the best things I learned was knowing what I don't know and being humble enough to ask for help."

"These [medical] clinics were destroyed years before," Dr. Wind said, explaining that the insurgents had overtaken the clinics, stolen medical supplies, and driven the local physicians into hiding. "Only [after security was established] could we start focusing on delivering humanitarian aid." His battalion rebuilt 14 clinics. They brought back the Iraqi physicians and retrained the staff. They gradually rebuilt trust between the non-combatant Iraqi population and the battalion, and the reintegration of the clinics into the healthcare system lessened the intense demand on the region's hospital.

Dr. Wind was the sole battalion surgeon in the primary medical unit where he was stationed in Haditha. "I've had to figure things out myself," he said. "When dealing with Marines, most are 18-35, relatively healthy. But the local population. . . You've got a kid who's 13 and blue. You've got a satellite phone or video chat with specialists, but they're depending on your history and assessment. You were unprepared." In the field, Dr. Wind always had to question: What are the resources at hand? Is that therapy around? "You become your own MacGyver," he said.

Dr. Wind said physicians like him who have a "pause in training" and take a non-traditional route to complete their education often better understand the more humanistic aspects of medical care, such as how to talk to patients and build relationships. "Patients won't give full answers until they trust you. In a conflict, people aren't quick to offer blind trust." Dr. Wind recalled a Marine who had befriended an Iraqi cop and ultimately learned of his daughter's heart problems. "The Marine came to me through his chain of command. The patient had [a congenital heart defect]." It was impossible and impractical to shuttle all the patients with severe health problems to the U.S.– they needed to develop local resources. Several phone calls later, a passport was provided, and the cop's daughter flew to Jordan for surgery. "None of this would have happened without that relationship. She probably would have passed away as her cousin did."

It was hard for Dr. Wind to return to the U.S. as a resident, where his former classmates were now attendings. "I'm older than many U.S. residents. I relate more to foreign medical professionals who have had to redo their residencies just so they can practice in this country."

Dr. Benjamin Wind with Amenah, a heart surgery patient at Haditha Hospital in Iraq.

Practicing medicine abroad afforded him unique experiences, such as helping the flood victims in Pakistan, treating Somali pirates and witnessing the uprisings in Bahrain, Egypt and Libya. The lessons from that period are reinforced daily in his work at St. Luke's-Roosevelt.

"One of the best things I learned was knowing what I don't know and being humble enough to ask for help," he said. The second lesson was decision making. "In residency, it's not until later on that you learn how to make a decision in a patient's care. The Marines have a saying, 'Who's gonna pull the trigger?' It's about having the confidence to make a decision."

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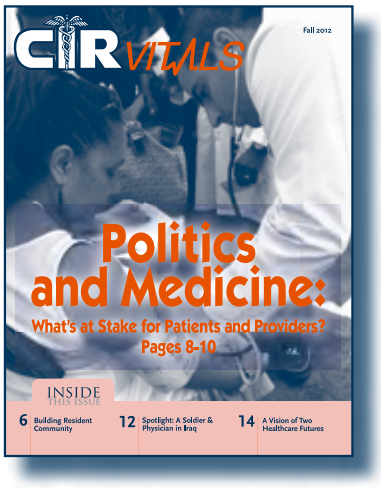

NEXT UP

Winter CIR Vitals: *"Finance for Residents"*

- Have you wondered what student loan repayment options exist for you?
- Are you struggling to support a family on a resident's salary?
- Do you have a grasp of how the changing economics of residency might affect safety net hospitals?

Don't Miss the Winter Finance Issue of CIR Vitals.
Have a question or story you want to see covered?
Send us a note at vitals@cirseiu.org.

What's online:

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