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**VA'S QUALITY
ENHANCEMENT
RESEARCH INITIATIVE:
Implementing Research Findings
Into Routine Practice**

John G. Demakis, MD

VA's Quality Enhancement Research Initiative (QUERI) is yielding results that are drawing some attention. Launched in January 1998, QUERI is a data-driven, multi-disciplinary, outcomes-based national quality improvement program designed to assure excellence in all settings where VHA provides care: in-patient, outpatient, and long-term care. Managed by VA's Health Services Research and Development Service (HSR&D), QUERI is operationalized through condition-specific groups located in QUERI Coordinating Centers throughout the country. These Coordinating Centers focus on conditions that are prevalent and/or present a heavy burden to veterans, their families, and to the health care system. QUERI conditions include: Colorectal Cancer, Diabetes, HIV/AIDS, Ischemic Heart Disease, Mental Health, Spinal Cord Injury, Stroke, and Substance Use Disorders. Two more QUERI Centers—one on Chronic Heart Failure and one on Amputations—will be established soon.

In an editorial that recently appeared in the *British Medical Journal*, Jonathan Lomas, Executive Director of the Canadian Health Services Research Foundation, lauded achievements in VA's health care (VHA) system, including "improved diabetes control from 51% to 94% (annual measurement of glycosylated hemo-

globin), screening for cervical cancer from 62% to 93%, and use of B blockers for myocardial infarction at discharge from hospital from 70% to 95%."^{1,2} He went on to praise VHA's success in quality improvement, "Between 1995 and 2000 the Veterans' Affairs healthcare system achieved these remarkable improvements in quality for its more than 3.5 millions users while reducing costs per patient by 25%."^{1,3} These results were achieved by an ambitious VHA-wide organizational transformation to improve quality of care while decreasing costs. The development of the Quality Enhancement Research Initiative is an important part of this effort, and it remains a central component of VA's commitment to evidence-based quality improvement in health care.

QUERI's Six-Step Process

The QUERI program was designed to translate research into optimal patient care and systems improvements by identifying best practices, systematizing their use and providing the ongoing feedback necessary to sustain outcome improvements. Thus, QUERI's six-step process was designed to: 1) identify high-risk/high volume diseases or problems; 2) identify best practices; 3) define existing practice patterns and outcomes across VA and current variation from best practices; 4) iden-

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ACGIM COLUMN

Exploring the Generalist-Subspecialist Interface: The ASP Workforce Committee

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In July 2003, SGIM and ACGIM joined ASP (the Association of Subspecialty Professors). Under the joining arrangement, a name change for ASP will be considered, and a new committee was formed on generalist-subspecialist issues. The ASP Workforce Committee has been constituted, and I have the privilege of co-chairing this vigorous group with Bob Myerburg, chief of Cardiology from Miami. The committee consists of several specialists (cardiology, GI and Rheumatology) and generalists (Jean Kutner from Denver, Gene Oddone from Duke and me.)

The Committee is charged with developing models of chronic illness management, highlighting the roles of generalists and subspecialists. Some of the questions we are trying to answer include, for a short list of specified chronic illnesses:

1. when to refer (from GIM to SSIM)?
2. when to refer back (from SSIM to GIM)?
3. what are the communication issues and methods recommended between GIM and SSIM?
4. are there educational issues for generalists co-managing patients with specialists? how is the education best accomplished?
5. how will specialists deal with health maintenance and screening when they are principle providers?
6. what strategies are recommended for specialists managing patients with multiple chronic illnesses? co-management with a generalist or referral to multiple specialists?
7. what are the workforce implications for GIM and SSIM that result from answering the above questions?
8. which answers to the above are supported by existing data, and which will require new research?

The short list of illnesses includes, but may not be limited to: diabetes, hypertension, CAD, hyperlipidemia, atrial fibrillation, chronic renal disease, rheumatoid arthritis and osteoarthritis, asthma and COPD, CHF, and inflammatory bowel disease.

The committee has had 3 or 4 conference calls to date and it has been extraordinarily collegial and educational as generalists and specialists bring their own perspectives to the table. The answers to the above questions may seem self evident to us in GIM, but I can tell you that they are equally self evident, but with very different responses, to our subspecialist colleagues. The committee is working hard to honor everyone's opinion, to rely upon data, and to form a new basis for discussion and consensus among generalists and specialists.

For each chronic illness, we are using discussion with experts and review of the literature to produce a "grid" of suggested practice patterns for referral and co-management. An example of the work we are producing can be seen on page 8 where the grid for the management of reactive airway disease is included.

Issues

The issues that we are struggling with in the generation of this management pathway include:

- 1) How to bring generalists up to speed with guidelines by NAEP (PEF use, triggers and controller meds in RAD) and the GOLD guidelines (inhaled steroids not first line Rx in COPD);
- 2) proposed models of co-management (how often to see subspecialist vs generalist; a "dynamic equilibrium" depending on disease activity and severity);

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THE TOP TEN HIGHLIGHTS OF THE YEAR

JudyAnn Bigby, MD

Looking back on 2004, I have been thinking about the highlights of my year as SGIM President. There are many, but the top ten are below (in descending order):

10. **Martin Shapiro's presidential address.**
9. **Worrying about my presidential address.**
8. **Monthly emails from Missy McNeil.**

Missy has quite a repertoire of ways to ask about the column that was due yesterday, last week, last.... Perhaps my tardiness in meeting the *Forum* deadlines was simply a way to test Missy's ability to come up with yet another way of asking "Where's your column?" Maybe she actually has only 11 ways of asking and she recycles them with each president. (By the way, Mike tells me he already has ten columns written and ready to go.) Missy, thanks for your patience and your excellent job as editor of *Forum*.

7. **Working with the SGIM staff.**

The staff in the national SGIM office is dedicated and committed to the organization and the values that we embrace. They have mastered the skills needed to work with an organization dominated by volunteers who are ever changing. It seems that someone is always there to answer the phone, whether in the early morning or the late evening. David Karlson works tirelessly to build bridges between SGIM and other internal medicine organizations and to promote the organization and our work on behalf of patient care, education, and research in general internal medicine.

6. **Conference calls.**

Thank goodness for teleconferencing and speakerphones. SGIM council members, committee members, and task force members spend a significant amount of time on lengthy conference calls. Kudos to the meeting leaders who

pull together the agendas and set the tone for bringing people who can't see one another together to try to complete a task. The Council has been committed to attending the monthly meetings and being involved in making important decisions. During the year I had to ask, "Can I get an Amen?" only once when there was complete silence on the other end of the line and I thought everyone must be checking email simultaneously. I think its time for *frequent listener minutes*.

5. **Working with seasoned SGIM leaders.**



We are fortunate to have many seasoned leaders who are still willing to give their time. Lisa Rubenstein, Eric Larson and Sankey Williams are just three of many who have contributed immensely in the last year in very tangible ways. Other seasoned leaders have

given advice when asked (and not asked) and their guidance is much appreciated. We owe outgoing members of the Council recognition for their leadership through some difficult times, including the financial difficulties SGIM experienced. The *Journal of General Internal Medicine* will change editors in July; Eric Bass deserves

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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>

RESEARCH FUNDING CORNER

More NIH-funding for Health Disparities Research

Said A. Ibrahim, MD, MPH

This month's Research Funding Corner highlights a new NIH funding opportunity in health disparities research. Specifically, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) seeks research to understand and mitigate issues of health disparities in high priority diseases such as diabetes, obesity, nutrition-related disorders, hepatitis C, gallbladder disease, H. Pylori infection, sickle cell disease, kidney diseases, and metabolic, gastrointestinal, hepatic, and renal complications from infection with HIV.

This program announcement comes in recognition of the diseases and disorders that disproportionately affect the health of racial and ethnic minority populations in the United States. The announcement cites the evidence that African-Americans, Hispanic Americans, American Indians, Alaska Natives, some Asian Americans, and Native Hawaiians and other Pacific Islanders experience much higher risks and poorer health status than the general population. More specifically, individuals in these groups are at particularly high risk for the development of Type 2 diabetes. Diabetes prevalence rates among American Indians are two to five times those of whites. On average, African-American adults are 1.7 times as likely and Mexican Americans and Puerto Ricans are twice as likely to have the disease as non-Hispanic whites of similar age. Japanese Americans and Samoans have elevated rates of diabetes.

Other areas of significant disparities cited by this program announcement include obesity, end-stage renal disease (ESRD), hepatitis C, HIV/AIDS, gallbladder diseases, peptic ulcer disease, H. Pylori infection, and sickle cell disease. The overall objective of this Program Announcement is to under-

stand and reduce/eliminate health disparities in the development, diagnosis, and treatment of the aforementioned conditions. Research strategies that could meet the objectives of this program may include metabolic, genetic, clinical, and/or epidemiologic studies in representative populations.

Examples of areas of research that not only meet the NIH program goals but also are directly relevant to areas of research interest for SGIM members include:

- ◆ Studies on the impact of medical services for the prevention and

treatment of diabetes, obesity, nutrition-related disorders, hepatitis C, gallbladder diseases, H. Pylori infection, sickle cell disease, kidney diseases, and complications from infection with HIV the in diverse racial/ethnic groups.

- ◆ Studies to better understand racial and ethnic differences in the incidence and prevalence of these diseases and whether there are differences among sub-groups in the rates of progression.

- ◆ Epidemiologic studies to determine

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Partnerships in Caring for Torture Survivors

David Goldberg, MD; Irene Martinez, MD; Mary Fabri, PsyD; and P. Preston Reynolds, MD, PhD

Amidst a global refugee crisis with an estimated 35 million refugees and internally displaced persons, there were over 64,000 applications for asylum filed in the United States in 2002 with over 300,000 cases pending. More important, there are an estimated 500,000 survivors of torture currently living in the US. Among asylum seekers in Chicago in 2002 alone, approximately 30% are torture survivors, from 47 countries.

Torture results in numerous medical and mental health sequelae. Torture severs trust, severely disrupts concentration, and causes symptoms of anxiety and depression. Injuries sustained during torture often result in chronic physical symptoms such as organic sexual dysfunction and irritable bowel disease. The physical and psychological trauma of torture also leads to psychosomatic symptoms, including headaches and sleep disturbances.

Torture survivors seeking asylum in this country face a number of unique problems accessing appropriate medical

care because of significant language barriers and a lack of health insurance. When they turn to public systems or emergency rooms for care they find crowded waiting rooms and long waiting times that are difficult to tolerate because of the prolonged psychological effects of torture. They may see police and shackled prisoners that stimulate intrusive memories of their torture experience, and may see providers without the benefit of interpreter services for the myriad of languages spoken. Furthermore, survivors of torture seldom disclose voluntarily their trauma history and thus, their complaints often are misinterpreted as those of the "worried well." These encounters rarely lead to satisfactory outcomes where medical needs are met.

In response to this situation, a movement for specialized torture treatment has emerged. The National Consortium of Torture Treatment Centers lists 26 affiliated treatment

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MOUNTAIN WEST REGIONAL MEETING UPDATE

Ellen Yee, MD and Elizabeth Lawrence, MD

The Mountain West Region of SGIM held its 2004 meeting from February 13th through the 15th in Santa Fe, New Mexico. The historic Bishop's Lodge, set in the foothills of the beautiful Sangre de Cristo Mountains, served as the setting for this unique three-day meeting. Twenty-six SGIM attendees from Arizona, Colorado, and New Mexico gathered to learn new concepts, exchange ideas, network, meet old friends, make new friends, and enjoy the spectacular environs of Santa Fe. Elizabeth Lawrence, MD, Program Chair, was pleased at the enthusiastic response to the call for abstracts and vignettes submissions. The Mountain West Region had a 200 percent increase in the numbers of abstract submissions and a 100 percent increase in the numbers of posters and clinical vignettes presentations. Diverse educational topics were presented on dietary supplements in obesity (Priya Radakrishnan, MD), anticoagulation (David Garcia, MD), and antibiotic resistance (Barbara Murray, MD).

Steve Obeler, MD and Sylvia Obeler, MD presented their stunning slide show showcasing the beauty of nature in the Southwest. The Obelers' objective was to remind us of the importance of enjoying activities outside of the medical field and to share with us a humanistic side to medicine. This was an extremely successful integration of the Art of Medicine into the program, and the presentation was greatly appreciated by the audience.

Michael Barry, MD, MPH, and SGIM President-Elect, joined us from Massachusetts to lead a stimulating discussion on patient decision-making in general and as it relates to prostate cancer screening in particular. This was followed by a panel discussion with Jack Pierce, MD, Allan Prochazka, MD, and Tom Denberg, MD.

During our business meeting, several awards were presented to faculty and students:

Richard Hoffman MD, MPH, was recognized as the Mountain West Clinician Investigator of the year.

Elizabeth Lawrence, MD, was the recipient of the Mountain West Clinician Educator of the year.

Michael Kreur, medical student, won the associates competition with his presentation "Tension Headache With a

Surprising Etiology: A Case of Neurocysticercosis."

Jack Pierce, MD, was noted to have won the national Elnora Rhodes Service Award in 2003.

Bruce Horowitz, MD, completed his two-year term as President of the Mountain West Region. His service and leadership were greatly appreciated. The new president of the Mountain West Region is Tom Denberg, MD. *SGIM*

International Medical Graduates & SGIM—Partnership for Success

Shakaib Rehman, MD

Coming from all over the world, International Medical Graduates (IMGs) play an integral role in providing medical services in the United States. Currently representing 25 percent of all physicians nationwide, IMGs provide up to 43 percent of health care services in several states. There are many IMG dependant residency programs, often in internal medicine. There are more IMGs than USMGs practicing in needy rural counties of many states, and in poor areas in a number of major cities. There is no forum where IMGs can meet and discuss their problems and work on solutions to not only help IMGs to provide a meaningful contribution to the US health care but also to identify areas where organizations/government could develop plans to utilize IMGs services more efficiently.

SGIM could play a unique role, as its membership comprises of a large proportion of IMGs. In the 2003 National Meeting in Vancouver, British Columbia, the IMG Interest group met for the first time and identified the areas

where IMG would need help. We also discussed the current and future role of IMGs in health care delivery, medical education, and research.

Mentoring in research and academics and personal and social adjustment will be the main focus in this year's meeting in Chicago. Interest group participants will brainstorm strengths and problems faced by IMGs and how SGIM could help and provide a platform to raise the IMG voice. We'll make recommendations to the leadership of SGIM and policy makers.

We are proud to have Dr. Dennis Cope, Chairman and Professor at UCLA-Olive View Program and Dr. Richard Frankel, Professor and Senior Scientist, Regenstrief Institute for Health Care, Indiana University as our keynote speakers. Elizabeth Kachur, PHD, an educational specialist will provide assistance for issues surrounding academics. Drs. Gustavo Heudebert (Associate Professor & Program Director, UAB), Ali Rahimi (Associate Program Director at MCG), Tariq Malik

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Collaborative Centers for Research and Education in the Care of Older Adults: Oregon Health Sciences University and the University of Virginia

Elizabeth Eckstrom, MD, MPH; Judith L. Bowen, MD; Carol Joseph, MD; Sima Desai, MD; Marnie Ririe, MD; and Andrew Wolf, MD

In this fourth in a six-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. Through funding from the John A. Hartford Foundation, SGIM is sponsoring ten Collaborative Centers for two years to develop new collaborative programs between general medicine and geriatrics in education and research. These articles describe 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 education and research.

Oregon Health & Science University Collaborative Center

Oregon Health & Science University, the Portland VA Medical Center, and Legacy Health System are participating in a city-wide collaborative Center funded by a Hartford Foundation grant to SGIM. We plan to assist academic general internists in their efforts to improve care to older adults, and to teach geriatric medicine in all clinical settings. The first step will be a faculty development workshop for general internists at all our institutions.

To prepare for the workshop we conducted structured focus groups with internists and geriatricians. We asked the internists to tell us their greatest areas of frustration and challenge in caring for older adults. They recognized knowledge and skill gaps in all the “geriatric syndromes,” but also reported high levels of frustration compared to geriatricians caring for similar patients. Internists were more focused on the medical issues of patients and less skilled in addressing the psychosocial

context of caring for older adults. In hospital settings, general internists find care transitions challenging. In ambulatory settings, they reported having less time than geriatricians to address psychosocial issues when caring for older adults.

From the focus group information, we identified the following content areas for the workshops: 1) cognitive impairment (dementia, delirium, cognitive assessment, capacity to make decisions, and depression); 2) polypharmacy; 3) functional assessment (falls/mobility, incontinence); 4) facilitating care transitions; and 5) behavioral issues related to dementia, depression, and delirium. Each workshop will include didactic presentations by geriatric experts, interactive group discussion with cases, and small group role-plays using trained “standardized learners” who will present clinical cases to participants. Participants will have the opportunity to recognize geriatric “teaching moments” and apply learning from the didactic sessions to these teaching situations.

Each of our institutions has identified four “Star-Educators” (two inpatient and two outpatient faculty) who will participate in our initial workshop, and then help teach and disseminate the information via future workshops and other methods at each institution. We will use “academic detailing” to accomplish the task of providing tools for teaching, regular updates, and to alert core teaching faculty to the project. We will also design and construct a web site to assist Star Educators in sharing ideas and challenges, and to post geriatric tools and teaching cases for all faculty participants.

Our project’s primary aim is to

improve the geriatric knowledge, skills, and attitudes of our academic general internists such that our current and next generation residents will learn a high quality, efficient approach to geriatric care. We will measure faculty knowledge and self-assessed confidence in recognizing and acting upon geriatric teaching moments and internal medicine residents’ perceptions that the geriatric teaching “culture” has been positively influenced by our project. Additionally, we will assess our participants’ commitment to changing their approach to caring for older adults and to responding to geriatric teaching moments. If successful, we anticipate disseminating the workshop at a national level.

University of Virginia

The centerpiece of the Hartford-SGIM Center for Collaboration in General Medicine and Geriatrics (C2G2) at the University of Virginia (UVA) is a quality improvement project to improve geriatric prescribing among general internal medicine residents and faculty. Recent studies have highlighted the high prevalence of adverse drug events in ambulatory elderly populations.^{1,2} Given the burgeoning of the U.S. elderly population, better preparation of internists to prescribe appropriately for elderly patients will be critical. UVA’s C2G2 project attempts to address this need through the following activities:

- ◆ A focus group and survey of residents was conducted to assess self-perceived learners’ needs.
- ◆ A comprehensive review of medication prescribing at UVA’s resident-faculty internal medicine practice is being conducted by the multidisciplinary C2G2 team with

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VA'S RESEARCH INITIATIVE

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tify and implement interventions to promote best practices; 5) assure that the evidence-based quality improvement tools and findings get to the bedside and the policy table quickly; and 6) evaluate the impact of these tools and findings on patient outcomes and system wide improvement.

QUERI Impacts Veterans' Health

QUERI groups are working to implement interventions that promote best practices and the use of quality improvement tools and research findings in real situations and at all system levels. Examples thus far include:

- ◆ Increasing the number of veterans who received care for opioid addiction in an opioid agonist therapy (OAT) clinic by 19%, and increasing compliance with methadone dosing recommendations in eight VA OAT clinics across the country.
- ◆ Doubling influenza and pneumococcal vaccination rates in veterans with SCI at all 23 SCI centers nation-wide through several interventions such as computerized clinical reminders to document vaccine delivery and patient reminders that included educational materials.⁴
- ◆ Increasing optimal blood pressure control among veterans with diabetes (< 140/90) from 43% in FY99 to 58% in FY02.

In addition, QUERI work has improved outcomes regarding decreased expenditures for antipsychotic drugs for veterans with schizophrenia in one VA healthcare network, overall reductions in LDL cholesterol levels in veterans with ischemic heart disease that translates into a commensurate reduction of approximately 75 major coronary events in another VA healthcare network, and improved management of cardiovascular and cerebrovascular conditions in HIV-infected patients who are on long-term highly active antiretroviral drug therapy.

QUERI was developed not only to make it easier to investigate what works and does not work when trying to link

evidence and practice, but also to study the conditions that foster sustained, measurable improvement at the national, regional, local, and individual levels. Because of these system-wide goals, QUERI's success is based on a close partnership with all levels of the VA health care system. For example, QUERI works in close cooperation with VA's offices of Quality and Performance, Patient Care Services, and Informatics. In addition, QUERI fosters collaborations with many organizations outside VA, such as the Agency for Healthcare and Research (AHRQ), the National Cancer Institute (NCI), the Centers for Disease Control (CDC), and the Department of Defense (DoD).

As this program expands, we welcome new investigators and collaborators who are committed to evidence-based quality improvement in health care. More information about the QUERI program, including research opportunities, and links to individual QUERI program sites and projects can be found at <http://www.hsrd.research.va.gov/research/queri/>. **SGIM**

RESEARCH FUNDING CORNER

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the rates of microvascular (nephropathy, retinopathy, and neuropathy) and macrovascular (cardiovascular disease and stroke) diabetic complications in appropriate representative samples of contemporary populations; studies to compare the contribution of glycemia versus other risk factors (e.g., smoking, dyslipidemia, body composition, blood pressure, markers of inflammation) in the development of microvascular and macrovascular disease in patients with diabetes; studies of how the treatment of these factors may influence rates of development of complications in different racial/ethnic groups; and studies to investigate environmental or behavioral factors, such as medical care, lifestyle,

Editor's Note—Dr. John G. Demakis is the Director of the VA Health Services Research and Development Service.

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and socioeconomic status that may contribute to risk for development and progression of obesity or diabetes and its complications.

- ◆ Studies that examine the reasons for the racial and ethnic disparities in the incidence and prevalence rates of ESRD.
- ◆ Studies to further explore ethnic differences in prevalence of gallbladder disease and disparities in health care access and utilization.

This program announcement will use the NIH research project R01 and R21 award mechanisms. Detailed information on this program announcement can be found at <http://grants1.nih.gov/grants/guide/pa-files/PA-04-074.html>. **SGIM**

GENERALIST-SUBSPECIALIST INTERFACE

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...we have agreed that what is best for the patients will be what guides our recommendations!

3) communication issues (esp. generalist to subspecialist during co-mgmt).

The literature on COPD and RAD was a tough read for me; many articles, all quite consistent, show better outcomes (hospitalizations and QOL), and more adherence to guidelines (e.g. inhaled steroid use in RAD) by specialists over generalists. A recent article on a study

supported by AHRQ (Ma and Stafford, *J Allergy Clin Immunol*, 2003;112:633-35) comes to a similar conclusion. I am glad, therefore, that the workforce committee is doing its work, bringing generalists and specialists closer together for the benefit of all of our patients. Turf battles are not allowed—we have agreed that what is best for the patients will be what guides our recommendations!

Ultimately, our goal is to seek support from AHRQ for a consensus conference that will define the state of the practice for several chronic illnesses,

and spark research in other illnesses where less is known. For now, the committee's work will be highlighted in October of 2004 at the upcoming Academic Internal Medicine week, where several national organizations are meeting concurrently in Nashville. It will be an exciting time to share our preliminary efforts with the academic IM community.

If you are interested in working with the workforce committee as a consultant in one of our targeted areas, or if you know of another area in which we could be working and you'd like to join Jean, Gene and me, please let us know! Write me at mxl@medicine.wisc.edu. **SGIM**

Clinical Setting	Primary Care MD	Pulmonologist/Allergist
Mild RAD	Ongoing management Refer if unstable, uncertain Dx (PIE), adherence pblms	Available for consultation
Mod-severe RAD (prolonged oral steroids, frequent exacerbations, hx near fatal asthma)	co-manage with allergist or pulmonologist	Principle care for pts with severe RAD; co-manage with PC for pts with complex RAD (e.g. SI/GERD); may refer back to PC if stable, mild-mod sx.
Mild-moderate COPD	ongoing mgmt; refer if unstable, uncertain Dx (e.g. ILD, bronchiectasis)	Available for consultation
Severe COPD (pCO ₂ > 60, FEV ₁ < 1, cor pulmonale, O ₂ dependent, frequent exacerbations)	general medical care possible co-mgmt of stable but severe cases	Principle care of COPD; if stable, can co-manage with PC.

*Based upon expert opinion by pulmonologists (3) and allergist (1), literature review with key references: Wu AW et al. Quality of care and outcomes of adults with asthma treated by specialists and generalists in managed care. *Arch Intern Med*. 2001;161:2554-60; Vollmer WM, et al. Specialty differences in management of asthma. *Arch Intern Med*. 1997;157:1201-08; Li JT, et al. Consultation for asthma: results of a generalist survey. *Ann Allergy Asthma Immunol*. 1999;83:203-06; Buist AS. Guidelines for management of COPD. *Resp Med*. 2002;96 (Suppl C):S11-16.

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congratulations for leading JGIM for five years, maintaining its excellence, and producing a record number of special issues.

4. Working with new SGIM leaders.

New and emerging leaders brought new ideas and vitality to the organization. Valerie Stone, Tom Gallagher, Eric Holmboe, Nancy Keating, and Redonda Miller involved new SGIM members in their roles as committee or task force chairs. They have made significant and tangible contributions this year. SGIM will benefit from their vision for years to come.

3. The generosity of SGIM members.

The volunteer nature of SGIM has never been more apparent. Hundreds of members contribute every day as active members of committees and work groups. Others contribute by writing for the *Forum* or by submitting their work to JGIM. Many volunteer their time as mentors for the long distance mentoring program. Regional meetings noted record-breaking attendance this year. I had the privilege of attending two regional meetings and observing first hand how the generosity of a few bubbles over to others who in turn contribute to the regional effort. I am hopeful that the *Make a Difference Campaign* will reflect this spirit of giving. Thanks to all who have given in so many ways.

2. Promoting general internal medicine.

This past year every internal medicine organization has been occupied with how to “revitalize” internal medicine. It has been a challenge to understand exactly what the problem is. Internal medicine is like the elephant the four blind men try to describe. Each understands what an elephant is from his limited understanding of what he can feel without being able to see the whole. I started the year thinking that as a generalist, I understood the challenges facing the whole of internal medicine but I have learned more than I ever

expected. Understanding more about the challenges facing subspecialists has made me a better general internist for my patients.

I also have a much stronger opinion about why general internal medicine is valuable and why SGIM must continue to promote its role in the care of patients, education, and research. Long live SGIM!

1. Serving SGIM.

The chair of four or five different SGIM nominating committees asked me to run for SGIM president before I finally said yes. I was worried about the time commitment and whether I could shape an agenda consistent with both SGIM's core mission and the emphasis of my eclectic career in general internal medicine. The challenges for SGIM are

Hundreds of members contribute every day as active members of committees and work groups.

numerous and diverse because that is the nature of generalism. I am a generalist because I accept the challenge of trying to understand the whole and can't limit myself to one part of the “elephant.” What the four blind men don't understand is that there is a fifth blind person who has taken the time to walk around and on top of the whole elephant and has a pretty good picture of what an elephant looks like. Serving as President of SGIM has been a privilege. **SGIM**

PARTNERSHIPS IN CARING

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Centers in 24 cities. They have developed models of care including multi-disciplinary health services that integrate interpreters into all levels of care. The Centers often have cooperative relationships with community-based legal, social service, and educational organizations, and with human rights organizations such as Physicians for Human Rights.

Physicians who are attuned to the special needs of torture survivors can have an important role in uncovering the history, providing safe and sensitive medical care, and referring survivors to one of these Centers. General internists can play a pivotal role in helping asylum seekers by documenting the medical consequences of torture for the immigration courts. Asylum seekers who are screened by these Centers, assisted

Asylum seekers who are screened by these Centers, assisted by attorneys, and evaluated by physicians have a 90% likelihood of being granted asylum.

by attorneys, and evaluated by physicians have a 90% likelihood of being granted asylum.

To learn more about the effects of torture, the torture treatment movement, and medical/forensic evaluations, we invite you to the SGIM National Meeting Pre-Course, Human Rights in Clinical Practice to be held at the nationally renowned community based torture treatment center, the Marjorie Kovler Center of Heartland Alliance. **SGIM**

COLLABORATIVE CENTERS

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- representation from general internal medicine, geriatrics, pharmacy, and the internal medicine residency. The review examines appropriateness of medication selection (based on the recently updated Beers list of potentially inappropriate medications), appropriateness of dosing, potential drug-drug and drug-disease interactions, and polypharmacy.³ The review also looks for discrepancies between charted prescriptions and those actually filled by patients.
- ◆ Individualized feedback will be provided to residents and faculty based on the medication review, and the impact on prescribing practices and documentation will be assessed through a follow-up review.
 - ◆ An electronic prescription-writing program is being implemented, and its impact on geriatric prescribing is being evaluated.
 - ◆ Results of the resident focus group and survey are being used to inform a revised geriatric prescribing curriculum for PGY-1 residents.
 - ◆ A home visit program for PGY-2 and PGY-3 internal medicine residents being implemented this spring features an in-depth examination of elderly patients' medication experience. Following a semi-structured interview outline developed by the C2G2 team, residents will travel in pairs to the homes of elderly patients and explore how patients are taking their medications, their understanding of medication purpose, dosing, and perceived therapeutic and adverse effects. Cohorts of residents will be debriefed by C2G2 team members, thereby gaining a broader appreciation of the issues that arise in prescribing for the elderly.
- In addition to the geriatric prescribing focus, UVA's C2G2 activities include:
- ◆ Integrating a geriatrician into outpatient morning report and assessing its impact.
 - ◆ Revamping the geriatric rotation for internal medicine residents to include

more primary care and community-based geriatrics experiences, so as to better prepare general internist to practice geriatrics.

- ◆ Implementing a joint general internal medicine-geriatrics research conference to foster greater research collaboration between the two disciplines. **SGIM**

Editor's Note—Drs. Eckstrom, Bowen, Joseph, Desai, and Ririe are affiliated with Oregon Health Sciences University. Dr. Wolf is affiliated with the University of Virginia. Brent Williams serves as the series editor for the Collaborative Centers.

PARTNERSHIP FOR SUCCESS

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(Associate Professor, Mount Sinai Medical School), Chiagozie Nwasuruba (Associate Professor at Univ of Texas),

and Tariq Shafi (Assistant Professor, Wayne State University) will help in mentoring and other issues. **SGIM**

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**— Director —
General Internal Medicine**

Denver Health (DH) and the Department of Medicine, University of Colorado Health Sciences Center (UCHSC), are seeking candidates for Director of the Division of General Internal Medicine at DH. DH is the major safety net institution for Colorado and a model integrated health care system which includes the 911 system, an acute care hospital, neighborhood health centers, school-based clinics, correctional care, an HMO, and the regional poison and drug center. This is an academic position with expected appointment at the rank of Associate Professor or Professor. The Director has responsibility for outpatient based general internal medicine, in a community health setting as well as for developing strong student and resident teaching programs. Opportunities include outpatient based research as well as direction and development of faculty and program development. Denver Health is an equal opportunity employer.

Send curriculum vitae and a letter of interest to:
Denver Health
777 Bannock Street, MC 4000
Denver, CO 80204



E-mail address: **Stuart.Linas@DHHA.org**

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.sгим.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 MEDICAL DIRECTOR, BAYSTATE MEDICAL CENTER SPRINGFIELD, MASSACHUSETTS. Baystate Medical Center (BMC) seeks an outstanding academic physician to be Medical Director of High Street Health Center, the medical center's south campus. HSHC has a \$3 million annual budget and over 30,000 adult patient visits each year. It serves as the ambulatory teaching site of Baystate's Medicine Residency Program with 55 residents, 8 clinician-educators, 3 nurse practitioners, and many subspecialty programs. Applicants must be ABIM certified and qualified for faculty appointment at the Assistant/Associate Professor level. The successful candidate will have demonstrated excellence in clinical care and medical education, experience in clinical practice management, and the skills to expand academic opportunities within the Department of Medicine. Baystate Health System is one of New England's largest integrated healthcare delivery systems. BMC is the health system's flagship hospital, affiliated with Tufts University School of Medicine, with 650 beds, a new basic science research facility, 3 community health centers, and training programs in many specialties and subspecialties. Springfield is located in the scenic Connecticut River Valley at the foothills of the Berkshires, with convenient access to the coast, all-season recreation, and to metropolitan Boston and New York. The area is culturally diverse, with numerous universities and colleges. Interested applicants should submit a CV and cover letter to: David N. Rose, MD, Chief, Division of General, Medicine & Geriatrics, c/o Claudia Roberts RN, Baystate Medical Center, 759 Chestnut Street, Springfield, MA, 01199. Fax: (413) 794-3325. Email: Claudia.Roberts@bhs.org. EOE/AA

CLINICIAN-EDUCATOR FACULTY POSITION - Division of General Internal Medicine
The Division of General Internal Medicine, Department of Medicine at the University of Colorado Health Sciences Center is seeking a clinician-educator at the Instructor level to begin approximately July 1, 2004. Candidates should be board certified or board-eligible in internal medicine and interested in a career as a clinician, practicing and teaching general internal medicine. The physician will practice nine half days, with the opportunity for one half-day attending for primary care residents' clinical education. The physician will practice at the University Medicine Clinics in Denver. Starting salary is commensurate with experience, with

opportunity for additional compensation based on clinical earnings. Teaching activities include attending one month annually on the general medical inpatient services, teaching in the housestaff and/or medical student ambulatory care program, participating in weekly GIM clinical conferences and Medical Grand Rounds. The faculty share the responsibilities for night, weekend, and vacation coverage with other members of the group practice and will participate in decisions regarding the practice operation. These clinician-educators may collaborate with other faculty in clinical research projects, but are not expected to be clinician-researchers. Review of applications will start April 10, 2004 and commence until the positions are filled. Contact: Jean S. Kutner, M.D., attn: Kathryn Gray Acting Head, Division of General Internal Medicine, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Campus Box B180, Denver, Colorado 80262, Fax 303-372-9082 or e-mail at Kathryn.Gray@UCHSC.edu. University of Colorado Health Sciences Center is committed to diversity and equality in education and employment.

HICKLIN CHAIR. The Department of Medicine at the University of Missouri—Kansas City School of Medicine is seeking an individual to serve as the Vice-Chair for Research and Section Chief of the Division of General Internal Medicine. This individual would occupy the Merl and Muriel Hicklin/Missouri Endowed Chair at the University of Missouri—Kansas City School of Medicine. This individual must have a passion for teaching, health care

delivery, and outcomes research. This individual should be an accomplished investigator in outcomes research in healthcare delivery. This individual should be an effective leader to the Section of General Internal Medicine that is central to the educationally innovative environment at UMKC. This individual should be an effective mentor to junior faculty in the development of outcomes research. This individual should foster collaboration with other academic divisions, sister institutions within UMKC, and local public health organizations. The Department of Medicine is proud of its diverse faculty, and is an equal opportunity employer. We welcome applications from female and minority applicants. Applicants should send a curriculum vitae and the names and addresses of three references to: George Reisz, MD, Chair, Hicklin Chair Search Committee, Department of Medicine, Truman Medical Center, 2301 Holmes Street, Kansas City, MO 64108. UMKC is a strong public research university living the values of Education First, Discovery and Innovation; Integrity and Accountability; Diversity, Inclusiveness and Respect; and Energized collaborative Communities. More about UMKC is at umkc.edu/thevision. The University of Missouri-Kansas City is an equal opportunity employer.

INTERNISTS. Forsyth Medical Group has openings for BE/BC internists to join our growing practices in the Winston-Salem area. We offer a competitive salary based on credentials and experience,

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Hospice Medical Director



Hospice of Kankakee Valley, conveniently located 60 miles south of Chicago on the scenic Kankakee River, has provided excellence in end-of-life care to thousands of Kankakee River Valley patients and their families for the past 20 years. We are expanding our services and seeking a full time **Medical Director** with a strong interest in palliative care and a wholistic, patient/family focus. IL license to practice medicine and board certification in an ABMS specialty required. Board certification in Hospice and Palliative Medicine and EPEC training preferred or willingness to obtain these certifications upon acceptance of the position. We are seeking a Medical Director to collaborate with our dedicated interdisciplinary team and attending physicians. Excellent communication skills and a desire to champion hospice and palliative care and promote Hospice of Kankakee Valley required. Full benefits package available.

Please submit resume to:
Hospice of Kankakee Valley
Dotty Lagesse, Executive Director
1015 N Fifth Avenue, Ste 5
Kankakee, IL 60901

PHONE: (815) 936-3370
FAX: (815) 936-3375 fax
E-MAIL: hkv_lagessed@sbcglobal.net

SGIM
FORUM

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CLASSIFIED ADS

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plus an opportunity to earn an incentive bonus, as well as an excellent benefits package. Forsyth Medical Group is part of North Carolina's largest integrated healthcare system and is affiliated with Forsyth Medical Center, a 905-bed tertiary care

center. Located within 2 hours of the mountains and 4 hours of the beach, Winston-Salem is a family-oriented community with many cultural and athletic opportunities in the Piedmont Triad of NC. For immediate considerations, send CV to

mjdavis@novanthealth.org; or mail to Mimi Davis, Forsyth Medical Group, 2085 Frontis Plaza Blvd., Winston-Salem, NC 27103 or Fax to 336/277-9164.

Faculty Internist – General Medicine Unit

The Unity Health System in Rochester, NY, is seeking a BC/BE internist to join the core faculty teaching unit of its outstanding 37 resident Internal Medicine Program. A commitment to medical education is essential; duties will include general medicine primary care faculty practice and precepting, as well as other teaching responsibilities. Unity's Park Ridge Hospital is a suburban, 208 bed, community hospital with excellent facilities, quality care, and a collegial atmosphere. Excellent compensation package. Unity is a major teaching affiliate of the University of Rochester School of Medicine and Dentistry.

Send resume to:
James M. Haley, MD; Chairman
Department of Medicine, Unity Health System
1555 Long Pond Road
Rochester, NY 14626
FAX: 585-723-7834
