Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE AND GENERAL INTERNAL MEDICINE

SGIM FORUM

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PHYSICIAN PAYMENT—2004 AND BEYOND

John D. Goodson, MD and Pamela Ferraro, MASI

The January 2004 Center for Medicare and Medicaid Services (CMS) release of the Medicare Fee Schedule (MFS) has alleviated physician fears that future reimbursement will be significantly reduced. Unfortunately, this reprieve should not allay physician concerns with the MFS.

What is the fee schedule all about? CMS assigns value to about 7,500 different medical and surgical services, including just about everything a physician does as a clinician. The payment for each reflects three components; each is assigned a value (known in Medicare-speak as relative value units, or RVUs).

RVU components

There are three components to the RVU assessment:

1. Physician work RVU
2. Practice expense (overhead) RVU
3. Malpractice expense RVU

Practice expense has two categories, "facility" and "non-facility." Most SGIM members fall into the facility category, as this includes hospitals (as opposed to private physician offices). In this article, when we refer to practice expense, or overhead, we are specifically referring to facility RVU, as opposed to non-facility RVU.

Each component is separately adjusted for a specific geographic area (this is the Geographic Practice Cost Index, GPCI). Actual payment is based on the multiplication of the total RVUs times the conversion factor (or CF, discussed in greater detail below).

Your payment = [Your physician work RVU + your practice expense RVU + your malpractice expense RVU] × conversion factor.

Below is a table of the RVUs, CF, and total payment for a variety of different regions for an extended office visit, 99214, based on the current MFS values and CF.

The conversion factor, CF, is determined by CMS based on a unique (and confusing) formula directly linked to the gross national product called the sustainable growth rate (SGR). Clearly, when the economy thrives, physician reimbursement benefits. In times of recession or depression, the formula dictates a decline in payment. An anticipated decline this year was narrowly adverted.

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99214 RVUs, CF and Payment

	Work	+ Overhead	+ Liability	× CF	= Total
Boston	1.15	0.5	.04	$37.3374	$62.76
Atlanta	1.11	0.42	.05	$37.3374	$58.91
Minneapolis	1.10	0.39	.02	$37.3374	$56.42
Omaha	1.10	0.35	.02	$37.3374	$54.99
Tucson	1.10	0.39	.05	$37.3374	$57.71
Los Angeles	1.16	0.46	.05	$37.3374	$62.16

Contents

Networking, Collaboration, Professional Development: SGIM Women's Caucus Offers Many Opportunities

Susan L. Davids, MD, MPH and Jennifer R. Zebrack, MD

At the 1986 national meeting, the idea of a creating an SGIM Women's Caucus was born. The following year, the first Women's Caucus meeting was held at the national meeting and attended by over 80 women. Eighteen years later, the Women's Caucus continues to provide opportunities for networking and collaboration and sponsors precourses and workshops at meetings on topics such as women's health and faculty development.

Every two years, a new local or regional group (Host Group) is responsible for planning the annual meeting, overseeing the finances, and providing communication during the year. For the second year in a row, women faculty from the Medical College of Wisconsin are proud to be leading the Women's Caucus. The faculty involved in this year's program include Susan Davids, Jennifer Zebrack, Joan Neuner, Mary Ann Gilligan, Ann Maguire, Julie Mitchell, Monica Ziebert, Sandra Green, Marilyn Schapira and Ann Nattinger. A new Host Group for the 2004–2005 year will be selected this Spring and announced at the 2004 meeting.

At last year's meeting in Vancouver, the focus of the Women's Caucus was to discuss how reading is one way to enhance professional and personal growth. The Host Group compiled a recommended book list for professional and/or personal growth in women obtained from women leaders in academic medicine. This list was distributed at the interest group meeting and is available to all SGIM members on the SGIM website (under Women's Caucus interest group).

For the 2004 meeting in Chicago, we are honored to have Dr. Barbara Schuster, Chair and Professor of the Department of Medicine at Wright State University, as our featured guest speaker. Dr. Schuster is a general internist and SGIM member. Before becoming the Chair of Medicine in 1995, she served as Residency Program Director for the Primary Care Program in Internal Medicine and the Combined Internal Medicine and Pediatric Program at the University of Rochester School of Medicine & Dentistry. Dr. Schuster has served in leadership roles in several national organizations. She is a Master of the American College of Physicians (ACP), a member of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) Board of Regents, and is a past President of the Association of Program Directors in Internal Medicine (APDIM). She is also the APDIM representative and Chair of the AAMC Council for Academic Science and an active member of the Association of Professors in Medicine. At our Women's Caucus meeting (to be held Thursday, May 13 from 7:00–8:30pm), Dr. Schuster will speak on gaining a national reputation, including the advancement in professional societies. All current Caucus members and interested women and men are invited to attend.

In addition, the Women's Caucus is sponsoring two precourses and two workshops at this year's meeting in Chicago: 1) a full day precourse Reproductive Care for Women I: Screening and Prevention (Wednesday May 12th) and Reproductive Care for Women II: Evaluation of Common Gynecological Problems (Thursday May 13th) coordinated by Jennifer Potter; 2) a half-day precourse Women in Research: Strategies for an Effective Career coordinated by Cheryl Rucker-Whitaker (Thursday May 13th); 3) Empowering the Internist: How to Manage Common Breast

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HARD TIMES, DIFFICULT CHOICES: PITTING PHYSICIANS AGAINST PATIENTS

JudyAnn Bigby, MD

One of the greatest pleasures of my current year as President has been the opportunity to meet general internists from all over the country and from diverse practice settings. Most say they love taking care of patients. Almost all complain about the time pressure to see more patients and the low compensation for their efforts. Many are concerned that their compensation has remained flat while their office expenses have increased. They want an office that is adequately staffed and they want their staff to know they are appreciated.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed by President Bush in December, speaks to some of the concerns of practicing physicians. The bill addresses more than prescription drugs.

The Medicare bill blocks a planned 4.5% cut in physician payment for 2004. Instead physician payments will increase by 1.4%. Jenn Brunelle, SGIM's health policy advisor, announced in her January health policy update that internists would receive, on average, a 3% increase. Payment for evaluation and management performed by internists will increase by 2% to 5%. Other provisions in the bill that are favorable to physicians and hospitals include: delaying the decrease in payments to hospitals for indirect medical expenditures; giving the Secretary of HHS the authority to clarify that training programs in geriatrics are eligible for 2 years of fellowship support; and hospital reimbursement for emergency care provided to undocumented immigrants.

But the question everyone is asking is how does the bill actually benefit Medicare beneficiaries? The bill provides coverage for additional preventive services and increases reimbursement for preventive services such as screening mammograms that are already covered. Patients will have the option to participate in the new Medicare Part D program that provides funding for prescription drugs under multiple different, complicated scenarios. Analysts differ in opinion as to whether most seniors will be able to afford to participate in the programs. According to the Medicare Rights website, seniors and the disabled will benefit if they currently do not have drug coverage and their drug costs are over $800 per year. Whether beneficiaries will save money depends on whether insurance companies offer coverage at a reasonable premium, whether the drug benefit covers the drugs the beneficiary needs, and whether drug discount plans are available. Seniors will pay a monthly premium, co-payments for covered drugs, and will need to incur significant out of pocket expense before reaping the full benefit of the plan.

Seniors and disabled persons who are also eligible for Medicaid will no longer be able to receive drug benefits through their state Medicaid programs unless states pay 100% of the cost.

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SGIM FORUM

Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. *SGIM Forum* seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.
SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.
The SGIM World-Wide Website is located at **http://www.sgim.org**

DEPUTY DIRECTOR FROM THE OFFICE OF NATIONAL DRUG CONTROL POLICY TO ATTEND SGIM NATIONAL MEETING

Yngvild Olsen, MD, David Fiellin, MD and Richard Saitz, MD

As general internists, we recognize our role in providing comprehensive care to our patients and sharing our experiences, perspectives, and knowledge through teaching and research. But despite our desire to be comprehensive, we often fall short in addressing health behaviors and related diseases, such as adherence to medication regimens, dietary and other lifestyle counseling for treating and preventing diabetes and heart disease, and identifying and treating addictions. This year, SGIM Substance Abuse Task Force members have a number of events planned at the national SGIM meeting to help with the latter.

Andrea Barthwell MD, FASAM, appointed by President Bush as Deputy Director for Demand Reduction for the White House Office of National Drug Control Policy, has accepted an invitation by the SGIM Substance Abuse Task Force to serve as faculty for a Precourse entitled "Office-Based Treatment of Prescription Opioid and Heroin Dependent Patients," led by David Fiellin. Dr. Fiellin and other SGIM Substance Abuse Task Force members have been spearheading national efforts to train physicians in many specialties in office-based treatment of opioid dependence using buprenorphine, a partial opioid agonist. In Chicago, the Precourse, co-sponsored by the American Society of Addiction Medicine (ASAM), will allow SGIM members to add this novel treatment to their clinical practice.

In office and hospital settings, general internists care for many of the co-morbid medical disorders affecting the estimated 2 to 3 million patients addicted to prescription opioids (e.g. oxycodone, hydrocodone) or heroin. Historically, however, the treatment of patients' addictive disorders has been restricted to a specialized and separate treatment system with limited capacity. This has meant that only about 20% of opioid dependent patients are receiving effective treatments such as methadone, which has repeatedly been shown to decrease illicit drug use, criminal behavior, and HIV transmission.

With the passage of the Drug Addiction Treatment Act of 2000 and the Food and Drug Administration's approval of buprenorphine and a buprenorphine/naloxone combination in 2002, general internists and other office-based physicians now have an opportunity to treat opioid dependence with effective pharmacotherapy. In order to prescribe buprenorphine/naloxone a licensed physician is required to have completed an 8-hour training course in the treatment of opioid dependence. These courses, provided by the American Society of Addiction Medicine and other specialty societies, typically provide didactics and small group discussions that cover the neurobiology of addiction, opioid pharmacology, the role of counseling and psychosocial services, and practical issues regarding office logistics. Trained physicians apply to the federal government for a supplemental Drug Enforcement Administration registration. The one page registration application form is available on the web at **www.buprenorphine.samhsa.gov** and takes approximately 5 minutes to complete. Prescriptions for

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Research Funding Corner

Joseph Conigliaro, MD, MPH

NIH Director's Pioneer Award

In an effort to spur innovative or somewhat risky ideas the NIH has announced a new program, known as The NIH Director's Pioneer Award. To tap into exceptional minds willing and able to explore ideas considered risky at their inception, especially in the absence of strong supportive data, the NIH Director's Pioneer Award (NDPA) program seeks to identify and fund investigators of exceptionally creative abilities and productiveness, for a sufficient term (five years) to allow them to develop and test far-ranging ideas. Awardees are expected to commit the major portion of their effort to activities supported by the NDPA. This program will complement the other NIH research grants programs (R-O1, R-21, etc) and would provide additional opportunities to those afforded within the Institutes and Centers for research that contests the status quo across the breadth of the NIH mission. The research need not be related to conventional biomedical or behavioral disciplines. Investigators at early stages of their career as well as those who are established will be eligible but individuals must show evidence of infrastructure support. NIH expects to provide 5–10 awards of up to $500,000 direct costs each year, for five years.

To apply, individuals must be nominated by mentors, colleagues, institutions, or by themselves. A nomination package will include a letter explaining why the nominee should be considered exceptional and highly likely to pursue original avenues of research and the nominee's curriculum vita or resume (each no more than

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Collaborative Centers for Research and Education in the Care of Older Adults: Medical College of Wisconsin and MetroHealth

Marilyn Schapira, MD and Elizabeth O'Toole, MD

In this, the third in a 5-part series describing the SGIM Collaborative Centers for Research and Education in the Care of Older Adults, selected aspects of projects at two institutions are highlighted. Emphasis is on innovative aspects of these programs that are of potential relevance to SGIM members at other institutions interested in combining the strengths of general medicine and geriatrics in research and education.

Medical College of Wisconsin

The Medical College of Wisconsin has developed a collaborative effort in both clinical education and research supported by the grant from SGIM and the John A. Hartford Foundation. Our center, the COllaborative Center for the Care of Older Adults, or COCOA, has an emphasis on research and clinical care relevant to older women. The specific initiatives undertaken are highlighted below.

Education

- Two junior clinician-educators in GIM, Dr. Monica Ziebert and Dr. Julie Mitchell, are collaborating with clinician-educators in geriatrics and senior mentors to develop a series of CD-ROM based tools that can be used to assess the six ACGME core competencies using geriatric clinical cases. Our program, in collaboration with other recipients of the Collaborative Centers SGIM/Hartford Awards, will be presenting a workshop on this topic at the National SGIM meeting in Chicago this spring. These tools will serve as a way to integrate geriatric training and skill assessment into our internal medicine residency program.
- The development of "Senior Moments" at our ambulatory conferences series. These conferences are designed to add geriatric content to an ongoing conference series for internal medicine residents. For example, after a conference is presented on management of hypertension, the residents are then asked to consider how their approach may differ if the patient was elderly. The content provided is evidence based and includes a functional assessment focus in additional to diagnostic and therapeutic approaches to the care of older adults.
- Geriatrics content is being integrated onto a newly developed web based women's health curriculum.
- Monthly meetings occur between junior clinical-educators in our GIM and geriatrics divisions and senior mentors on this collaborative team. Progress made and barriers discovered in the course of this ongoing work are discussed.

Research

- A collaborative research effort is being undertaken between junior and senior researchers in the divisions of GIM and geriatrics. These efforts are focused around a research study of physician attitudes, practice, and risk perceptions regarding the diagnosis and treatment of osteoporosis. Dr. Joan Neuner, a GIM clinician-investigator, is leading this effort. A survey using clinical vignettes has been developed collaboratively between GIM and geriatrics health services researchers and will be administered to a random sample of primary care physicians that was

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Evidenced Based Medicine Task Force Update

Sharon E. Staus, MD, MSc and Rajesh Mangrulkar, Md, MSc

On behalf of the SGIM EBM Task Force, I would like to take this opportunity to update you on the progress of our EBM Project. The SGIM EBM Task Force has continued to extensively evaluate the "EBM for the Practicing Clinician" Workshop, which was developed in 2000. In 2003–2004 we will complete a second cycle of three workshops that were funded by a small conference grant from the Agency for Healthcare Research and Quality. An abbreviated workshop has also been developed for clinicians interested in teaching EBM and this workshop was held at the SGIM Annual Meeting in Vancouver.

Participants of previous workshops described barriers to completing onsite workshops including the time required to attend such an event. In response to these expressed needs, an online EBM educational course is currently under development and seed funding has been received to initiate this project.

Several clusters within the Task Force have been active over the last year. The Evaluation Cluster of the Task Force has been extremely active and is working on two publications, one presenting a new conceptual framework for the evaluation of EBM outcomes, and the second is an updated systematic review of the evaluation of EBM curricula. In addition, the cluster has been successful in receiving seed funding to begin development of an EBM Evaluation Clearinghouse, designed to house, categorize and share tools used to evaluate EBM curricula. The Web Cluster has developed

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COLLABORATIVE CENTERS

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obtained from the AMA database. The results will help us to understand practice patterns in the diagnosis and care of osteoporosis.

- An ongoing biweekly research conference series has highlighted methods used in health services research involving older adults such as functional status measures and measures used to assess cognitive function. This conference has helped researchers broaden their awareness of clinical issues and measures relevant to health services research in older adults.

MetroHealth—Case Western Reserve University

Our program, Geriatric Education and Research to Improve Quality (GERIQ), is designed to engage clinical and research faculty in general medicine along with geriatric trained faculty in working together to improve care of older adults in the MetroHealth system.

The various interventions are incrementally dosed across a system of firms, providing an opportunity for better assessment. Patients, residents, and faculty in Internal Medicine are randomized to one of three firms, which function as practice groups in both inpatient and outpatient care settings. The program is the result of the combined work of a clinical education team and a research/evaluation team.

The Clinical Education team seeks to improve geriatric knowledge, skills, and attitudes in the educational environment and in the care of older patients for both faculty and trainees. Together, general medicine and geriatric faculty have devised a curriculum covering important areas in geriatrics that are relevant to generalist practice. To enhance curriculum effects, general medicine faculty partner with geriatric faculty in its development and delivery. This provides an opportunity for involved faculty to improve their own skills by collaboration with others who have complementary experience.

Our Research/Evaluation team involves general medicine-health services research trained and geriatric trained faculty working together to address issues of data utilization in solving clinical problems and evaluative techniques to understand the effects of the interventions. Team members and junior faculty are working together to use the electronic medical record to allow trainees and faculty to identify issues and assess practice. A continuous quality improvement project on the geriatric relevant topic of advance directives is one example of such faculty involvement. The Firm Three curriculum includes increased exposure to data gathered in clinical settings, e.g. the Minimum Data Set (MDS) in long term care. Evaluation of the curriculum has been planned by the team. Pre- and post-examinations using modifications of standardized paper and pen tests, checklists for observed clinical interactions, and on-line review and testing of case studies are among the techniques employed.

The innovations of the Center support a new and substantial geriatric medicine presence in General Internal Medicine at our institution that is expected to be ongoing.

The innovations of the Center support a new and substantial geriatric medicine presence in General Internal Medicine at our institution that is expected to be ongoing. This joint effort also fosters adoption of a geriatric related focus to research. We are making progress in development and implementation of our program and look forward to seeing the work of the other Centers and opportunities to adopt other promising interventions. SGIM

Editor's Note—*Marilyn Schapira is affiliated with the Medical College of Wisconsin; Elizabeth O'Toole is affiliated with Case Western Reserve University-MetroHealth. Brent Williams serves as the series editor for the Collaborative Centers.*

OPPORTUNITIES

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Problems and Concerns coordinated by Frances Norlock (Friday May 14th); and 4) Update in Cervical Cancer Screening and Abnormal Pap Test Management coordinated by Shobhina Chheda (Saturday May 15th).

SGIM members may view more information about the Women's Caucus on the SGIM website (**www.sgim.org**). The website allows members to learn more about the Caucus, download the book list, join the list serve, and print a dues form. Dues are $30 per year and optional, however, the continued efforts of the Caucus would not be possible without your financial contributions. Dues support the sponsorship of precourses and workshops, honorariums for guest speakers, and projects proposed by members.

We hope to see you at this year's Women's Caucus interest group in Chicago! If you have questions about the Women's Caucus or ideas future programs please contact us at: **susan.davids2@med.va.gov** or **jennifer.zebrack@med.va.gov.** SGIM

Editor's Note—*Drs. Davids and Zebrack are currently serving as the Co-Chairs of the SGIM Women's Caucus.*

HARD TIMES, DIFFICULT CHOICES

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…the states have an incentive to keep the number of beneficiaries who enroll at the lowest possible number.

Under the new bill, persons eligible for Medicare and Medicaid are expected to obtain drug coverage through Medicare Part D. The state will pay their premiums. Recipients will pay a co-payment of $1 to $3 per prescription. States will pay the federal government for the drug coverage the federal government provides. The amount the state pays is based on a formula that includes a state's per capita expenditure on drugs for dually eligible beneficiaries. Since the states' payments to the federal government are based in part on the number of persons who enroll in Part D coverage, the states have an incentive to keep the number of beneficiaries who enroll at the lowest possible number. The drug coverage that Medicare and Medicaid eligible persons receive will likely be less comprehensive than coverage currently provided under Medicaid. Beneficiaries will pay co-payments for each prescription. The proposed co-payments are higher than the co-payments current Medicaid beneficiaries pay in 24 states. Unlike under Medicaid, if a patient does not have the co-payment, the pharmacy is not obligated to provide the drug. The new bill also provides financial support for low-income people who are not eligible for Medicaid by capping their out of pocket expenses.

One surprise in the new bill is a provision to pay providers for care delivered to undocumented immigrants. States will receive a proportion of 167 million dollars in funds annually based on the total number of undocumented immigrants living in the state and a proportion of 83 million dollars based on the percentage of undocumented immigrants apprehended in the state as reported by the Department of Homeland Security. The Committee on Energy and Commerce is also reviewing an amendment to the Medicare bill introduced by Representative Dana Rohrabacher of California. The amendment requires hospitals that receive these funds to provide the Department of Homeland Security with information about undocumented immigrants including a thumbprint or photograph and information about the patient's employer. The immigrants would be deported for medical treatment in their own country once they are stabilized. Representative Rohrabacher states he voted for the bill in exchange for being able to introduce this amendment.

It is clear that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is a mixed bag. Potential benefits in the bill include providing relief for many Americans who are struggling to afford prescription drugs. It is unclear how much relief seniors will see, since the bill prohibits Medicare from negotiating for lower drug costs. Physicians, particularly primary care internists, struggling to keep up with the cost of practicing medicine, welcome the increase in payments to physicians.

There are many down sides to the bill. Medicaid recipients who also have Medicare are likely to suffer due to higher out-of-pocket expenses and less comprehensive drug coverage. They may also find themselves without coverage if states are not aggressive about informing Medicaid recipients about the opportunity to enroll in Medicare Part D programs. Hospitals should receive reimbursement for care they provide to undocumented immigrants, but reimbursement should not be tied to the number of undocumented immigrants who are apprehended in the state. Representative Rohrabacher's proposed amendment should never see the light of day. Physicians, other providers, and hospital staff must engender the trust of all patients. They cannot engender trust if they are also required to identify and report undocumented immigrants.

Physicians should not have to choose to accept a bill that may not benefit patients and very clearly harms some patients while physicians benefit financially. As we learn more about the details of the bill, physicians should refuse to fall prey to a strategy that essentially pits their concerns against those of patients. We should work for policies that appropriately benefit patients and physicians. ***SGIM***

PHYSICIAN PAYMENT

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SGIM and virtually all other professional organizations are working to correct problems for 2006 and beyond so that the formula for future CF calculations is more predictable. Unfortunately, physician reimbursement is pitted against other health care expenditures, such as hospital reimbursement and prescription benefits.

As primary care physicians, general internists are particularly vulnerable to these reimbursement changes. Most physicians will find it difficult to increase productivity in order to maintain income. Furthermore, since most commercial product reimbursement is modeled after Medicare fee schedules, the broader effects on overall physician payment is profound.

The Primary Care Cluster of the SGIM's Health Policy Committee continues to follow this issue. SGIM may need to activate our membership, along with other professional organizations, to achieve a short-term stabilization of the CF and a long-term revision of the calculation methodology. ***SGIM***

DEPUTY DIRECTOR TO ATTEND MEETING

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buprenorphine/naloxone can be filled by patients at their regular pharmacy. Some challenges remain even for physicians and patients involved with this treatment—no physician or group practice can have more than 30 patients on buprenorphine/naloxone at a time, and there should be counseling available in the practice or by referral.

Several SGIM members are currently providing this type of treatment in their practices. At the Precourse in Chicago, these physicians will lead small group case discussions with attendees to share their clinical experience. Anecdotally these physicians note that some patients who have never been in drug treatment are coming in to get this therapy, and are succeeding, as measured by continuous abstinence from opioids. Young heroin and prescription opioid abusers are presenting for care, drawn in by a treatment that is provided in a physician's office, rather than a drug treatment setting. This has allowed their physicians to effectively address their comorbid medical and psychiatric disorders problems now that their addictions are under control.

Currently, across the country, approximately 4000 physicians have received training in office-based treatment of opioid dependence and approximately 2000 have the registration required to prescribe buprenorphine/naloxone. These physicians, from specialties such as internal medicine, family practice, psychiatry, and addiction medicine, are helping to increase access to effective treatment for the roughly 2 million untreated opioid dependent patients nationally. However, this workforce is not enough.

To evaluate this unique period in U.S. medicine, SGIM Substance Abuse Task Force members Yngvild Olsen and David Fiellin are conducting interviews and surveys of physicians to assess their interest in prescribing buprenorphine/naloxone, resources that might encourage this practice, and barriers that discourage physicians from adopting office-based treatment of opioid dependence. The Precourse is a resource that can help prepare physicians to provide this type of care. In addition to the opportunity to meet and learn from Dr. Barthwell, precourse attendees will be eligible to receive the DEA waiver required to treat patients with buprenorphine in their offices.

This year's national meeting will include a number of other opportunities for members to learn more about addictions, since prescribing a medication is clearly not the only skill needed in this area. General internists can play key roles in identifying substance use disorders, providing early intervention, and preventing relapse. In addition to submitting numerous research abstracts to the annual meeting, Task Force Members will run an Interest Group, a workshop to share updates in the alcohol and drug abuse literature, a workshop on research initiatives designed to address the impact of substance abuse on chronic illness, a precourse addressing chronic pain, and a pain interest group.

Many SGIM members have found substance abuse to be an area that is a perfect niche for the generalist clinician, educator and researcher. SGIM members play significant leadership roles in the American Society of Addiction Medicine, and hold prominent positions in the Association for Medical Education and Research on Substance Abuse (AMERSA). The SGIM Taskforce, in existence for over 15 years, has served as a source of collaboration and mentorship for its members. We invite all SGIM members to participate in the many activities planned for this year's meeting. SGIM

***Editor's Note**—Drs. Fiellin and Saitz are currently serving as the Co-Chairs of the SGIM Substance Abuse Task Force.*

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two pages in length). Nominations are to be submitted on the Internet (**http://nihroadmap.nih.gov/highrisk/initiatives/pioneer**) from March 1, 2004 through midnight April 1, 2004, Eastern Standard Time. This is followed by a second phase in June where candidates will be asked to provide an essay describing their views on the major challenges in biomedical and behavioral research to which they feel they can make contributions. Since the research plan is expected to evolve during the term of the grant, no detailed scientific plan is needed. In addition, a copy of his/her most significant publication or achievement and submission of support letters from three individuals will be needed. A subset of candidates will be interviewed in August/September 2004, by a panel of outside experts with final selections completed and announced by the end of September, 2004. More detail about the program is provided at: **http://nihroadmap.nih.gov/highrisk/initiatives/pioneer/faq.asp**.

Translating Research Into Practice—AHRQ

PA Number: PA-02-066
Deadline: June 01, 2004

The Agency for Healthcare Research and Quality (AHRQ) and the Health Services Research and Development (HSR&D) Service of the Department of Veterans Affairs (VA), have issued a program announcement: Translating Research Into Practice (TRIP) program. Using the R01 award mechanism, projects are sought that involve innovative and rigorous investigations and evaluations related to translation of research findings into quality improvements, patient safety, health care outcomes, cost, use, and access. The focus on translating research into practice has been a priority for AHRQ and the VA for the past several years. This PA, however, emphasizes the need for research that can bring promising models of treatment or system changes already shown to improve quality or efficiency in a particular setting and generalize that for use in multiple settings and on a large scale. Two specific priorities under this PA are to compare the use of interventions to translate research into practice across different health care systems (e.g., comparison of translation in a VA facility and in a non-VA facility using the same design, methods, measures, and patient population); and measure the impact of translation activities (including the testing of interventions that foster measurable and sustainable quality and patient safety improvement or consistent quality and patient safety at a lower cost). For more information see the following URL: **http://grants.nih.gov/grants/guide/pa-files/PA-02-066.html.**

Please contact **joseph.conigliaro@med.va.gov** for any comments, suggestions or contributions to this column. *SGIM*

Classified Ads

Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Website at http://www.sgim.org. Send your ad, along with the name of the SGIM member sponsor, to tractonl@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

ACADEMIC CARDIOLOGISTS. The Cardiovascular Division of the Department of Internal Medicine, The University of Iowa Roy J. and Lucille A. Carver College of Medicine, is recruiting faculty to practice at the University of Iowa Health Care and the affiliated Iowa City VAMC.

• Non-Invasive Cardiology to participate in clinical and teaching activities. Clinician-educators with an interest in research to participate in a wide variety of research activities. Level II training in echocardiography is required.

• Physician-scientist with clear potential for a funded research program. Preferred areas of research training and expertise are vascular biology, cardiac or vascular molecular biology, molecular genetics, or regulation of ion channels. Excellent mentors in these areas are available.

Positions are offered in two tracks. Faculty in the non-tenure clinical track have demonstrated outstanding ability in clinical medicine and teaching. Faculty in the tenure track have demonstrated ability in research, teaching and clinical medicine. The Iowa City/Coralville area offers a safe, comfortable, and diverse community setting with an outstanding public school system and Big Ten university attractions including cultural (nationally acclaimed theater, symphony, dance, and art), sports, and shopping.

Direct inquiries to Neal Weintraub, M.D., Interim Director, Division of Cardiovascular Diseases, Department of Internal Medicine (phone 319:353-7807 or e-mail neal-weintraub@uiowa.edu); The University of Iowa, Iowa City, IA 52242-1081.

The University of Iowa is an Equal Opportunity and Affirmative Action Employer. Women and minorities are strongly encouraged to apply.

ACADEMIC CLINICIAN-EDUCATORS PORTLAND, OREGON. Oregon Health & Science University, Division of General Internal Medicine & Geriatrics is seeking quialified candidates for three positions as academic clinician-educators. Two of the positions reside clinically in the outpatient practice, and one in the hospital setting. The hospitalist position has major teaching responsibilities with medicial students and residents. The clinic positions have teaching responsibilities in the residents' continuity practices and medical student preceptorship programs. All successful candidates will join a growing, dynamic Division with strengths in research, education, and clinical practice. Interested candidates should send a cover letter and CV via email to Pam Eckerson, eckerson@ohsu.edu.

ACADEMIC HOSPITALIST POSITIONS. Temple University School of Medicine. The Department of Medicine at Temple University School of Medicine is seeking outstanding clinician/educators to join our faculty in our expanding Hospitalist Medicine group. In addition to providing outstanding medical care to patients, hospitalists will have major responsibility for resident and medical student education. The group will also play an important role in quality and patient safety initiatives at Temple University Hospital. Candidates with previous hospitalist experience are encouraged to apply. Temple University School of Medicine is an Equal Opportunity Affirmative Action Employer and strongly encourages applications from women and minorities. Send CV to: Adriana Monferre, M.D., Director of Hospitalist Medicine, Section of General Internal Medicine, Temple University School of Medicine, 1316 W. Ontario Street, Philadelphia, PA 19140, monferre@temple.edu.

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ASSTISTANT PROFESSOR. Full-time faculty position as Asst Professor (In Residence) in the Division of General Internal Medicine and Health Services Research at UCLA. Position requires M.D. with strong background in independent scholarly work. Teaching requirements include medical students & residents. Interested applicants send CV to: M.F. Shapiro, MD, Chief, UCLA Medicine/GIM, 911 Broxton #101, Los Angeles, CA 90024. UCLA AA/EOE

CLINICIAN-EDUCATOR GERIATRICIAN. positions available with Boston University's Geriatrics Section. Successful applicants will develop new clinical programs at our closely affiliated Quincy Medical Center; participate in our newly awarded Donald W. Reynolds Foundation Comprehensive Geriatric Education Project; and teach in our training programs for medical students, internal medicine residents, Geriatric Medicine, Psychiatry, Dental, and Oncology fellows, and our John A. Hartford Foundation Center of Excellence faculty development program. Fellowship training in Geriatrics with CAQ eligibility/certification and excellence in clinical care/teaching are required. Experience in culturally diverse settings and interest in innovative use of technologies a plus. Please send CV and letter of interest to: Rebecca A. Silliman, MD, PhD, Chief, Geriatrics Section, Boston Medical Center, 88 East Newton Street, Robinson 2, Boston, MA 02118; rsillima@bu.edu.

GIM FACULTY, MEDICAL COLLEGE OF WISCONSIN. The Medical College of Wisconsin Division of General Internal Medicine is seeking additional faculty members at the Assistant or Associate Professor level. Faculty should have a special interest in inpatient ward medicine and/or inpatient consultative medicine in an academic setting. Opportunities for teaching and scholarship exist, and the division has in place a well-established, successful career development program to foster academic skills. Milwaukee is located on the shoreline of Lake Michigan, and offers excellent schools and cultural opportunities. Send CV and letter describing interests to: Ann B. Nattinger, MD, MPH, Chief, Division of General Internal Medicine, Medical College of Wisconsin, 9200 W Wisconsin Avenue, Suite 4200, Milwaukee, Wisconsin 53226, anatting@mcw.edu. EOE M/F/D/V

GENERAL INTERNAL MEDICINE MASTER EDUCATOR FELLOWSHIP AT NEW YORK UNIVERSITY/BELLEVUE. NYU's Division of Primary Care 2-year Fellowship Program has openings for candidates for academic year 2004-2005. Fellows prepare for academic general internal medicine careers through formal training and practical, mentored experience in clinical research and medical education, including courses on research methods, clinical epidemiology, health policy, clinical teaching, curriculum design, leadership, psychosocial medicine, cross-cultural medicine/immigrant health and quality improvement. Fellows will earn a Masters of Medical Education Degree. For inquires: Dr. Mark Schwartz, Mark.Schwartz@nyu.edu. For applications: Cecily Griesser, Cecily.Griesser@med.nyu.edu or 212-263-8895.

GENERAL INTERNIST. Assistant Clinical Professor positions (2) available at the University of California, San Diego, in the Division of General Internal Medicine/Department of Medicine. Full-time clinical practice in internal medicine in an academic managed care setting. Includes some weekend call. Excellent opportunities for teaching and pursuing other primary care/academic interests. Superb benefits package. Salary/rank commensurate with candidate's experience and established UCSD salary scales. California medicine license/eligibility and board certification/eligibility in internal medicine required. Reply to: Paul Gamble, MD, UCSD Medical Center, 200 W. Arbor Drive # 8415, San Diego, CA 92103-8415; 619-543-6275. AA/EOE

SENIOR HEALTH SERVICES RESEARCHER, DEPARTMENT OF HEALTH POLICY.
The Department of Health Policy of the Mount Sinai School of Medicine seeks a highly experienced health services researcher, at the current rank of associate or full professor, with a proven track record of outstanding scholarship and leadership to join a dynamic, multidisciplinary research team. Physician candidates are preferred. The successful candidate will assume an important leadership role in collaborating with other faculty to advance and enhance the Department's research mission. The Department of Health Policy has a strong record of research, primarily in the fields of measuring and improving quality of care, reducing racial and ethnic health care disparities, analyzing arrangements for delivering care, as well as a variety of other topical health policy issues. The Department also serves as a central resource for quality improvement within the Mount Sinai Medical Center. Dr. Mark Chassin, the Department Chairman, is leading a new initiative in the Medical Center which has the explicit aim of establishing unprecedented excellence in patient safety, clinical outcomes, the experiences of patients and families, and the working environment of caregivers. The position may entail 20% or more clinical time. Rank and compensation will be commensurate with qualifications. Review of applications will continue until the position is filled. The Mount Sinai School of Medicine is an equal opportunity and affirmative action employer. Ap-

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ANNOUNCEMENT

Summer Institute on the "Basic Pathways Linking Behavior & Disease"
June 2–5, 2004, Pittsburgh, PA

THE PITTSBURGH MIND-BODY CENTER IS SPONSORING ITS FIFTH ANNUAL SUMMER INSTITUTE. Objectives are to: 1) describe recent advances in understanding the ways in which behavioral factors or biobehavioral processes cause disease or affect pathophysiology, including identification of basic pathways linking health and behavior and sources of complexity inherent in studying them; 2) critically evaluate methodological approaches to the study of behavior and diseases such as cardiovascular disease, cancer, and infectious illnesses; 3) highlight new skills and tools available for building etiological models of disease progression that feature behavioral factors as key components; and 4) integrate conceptual models describing health and behavior relationships across disease types and diverse population subgroups.

Lecturers during the 4-day institute include: Drs. Andrew Baum, Margaret Clark, Sheldon Cohen, Christopher Coe, Martica Hall, Vicki Helgeson, J. Richard Jennings, Thomas W. Kamarck, David S. Krantz, Lewis Kuller, Lynn Martire, Karen A. Matthews, Frank Penedo, Michael F. Scheier, and Richard Schulz.

The institute will be directed toward professionals who have a *limited* background in behavioral medicine. Lectures and workshops will be geared toward individuals at the postdoctoral fellow, resident and/or junior faculty level. Applicants should have their doctorates or completed all doctorate degree requirements.

There is no tuition fee associated with the Institute. Travel stipends will be available to offset expenses. Accommodations are available at the conference site for out-of-town attendees. Please indicate in your application whether you are interested in reserving one of these rooms.

Questions about the content of the 2004 Summer Institute can be sent by E-mail to one of the Institute Co-Directors: Dr. Andrew Baum (**baum@pitt.edu**) or Dr. Karen Matthews (**matthewska@upmc.edu**). For additional details about PMBC, visit **http://www.pghmbc.org**.

Applications are due by ***April 19, 2004***. To apply, send a 2-page biosketch or curriculum vitae, a brief statement on why you want to attend, one letter of recommendation, and contact information (mailing address, phone, fax, and E-mail) to Lori Liller Arnold (**arnoldla@upmc.edu**; fax: 412-246-5333). Team applications from 2–3 researchers at the same institution or institutions near each other will be given special consideration. Early application is encouraged because there is limited space for the institute. Applicants will be notified no later than April 30, 2004 about acceptance.

SGIM
FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

EBM TASK FORCE UPDATE

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materials for the SGIM EBM website which will be launched in March 2004.

The Task Force will be holding two half-day pre-courses at the 2004 SGIM Annual Meeting. These sessions are entitled, "Integrating Evidence into Clinical Decisions" and "Using Evidence-Based Resources in Clinical Practice." We invite interested members to join us at these sessions.

In addition, the Task Force has developed relationships with the publishers of the four EBM databases we use in our workshops and with organizations that will be key to the dissemination of our products. We are in the process of identifying organizations representing other specialties, such as the Alliance for Continuing Medical Education, to assist us with dissemination once we have demonstrated an effective dissemination strategy within internal medicine.

This has been an exciting year for us and we look forward to the next year. Please look to our website to identify opportunities for you to collaborate with us. SGIM

***Editor's Note**—Dr. Straus serves as the current Chair of the Steering Committee of the SGIM EBM Task Force, and Dr. Mangrulkar is the Chair-Elect of the Steering Committee.*

CLASSIFIED ADS

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plicants should email or mail a letter indicating research accomplishments, interests, and experience, a curriculum vitae (including a research grant history), a recent paper or two they judge to be a most significant contribution, and three references whom we may contact to Nina A. Bickell, M.D., M.P.H. or Paul Hebert Ph.D. Assistant Professors of Health Policy, Box 1077; The Mount Sinai School of Medicine; New York, NY 10029-6574; nina.bickell@mssm.edu, paul.hebert@mssm.edu; fax 212-423-2998, telephone 212-659-9567.

TRAINING IN FACULTY DEVELOPMENT. The Stanford Faculty Development Center is currently accepting applications for two month-long, facilitator-training programs. The training prepares faculty to conduct a faculty development course for faculty and residents at their home institutions. (1) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. (2) The Geriatrics in Primary Care course enhances primary care physicians' ability to care for older patients and teach geriatrics. 2004 program dates: Geriatrics in Primary Care (September 7- October 1) Clinical Teaching (October 4–29) Application deadline: June 1, 2004. For information: visit http://sfdc.stanford.edu or contact Georgette Stratos, PhD, gstratos@stanford.edu