

ANNUAL MEETING UPDATE: PART I

SGIM Plenary Speakers Reflect on Advancing Teams in General Internal Medicine

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SGIM's 2015 Annual Meeting theme of "Generalists in Teams: Adding Value to Patient Care, Research, and Education" will be reflected in the conference's plenary sessions. SGIM President William P. Moran, MD, professor of medicine and director of General Internal Medicine & Geriatrics at the Medical University of South Carolina, will open the meeting on Thursday with his presidential address. Friday morning, Jeffrey Turnbull, MD, FRCPC, chief of staff at The Ottawa Hospital, will speak on "The Role of the General Internist in Canada's Evolving Healthcare System." Finally, the Malcolm L. Peterson Honorary Lecture at the Saturday awards breakfast will feature Malcolm Cox, MD, who will present a talk titled "Building Health Care Value through System Redesign: Leverage at the Point of Interprofessional Care and Education."

SGIM recently asked each of our plenary speakers to address several questions as they prepare for the meeting. Their answers illustrate just how exciting this era is in our field and how advancing teams will change the landscape of general internal medicine (GIM). Here are their responses:

What are the current opportunities for advancing teams and teamwork in general medicine?

Dr. Moran: The opportunities for advancing teams and teamwork in general medicine are many. First, teams with physicians and other professionals offer us the ability to more efficiently and effectively deliver care in both the inpatient services and the outpatient primary care setting. Many tasks that physicians currently are responsible for could be effectively managed by another team member. For example, pharmacists offer incredible depth of knowledge in medication management and are especially valuable to patient care when focused on high-risk medications, complex medication regimens, and titrating existing regimens for chronic illness such as diabetes and hypertension. Medical assistants can be trained to perform accurate and thorough medication histories within the clinical setting, and care coordinators can focus on challenges patients

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Get Ready for the SGIM Annual Meeting!

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If you are an academic general internist, the SGIM annual meeting—the premier venue for networking, mentorship, and career development in general internal medicine (GIM)—is designed to support your career aspirations. How can you maximize this impact on your career? Here are some strategies to consider:

1. Start with a needs assessment. Where are you in your career? What are your short- and long-term career goals? (*Write them down!*)
2. Craft a mental “roadmap” detailing how you will get from your starting point to your goal.
3. List the skills, training, or experience you need to attain your goals.
4. Identify key influencers and contacts who can advise, mentor, or sponsor you on your career path.
5. Be strategic in your choice of meetings to attend. Plan to attend workshops and seminars that offer training in areas you have identified. (See step 3.)
6. Consider signing up for a mentoring session. A review of your new needs assessment is a great place to start. If you are further along in your career, identify some specific questions you have or areas to work on, and request a mentor who can help you focus on these.
7. Make an action plan for how you will do things differently after attending the meeting. This might include staying in touch with new mentors, initiating a new project, pursuing training to attain a new skill or credential, or joining a working group focused on a professional interest of yours.
8. Come prepared. Rewrite your CV, and polish your elevator speech. Dress for success. You are about to meet an outstanding group of colleagues who want to know who you are and what you do! More importantly, these colleagues are here to guide you in pursuing your career aspirations.

The SGIM annual meeting is a great opportunity for those considering a career in academic GIM to gain insights into the many opportunities and career paths taken by GIM professionals. Early career physicians may be interested in attaining specific skills such as research training, clinical teaching, or professional writing. Mid-career people may wish to add leadership training, grant writing, editing a publication, or health policy advocacy. More senior SGIM members may look to the meeting as a chance to network with supportive colleagues, gain insights into best practices and feedback on career challenges, expand the reach of an educational program or research project, and mentor younger GIM professionals. At any stage of your career, the SGIM annual meeting provides unique opportunities to present your work on a national stage, seek out new professional opportunities, and network with influential leaders who share your commitment to GIM and can guide you on your career path.

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Generalist Collaboration: The Three Bills' Breakfast

William P. Moran, MD

Primary care service lines seem to be a common response to the transformation challenge, and those service lines bring together the generalist disciplines in a way that has rarely been seen in AHCs.



Shortly after I arrived at MUSC as the new general internal medicine (GIM) division chief, I received an e-mail from Bill Houston, chair of the department of family medicine. He copied Bill Basco, the chief of general pediatrics, and asked if we wanted to get together for breakfast. All of us had been Robert Wood Johnson Faculty Scholars but only saw each other on occasion. We worked out a 7 am meeting, and we talked about primary care, hospital medicine, and a range of topics at MUSC. We agreed to have breakfast monthly, and each discussion was part clinical, faculty management, academics, and a little psychotherapy as the three of our units struggled to thrive in a traditional academic health center (AHC).

At about that time in 2007, the four generalist disciplines issued the joint principles of the patient-centered medical home (PCMH),¹ a major accomplishment that helped set the stage for the emergence of PCMH as a delivery system innovation within the Affordable Care Act (ACA) of 2010. The year ACA was enacted into law the four disciplines again published this time a less-well-known joint principles statement on medical education of physicians for practice in PCMH.² Since then, significant effort and study have been devoted to transforming the primary care practice environment to meet the principles of PCMH for both clinical care delivery and medical education.³

Driven by the ACA and consumer demand, the primary health care de-

livery environment is also diversifying in response to ACA, with the rapid expansion of retail clinics, direct patient care arrangements, and the prospects of care delivered by telemedicine. We do not know how much these alternatives will alter the delivery and financing of primary care, but many are concerned that they will adversely impact the ongoing relationship of patients and primary care professionals. The American Academy of Family Physicians (AAFP) is now launching a major communications initiative called "Health is Primary," emphasizing the importance of a longitudinal relationship with a primary care provider in maintaining health.

Over the past few years, SGIM has been building closer relationships with other primary care organizations including AAFP. I recently represented SGIM at the meeting of the Chairs of Departments of Family Medicine (CDFM), a relatively new collaboration for SGIM. I was not surprised to learn that the challenges facing academic family medicine are common to all the academic generalist disciplines. A large proportion of students enter medical school with a desire to practice family medicine, but many fewer graduate to do so. GIM has a different challenge: Early medical students are not sure what a general internist career offers. Targeting a much narrower audience than the AAFP campaign, SGIM has been developing a communication initiative to help early medical students un-

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derstand the role of general internists as primary care and hospital medicine physicians. The products of that initiative will be unveiled at the SGIM annual meeting in Toronto.

We have other common concerns with our generalist colleagues. Stress and burnout are a common threat to our faculty and clinicians. As AHCs struggle to transform, the generalist disciplines have been tasked with leading the transformation of primary care and population health efforts. I am not sure if collaboration across generalist specialties has become the norm in AHCs, but I was pleasantly surprised at the number of chairs of family medicine

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Inpatient Falls and Interprofessional Communication

Erin Bredenberg, MS4 (presenter), and Anne Tomolo, MD, MPH (discussant, in *italic*)

Ms. Bredenberg is a fourth-year medical student at Emory University. Dr. Tomolo is chief of quality for the medicine specialty service at the Atlanta VA Medical Center and an associate professor of medicine at Emory University.

Mr. J is a 68-year-old man who presents to the emergency department with chief complaints of acute nausea, vomiting, constipation, and fever of 101°. He is initially diagnosed with acute gastroenteritis and is started on supportive therapy, including fluids and antiemetics, in addition to a bowel regimen of stool softener and multiple laxatives. Approximately one week prior to admission, the patient experienced an eight-foot fall from a ladder resulting in pelvic, coccyx, and rib fractures. Aside from a history of hyperlipidemia, the patient has no other chronic medical problems. During his hospital stay, Mr. J is found to have MSSA bacteremia and is started on nafcillin. Imaging eventually reveals a left-sided piriformis abscess, which is drained via CT-guided procedure. Mr. J's hospital course is complicated by hyperbilirubinemia of unclear source and the development of a rash in response to nafcillin therapy, which necessitates switching to cefazolin.

Because of his recent fall, orthopedics, occupational therapy, and physical therapy consultations are requested upon admission. The occupational therapy and orthopedics teams evaluate the patient soon after he arrives on the floor. The orthopedics team recommends that the patient be non-weight bearing on the left lower extremity while weight bearing on the right lower extremity. The nursing staff assessment includes a fall risk assessment utilizing the Morse score. Due to his recent fall and the resulting limited mobility, his Morse score is 95 (i.e. at high risk for fall if greater than or equal to 45; see Table 1). Several safety measures are put in place to decrease his risk of falls, including patient education (e.g. request assistance with daily activities, use mobility aids and non-skid socks) and modifications to environment of care (e.g. bedside

commode in place, bed in low position, call light in easy reach).

The Morse Fall Scale (MFS) is one of several tools that is commonly used to predict a patient's risk of inpatient fall. Other scales include the St. Thomas Risk Assessment Tool in Falling (STRATIFY) and the Hendrich Falls Risk Model II (HFRM).¹

The authors of the MFS claim a sensitivity of 79% and specificity of 82% in predicting inpatient falls, though more recent studies show that the MFS and other scales lack both sensitivity and specificity in an inpatient setting.¹ However, in the absence of other tools to predict inpatient falls, such scales remain the best available method for estimating a patient's risk of falls and have been used to target those who need more intensive fall-prevention interven-

tions. Better instruments are needed to identify and target patients at high risk for inpatient falls.

Nine days after admission, the patient experiences a fall. Immediately prior to the fall, his nurse is in the room preparing to administer his nafcillin. She steps away from the room briefly in order to complete this task, and while she is away, Mr. J reports an urgent need to use the toilet. He asks his son to assist him to the commode because he feels he cannot wait for the nurse's help. Mr. J then has an acute episode of diarrhea and slips in his own stool while trying to use the bedside commode. The nurse hears Mr. J fall and returns to the room, at which point she takes his vital signs, which are within normal limits; notifies the overnight provider and her supervisor; and after assisting the patient back to bed, completes a note in the chart describing the circumstances surrounding the fall in detail. The overnight provider does not document assessing the patient.

A wide variety of factors put inpatients at risk for falls, including muscle weakness, agitation, confusion, changes in urination, postural hypotension, and use of certain prescription drugs.¹ Inpatient falls are a source of significant morbidity. Approximately 28% of those who fall in the hospital have minor soft tissue injuries such as bruises while 11% have severe soft tissue injuries, including lacerations.¹ More serious injuries, including fractures and head trauma, occur in another 7% of inpatients who fall.¹ Certain groups of patients are at particularly high risk of injury from falls. For example, patients on warfarin and those with high blood alcohol are at higher risk of brain injury following a ground-level fall.² Injury rates are also higher among older patients, patients who

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Table 1. Morse Fall Scale Scoring

HX of Fall	Score
No	0
Yes	25
Secondary DX	
No	0
Yes	15
Ambulatory Aid	
Walks without assistance or nurse help, wheelchair or bed rest	0
Crutches, walker, cane	15
Clutching furniture for support	30
IV or IV access	
No	0
Yes	20
Gait	
Normal/bed rest/immobile	0
Weak	10
Impaired	20
Mental Status	
Consistent/normal	0
Non-consistent/unrealistic	15

The Journey from I to We: Building Effective Teams

Aparna Kamath, MD, MS

Dr. Kamath is a clinical assistant professor and quality and safety officer for the Department of Medicine at the University of Iowa.

In 2000, the Institute of Medicine (IOM) report *To Err is Human* served as a call to action to improve patient safety.¹ Meaningful improvements have been difficult to achieve, however, and require a systemic, multidisciplinary approach to preventing medical errors.

In the last decade, the health care industry has moved from defining and measuring quality to publicly reporting performance metrics. The Patient Protection and Affordable Care Act (PPACA) has emphasized the concept of teamwork, requiring health care professionals to work with multidisciplinary teams. Unfortunately, most health care professionals currently in practice were not trained to work in a multidisciplinary framework.

Nonetheless, interprofessional teamwork is viewed as a critical component of high-value, safe, and effective health care. Teamwork not only enhances professional satisfaction but can also produce measurable gains in efficiency and outcomes by emphasizing disease management and prevention over acute episodic care.² Emerging evidence suggests that team training not only reinforces good team behaviors and attitudes but also improves clinical outcomes and patient satisfaction and reduces medical errors.^{3,4}

Within this new paradigm shift from solo performers to high-functioning teams, teamwork skills need to be developed and practiced to achieve the best patient outcomes.

Team and Teamwork

Mosser et al. define teams as groups of interdependent individuals who share responsibility for achieving a common goal, with each individual having sufficient authority to take action to achieve the goal.⁵ In addition to physicians, patients, and health care workers such as regis-

tered nurses, social workers, pharmacists, and administrators are essential to the clinical team.

Understanding the unique roles, skills, experience, and education of team members builds a foundation for cooperation and appreciation of shared resources to achieve the desired outcome. Salas et al. identified five core components of effective teamwork: 1) effective team leadership, 2) mutual performance monitoring, 3) backup behavior, 4) adaptability, and 5) team orientation.⁶ Additionally, a shared mental model, closed-loop communication, and mutual trust were identified as important facilitators of the five teamwork skills.

Resources to Promote Teamwork

Geographic cohorting of patients to specific inpatient units can improve nurse-physician communication and thus be used as a first step in creating an environment that promotes inter-professional teamwork.⁷ Whiteboards in patient rooms, checklists, interdisciplinary bedside rounds, and daily huddles can be useful tools for ensuring safe handoffs between hospitalists and other members of the health care team.

Adoption of a team training curriculum such as AHRQ's Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS), Crew Resource Management (CRM), and VA Medical Team Training (MTT) can help build physician teamwork skills. In addition, simulation can provide opportunities for deliberate practice in realistic and safe environments.

At our own academic medical center, we trained multidisciplinary teams on a general inpatient unit using TeamSTEPPS and supplemented training with simulation to increase the effectiveness of the curriculum. The majority of the partic-

ipants at our team-training workshop felt that the workshop was useful and that the skills they learned would be transferrable to their practice on the inpatient unit.

Challenges to Effective Teamwork

Organizational culture can be a significant barrier to effective teamwork. Before undertaking any teamwork training or activity, it is imperative to assess readiness within the organization and unit as well as among participants. Local frontline stakeholder buy-in is as important as organizational leadership buy-in. Resistance to change, personality conflicts, and a culture of independent practice can act as potential barriers to team building. Our own experience promoting teamwork on a general medicine inpatient unit was hampered by a lack of complete buy-in from all the key stakeholders working on the unit.

Conclusions

Teamwork and collaboration are cornerstones of success for high-reliability organizations. By providing resources and team-based incentives, organizational leadership can help cultivate a culture that promotes teamwork. Hospitalists are in a unique position to lead and manage these efforts.

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Changes in Maintenance of Certification (MOC)

Eric H. Green, MD, MSc, FACP

Dr. Green is chair of the MOC Task Force, program director of the Internal Medicine Residency Program at Mercy Catholic Medical Center, and clinical associate professor of medicine at Drexel University College of Medicine.

On February 3, most of us opened an e-mail from the American Board of Internal Medicine (ABIM) with the header “We got it wrong. We’re sorry.” The changes in the Maintenance of Certification (MOC) process launched on January 1, 2014,¹ have been subject to much criticism from physicians, ranging from online petitions to negative editorials and comments in major medical journals. SGIM, along with other major medical societies, has had active dialogue with ABIM to help them understand the concerns and frustrations felt by many physicians who believed the changes in MOC were the equivalent of the “straw that broke the camel’s back.” With his e-mailed apology, ABIM President and CEO Richard Baron, along with the Board of Directors, demonstrated that they “heard” us and were willing to listen to the voices of the “house of medicine.”

First, let’s examine what changed:

1. *Costs.* ABIM agreed to freeze costs of its MOC program until 2017. Of note, ABIM had previously announced reductions in fees associated with the MOC secure exam.
2. *Reporting.* Within six months, ABIM will change its public reporting language from “Certified, Meeting MOC requirements: YES/NO” to “Certified, Participating in MOC YES/NO.”
3. *Requirements.* The practice assessment, patient voice, and patient safety requirements have been suspended for at least two years.¹ Points earned from activities in these areas will continue to count toward the total required for MOC.
4. *Secure Exam.* Starting this fall, the internal medicine MOC

secure exam will implement changes to make it “more reflective of what physicians in practice are doing.” Of note, ABIM discussed changes in content (not in format), so for the near future the exam will remain a closed-book multiple-choice question test.

5. *Medical Knowledge Activities.* ABIM is rapidly moving toward broader recognition of medical knowledge activities including live activities, journal-based continuing medical education (CME), and point-of-care CME that can count for MOC credit.

At the same time, the Board did not modify many of the fundamental changes in MOC implemented in 2014, including:

1. Continuous MOC (i.e. some activity every two years),
2. More MOC than before (i.e. 100 points every five rather than 10 years), and
3. Reporting MOC status on all physicians, including those with life-long certification previously exempted for MOC requirements.¹

What do these changes say about ABIM and the future of MOC? First, ABIM is in the midst of a number of transformations. They have begun to systematically incorporate both non-academic physicians and non-physicians in their governance structure. Their assessment 2020 project has long been underway to explore new methods of verifying cognitive expertise outside of the traditional multiple-choice question exam. Finally, they have publicly stated their intention to collaborate more closely with professional societies such as SGIM in fu-

ture efforts. The sentiments expressed in the e-mail suggest that these changes are more than superficial.

Fundamentally, however, MOC is probably here to stay. Few question the ideals of MOC—after all, continuous enhancement of knowledge and skills is a cornerstone of good medical practice. Our concern has always been with the details so that the time (and money) we spend in MOC actually achieves these goals. Hopefully, a re-tuned ABIM committed to working with SGIM and other medical societies to improve MOC will gradually get all of the details right.

Although many have questioned the need for ABIM or its MOC program, the concerns of the public outlined by ABIM and the American Board of Medical Specialties when constructing the MOC programs are real. Patients equate board certification with an endorsement of competence and not a measure of passing minimal standards. In this instance, ABIM has demonstrated an unprecedented responsiveness to our concerns. It is hard to imagine any other group abruptly halting the implementation of a new change and almost inconceivable that they would place the words “We’re sorry” in the header of their correspondence to physicians.

On June 16, 1858, Abraham Lincoln stated, “A house divided against itself cannot stand.” It is time for the “house of medicine” to reunite to address our need to ensure competence throughout an individual’s lifetime in practice. Hopefully, the apology offered by ABIM will be an important initial step.

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1. <http://www.sгим.org/File%20Library/SGIM/Resource%20Library/Forum/2014/Aug2014-09.pdf>

SGIM

PCORI Conference Award

Jennifer Kraschnewski, MD, MPH, and Leslie Dunne, MPA

Dr. Kraschnewski is assistant professor of medicine and public health sciences at The Pennsylvania State University College of Medicine, and Ms. Dunne is SGIM Director of Development and Project Management.

Patient-centeredness is not a new concept in general internal medicine (GIM). Whether in clinical settings or in education, we are trained to focus on the needs of our patients. Patient centeredness in our research—defined as engaging patients in all study aspects—has more recently been highlighted through efforts of the Patient-centered Outcomes Research Institute (PCORI). PCORI is a nonprofit non-governmental organization whose establishment was authorized by Congress through the Patient Protection and Affordable Care Act of 2010. PCORI's approach to comparative clinical effectiveness research, known as patient-centered outcomes research, unites patients, caregivers, clinicians, and other health stakeholders with researchers throughout the research process. The vision of PCORI is for both patients and the public to "have information they can use to make decisions that reflect their desired health outcomes."

Given our Society's mission to lead excellence, change, and innovation in clinical care, education, and research in GIM, our members are obvious stakeholders in PCORI's vision. SGIM members have historically been the champions and, in some cases, originators of concepts such as shared decision making, physician-patient communication, and effective care—all core elements of the PCORI mission. Our members include current researchers who are uniquely positioned to serve as PCORI investigators, given that primary care is ideally patient-centered care (i.e. patient-centered medical homes). In addition, our membership includes academically oriented clinicians and educators who are particularly well

suited to make valuable contributions to patient-centered outcomes research, bringing their important perspective to such research. Furthermore, SGIM engages trainees (i.e. medical students, residents, and fellows) who can benefit from these important connections at the beginning of their careers. Given these many synergies, SGIM applied for and received a Eugene Washington PCORI Engagement Award with a project goal to educate our members about PCORI research and to provide avenues for better engagement of clinicians and clinician-educators in this research process. We also aim to provide PCORI with key perspectives from SGIM members regarding their participation in patient-centered outcomes research.

In order to accomplish these project goals, we've engaged a lead group demonstrating the breadth of SGIM members, including representation from the Education, Clinical Practice, and Research committees. We have also partnered with Family Voices, a national nonprofit family-led organization that aims to achieve family-centered care, and have included one of their representatives in our lead group for true patient engagement. We are looking forward to learning about our members' attitudes and needs regarding possible participation in patient-centered outcomes research. More importantly, we're excited about the opportunity to provide educational opportunities on a variety of patient-centered outcomes research topics through the creation of a PCORI "track" during the annual meeting in Toronto. Highlights of this project will include a keynote presentation by Joe Selby, MD, executive director of PCORI. In addition, we will offer a series of workshops, including "Incorporating

Patient-Centered Outcomes Research to Develop Learning Health-care Systems," "Understanding Patient-Engagement," and "Pragmatic and Patient-Centered: Clinical Trials Done Differently."

We will also host a session on understanding PCORnet, the National Patient-Centered Clinical Research Network, and how you can get involved. PCORnet, supported by PCORI, is developing a large, highly representative national network for conducting clinical outcomes research. This innovative health data network brings research and patient care together, improving our nation's infrastructure to conduct comparative effectiveness research to answer questions that matter the most to patients. PCORnet presents a tremendous opportunity for SGIM members to engage in patient-centered outcomes research. Similarly, PCORnet can benefit from the clinical, educational, and research expertise of key stakeholders within SGIM. Frontline clinicians, such as SGIM members, will be necessary to best use PCORnet to determine the types of prevention, diagnostic, and therapeutic questions most necessary to advance patient-centered medical care. As primary care physicians, our members have unique relationships with their patients that can allow for true patient engagement in these critical research investigations.

Not planning on coming to this year's annual meeting? There are still opportunities for you to learn more about patient-centered outcomes research. This two-year contract will allow us to reach each of SGIM's seven regional meetings. In addition, we have even more in store for our 2016 annual meeting,

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General Internal Medicine Fellowship: Creating Leaders in GIM

Archana Radhakrishnan, MD, and Brita Roy, MD, MPH, MS

Dr. Radhakrishnan is a first-year general internal medicine fellow at Johns Hopkins University, and Dr. Roy is a Robert Wood Johnson Foundation clinical scholar and assistant professor of medicine in the Yale University School of Medicine and Veterans Administration Connecticut Health Care System in West Haven, CT.

Upon completion of residency, internal medicine graduates face a diverse array of career paths. Some choose to start practicing medicine immediately as primary care physicians or hospitalists. Others choose to pursue fellowship training in a medical subspecialty. A lesser-known option is the general internal medicine (GIM) fellowship.

What exactly is a GIM fellowship, and what does it add beyond residency training? The GIM fellowship is designed to provide expertise in content areas such as medical education, health policy, quality of care, and research in public health and health systems design. Fellowships can be tailored to meet individual interests, and specific tracks for research, quality improvement, and medical education may be offered. Many fellowship programs also incorporate a master's degree program in one of these areas of specialization.

GIM fellowships provide the knowledge, foundation, and skills necessary for success in academic GIM and for leadership roles in medical administration and health policy. Although most residents are encouraged to participate in research or quality improvement projects during residency, most residency programs do not provide formal training in study design or biostatistics. With the common “learn-as-you-go” approach, residents are often left with many knowledge gaps in designing and conducting sound research.

Similarly, during residency there is little formal training in adult learning theory and best practices in medical education, health policy, quality improvement, or redesign of clinical systems of care. Furthermore, most residents are ill equipped to analyze results from medical research and have little training in scientific writing. These skills are key elements in the education of GIM fellows and position them to lead in academic and administrative careers.

GIM fellowships achieve this goal through several mechanisms. First, as briefly mentioned, the GIM fellowship often provides content expertise through formal master's-level degree programs in public health, health sciences (including clinical epidemiology), or education. Fellows acquire the methodological skill set needed for a career in research or medical education. Second, fellowships provide close structured mentorship in the trainee's area of interest. This usually involves a panel of mentors who provide invaluable guidance and counseling with respect to research projects, work-life balance, and career development. Lastly, throughout the fellowship years, fellows participate in outpatient clinics and/or rotate through inpatient or consult services as both clinicians and educators.

Awareness and interest in GIM fellowship are growing among internal medicine graduates; the pro-

grams, however, are few, and the application process remains decentralized. To facilitate access to information about individual GIM fellowship programs, SGIM has begun to compile a list of GIM fellowship programs accessible online at <http://www.sgim.org/career-center/training-directories>. This includes links to the specific fellowship-sponsoring institutions. At this time, each institution has its own application process. Application deadlines also vary, ranging from February to September of the year prior to starting the program.

If you are interested in subjects that augment and enhance clinical care for patients—including health services research, public health, health policy, quality improvement, health care administration, or medical education—you should consider a GIM fellowship. Graduates of GIM fellowships pursue interesting and diverse careers, which can evolve along many different paths. A week in the life of a GIM professor may include a half day precepting in clinic, a day providing direct patient care, a half day participating on a health system quality improvement team, a few hours leading sessions like resident morning report and journal club, and the remaining time working on process improvement projects in inpatient or ambulatory care. GIM “specialists” are often sought after for leadership roles both within and outside the health care system. GIM graduates are now leading large research centers, health care systems, and public health agencies. If you want to become one of our nation's next leaders and innovators in medical education, health policy, or public health, the GIM fellowship is right for you.

Fellowships can be tailored to meet individual interests, and specific tracks for research, quality improvement, and medical education may be offered.

Northwest Regional SGIM Meeting 2015: Teaching, Teamwork, and Physician Wellness

Carol Sprague, MD

Dr. Sprague is clinical associate professor of medicine, section of general internal medicine, at the VA Medical Center in Portland.

On February 6, 2015, 119 participants attended the Northwest Regional SGIM Meeting. The theme of the meeting, held at the historic Sentinel Hotel in Portland, was “Strengthening the Internal Medicine Team,” which dovetails with the team theme of the 2015 Annual Meeting in Toronto. In addition to a large group of local Oregonians, we had a diverse group of participants from Idaho and Washington. This year we added a happy hour “meet and greet” the night before the conference. A large group of SGIM members gathered for networking and fellowship, enjoying wonderful Portland food and drink at a local restaurant. The weekend was beautiful, and some members brought their families and enjoyed Portland’s great food and local attractions.

Our list of dynamic speakers included Colin West, MD, PhD (Mayo Clinic), and Judy Bowen, MD (Oregon Health Sciences University). Dr. West, an expert on physician burnout, reviewed the key drivers and widespread prevalence of physician dissatisfaction and introduced data supporting interventions to reduce burnout and rediscover meaning in work. Dr. Bowen discussed the key elements to developing strong and effective teams, including the characteristics of leader inclusiveness, which acknowledge hierarchy in diverse teams yet still invite and appreciate all team members. Both of these speakers came with exemplary records in education, communication, and teamwork. Martha Gerrity, MD, MPh, PhD (National SGIM Treasurer), gave the national update during lunch, inspiring members to become involved in SGIM’s many national activities. Bookending the meeting were up-

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Dr. Colin West discussing the prevalence of physician burnout and possible approaches to address this widespread problem



Dr. Martha Gerrity providing the national SGIM update



The 2015 Northwest Society of General Internal Medicine meeting in the historic Sentinel Hotel in Portland, Oregon



Dr. Judy Bowen presenting a plenary session on concepts in teamwork among health professionals



Poster sessions at the 2015 Northwest Society of General Internal Medicine meeting in the historic Sentinel Hotel in Portland, Oregon

Notes from a Patient-centered Medical Home Pharmacist

Amy Thompson, PharmD, BCACP, CDE

Dr. Thompson is assistant professor in the South Carolina College of Pharmacy at the Medical University of South Carolina campus in Charleston, SC.

As one of three pharmacists in an internal medicine patient-centered medical home (PCMH), I have the opportunity to work with a diverse care team of nurses, medical assistants, faculty, resident physicians, advanced practice providers, medical and pharmacy students, and social workers. Our pharmacists are heavily involved in resident and faculty education and support; daily, we answer drug information questions and help physicians streamline complex medication regimens. We participate in weekly PCMH team meetings within the clinic, and we are also involved in nursing education. In fact, we have developed a medication history training and certification program for medical assistants and licensed practical nurses. As a result, every patient who visits the clinic has a reliable medication history before seeing the physician,

thereby saving time and increasing medication safety.

A patient care team is a group of clinicians who work closely together and communicate regularly to provide optimal patient care. Clinical pharmacist involvement in the care team has been shown to have a positive effect on prescribing behavior and improving patient outcomes. Pharmacists can optimize medication regimens to increase efficacy and decrease the potential for adverse effects. With collaborative drug therapy agreements with physicians, pharmacists have the authority to initiate, modify, or continue drug therapy. From a patient care and safety perspective, there is an abundance of literature that demonstrates pharmacists improve quality of care and safety through team-based care in managing anticoagulation, diabetes, hypertension,

hyperlipidemia, and complex medication regimens. Pharmacists not only educate patients but also actively contribute to improving therapeutic management of a variety of disease states. Pharmacists complement the efforts of other team members since pharmacists can see patients more frequently or between physician visits to help patients achieve set therapeutic goals.

Over the years, I have been able to build strong relationships with not only our staff of physicians and nurses but also with the patients who I routinely see. Providing anticoagulation and diabetes management allows me to see patients monthly—or more frequently when needed—and help them achieve and maintain their therapeutic goals. I also enjoy the challenge and excitement of helping a patient simplify a complex medication regimen or working with the patient and physician to develop a more cost-effective treatment plan. The role of pharmacists within the patient care team is continuing to grow, and my passion for this role is deepening. I am excited to see where the role of PCMH pharmacists is heading in the years ahead of us!

I also enjoy the challenge and excitement of helping a patient simplify a complex medication regimen or working with the patient and physician to develop a more cost-effective treatment plan.

ANNUAL MEETING UPDATE: PART I

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face when moving from hospital to home or other care delivery venues. Each team member brings his/her unique skills and training to the entire patient experience, and each contributes uniquely to patient care.

Dr. Turnbull: New strategies for chronic disease management will require the general internist to work in

teams to provide integrated care for the complex patient. As most patients that we see have a number of chronic diseases, it is important that there be oversight and coordination among specialists, family practitioners, and other health care providers. It is inevitable that we will be working in teams in the hospital and within the community. General internists will

be essential in ensuring that transitions in care are safe and effective.

Dr. Cox: Interprofessional education has had an “on again, off again” history over the past 40 or so years. However, recent changes in the US health care delivery system—most especially those generated by the Af—
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FROM THE EDITOR

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Need a place to start? Career tracks at the annual meeting can assist you in formulating your agenda. These include medical education, women’s health, Veteran’s Affairs, teaching, leadership, and hospitalist medicine. The long list of interest groups provides a glimpse of the broad range of opportunities for a GIM career. Take a chance, and attend an interest group—you will meet talented, dedicated professionals who are thoroughly committed to strengthening GIM and their field of interest for the benefit of patients, trainees, and society. If you are look-

ing for research opportunities, the exciting collaboration between PCORI (the Patient-Centered Outcomes Research Institute) and SGIM (see page 7) is designed to open doors for you into this innovative field of research.

Now is the time to plan your itinerary. Meeting registration and program information are available online at <http://connect.sgim.org/annualmeeting/home>. Don’t forget to include *Forum* in your meeting plans! The new SGIM *Forum* Prospective Writers’ Interest Group meeting on Friday at 3 pm is for all those who

would like to know more about the workings of our newsletter. For a more in-depth session on writing for *Forum*, our “Write it for *Forum*!” workshop will take place on Friday, April 24, at 1:15 pm. You will meet our editorial team and learn more about how you can contribute to the voice of SGIM.

The *Forum* editorial team will be wearing ribbons that identify us at the meeting. Please stop us to say “Hi!” and give us your feedback! Ask us how you can also write for *Forum*! We are looking forward to meeting you in Toronto! *SGIM*

SIGN OF THE TIMES

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ANNUAL MEETING UPDATE: PART II

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including a patient-centered outcomes research poster session and more targeted workshop sessions with a focus on new research trends in this exciting area. Stay tuned for opportunities through GIM Connect to stay connected with

learning sessions between meetings and watch for articles highlighting this important topic in *SGIM Forum*. Patient centeredness is a key aspect of our specialty. Thanks to PCORI, we have the opportunity to serve on the frontlines of keeping the patient

in the center of our research agenda.

This event is supported through a PCORI Program Award, EA-1283-SGIM.

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fordable Care Act and the growing realization that effective teamwork is essential if we are to achieve the so-called triple aim (improving the experience of care, enhancing population health, and limiting increases in per capita health care costs)—have moved interprofessional education and team-based collaborative care once again to the top of the agenda. Interprofessional teams have long been an important part of geriatric and end-of-life care and are now being increasingly employed in primary care settings such as the patient-centered medical home—a natural domicile for the general internist. Leadership from the general medicine community is seen by many as essential to the continued growth of collaborative practice... and especially of interprofessional education and research.

What do you see as current barriers to adoption of team medicine in clinical practice, education, and research?

Dr. Moran: One significant barrier to moving toward team medical care is the financing of care. In primary care, the resources are still inadequate to support interprofessional teams in managing complex patients. Payment driving the patient-centered medical home transformation will support interprofessional teams in improving care. A cultural barrier also exists in physician training and practice: We as physicians are not trained to work in teams and have not learned to trust in the knowledge and skills of our team members.

Dr. Turnbull: The challenges of team-based care are often misalignment of expectations and reward systems with lack of a clear description of scopes of practice and encouragement for integration of care. There are institutional barriers such as regulation and legislation as well as cultural and practice impediments. It is important that education and research programs focus on team-based care.

Dr. Cox: If team-based collaborative care is to grow and thrive, we will

need more effective ways of educating the health professions together rather than separately... and we will need to do this across the entire continuum of education rather than focusing only on a particular segment of that continuum. Learning together in classroom settings may be foundational, but it is hardly sufficient. Interprofessional learning must continue into clinical settings, graduate education, and lifelong continued professional development. The scope of this effort alone is an enormous challenge, requiring strong and enduring leadership, agreement on taxonomy and educational models, development and testing of interprofessional competencies, and measurement of learning, practice, and system outcomes. In the present environment, cost may also be a significant barrier unless it can be shown that patient, population, and health system outcomes provide an overall positive return on investment. Changes in education and practice of the magnitude envisioned will only be achieved by more effective alignment of education, health care delivery, and policymaking than is presently the case.

What are the gaps in research or education in this area?

Dr. Moran: We need to build interprofessional training environments in both the inpatient and outpatient venues that break down barriers to interprofessional communication, build appreciation of the knowledge and skills each team member brings to the patient care experience, and entrust each team member to be accountable within the team. We also need to more thoroughly study and define systems of care of care that engage team members at the point in care at which they are needed—and in a way that is accountable to other team members. Furthermore, we need to leave behind our hierarchical view of patient care and be cognizant of the communication needs among team members as an interdependent team. Finally, we need to study gaps in care—inpatient, outpatient, or other facility-based environ-

ments—where quality or cost issues emerge. At the same time, we must be mindful of the social and cultural characteristics that patients bring to the care experience and work within the patient's social and cultural norms to achieve a healing relationship with the patient by all team members.

Dr. Turnbull: There is very little high-quality research in the area of team-based care to demonstrate its cost effectiveness. Educational programs do not emphasize this enough at an undergraduate or postgraduate level.

Dr. Cox: There is much work to be done to move the vision of interprofessional education and collaborative practice toward more widespread adoption, and two areas in particular would greatly benefit from more active involvement by the general medicine community. The first is testing the models of interprofessional education that are being developed or deployed. More robust design and more reproducible toolkits for student assessment and program evaluation are needed. Learning outcomes would also benefit from more definitive analysis. Measures of team—as opposed to individual—excellence would be especially welcome. The second area is working toward a comprehensive analysis of the health and system outcomes of interprofessional education, without which a realistic description of the potential return on investment of interprofessional education will never be realized. The history, as well as the particular educational and research skills, of general medicine makes it an ideal candidate for both roles.

Join us at the SGIM 38th Annual Meeting, "Generalists in Teams: Adding Value to Patient Care, Research, and Education," April 22-25, 2015, in Toronto, ON, Canada. For more information, visit www.sgim.org/meetings/annual-meeting.

PRESIDENT'S COLUMN

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who have close collaborative relationships with GIM and general pediatrics at their AHCs. Primary care service lines seem to be a common response to the transformation challenge, and those service lines bring together the generalist disciplines in a way that has rarely been seen in AHCs. It seems that the generalist divisions and departments will be working hand in hand in solving some thorny clinical and educational challenges facing AHCs for the foreseeable future.

As for the three Bills' breakfast, early on we agreed to join forces and expand a generalist health services research fellowship under a Health Resources and Services Administration grant. We talked about PCMH transformation, and eventually all were certified. The three Bills' breakfast became a legend in our divisions/department—faculty asked us to work through issues

with the other chiefs at the breakfast. When Bill Houeston left MUSC to become a dean, the interim chair and then new chair attended breakfast. We had already been working together for months on a PCMH steering committee when MUSC formed a primary care service line. We have been productive in a mutually supportive way. So if you don't know your family medicine and pediatric neighbors, take them to breakfast. After all, we have a lot in common, and it's not what you do, it's how you think.

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MORNING REPORT

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fall outside of the patient room, and those who experience an unassisted fall.³ In this case, the patient required assistance by staff and further mobility training due to his partial non-weight-bearing status. He utilized the assistance of a family member in the act of toileting due to staff unavailability and subsequently had a fall.

Although falls are associated with increased mortality, death is often unrelated to the fall itself. Rather, falls may be a predictor of frailty or greater disease burden than initially indicated by the principal diagnosis. Falls may also reveal important clinical information, such as gait instability, muscle weakness, and decreased vision. Both inpatient and outpatient falls highlight the need for creating a safe environment in the home, which is important in the transition from inpatient to outpatient care. Patients who fall in the hospital, particularly those with multiple falls, are significantly more likely to fall after discharge than those who do not experience an inpatient fall.⁴

In the morning, the intern acknowledges the patient's overnight fall. Physical exam demonstrates no signs of injury. According to the intern's note, the patient describes the overnight fall as "a very light fall." Two days after his fall, the patient is assessed for the first time by a physical therapist and is issued a wheelchair due to his impaired mobility. The patient's mobility status and fall are not further addressed by his physicians during this inpatient stay.

Gait disturbance, muscle weakness, and improper use of ambulatory devices are risk factors associated with patient falls.⁵ Unfortunately, many hospitals limit patients' ambulation in an attempt to decrease the short-term risk for falls. This practice may put patients at higher risk for deconditioning and increased long-term risk for falls. An American Academy of Nursing Choosing Wisely recommendation relates to this problem: "Don't let older adults lie in bed or only get up

into a chair during their hospital stay. Walking while in the hospital is critical for maintaining functional ability. For years, bed rest was thought to be essential in overcoming illness or injury, but evidence shows a lack of walking increases the length of hospital stays and the need for rehabilitation services while elevating the risk of falling after being discharged."⁶

While it is counterproductive to discourage patients with limited mobility from ambulating, it is also necessary to ensure that those with gait or mobility problems have an appropriate level of support from staff to ambulate safely while in the hospital. Outpatient physical therapy is effective in reducing falls among older adults in the community.⁷ The influence of inpatient physical therapy on fall rates in the hospital is less clear, although many inpatient fall prevention initiatives include an exercise component. In this case, the patient was neither seen by a physical therapist nor issued a wheelchair until

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after his inpatient fall. Earlier assessment by physical therapy may have benefited this high-risk patient with limited mobility.

Despite the overnight nurse's documentation that the patient's fall was due to diarrhea, the intern fails to address this or other underlying causes of the fall. The intern reports in the patient's daily progress note that Mr. J was constipated and continues to use a stool softener and one laxative that he had been on previously. Ultimately, the patient is released home with no further interventions related to the fall. The inpatient fall is not reported in his discharge documentation.

Good communication between health care professionals is necessary to achieve optimal patient care. A variety of factors, including stability and physical proximity of team members, have been found to impact interprofessional team functioning and improve communication within the team.⁸ In this case, important clinical information was lost in communication between the night nurse, the overnight resident, and the primary team. Information was also lost in the patient's transition from hospital to home due to a failure to report Mr. J's inpatient fall in the discharge documentation.

Studies show that communication among health care providers is best when teams have relatively structured or standardized methods of communication.^{9,10} Use of standardized forms based on the SBAR (Situation, Background, Assessment, Recommendation) method for communication can improve subjective and objective measures of handoff effectiveness in a variety of clinical settings.¹⁰ Strategies for improving communication between health care professionals have been put into place at many institutions, but the data on these interventions are lacking. A 2009 Cochrane review found mixed evidence of the impact of interdisciplinary bedside rounds on clinical outcomes.¹¹ More recently, implementation of software to automatically alert residents to

events that occur during cross-cover was found to improve residents' perception of handoff accuracy and decrease handoff time. The impact of such a strategy on clinical outcomes is as of yet unknown.¹² Overall, research on communication between health care professionals is limited and often underestimates the complexity of real-world interactions.¹³ Some strategies for improving communication show promise, but more research is needed on the impact of interventions to improve interprofessional communication on health outcomes.

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FROM THE REGIONS

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dates in outpatient medicine by Neil Argyle, MD (Boise VA Medical Center), and Anna Golob, MD (Puget Sound VA), and hospital medicine by Michael Krug, MD (University of Washington), and Imran Mohamedy, MD (Providence Portland Internal Medicine Residency). Each group addressed key questions in general medicine over the last year. Drs. Argyle and Golob cautioned on the use of testosterone, aspirin for primary prevention, and steroid injections for shoulder impingement syndrome and informed the audience on the use of gabapentin for alcohol withdrawal. Drs. Krug and Mohamedy discussed atrial fibrillation as the cause of cryptogenic stroke, the risk of beta blockers

with spontaneous bacterial peritonitis, and age-adjusted D-dimer reference ranges, among many other topics.

We had five workshops focused on diverse academic and clinical issues, more than 40 poster displays, a plenary session for the best submitted research/innovation/vignette, and five oral vignettes by our colleagues, residents, and medical students. Winners of the sessions were Alisa Becker, MD (Best Oral Vignette); Milla Kviatkovsky, MD (Best Vignette Poster); Meghan Kiefer, MD (Best Research Poster); and Katie Iossi, MD (Best Clinical Innovations Poster). Congratulations to Andrew Wilper, MD, MPH (Clinician-Educator), and Karin Nelson,

MD, MSHS (Clinician-Investigator), who were the recipients of this year's regional awards.

Thanks to all who attended, our reviewers, the planning committee (Chair Erin Bonura, Bill Weppner, Mike Krug, Carol Sprague, Chris Wong, Melissa "Moe" Hagman, Kay Johnson, Paula Wichienkuer, Julie Silverman, Brinton Clark, Danielle Orchard, Joe Simonetti, Meghan Kiefer, Som Mookherjee, Kate Mackey, and Brian Ricci), national SGIM office support (Kat Cooper, Tracey Pierce), and all our judges and distinguished faculty. We appreciate your help in making this one of the best meetings yet. See you next year in Seattle.

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